Dr. Nicole Ingrando
Dr. Amanda Connelly
Dr. Aaron Proctor

North Orlando Spine Center, LLC

Chiropractic and Rehabilitation

Patient Name: _____ Gender: **M** **F**
How would you like us to refer to you? _____
Home Phone _____ Cell _____ Work _____
Address _____City _____ __State (abr.) ____ Zip_____
Date of Birth: ____/____/_____ Age: _____ Email: _____
Social Security # _____-_____-_____ Marital Status: **S**ingle **M**arried **O**ther
Employment Status: Employed/ Full-Time Student/ Part- Time Student/ Retired / Other
Occupation: _____ _____ Employer Name: _____
Employer Address: _____City_____ State (Abr.) _____Zip_____
How were you referred to us? _____

Who is your Medical Doctor? _____ _____Dentist_____
OB/GYN_____
Is your condition related to an auto accident? **Y**ES / **N**O Date of Accident: _____/_____/_____
Do you have an attorney? YES / NO If so what is your attorney's name? _____

Patient Signature _____ Date _____/_____/_____
Spouse or Guardian Signature_____ Date _____/_____/_____

By signing above, I (we) agree to pay for services rendered to the above mentioned patient as the charge is incurred. I (we) understand that health and accident insurance policies are arrangements between an insurance carrier and myself and that I am personally responsible for payment of any and all services, covered or non-covered. If the doctor is a contracted provider for my managed care plan, I understand that I am responsible for all co-payments and non-covered services. I also understand and agree to pay all co-pays and fees for non-covered services prior to seeing a doctor. I (we) authorize the doctor and his staff to release any information deemed appropriate concerning my physical condition to any insurance company, claims adjuster, case nurse, claims reviewer, employer, healthcare provider or attorney in order to process any claim for reimbursement or charges incurred by me as a result of professional services rendered and hereby release him/her of any consequences thereof. I agree that a photo static copy of this arrangement shall serve as the original. I (we) hereby authorize and direct payment of any medical/Chiropractic expense benefits allowable to the doctor as payment toward the total charges for professional services rendered.

Patient Name: _____

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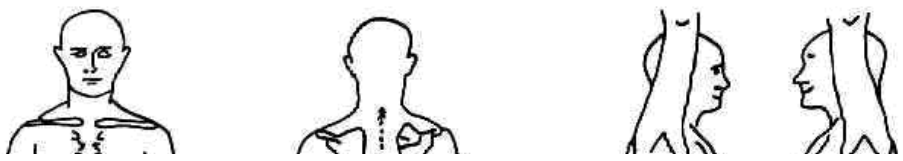
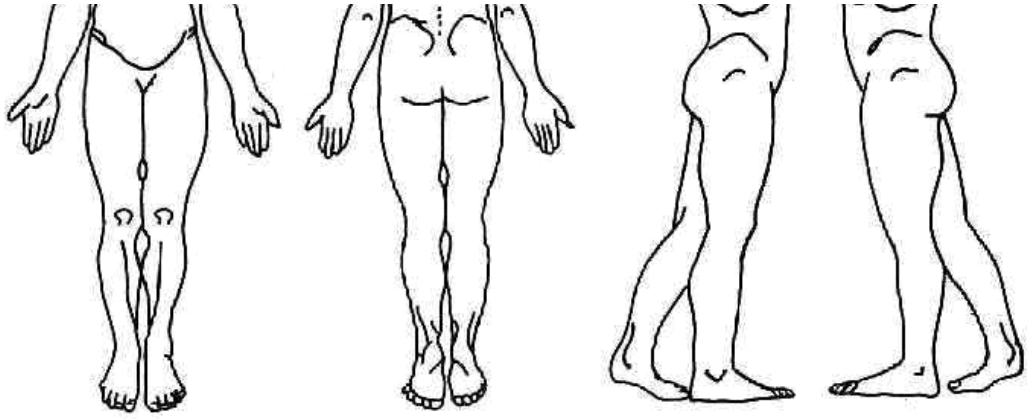
By using the key below, indicate on the body diagram where you are experiencing the follow

= Numbness X = Burning / = Stabbing O = Pins and Needles * = Du



Patient Name: _____



Please describe your symptoms below:

_____

_____

How did your symptoms begin? (Home, gym, work, etc.) _____

_____

When did your symptoms start? Month _____ Day _____ Year _____

Patient Name: _____

Surgeries:

0 Cardiovascular procedure 0 Lumbar disc procedure 0 cervical disc procedure 0 Hysterecto

0 Joint replacement 0 Laminectomies

Surgery : Year:

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Social History:

0 Caffeine used occasionally 0 Caffeine used often 0 Chew tobacco occasionally 0 Chew tobacco often

0 Drink alcohol occasionally 0 Drink alcohol often 0 Exercise not at all 0 Exercise occasionally

0 Exercise often 0 Experience occasional stress 0 Experience stress often

0 Smoke more than 1 pk per day 0 Smoke 1 pk or less per day 0 Former smoker 0 Non smoker

0 never wears seat belts 0 Wears seat belts usually 0 Wears seat belts always

Family History: (Check all that apply)

0 **Arthritis** 0 mother 0 father 0 brother 0 sister 0 grandmother 0 grandfather

0 **Cancer** 0 mother 0 father 0 brother 0 sister 0 grandmother 0 grandfather

0 **Cholesterol** 0mother 0 father 0 brother 0 sister 0 grandmother 0 grandfather

0 **Diabetes** 0 mother 0 father 0 brother 0 sister) 0 grandmother 0 grandfather

0 **Heart problems** 0 mother 0 father 0 brother 0 sister 0 grandmother 0 grandfather

0 **High Blood Pressure** 0 mother 0 father 0 brother 0 sister 0 grandmother 0 grandfather

0 **Psychiatric** 0 mother 0 father 0 brother 0 sister 0 grandmother 0 grandfather

0 **Stroke** 0 mother 0 father 0 brother 0 sister 0 grandmother 0 grandfather

0 **Thyroid** 0 mother 0 father 0 brother 0 sister 0 grandmother 0 grandfather

Is your mother still living? Yes or No if no, what was her cause of death? _____

Is your father still living? Yes or No if no, what was his cause of death? _____

Are your siblings still living? Yes or No if no please indicate which sibling and cause of death _____

Are your grandparents still living? Yes or No

Substance Use:

0 Alcohol (past) 0 Alcohol (present) 0 Amphetamines (past) 0 Amphetamines (Present)

Substance Use:

0 Alcohol (past) 0 Alcohol (present) 0 Amphetamines (past) 0 Amphetamines (Present)
0 Barbiturates (past) 0 Barbiturates (present) 0 Cocaine (past) 0 Cocaine (present)
0 Crystal Meth (past) 0 Crystal Meth (present) 0Heroine (past)

Male Children: 0 Under 6 years 0 under 10 years 0 Under 19 years
Female Children: 0 Under 6 years 0 under 10 years 0 Under 19 years

Occupational Activities: 0 Administration 0 Clerical/Secretarial 0 Computer User 0 Construction 0 Daycare/Childcare
0 Food Service Industry 0 Healthcare 0Heavy Equipment Oper. 0 Heavy Manual Labor 0 Household 0 Light Manual Labor
0 Manufacturing 0 Medium Manual Labor

Are you right or left handed? _____

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Allergies:
Please list any allergies to food, medication and other factors:

Current Medications: **Dosage:**

ADDITIONAL QUESTIONS

Do you have problems with recurring headaches? **Y N**
Have you lost weight without trying? **Y N**
Does your pain wake you at night? **Y N**
Have you had a change in bowel or bladder habits? **Y N**
Have you had a sore that doesn't heal? **Y N**
Have you recently had any unusual bleeding or discharge? **Y N**
Do you have thickening/lump in the breast or anywhere? **Y N**
Do you have indigestion or difficulty swallowing? **Y N**
Have you had an obvious change in a wart or mole? **Y N**
Do you have a nagging cough or hoarseness? **Y N**

Review of Systems	**Present**	**Past**	**N/A**		**Present**	**Past**	**N/A**		**Present**	**Past**	**N/A**
Cardiovascular				**Integumentary**				**Eyes**			
Poor Circulation				Skin Lesions				Glaucoma			
High Blood Pressure				Skin Ulcers				Double Vison			
Aortic Aneurism				Skin Disease				Blurred Vision			
Heart Disease				Eczema				**Neurological**			
Vascular Disease				Psoriasis				Stroke			

