CHIROPRACTIC CENTER
BISCAYNE

❑ CHIROPRACTIC
❑ ACUPUNCTURE

PATIENT INTAKE FORM

TODAY'S DATE _____

PATIENT INFORMATION

Title: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. Sex: ☐ M ☐ F Age: _____ Date of Birth: ___/___/___

First Name: _____ Middle Initial: _____ Last Name: _____

Address _____ Apt # _____

City _____ State _____ Zip Code _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

E-mail _____ May we contact you via email: ☐ Yes ☐ No

Facebook: _____ Twitter: _____

Have you received chiropractic care in the past? ☐ Yes ☐ No How did you hear about our office? _____

SPOUSE/PARTNER

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced Children: ☐ No ☐ Yes How Many: _____

First Name: _____ Middle Initial: ____ Last Name: _____ Date of Birth: ____/____/____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

EMERGENCY CONTACT (if different from above)

Name _____ Relationship _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Patient's Nearest Relative **(if different from above)** _____

Relationship _____ Phone _____

EMPLOYMENT INFORMATION

Occupation: _____

Employer: _____ Office Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

PURPOSE OF THIS APPOINTMENT

Is the condition due to injury or sickness arising out of auto or other accident? ☐ Yes ☐ No Employment? ☐ Yes ☐ No

Explain: _____

Days lost from work? _____ Date symptoms appeared or accident happened ___/___/___

Other doctors seen for this condition _____

PAST, FAMILY, AND SOCIAL HISTORY

Have you been treated for any health conditions by a physician in the past 6 months)? ☐ Yes ☐ No

If yes, when and describe _____

_____

Have you ever had the same or similar condition? ☐ Yes ☐ No

If yes, when and describe _____

_____

MEDICAL HISTORY

What medications or drugs are you taking (past 6 months)? _____

_____

Medical Doctor _____ Date of last physical exam ____/____/____

What operations have you had? _____ When? ____/____/____

Serious Illnesses? _____ When? ____/____/____

Allergies? ☐ No ☐ Yes _____

How often do you exercise? ☐ Always ☐ Often ☐ Occasionally ☐ Rarely ☐ Never

Do you use / consume? ☐ Tobacco ☐ Alcohol ☐ Caffeine How often per day? _____

Has anyone in your family had any of the following problems? ☐ Arthritis ☐ Cholesterol ☐ Heart Problems ☐ Psychiatric Problems ☐ Thyroid ☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Stroke ☐ Other: _____

REVIEW OF SYSTEMS - Have You Ever Had Any Of The Following?

Cardiovascular
- ☐ Aortic Aneurysm
- ☐ Chest Pain
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Pace Maker
- ☐ Poor Circulation
- ☐ Vascular Disease

Neurological
- ☐ Balance Problems
- ☐ Brain Aneurysm
- ☐ Carpal Tunnel
- ☐ Head Injury
- ☐ Numbness
- ☐ Pinched Nerves
- ☐ Seizures
- ☐ Stroke

Hematologic/Lymphatic
- ☐ Blood Clots
- ☐ Cancer
- ☐ Easy Bleeding
- ☐ Easy Bruising
- ☐ Fevers/Chills/Sweats
- ☐ Hepatitis

Musculoskeletal
- ☐ Arthritis
- ☐ Broken Bones
- ☐ Gout
- ☐ Joint Stiffness
- ☐ Joints Replaced
- ☐ Muscle Weakness
- ☐ Osteoporosis

Psychiatric
- ☐ Anxiety Disorder
- ☐ Depression
- ☐ Unusual Stress

Allergic/Immunologic
- ☐ Allergy Shots
- ☐ Cortisone Use
- ☐ HIV/AIDS
- ☐ Hives
- ☐ Immune Disorder

Genitourinary
- ☐ Blood in Urine
- ☐ Burning Urination
- ☐ Frequent Urination
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Lower Side Pain

