**S and B Chiropractic and Rehab, INC**

**14523 Bruce B Downs, Ste 405, Tampa, Florida 33613**

**(813)343-3868**

General Patient Information

First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_ SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Initial Visit\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender: \_\_\_\_Female Male\_\_\_\_ Marital Status ( S M W D ) DOA: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_ Driver License #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alternate #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**For Office Use Only:**

Insurance Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Adjuster (name ): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Adjuster Ph#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Ext# \_\_\_\_\_\_\_\_ Adjuster FX# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Benefits: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IRREVOCABLE ASSIGNMENT OF BENEFITS**

**AUTHORIZATION TO PROVIDE COPY OF UPDATED PIP PAYOUT SHEET AND**

**RESERVE THE RIGHT TO RESERVE MONIES IN ESCROW FOR BILLS DISPUTED**

**PRINT PATIENT NAME:**

I, the undersigned patient hereby assign the rights and benefits of insurance to the applicable personal injury protection, medical payments, and other insurance to **S and B Chiropractic and Rehab, INC**  (“Provider”), for services and supplies rendered for treatment of personal injuries sustained in any accident/incident, including but not limited to the accident/incident of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Date of accident/incident) to the undersigned patient and covered by Personal Injury Protection (PIP) Coverage or other insurance. I agree to pay any applicable deductible or co-payment not covered by the PIP or other insurance coverage. I authorize the Provider to release medical information as required.

This assignment includes but is not limited to all rights to collect benefits directly from the insurance company for services that I have received and all rights to proceed against the insurance company obligated to provide benefits in any action including legal suits for any reason the company fails to make payment to which I am due. As part of this assignment I authorize Provider to sign my name as an endorsement on any check made payable to myself and Provider for services or supplies rendered. This assignment also includes the right to collect payment for the reasonable costs for copying and mailing records. This assignment also includes any right to recover attorney’s fees and costs for such action brought by the Provider as patient’s assignee. I understand and agree that the attorney selected may be different than the attorney handling my personal injury/bodily injury claim or case.

I hereby instruct the insurance carrier that in the event the subject benefits are disputed for any reason, that the amount of benefits claimed is to be set aside and not disbursed until the dispute is resolved. As part of this assignment of benefits, I further instruct the insurance carrier to notify the Provider immediately after any dispute as to the payment so that it may preserve and exercise its legal rights. Also, in addition to notifying me and my legal representative, I instruct the insurance carrier to immediately notify the Provider of any scheduled examinations under oath or independent medical examinations. I authorize and instruct the insurance carrier to provide to Provider upon request any and all documents in my file, including but not limited to an up-to-date and unredacted and complete payout register and all medical records. I understand that any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement containing any false, incomplete, or misleading information is guilty of a felony of the third degree. I have read the information herein and it is true to the best of my knowledge and belief.

x\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_            \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature      Date

x\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Authorized Agent Representative Date

**Assignment of Benefits / Policy Rights**

PATIENT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_the undersigned patient hereby Assign the rights and benefits of insurance of the applicable personal injury protection, medical payments, and/or other insurance to **S and B Chiropractic and Rehab, INC**

for services and/or supplies rendered for treatment of personal injuries sustained in the incidents of date of

(date of occurrence) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to the undersigned patient and covered by Personal Injury Protection (P.I.P.) coverage or other insurance coverage under (insured’s name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ in accordance with Florida Statue §627.735(5). The undersigned agrees to pay any applicable deductible or co-payment by the P.I.P. or the insurance coverage. I have read the information herein and it is true to the best of my knowledge and belief.

The assignment includes, but is not limited to, all rights to collect benefits directly from insurance company for services that I have received all rights to proceed against the insurance company obligated provide benefits in any action including legal suit if for any reason the insurance fails to make payments of benefits which I am due. Specifically, this assignment includes the right to collect payment for the reasonable cost with copying and mailing records to the insurer at the insurers in accordance with Florida Statue §627.736(6). This assignment also includes any right to recover attorney’s fee and costs for such action brought by the provider as patient’s assignee. I agree that to **S and B Chiropractic and Rehab, INC** may select any attorney handling my personal injury/bodily injury claim or case.