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Aortic Aneurism
Heart Disease
Vascular Disease
Heart Attack
Chest Pain
High Cholesterol
Pace Maker
Jaw Pain
Irregular Heartbeat
Swelling of Legs
Genitourinary
Kidney Disease
Lower Side Pain
Burning Urination
Blood in Urine
Kidney Stone
Hematological/Lymph
Hepatitis
Blood Clots
Cancer
Easy Bruising
Easy Bleeding
Ever/Sweats/Chills
Respiratory
Asthma
Tuberculosis
Shortness of Breath
Emphysema
Cold/Flu
Coughing/Wheezing
Ear/Nose/Throat
Dizziness
Hearing Loss
Sinus Infection
Nose Bleed
Sore Throat
Difficulty Swallowing
Bleeding Gums

Skin Disease
Eczema
Psoriasis
Rashes
Allergic/Immune
Hives
Immune Disorder
HIV/AIDS
Allergy Shots
Cortisone Use
Gastrointestinal
Gallbladder Problems
Bowel Problems
Constipation
Liver Problems
Ulcers
Diarrhea
Nausea/Vomiting
Bloody Stools
Poor Appetite
Musculoskeletal
Gout
Arthritis
Joint Stiffness
Muscle Weakness
Osteoporosis
Broken Bones
Joints Replaced
Endocrine
Thyroid Disease
Diabetes
Hair Loss
Menopause
Menstrual Problems
Psychiatric
Depression
Anxiety Disorder
Unusual Stress
Weight Loss/Gain

Blurred Vision
Neurological
Stroke
Seizures
Head Injury
Brain Aneurysm
Numbness
Severe Headaches
Pinched Nerves
Parkinson's
Carpal Tunnel

By North Orlando Spine Center, LLC

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

This authorization may be used to permit a covered entity to use or disclose an individual's protected health information. Individuals completing this form should read the form in its entirety before signing and complete all the sections that apply to their decisions relating to the use or disclosure of their protected health information.

Information regarding patient for whom authorization is made:

Full Name: _____

Other Name(s) Used: _____ Date of Birth: _____

Address:_____ City:_____ State:_____ Zip Code:_____

Phone: (_____)_____ Email (*Optional*): _____

Address:_____ City:_____ State:_____ Zip Code:_____

Phone: (_____)_____ Email (*Optional*): _____

Information regarding health care provider or health care entity authorized to disclose this information:

Name: _____

Address:_____City:_____ State:_____ Zip Code:_____

Phone: (_____)_____ Fax: (_____)_____

Information regarding person or entity who can receive and use this information:

Name: _____

Address:_____City:_____ State:_____ Zip Code:_____

Phone: (_____)_____ Fax: (_____)_____

_____ I wish to revoke this authorization

Comments:

Patient/Legal Guardian Signature _____ Date _____

Consent to Treat /

Assignment of Benefits

I, the undersigned patient insured, knowingly, voluntarily and rights and benefits of my automobile insurance policy (i.e. Personal Injury Protection (ents benefits) to the above-stated Health Care Provider. I understand it is the intention of the He of Benefits in lieu of demanding payment at the time services are rendered. I understand that ider to file suit against the insurer either in my name or the provider's name for payment of the f benefits and to seek attorneys fees and costs under Fla. Stat. §§627.736(S), 627.428 and 57. efits includes, but is not limited to, the cost of medical care, transportation, medication, supplies, common law or statutory bad faith/unfair claims handling. If the insurer disputes the validi urer is instructed to notify the Health Care Provider in writing within five (5) days of receipt dispute. Failure to inform the Health Care Provider shall result in a waiver by the insurer to efits. The undersigned patient insured directs the insurer to pay the Health Care Provider th ctly to the Health Care Provider without any reductions and without including the undersigne his Health Care Provider's contention that its charges are reasonable.

This Assignment of Benefits applies to past, present and futur ted. A photocopy of this Assignment of Benefits is to be considered as valid as the orig to pay any applicable deductible or co-payments for services rendered, including payment for and for any other services unrelated to the date of injury. The above-stated Health Care dorse my, the undersigned patient's /insured's, name on any check for services rendered to request and obtain copies of any recorded statements or Examinations Under Oath given b 3) to request and obtain copies of any Independent Medical Examination report and/or peer re patient insured.