Eyes
- ☐ Blurred Vision
- ☐ Double Vision
- ☐ Glaucoma

Respiratory
- ☐ Asthma
- ☐ Cold/Flu
- ☐ Cough/Wheezing
- ☐ Coughing Blood
- ☐ Emphysema
- ☐ Shortness of Breath
- ☐ Sputum
- ☐ Tuberculosis

Ears/Nose/Throat
- ☐ Bleeding Gums
- ☐ Hearing Loss
- ☐ Nosebleed
- ☐ Sinus Infection
- ☐ Sore Throat
- ☐ Swallowing

Head
- ☐ Head Injury
- ☐ Headaches
- ☐ Migraines
- ☐ Severe Headaches

Gastrointestinal
- ☐ Bloody Stools
- ☐ Bowel Problems
- ☐ Constipation
- ☐ Diarrhea
- ☐ Gallbladder
- ☐ Liver Problems
- ☐ Nausea/Vomiting
- ☐ Ulcers

General
- ☐ Difficulty Sleeping
- ☐ Energy Level
- ☐ Weight Gain
- ☐ Weight Loss

Skin
- ☐ Eczema
- ☐ Psoriasis
- ☐ Skin Disease/Cancer
- ☐ Skin Lesions
- ☐ Skin Ulcers

Females: Are you or could you be pregnant?
☐ Yes ☐ No Due Date: _____

Other problems not elsewhere listed:

PAYMENT/INSURANCE INFORMATION - Payment is expected at time of visit.

Do you have health insurance: ☐ No ☐ Yes Company _____ Insurance phone number: _____

Person responsible for payment _____ Relationship _____

ID # _____ Cardholders Birth Date ____/____/____ SS # ____-____-____

I understand and agree that health and accident policies are an arrangement between an insurance carrier and me. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I hereby acknowledge that I have received and had an opportunity to ask questions concerning the Notice of Privacy Practices. In addition, I have read and agree to all the above Financial Policies and Notices.

Patient's Name (Printed) _____ Signature: _____ Date ___/___/___

Guardian's Signature: _____ Date ___/___/___

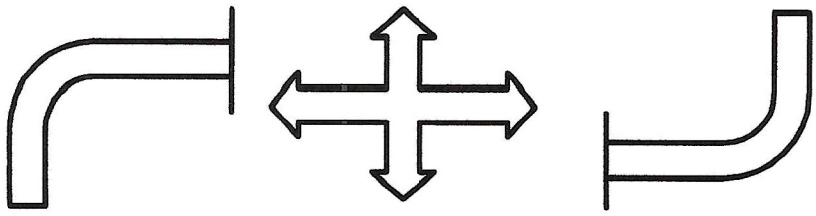
BISCAYNE CHIROPRACTIC CENTER

ACCIDENT DETAILS

First Name: _____ Last Name: _____ Chart #: _____

INDICATE ON THIS DIAGRAM HOW THE ACCIDENT HAPPENED

Date of Accident: ____/____/_____
Time: _____ AM PM
(Choose The Best Image)
Use #1 to indicate the car you were in
Use #2 to indicate the other vehicle
Use an ⇨ to indicate direction



Please explain in detail how your accident happened: _____

_____

You were heading: ☐ North ☐ East ☐ South ☐ West on _____ (Street or highway)
Other vehicle was headed: ☐ North ☐ East ☐ South ☐ West on _____ (Street or highway)
Were police notified? ☐ Yes ☐ No
Were you knocked unconscious? ☐ Yes ☐ No If so, how long? _____
Were you struck from ☐ behind ☐ Front ☐ Left Side ☐ Right Side
You were ☐ Driver ☐ Passenger ☐ Front Seat ☐ Back Seat
Were you using your seatbelt? ☐ Yes ☐ No ☐ Shoulder harness with lap belt ☐ Lap only
Where did you feel pain immediately after the accident? _____