As part of this assignment of rights and benefits, which only becomes binding upon the insurance carrier upon their receipt of said assignment after having been executed and dated by the health care provider, I hereby instruct the insurance carrier that in the event the subject medical benefits are disputed for any reason, including medical, reasonable, and/or necessity, that the amount of benefits claimed by to **S and B Chiropractic and Rehab, INC** is to be set aside and not disbursed until the dispute is resolved. As part of this assignment of rights and benefits, I further instruct the insurance carrier to notify the provider immediately of any disputes to payment so that he/she/it may exercise their legal rights. I understand that any person who knowingly and intend to injure, defraud or deceive any insurance company files a statement containing any false, incomplete, or misleading information is guilty of a felony of a third degree. I have read the information herein and it is true to the best of my knowledge and belief.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Signature Claim# Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_: Provider

The undersigned on behalf of **S and B Chiropractic and Rehab, INC**, hereby accepts assignment of the insurance rights and benefits for the services rendered to (Patient’s Name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and to be paid directly to **S and B Chiropractic and Rehab, INC**, under (Insured’s Name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Personal Injury Protection (P.I.P.) or other insurance coverage with (Insurance Company’s Name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and in accordance with Florida Statue §627.736 ct. seq. (5).

**S and B Chiropractic and Rehab, INC:**

By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_             \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  81-4802951

                Authorized Agent/Representative                             Date                                              E.I.N.#

**PRIVACY PRACTICES ACKNOWLEDGMENT**

https://lh4.googleusercontent.com/4zFLEs5gtaI-M7u7-_7Yz9EUVoBT2XcMFwmAqheRGpql1PfFNsxcXBQpImDjrf95Hg7xsHz2umMeFnEabbZF4yFXkflTuwx87nU-o6ZplGmAFQ1sPMk8NLBNaEVA-BmxYQ

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B. \_\_\_\_\_ /\_\_\_\_\_/\_\_\_\_\_

    \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_                                 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature    Date

**DISCLOSURE & CONSENT**

**CHIROPRACTIC ADJUSTMENTS AND CARE**

***TO THE PATIENT:****You have a right as a patient to be informed about your condition and the recommended chiropractic adjustments and other chiropractic procedures to be used so that you may make the decision whether or not to undergo the procedure after knowing the potential risks and hazards involved.  This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.*

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or the patient named below, for whom I am legally responsible) by the Doctor of Chiropractic named below and/or other licensed Doctors of Chiropractic or those working at the clinic or office who now or in the future treat me while employed by, working or associated with, or serving as a backup for the Doctor of Chiropractic named below.

I have had the opportunity to discuss with the Doctor of Chiropractic named below, my diagnosis, the nature and purpose of chiropractic adjustments and other procedures and alternatives.

I understand and I am informed that, in the practice of chiropractic there are some risks to exam and treatment including, but not limited to, fractures, disc injuries, strokes, dislocations, sprains and increased symptoms and pain or no improvement of symptoms or pain.  I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interest.  I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment.

I have read, or have had read to me, the above consent.  I have also had an opportunity to ask questions, and all my questions have been answered fully and satisfactorily.  By signing below, I consent to the treatment plan.  I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

*To be completed by the patient:           To be completed by the patient’s representative, if necessary, e.g.,*

*if the patient is a minor or physically or legally incapacitated:*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

print name           \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

           print name of patient

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

signature of patient            \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

           print name of patient’s representative

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date           \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

           signature of patient’s representative

           as:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

            relationship or authority of patient’s representative

            \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

            Date

*To be completed by doctor or staff*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_         \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

witness to patient’s signature            Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_         \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Translated by            Date

**DISCLOSURE OF PROTECTED HEALTH INFORMATION**

**PH#(813)343-3868 FX#(813)43-2434**

**Email; sandbchiro17@gmail.com**

Information may be disclosed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tel: (       ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    Fax: (        ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Information to be disclosed to:    **S and B Chiropractic and Rehab, INC**

**PATIENT WHOSE PROTECTED HEALTH INFORMATION IS TO BE DISCLOSED**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security: #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    Date of Accident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INFORMATION TO BE DISCLOSED**

|  |  |  |  |
| --- | --- | --- | --- |
|  | All Medical Records  (Please Mail/Fax) |  | X-rays/CT Scan/MRI/Ultrasound  (PLEASE FAX RESULTS) |
|  | Patient was involved in a prior MVA on or approximately |  | Final??? Dictated Report |
|  | Progress Notes/Consultation |  | Other: Any Imaging |

**EXPIRATION DATE:** This authorization will expire (insert date or event) 2 years from the above referenced date. I understand that I fail to specify an expiration date or event, this authorization will expire in six (6) months from the date on which was signed.

**RE DISCLOSURE:** I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

**CONDITIONING:** I understand that completing this authorization form in voluntary. I realize that treatment will not be denied if I refuse to sign this form.

