NEW PATIENT APPLICATION

Welcome to our Practice! Please thoroughly complete all questions. Thank you.

Patient Name_____ Today's Date_____

Birthdate_____ Age_____ Sex M / F E-Mail_____
Address_____City_____ State____Zip_____

Phone_____ Cell_____ Work_____
Ok to receive text messages: yes no

Occupation_____ Your Employer_____
Employer's Address_____

Marital Status M/W/D/S/P Their Name_____ Their Employer_____
Children's Names & Ages _____

Prior Chiropractor_____ Last appointment_____

Address_____ Phone_____

General Practitioner_____

Address_____ Phone_____

May we send a report of your findings to this Practitioner? ___Yes ___ No

Favorite Hobbies or Interests _____

Who may we thank for referring you?_____

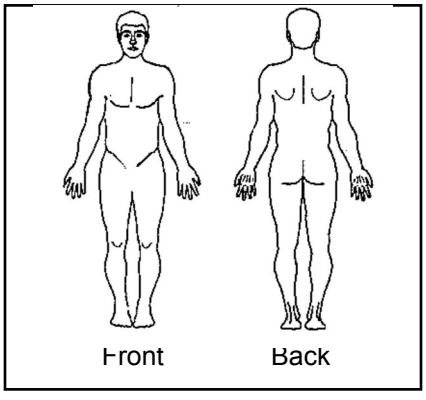
Please check the boxes next to any social media platforms you saw our practice on:
Google☐ Facebook ☐ Instagram☐ Youtube ☐

Health Reasons For Consulting Our Office:

1._____ 3._____

2._____ 4._____

Mark area of Health Concerns



Current Complaint (how you feel today): Please Circle

0 1 2 3 4 5 6 7 8 9 10
No Pain Unbearable Pain

How often are your symptoms present?

(Occasional) ___ 0-25% ___26-50% ___51-75% ___76-100% (Constant)

In the past week, how much has your pain interfered with your daily activities?
(for example work, social activities, household chores) Please Circle

0 1 2 3 4 5 6 7 8 9 10
No Interference Unable to carry on any activities

Have you had any X-rays, MRI, CT Scan for your area(s) of complaint? ___Yes ___No

Date Taken_____ What areas were taken?_____

Is this the result of an auto injury? ___Yes ___No work injury? ___Yes ___ No

If so, when? _____

Other Doctors who have treated this problem_____

Father/Mother/Brother/Sister/Children, with similar problems?_____

Please check all of the following that apply to you.

___Alcohol/Drug Dependence
___Recent Fever
___Diabetes
___High Blood Pressure
___Stroke (Date)_____
___Corticosteroid Use (Cortisone, Prednisone, etc.)
___Taking Birth Control Pills
___Dizziness/Fainting
___Numbness in Groin/Buttocks
___Osteoporosis
___Prostate Problems
___Menstrual Problems
___Urinary Problems
___Currently Pregnant, # Weeks ___
___Abnormal Weight ___Gain ___Loss
___Marked Morning Pain/Stiffness
___Pain Unrelieved by Position or Rest
___Pain at Night
___Visual Disturbances
___Epilepsy/Seizures

___Tobacco Use – Type_____Frequency_____/Day

___Cancer/Tumor (Explain)_____

___Surgeries_____

___Medications_____

___Other Health Problems (Explain)_____

___None of the Above

What have you heard about chiropractic?_____

Do you know what a subluxation is? ___Yes ___No

If yes, please describe_____

What daily rituals for spinal health do you presently practice?_____

Do you have health insurance? ___Yes ___No Insurance Plan_____

Method of Payment for First Visit: ___Cash ___Check ___Credit Card

The above information is true and accurate to the best of my knowledge. My reason for consultation with the Doctor is for evaluation of my physical health and the potential for improvement.

Patient or Guardian Signature:_____ Date:_____

ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

_____ _____

Patient Name (Please print) Date

_____

Parent, Guardian, or Patients Legal Representative

_____

Signature

THIS FORM WILL BE PLACED IN THE PATIENTS CHART AND MAINTAINED FOR SIX YEARS.