_____

List the extent of injuries as you know them: _____

_____

CHECK THE SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

☐ Headache	☐ Fatigue	☐ Sensitivity to Light	☐ Cold Sweats
☐ Neck Pain	☐ Irritability	☐ Shortness of Breath	☐ Feet Cold
☐ Neck Stiff	☐ Fainting	☐ Loss of Taste	☐ Hands Cold
☐ Head Seems too Heavy	☐ Loss of Balance	☐ Loss of Smell	☐ Pins and Needles in Arms
☐ Back Pain	☐ Nervousness	☐ Stomach Upset	☐ Pins and Needles in Legs
☐ Chest Pain	☐ Ears Ring	☐ Diarrhea	☐ Numbness in Fingers
☐ Buzzing in Ears	☐ Loss of Memory	☐ Constipation	☐ Numbness in Toes
☐ Dizziness	☐ Sleeping Problems	☐ Fever	
☐ Depression	☐ Tension	☐ Flushed	

Symptoms other than above: _____

Were you taken to a hospital after the accident? ☐ Yes ☐ No ☐ Ambulance ☐ Private Car
Name of Hospital: _____ Were you admitted? ☐ Yes ☐ No How Long?_____
What treatment was given? _____

OTHER TRETMENT

Was here any other doctor consulted after your accident? ☐ Yes ☐ No
What was the diagnosis? _____
What treatment was given? _____
How often did you see the doctor? _____
How long did you see the doctor? _____
Have you ever had any complaints in the involved area before? ☐ Yes ☐ No
If so, what were the complaints? _____
Before the injury, were you capable of working on an equal basis with others your age? ☐ Yes ☐ No
Are your work activities restricted as a result of this accident? ☐ Yes ☐ No
Since the accident are your symptoms: ☐ Improving ☐ Getting Worse ☐ Same

ATTORNEY INFORMATION

Have you retained an attorney? ☐ No ☐ Yes Name: _____ Phone: _____
Address: _____ City: _____ State: _____ Zip Code: _____

INSURANCE INFORMATION

Company: _____ Claim #: _____

CHIROPRACTIC CENTER
BISCAYNE

PAIN ASSESSMENT

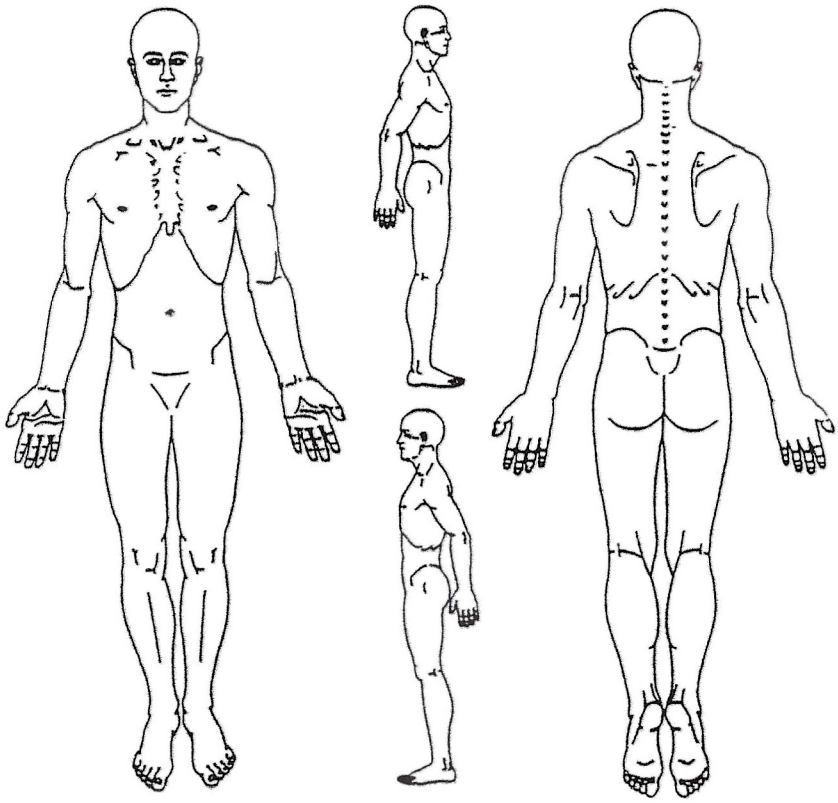
Patient's Name: _____ Patient's #: _____