**REVOCATION:** I understand that I have the right to revoke this authorization at any time by giving a written/verbal notice to the office listed above.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_                \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Signature (If minor, parent/guardian)            Date

You are entitled to a copy of this undersigned authorization.

A photocopy of this signed release form is an valid as the original.

**Letter of Protection; Personal Guaranty of Payment; Authorization for Release of Information; Authorization for Provider Lien**

I hereby authorize to **S and B Chiropractic and Rehab, INC** to furnish you, my attorney, with a full report of their examination of myself in regard to the accident in which I was involved.

I hereby guarantee full payment to **S and B Chiropractic and Rehab, INC**, and agree that I will remain personally responsible for any unpaid charges resulting from deductible, co-payment, or treatment after benefits are exhausted.  I also grant to **S and B Chiropractic and Rehab, INC** a lien against any recovery which I may have now or in the future against any persons responsible to or any responsible insurance carrier. I hereby direct that any attorney representing me now or in the future to execute this letter of protection in favor to **S and B Chiropractic and Rehab, INC.**

I hereby authorize and direct you, my attorney, to pay directly to to **S and B Chiropractic and Rehab, INC** such sums as may be due and owing them for professional services rendered to me both by reason of this accident and by reason of any other bills that are due to their office and to withhold such sums from any settlement, judgment or verdict as may be necessary adequately to protect to **S and B Chiropractic and Rehab, INC.** I hereby further give a lien on my case to S and B Chiropractic and Rehab, Inc.in an amount equal to the outstanding balance for services rendered to me by to **S and B Chiropractic and Rehab, INC.** This lien shall be against any and all proceeds of any settlement, judgment or verdict which may be paid to my attorney or myself due to injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to **S and B Chiropractic and Rehab, INC** for all professional bills submitted to **S and B Chiropractic and Rehab, INC** for services rendered to me and that this agreement is made solely for to **S and B Chiropractic and Rehab, INC** additional protection and in consideration of their awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee to **S and B Chiropractic and Rehab, INC.** may at its discretion bill me directly at any time for any amounts then due and owing.  I further agree to pay any amounts billed to me within ten (10) days of billing date.  If I should fail to pay any amount to **S and B Chiropractic and Rehab, INC** may put my account into collection, with the costs of collection, including a reasonable attorneys’ fee, to be borne by me.

Any failure of **S and B Chiropractic and Rehab, INC** to avail itself of any of the protection afforded it under this agreement shall not constitute a waiver of that remedy.

Dated:    \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The undersigned, as the lawfully retained attorney for the above patient, does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary adequately to protect to **S and B Chiropractic and Rehab, INC** named above.  Attorney shall withhold all amounts necessary to fully compensate to **S and B Chiropractic and Rehab, INC** for services rendered to Patient, and shall not distribute funds received in settlement of Patients claim unless first satisfying to **S and B Chiropractic and Rehab, INC** full balance or receiving a written acceptance of less than the full amount from to **S and B Chiropractic and Rehab, INC**

Dated:    \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Attorney Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PIP Deductible/Co-Insurance Payment Agreement**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ understand that my auto insurance covers my medical expenses at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ percent. I’m also aware that there is a \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ deductible.

Please read the following options and check the appropriate box.

* I have medical coverage that will be used to satisfy the above deductible and/or co-insurance
* I have at Attorney on this case and will have a letter of protection signed with \_\_\_\_\_\_\_\_\_\_\_\_\_\_ to satisfy the above deductible and/or insurance.
* I will satisfy the deductible personally.

Pay $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ is full.

Pay $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ per visit.

Pay $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ per week.

Pay $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ per month.

* I will satisfy the deductible personally.

Pay $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ per visit.

Pay $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ per week.

Pay $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ per month.

Patient Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    Date\_\_\_\_/\_\_\_\_/\_\_\_\_

Witness Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    Date\_\_\_\_/\_\_\_\_/\_\_\_\_

**EXPLANATION OF OFFICE PROCEDURES**

This page will explain all the possible services that we may provide to you while you are treating with us. If you have any further questions regarding your treatment plan, please ask the doctor.

**Examination (Exam)** - This is when the doctor sits down with you and discusses your injuries/complains. Orthopedic and neurological tests are also done at this time. This is normally performed on the first visit. (ICD-9 codes - 99201-25, 99202-25, 99203-25, 99204-25 or 99205-25).

**Reexamination (Re-exam)** - This is usually performed every twelve visits or every thirty days, whichever comes first. It is an assessment of the patient's progress and will determine the need for changes or referrals. (ICD-9 codes - 99211-25, 99212-25, 99213-25, 99214-25 or 99215-25).