PATIENT CONSENT TO X-RAYS

I, _____ AUTHORIZE THE PERFORMANCE OF DIAGNOSTIC X-RAY EXAMINATIONS OF MYSELF, WHICH THE ABOVE DOCTOR OF HIS ASSOCIATES MAY CONSIDER NECESSARY OR ADVISABLE IN THE COURSE OF MY EXAMINATION AND TREATMENT.

SIGNATURE: _____ DATE: _____

NON-PREGNANCY VERIFICATION

THIS IS TO CERTIFY THAT, TO THE BEST OF MY KNOWLEDGE, I AM NOT PREGNANT AND THE ABOVE DOCTOR AND HIS ASSOCIATES HAVE MY PERMISSION TO PERFORM DIAGNOSTIC X-RAY EXAMINATION. I HAVE BEEN ADVISED THAT X-RAYS CAN BE HAZARDOUS TO AN UNBORN CHILD.

LAST DATE OF MENSTRUAL PERIOD: _____

SIGNATURE:_____ DATE: _____

Authorization to Use or Disclose Protected Health Information

Your authorization is requested for purposes of delivering your care in an open-adjusting or open-door adjusting environment as described in the office's privacy notice.

In the course of your care in either of these environments routine details of your condition and care may be disclosed to other patients or staff in the approximate vicinity of where your care is being delivered. We cannot assure that any of the details of your care will be addressed and considered as confidential by other patients.

We are requesting your authorization in this regard to assure that you are fully informed and in agreement with the method and circumstances in which we deliver chiropractic care. Your care will not be conditioned on your agreement to this authorization. You have the right not to sign this authorization and you also have the right to revoke this authorization at a later date if that is your wish. If you wish to revoke this authorization at some time in the future please advise us accordingly in writing.

If you agree to this authorization a copy will be maintained by this office and a copy will be provided to you.

Thank you for your cooperation and understanding.

First Name Last Name

Signature Date

If you are a minor or if you are being represented by another party please provide the appropriate person's:

First Name Last Name

Signature Date

Relationship to the patient

This authorization expires on: _____

CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic procedures, including various modes of physio therapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, factures, disc injuries, strokes, dislocations and sprains. 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 upon the facts then known, is in my best interests.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if I wish to cancel the treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Name of Patient: _____

Signature of Patient: _____

Name Printed of Guardian/Parental and Relationship to Patient: _____

Guardian/Parental Signature: _____

Date: _____

Doctor of Chiropractic Name: _____

Signature of Doctor of Chiropractic: _____

Date: _____

SEASON SCHELIN, DC, PA

5347 Lyons Rd, Coconut Creek, FL 33073 (P)954-422-8500 (F) 954-422-8568

ASSIGNMENT OF INSURANCE BENEFITS, RELEASE, & DEMAND

Insurer and Patient Please Read the Following in its Entirety Carefully!

I, the undersigned patient/insured knowingly, voluntarily, and intentionally assign the rights and benefits of my automobile Insurance, a/k/a Personal Injury Protection (hereinafter PIP), and Medical Payments policy of insurance to the above health care provider. I understand it is the intention of the provider to accept this assignment of benefits in lieu of demanding payment at the time services are rendered. I understand this document will allow the provider to file suit against an insurer for payment of the insurance benefits or an explanation of benefits and to seek §627.428 damages from the insurer. If the provider's bills are applied to a deductible, I agree this will serve as a benefit to me and I authorize and request such litigation. This assignment of benefits includes the cost of transportation, medications, supplies, over due interest and any potential claim for common law or statutory bad faith/unfair claims handling. If the insurer disputes the validity of this assignment of benefits then the insurer is instructed to notify the provider in writing within five days of receipt of this document. Failure to inform the provider shall result in a waiver by the insurer to contest the validity of this document. The undersigned directs the insurer to pay the health care provider the maximum amount directly without any reductions & without including the patient's name on the check. To the extent the PIP insurer contends there is a material misrepresentation on the application for insurance resulting in the policy of insurance is declared voided, rescinded, or canceled, I, as the named insured under said policy of insurance, hereby assign the right to receive the premiums paid for my PIP insurance to this provider and to file suit for recovery of the premiums. The insurer is directed to issue such a refund check payable to this provider only. Should the medical bills not exceed the premium refunded, then the provider is directed to mail the patient/named insured a check which represents the difference between the medical bills and the premiums paid.