Please mark the figures below with the letters that best describes the sensation or pain you are feeling. Please mark arrears where pain radiates or spread with an arrow ↑, ↓, → or ← to indicate the direction of radiating pain.
(Include all affected areas)

A = Ache	**B** = Burning	**R** = Radiating Pain	**D** = Dull Pain
N = Numbness	**S** = Stabbing	**P** = Pins and Needles	**O** = Other

Next to each area, mark the intensity of pain:

0	1 2	3 4	5 6	7 8	9
No Pain	Minimal	Tolerable, but hinders Activities	High - 50% of Activities Impaired	Extreme - most activities impaired	Unbearable



Patient's Signature _____ Date ____/____/____

OFFICE OF INSURANCE REGULATION
Bureau of Property & Casualty Forms and Rates

Standard Disclosure and Acknowledgement Form
Personal Injury Protection - Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

1. The services or treatment set forth below were **actually rendered.** This means that those services have **already been provided.**

_____

_____

2. I have the right and the **duty to confirm** that the services have already been provided.

3. I was **not solicited** by any person to seek any services from the medical provider of the services described above.

4. The medical provider has **explained** the services to me for which payment is being claimed.

5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to $500.

Insured Person (patient receiving treatment or services) or Guardian of Insured Person:

_____	X _____	_____
Name *(PRINT or TYPE)*	Signature	Date

The undersigned licensed medical professional or medical director, if applicable, affirms the statement numbered 1 above and also:

A. I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.

B. The treatment or services rendered were explained to the insured person, or his or her guardian, **sufficiently** for that person to sign this form with informed consent.

C. The accompanying statement or bill is **properly completed** in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to **truthfully, accurately**, and in a **substantially complete** manner.

D. The coding of procedures on the accompanying statement or bill is proper. This means that **no service has been upcoded, unbundled**, or constitutes an invalid **or not medically necessary diagnostic test** as defined by Section 627.732(14) and (15), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Licensed Medical Professional Rendering Treatment/Services or Medical Director, if applicable *(Signature by his/ her **own hand**)*:

Randy S. Schulman, DC	_____	_____
Name *(PRINT or TYPE)*	Signature	Date

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of Claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234(1)(b), Florida Statutes.

Note: The **original** of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may **not** be electronically furnished. Failure to furnish this form may result in non-payment of the claim.

CHIROPRACTIC CENTER
BISCAYNE

ASSIGNMENT OF BENEFITS

I, the undersigned insured or beneficiary of an insurance policy, irrevocably assign to **(Biscayne Chiropractic Center)** whatever rights I have under any policy of insurance and under Florida law, including, without limitation, any and all claims for attorney's fees, costs, interest and /or damages pursuant to Florida Statute 624.155. This Assignment of Benefits (AOB) includes an assignment of any potential claim for common law or statutory bad faith. If the Insurer disputes the validity of this AOB, then the insurer is instructed to notify the provider in writing within 10 days of receipt of this document. Failure to do so shall result in the provider relying on this AOB for direct payment and could constitute a waiver by the insurer to contest the validity of this document. I do hereby confirm that this AOB is irrevocable and instruct any insurance company or other collateral source for which I am entitled to benefits to pay for monies owed as a result of medical services rendered by **Biscayne Chiropractic Center** to promptly make payment in the name of and directly to **Biscayne Chiropractic Center**.

Pursuant to this AOB, **Biscayne Chiropractic Center** is authorized to file suit on my behalf against any insurance company that reduces or denies benefits for medical services rendered to me and to collect any damages awarded or settlement monies for services rendered, plus interest, costs, reasonable attorney's fees and a contingency fee multiplier. I understand that in any such lawsuit, my name or other identifying information will need to be included in and/or portions of my medical file attached to pleadings and/or formal discovery. I waive any confidentiality of my records and /or information but only to the extent necessary to prosecute a claim for unpaid or owed medical expenses against the insurance company or any other responsible party.