**Manual muscle Testing (MMT)** - Throughout your care, the doctor will perform certain muscle tests. You will be asked to hold certain positions and resist the force of the doctor. A separate report will be filed out and sent to your insurance company and / or attorney. (ICD-9 code- 95831-59).

**Range of Motion Test (ROM)** - Throughout your care, the doctor will ask you to move you head and/or lower back in certain directions. This test will show any restriction in movement due to pain and / or anatomical reason. A separate report will be filled out and sent to you insurance company and/or attorney. (ICD-9 code -95851-59).

**Adjustment (ADJ)** - This is performed when the doctor finds a fixation/misalignment in your skeletal and corrects it. This can be performed with hands or Instrument(s).  (ICD-9 codes -98940, 98941 or 98942).

**Extremity Adjustment (EXT ADJ)** - This is performed when the doctor finds **a** fixation/misalignment extra spinally (not in the spine). This can be performed with hands or Instrument(s). (ICD-9 code -98943).

**Neuromuscular Re-education (NMR)** - The purpose of this technique is to reeducate your body movement, balance coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing. This can be performed using various soft tissue or СВР (Chiropractic Biophysics) techniques. (ICD-9 code-97112).

**Electrical Muscle Stimulation (EMS)/ Interferential Current (IF)** - These electrical therapies are used to breakup muscular spasms, relax soft tissue, decrease pain and increase local circulation. (ICD-9 codes - 97014 (unattended) or 97032 (attended)).

**Ultrasound (US)** - This therapy uses a sound head that disperses ultrasound waves deep in to the tissue.  The goals of this therapy are to provide pain relief, relax soft tissue, decrease pain and increase local circulation. (ICD-9 code- 97035).

**Inter-segmental Traction (Traction)** - This therapeutic procedure utilizes either the spinalator table or the flexion/distraction table for Fifteen minutes. The goal is to gently stretch the spine. (ICD-9 code -97012).

**Gait Training** - Gait training entails retraining your proprioception by performing step exercises or certain style of walking, including rhythm and or speech. (ICD-9 code - 97116).

**Manual Therapy / Myofascial release (MT/MyoRel)** - This treatment is used in increase lymphatic drainage and to decrease muscle spasms. (ICD-9 code -97140-59).

**Activities of Daily Living Home or Work (ADL - home/work)** - This is when the doctor finds out about your home *or* work activities and modifies them to accommodate your present- state of health.   The doctor may give instructions on how to use ice or heat; the amount of water' you should drink; certain stretches you should do (depending on the chief complaint), etc. (ICD-9 codes - 97535 (home ADL) or 97537 (work ADL)).

**SOT Blocking (SOT blocks)** - This is a technique where the doctor utilizes wedge-shaped devices and places them under you. The goal is to decrease muscular strain, decrease pain and increase local circulation. (ICD-9 code 97039).

**Whirlpool** - This procedure involves the patient seated in a chair that administers various pressure levels of aquatic therapy.  This procedure is performed for fifteen minutes. (ICD-9 code - 97039).

**Therapeutic Exercises (THER. EXERCISE.**) - Therapeutic exercises involve increasing the quality of the muscle. This includes increasing flexibility, range of motion and/or endurance. (ICD-9 code -97039).

**Therapeutic Activities (THER. ACT.)** - Therapeutic activities involve increasing the quality of the muscle.  This includes throwing, catching, swinging or strengthening exercises. (ICD-9 code - 97110).

**Disposable Pads (Disp. Pads)** - These pads are used when utilizing EMS or interferential current.  They are single use electrodes.'(ICD-9 - A4556).

**Hydro Collator Therapy (Heat)** - Hot packs, worn moist towels, beating pads, water bottles or infrared lamps will be applied to provide relief and increase circulation to the injured area. (ICD-9 code 97010).

**Trigger Point Therapy (Trigger Pt.)** - A manual therapy technique that locates pockets of lactic build up in the muscles that can cause radiation of pain to specific areas.  By manually applying pressure to these points, the trigger points are broken up and reabsorbed into the blood stream and usually relieves the symptoms in the area of involvement. (ICD-9 code-97139).

**Computerized Posture Analysis (Comp Analysis)** - Computerized Posture Analysis is a physical performance test or measurement made upon the analysis form the patient's photo (e.g. muscle-skeletal, fractional capacity), with write report.  (ICD-9 code -97750).

By signing below, I acknowledge that I have read and understand the above procedures.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_                                      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature                                                                                 Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_                                          \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Signature                                                                                  Date