Disputes: The insurer is directed by the provider and the undersigned to not issue any checks or drafts in partial settlement of a claim that contain or are accompanied by language releasing the insurer or its insured/patient from liability unless there has been a prior written settlement agreed to by the health provider (specifically the office manager) and the insurer as to the amount payable under the insurance policy. The insured and the provider hereby contests and objects to any reductions or partial payments. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by the provider shall be done so under protest, at the risk of the insurer, and the deposit shall not be deemed a waiver, accord, satisfaction, discharge, settlement or agreement by the provider to accept a reduced amount as payment in full. The insurer is hereby placed on notice that this provider reserves the right to seek the full amount of the bills submitted. Any effort by the insurer to pay a disputed debt as full satisfaction must be mailed to the address above, after speaking with the office manager, and mailed to the attention of the Office Manager. See 673.3111.

EUOs and IMEs: If the insurer schedules a defense examination or examination under oath (hereinafter "EUO") the insurer is hereby INSTRUCTED to send a copy of said notification to this provider. The provider or the provider's attorney is expressly authorized to appear at any EUO or IME set by the insurer. The health care provider is not the agent of the insurer or the patient for any purpose.

This assignment applies to both past and future medical expenses and is valid even if undated. A photocopy of this assignment is to be considered as valid as the original. I agree to pay any applicable deductible, co-payments, for services rendered after the policy of insurance exhausts and for any other services unrelated to the automobile accident. The health care provider is given the power of attorney to: endorse my name on any check for services rendered by the above provider; and to request and obtain a copy of any statements or examinations under oath given by patient.

Release of information: I hereby authorize this provider to: furnish an insurer, an insurer's intermediary, the patient's other medical providers, and the patient's attorney via mail, fax, or email, with any and all information that may be contained in the medical records; to obtain insurance coverage information (declaration sheet & policy of insurance) in writing and telephonically from the insurer; request from any insurer all explanation of benefits (EOBs) for all providers and non-redacted PIP payout sheets; obtain any written and verbal statements the patient or anyone else provided to the insurer; obtain copies of the entire claim file and all medical records, including but not limited to, documents, reports, scans, notes, bills, opinions, X-rays, IMEs, and MRIs, from any other medical provider or any insurer. The provider is permitted to produce my medical records to its attorney in connection with any pending lawsuits. The insurer is directed to keep the patient's medical records from this provider private and confidential and the insurer is not authorized to provide these medical records to anyone without the patient's and the provider's prior express written permission.

Demand: Demand is hereby made for the insurer to pay all bills within 30 days without reductions and to mail the latest non-redacted PIP payout sheet and the insurance coverage declaration sheet to the above provider within 15 days. The insurer is directed to pay the bills in the order they are received. However, if a bill from this provider and a claim from anyone else is received by the insurer on the same day the insurer is directed to not apply this provider's bill to the deductible. If a bill from this provider and claim from anyone else is received by the insurer on the same day then the insurer is directed to pay this provider first before the policy is exhausted. In the event the provider's medical bills are disputed or reduced by the insurer for any reason, or amount, the insurer is to: set aside the entire amount disputed or reduced; escrow the full amount at issue; and not pay the disputed amount to anyone or any entity, including myself, until the dispute is resolved by a Court. Do not exhaust the policy. The insurer is instructed to inform, in writing, the provider of any dispute.

Certification: I certify that: I have read and agree to the above; I have not been solicited or promised anything in exchange for receiving health care; I have not received any promises or guarantees from anyone as to the results that may be obtained by any treatment or service; and I agree the provider's prices for medical services, treatment and supplies are reasonable, usual and customary.

Caution: Please read before signing. Please ask to view a copy of our charges. If you do not completely understand this document please ask us to explain it to you. If you sign below we will assume you understand and agree to the above.

Patient's Name _____
(Please Print)

Patient's Signature_____
(If patient is a minor, signature of parent/guardian)

Date_____