I acknowledge that **Biscayne Chiropractic Center** objects to any reductions or partial payments by the Insurer. Any partial or reduced payment, regardless of the accompanying language, issued by the Insurer and deposited by **Biscayne Chiropractic Center** shall be done 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. **Biscayne Chiropractic Center** reserves the right to seek the full amount of the bill submitted from the insurance company(ies) or me. Accordingly, the insurer is hereby instructed to set aside (escrow) any and all reduced or denied benefit payments for medical services rendered by this provider and not pay the disputed amount to anyone until the dispute is resolved.

I further instruct my insurance company to cooperate with the above-captioned **Biscayne Chiropractic Center** in resolving all medical billing disputes. Cooperation includes, but is not limited to, providing any and all declaration pages, PIP logs, payout ledgers, explanations of benefits, copies of checks, and any and all other documents or information to **Biscayne Chiropractic Center** or its attorneys, employees or other representatives acting on behalf of **Biscayne Chiropractic Center**. If the insurer schedules a defense examination, examination under oath (EUO) or Independent Medical Examination (IME) of the patient, the insurer is hereby instructed to send a copy of said notification to this provider and the provider's attorneys. The provider and/or the provider's attorneys are authorized to appear at any patient EUO or IME set by the insurer. **THIS ASSIGNMENT OF BENEFITS DOES NOT ASSIGN ANY RIGHTS OR OBLIGATIONS UNDER THE POLICY OF INSURANCE, TO SUBMIT TO AN EUO OR RECORDED STATEMENT.** I further direct and authorize you to speak to an attorney, employee or any other representative of **Biscayne Chiropractic Center** or anyone acting on their behalf over the phone and provide them with any and all information you may have or documentation not previously listed above that they may request.

I, as the patient, agree to remain personally liable for the amounts billed by **Biscayne Chiropractic Center** regardless of the amount paid by the insurance company, unless ordered by a court of law. I fully understand that said health care services were provided to me in consideration for an unconditional promise to pay and for me providing these instructions to my insurance company. I, as the patient, further agree to be liable for reasonable attorney's fees and costs incurred in collecting any delinquent accounts or unpaid balances. By executing this document, I am placing my insurance company(ies) on notice that the claims for medical treatment rendered by **Biscayne Chiropractic Center** are related to my accident (or my covered conditions) and should be paid directly to **Biscayne Chiropractic Center** pursuant to his assignment of benefits and Florida law. Any delay in paying benefits owed under the insurance policy could adversely affect me.

BY EXECUTING THIS DOCUMENT, I AM PLACING MY INSURANCE COMPANY ON NOTICE THAT THIS IS A DIRECT ASSIGNMENT OF BENEFITS PURSUANT TO FLORIDA LAW. AS THE INSURED OR BENEFICIARY OF SAID INSURANCE POLICY, I AM IRREVOCABLY ASSIGNING WHATEVER RIGHTS I HAVE UNDER MY POLICY OF INSURANCE (LESS THE DUTY TO ATTEND AN EUO) AND UNDER FLORIDA LAW TO THIS HEALTH CARE PROVIDER. A photocopy of this assignment shall be considered as effective and valid as the original.

_____ ____/____/____
Patient's Name Date of Birth

_____
Name of Policy holder or Claimant

X_____ ____/____/____ _____ ____/____/____
Signature of Policy holder or Claimant Date **Biscayne Chiropractic Center/** Date

BISCAYNE CHIROPRACTIC CENTER

STATEMENT OF PATIENT

On this date, ____/____/____, I, _____, hereinafter referred to as the patient, hereby make the following statement:

As a direct result of an accident, I have suffered serious injuries to my body, which have necessitated my need for immediate attention and treatment and I plan to continue to seek such medical attention.