Disputes

The insurer is directed by the Health Care Provider and the undersigned patient/insured not to 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 is a written settlement agreement between the Health Care Provider, specifically the Office Manager, and the insurer as to the amount to be paid by the insurer for the services rendered only to the undersigned patient, insured. The undersigned patient insured and the Health Care Provider hereby contest and object to any reductions or partial payments made by the insurer. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by the Health Care 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 Health Care Provider to accept a reduced amount as payment in full. The insurer is hereby placed on notice that this Health Care Provider reserves the right to seek payment in full for the bills submitted. If the insurer asserts that it can pay claims at 200% of the Medicare Fee Schedule, then the insurer is instructed and directed to provide this Health Care Provider with a copy of the policy of insurance within ten (10) days. Should the insurer and Office Manager of the above-stated Health Care Provider reach an agreement to settle any of the bills submitted at a reduced amount, this agreement shall be reduced to writing and submitted to the attention of the Office Manager for written approval. See Fla. Stat. §673.3111.

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Release of Information

I, the undersigned patient/ insured, hereby authorize this Health Care Provider to: furnish an insurer, medical providers and my attorney(s) via mail, facsimile or e-mail, with any and all information that r records to: obtain insurance coverage information (i.e. declarations page and policy of insurance) in w insurer, request from any insurer all Explanation of Benefits/Review forms (EOBs) for all of my medic payout sheet, obtain written and verbal statements that I or anyone else provided to the insurer, obta medical records, including, but not limited to: documents, reports, scans, notes, bills, opinions, X-rays, IMEs, peer reviews and MRIs from any of my medical providers or any insurer. The Health Care Provider is permitted to produce my medical records to its attorney in connection with pursing a legal action. The insurer is directed to keep my, the undersigned patient's/insured's medical records confidential. The insurer is not authorized to provide my, the undersigned patient's/ insured's, medical records to anyone without my, the undersigned patient's/insured's and the Health Care Provider's express written permission.

MEDICARE PATIENT CERTIFCATION — PATIENTS CERTIFICATION AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST: I certify that the information given by me in applying for payment under Title XVIII and or Title XI of the Social Security Act is correct. I authorize any holder of medical or other information about me, to release to the Social Security Administration or its Intermediary carriers, any information needed for this or related Medicare claims. I request that

INFORMATION AND PAYMENT REQUEST: I certify that the information given by me in applying for payment under Title XVIII and or Title XI of the Social Security Act is correct. I authorize any holder of medical or other information about me, to release to the Social Security Administration or its Intermediary carriers, any information needed for this or related Medicare claims. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to North Orlando Spine Center, LLC, for physician(s) services. I understand that I am responsible for my health insurance deductibles and coinsurance.

Missed Appointment Policy: In an effort to accommodate other patients seeking an appointment, we ask that you notify us within 24 hours if you need to change or cancel your appointment. **North Orlando Spine Center, LLC reserves the right to charge up to a $100 fee for missed appointments without proper notification.**

WOMEN: Verification of Pregnancy: By my signature, I do hereby state that, to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time. If I am pregnant, by my signature, I confirm that I have made the physician(s) aware of my pregnancy.

Acknowledgment of receipt of Privacy Practices: By my signature, I have received and understand the Notice of Privacy Practices of North Orlando Spine Center, LLC, which describes the practice's policies and procedures regarding the use and disclosure of any of my protected health information created, received or maintained by the practice.

Certification

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

Caution: Please read this document carefully before signing. Please ask to review a copy of the above-stated Health Care Provider's charges. If you do not completely understand this document, please ask the front desk personnel or the medical provider to explain it to you. If you sign below it will be understood that you understand and agree with the contents of this Assignment of Insurance Benefits.

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Patient Insured Name: _____
(Please Print)

Patient /Insured Signature: _____ **Date:** _____
(If patient/insured is a minor, signature of parent/guardian)

North Orlando Spine Center, LLC
2160 West SR 434, Suite 108, Longwood, FL 32779
Phone: 407-331-9913 Fax: 407-331-9918