The I have been informed that according to Florida Statute Section 627.7375 (2)(b) that "any person who knowingly and with intent to injure, defraud or deceive any Insurance Company files a Statement of Claim confiding any false, incomplete or misleading information is guilty of a felony of third degree".

That I was not offered or given gratitude of any kind by **BISCAYNE CHIROPRACTIC CENTER** or anyone else.

I have been truthful with **BISCAYNE CHIROPRACTIC CENTER** and have not given any false, incomplete or misleading information and that no person working for **BISCAYNE CHIROPRACTIC CENTER** or associated with **BISCAYNE CHIROPRACTIC CENTER** has asked me to give false; incomplete or misleading information.

At this time, I do not know the full extent of the injuries suffered. However, I have not lied or exaggerated the severity of my injuries nor have anyone working or associated with **BISCAYNE CHIROPRACTIC CENTER** asked me to lie or exaggerated the severity or my injuries.

I have knowingly and voluntarily signed this Statement of Patient and I waive **BISCAYNE CHIROPRACTIC CENTER** of any liability for any such information concerning my injuries that is not correct.

I, the patient, acknowledge that I have read and understand this Statement of Patient.

X _____ _____

Signature of Patient | Patient's Printed Name

____/____/____

Date

CHIROPRACTIC CENTER
BISCAYNE

LETTER OF PROTECTION

I, the undersigned, hereby agree that this agreement constitutes a lien against any recovery of proceeds paid by any insurance carrier or from whatever source, settlement, judgment or verdict which may be paid to my attorney or myself as a result of the injuries by reason of this accident.

I hereby authorize my attorney to discuss my case or provide **Biscayne Chiropractic Center** with any information necessary to have payment paid directly to them for such sums as may be due and owing for medical services rendered to me. I, furthermore, authorize my attorney to withhold such sums from any insurance payments or from whatever source, settlement, judgment or verdict and pay **Biscayne Chiropractic Center** as soon as possible for said debt.

I authorize the release of any information pertinent to my case to my insurance company, adjustor and attorney to facilitate collection. I also authorize the release of medical records to any other doctor involved in my case. Further, I hereby authorize the **RELEASE OF MEDICAL RECORDS.**

I, _____, fully understand that I am directly responsible to **Biscayne Chiropractic Center** for all medical bills for services rendered to me and this agreement does not relieve me of any personal responsibility for said charges. I further understand that this agreement is made solely for the protection of said provider and such payment is not contingent on any settlement, judgment or verdict by which I may recover said fee.

I understand that this Letter of Protection is irrevocable and shall apply to any cause of action whether or not I should engage legal counsel or substitute attorney at any future time. I further understand and agree to notify **Biscayne Chiropractic Center** in writing if I change or terminate attorney/client relationship.

X_____ ____/____/____ _____ ____/____/____

Patient Signature | Date | Claim # | Accident Date

ATTORNEY

I, the undersigned, being the attorney of record for the above patient, do hereby agree to observe all the terms of the above agreement and agree to withhold such sums from any insurance payments or from whatever source, settlement, judgment or verdict and pay **Biscayne Chiropractic Center** as soon as possible for said debt.

I, furthermore, understand and agree to immediately notify **Biscayne Chiropractic Center** in writing should there occur a substitution of counsel, referral to another attorney or law firm, retention of co-counsel or should the attorney/client relationship be terminated or modified in any manner.

NOTICE TO MY ATTORNEY OF THIS DOCTOR'S LIEN: I, THE UNDERSIGNED, HEREBY NOTIFY MY ATTORNEY OF RECORD THAT I HAVE SIGNED AND AGREED TO THIS DOCTOR'S LIEN, and it **CANNOT BE RESCINDED, REVOKED OR ALTERED** BY ME OR ANY LEGAL REPRESENTATIVE THAT I HAVE PRESENTLY OR MAY HAVE IN THE FUTURE.

(A photocopy of this agreement shall be considered as effective and valid as the original)

_____ _____ ____/____/____

Attorney Name | Attorney Signature | Date

CHIROPRACTIC CENTER
BISCAYNE

PAYMENT PLANS/WELLNESS PLANS

Biscayne Chiropractic Center, Inc believes in the value of chiropractic care for you and your family toward the goal of achieving total health care and wellness. Therefore, we have created a pricing structure that is flexible enough to allow you to get the chiropractic care you need, no matter what your budget. Our chiropractic office participates in most insurance programs. We also accept auto accident and workers compensation cases that result in back pain, headaches or other symptoms which can be addressed with chiropractic care. For patients who have little or no chiropractic insurance coverage, flexible chiropractor payment plans can be arranged.

Insurance

Most health insurance plans are accepted at our chiropractic office. We accept auto accident insurance, workers compensation, personal injury cases that have resulted in back pain, neck pain, headaches, or other related pain conditions. We also accept most health insurance plans, including Medicare. Because there are so many insurance plans out there, and because coverage for chiropractic care varies widely, please call us to find out if your plan covers care in our office. Before you start a chiropractic care plan, our staff would be happy to verify your benefits and explain them to you at no charge.

No Insurance

Our goal at Biscayne Chiropractic Center, Inc is to allow everyone to experience the benefits of chiropractic care and adjustments. For patients who have little or no chiropractic insurance coverage, we can work with you to arrange a flexible payment program that fits your budget. If you have no insurance or if your insurance does not have any chiropractic benefits, there are still ways for you to receive the pain relief and chiropractic care that you need. Many patients choose to pay directly for their visits with the chiropractor, especially as they discover that chiropractic care is actually extremely cost-effective and affordable. For these patients, chiropractic care is often cheaper and more effective than alternative pain treatments such as pain medications or invasive surgery.

Family Plans

Our focus at Biscayne Chiropractic Center, Inc is to actively help you and your family in taking responsibility for your total health, wellness, and disease management. Our chiropractor will assist and guide you as you take the time to care for some of the most important people in your world: you and your family. In an effort to make living the wellness lifestyle as easy and affordable as possible, we can create a customized family chiropractic plan that is specific to you and your family.

Health on a Budget with Chiropractic Care

At Biscayne Chiropractic Center, Inc, we are convinced that chiropractic care will help you stay healthy and pain-free, using only a small amount of your time and money. Our chiropractic health professionals will help you care for your most important asset - your health. We truly believe the prevention is the best cure, and regular chiropractic care will be far less time consuming and expensive than trying to recover from pain or an injury after it's happened. If you feel you do not have enough time or money to take care of yourself, please contact us-we can help! The last thing we want is for you to come to our chiropractic center in crisis. So please, we would like to encourage you to take your health very seriously. As the old saying goes, if you don't have your health, you don't have anything. Unfortunately, too many people don't discover how true that statement is until it is too late.

Groupons

- If I have purchased a Groupon, I agree not to purchase a Groupon in the future for any service even if I received the Groupon price in office. All Groupon packages must be used within two months of initial treatment. **Groupons are for new patients only. We Will Ask You To Cancel The Voucher.**

Appointments Cancellation Policy and Memberships

For all massage appointments: There is a 24 hour cancellation policy. A $39 cancellation fee will apply if cancelled within 24 hours or same day. If you do not show for your appointment, you will be charged the full amount of your scheduled massage session.

- **Missed massage appointment – Price of appointment / Cancellation fee of $39 (same day cancellations)**
- If I join any membership program offered by Biscayne Chiropractic Center, Inc, I consent that my credit/debit card will be charged monthly on the date that I join. **I understand that:** there is a three month commitment, I must cancel prior to the renewal date and I must maintain my membership to use my rollover massages. If I do not maintain my membership, I understand that my rollover massages are forfeited. All prices are subject to change.

CHIROPRACTIC INFORMED CONSENT

"Chiropractic physician" as defined in Florida Statute 460.403(5)(2008). Chiropractic physicians examine, analyze, and diagnose the human living body and its disease by use of (a) any physical, chemical, electrical or thermal methods, (b) x-ray for diagnosing, (c) blood tests and (d) other chiropractic methods. *See* Florida Statute 460.403(3)(b)

Before you, the Patient, receive chiropractic care, it is important that you read this Consent and understand the nature and risks of chiropractic medicine. The "practice of chiropractic medicine" (or chiropractic care) involves the adjustment, manipulation and treatment of your body in which vertebral subluxations and other malpositioned articulations and structures may be interfering with the normal generation, transmission and expression of nerve impulse between the brain, organs and tissue cells, thereby causing disease. *See* Fla. Stat. 460.403(9)(a). Chiropractic adjustments, manipulations, and treatments are intended to restore the normal flow of nerve impulse which produces normal function and consequent health. *See* Fla. Stat. 460.403(9)(a)

The undersigned Patient understands and acknowledges that there are risks associated with the practice of chiropractic medicine and chiropractic care including, but not limited to ataxia, bruising, thermal injuries, dislocations/subluxations, dizziness, fracture(s), mobility disruption, paralysis, spinal injury, stroke, vision disturbances and others. The most common side effect following chiropractic manipulation/adjustment is an ache or stiffness at the site of the adjustment.

I, also hereby give authorization for **consent of treatment** to **Biscayne Chiropractic Center** and whomever they may designate as their assistants to perform and administer therapy and treatment as they deem necessary.

I, the undersigned Patient, understand the risks and limitations associated with the practice of chiropractic medicine, including the use of chiropractic care, evaluation, diagnosis, adjustments, manipulations, physical therapy and therapeutic modalities such as heat, ice, ultrasound, stimulation, traction, muscle stimulation and others treatments by Biscayne Chiropractic Center. All of my questions have been answered in detail and I fully understand and certify that no guarantee or assurances have been made to the results or outcome from treatment that may or will be rendered.

COVID-19 LIABILITY RELEASE WAIVER

I acknowledge the contagious nature of the **Coronavirus/COVID-19** and that the CDC and many other public health authorities still recommend practicing social distancing. I further acknowledge that Biscayne Chiropractic Center, Inc has put in place preventative measures to reduce the spread of the **Coronavirus/COVID-19.** I further acknowledge that Biscayne Chiropractic Center, Inc cannot guarantee that I will not become infected with the Coronavirus/Covid-19. I understand that the risk of becoming exposed to and/or infected by the **Coronavirus/COVID-19** may result from the actions, omissions, or negligence of myself and others, including, but not limited to, staff, and other clients and their families. I voluntarily seek services provided by Biscayne Chiropractic Center, Inc and acknowledge that I am increasing my risk to exposure to the **Coronavirus/COVID-19.** I acknowledge that I must comply with all set procedures to reduce the spread while attending my appointment.

I hereby release and agree to hold Biscayne Chiropractic Center, Inc harmless from, and waive on behalf of myself, my heirs, and any personal representatives any and all causes of action, claims, demands, damages, costs, expenses and compensation for damage or loss to myself and/or property that may be caused by any act, or failure to act of the office, or that may otherwise arise in any way in connection with any services received from Biscayne Chiropractic Center, Inc. I understand that this release discharges Biscayne Chiropractic Center, Inc from any liability or claim that I, my heirs, or any personal representatives may have against the office with respect to any bodily injury, illness, death, medical treatment, or property damage that may arise from, or in connection to, any services received from Biscayne Chiropractic Center, Inc. This liability waiver and release extends to all owners, partners, and employees. **My signature at the bottom of this form acknowledges the above and I understand that this liability release waiver will be placed in my file and will be active for all future visits to the office.**

By signing below, I agree to abide by all the terms above and policies set forth by Biscayne Chiropractic Center and this will also **act as authorization to charge my card on file for any fees due, services rendered or payments due for me or my children or spouse**. I understand the above and I am aware that Biscayne Chiropractic Center offers reduced fees (time of service discounts). These fees cannot be combined with any insurance.

Patient's Printed Name _____ X _____ Signature of Patient _____/_____/_____ Date