ORLANDO SPORTS CHIROPRACTIC
7567 West Sand Lake Road ♦ Orlando, FL 32819 ♦ 407-345-8686
www.orlandosportschiropractic.com
Dr. Sabrina Atkins-Bathalter

FEES ARE PAYABLE WHEN SERVICES ARE RENDERED UNLESS OTHER ARRANGEMENTS ARE MADE. WE ARE REQUIRED TO MAINTAIN ORIGINAL X-RAYS AND RECORDS AS PROPERTY OF THIS CLINIC. X-RAY COPIES ARE AVAILABLE ($10 per disc).

PERSONAL INFORMATION

Full Name ____ Nickname ____________________________

Address ____ City ____________________ State _____ Zip _________

Home Phone ____________________ Work Phone ________________ ext. ________ Cell Phone ____________________

Sex ☐ M ☐ F **Marital Status** ☐ S ☐ M ☐ D ☐ W Age _____ Birthday ____/____/____ Email ____________________

Race ☐ Caucasian ☐ African-American ☐ Hispanic ☐ Asian ☐ Other ___________

How did you hear about our clinic? ____________________

Emergency Contact Name ____ Phone __________________________

Employer: ____________________ Occupation: ___________________ ☐ F/T ☐ P/T ☐ Seasonal ☐ F/T student ☐ P/T student

REASON FOR VISIT

The reason for this visit is a result of (please circle): work, sports, auto, trauma, or chronic.

Explain what happened:
____
____

When did the problem begin?
________/_________/_________

Is this condition getting worse? ☐ Yes ☐ No
☐ Constant ☐ Comes and goes

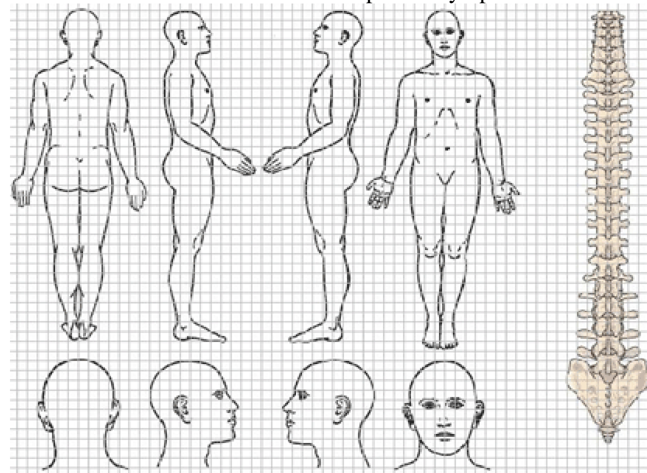
Is this condition interfering with your: (please circle)
work, sleep, daily routine

If so, please explain: ________________________________
____

Have you seen another Physician for this condition?
☐ Yes ☐ No
If so, where? ____________________________________

Have you ever been treated by a Chiropractor before?
☐ Yes ☐ No
If so, where? ____________________________________

Please mark with an 'X' the areas of pain or symptoms.



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HEALTH HISTORY

Are you taking any of the following medications? □Nerve pills □Blood Pressure Med. □Muscle Relaxers □Stimulants □Blood Thinners □Tranquilizers □Insulin □Over-the-counter pain killers □Prescribed Pain killers □Others
____

Do you have or have you ever had any of the following diseases or conditions?

Y N Heart Attack/Stroke
Y N Congenital Heart Defect
Y N Alcohol/Drug Abuse
Y N HIV+/AIDS
Y N Frequent Neck Pain
Y N High/Low Blood Pressure
Y N Severe/Frequent Headaches
Y N Fainting/Seizures/Epilepsy
Y N Diabetes/Tuberculosis
Y N Lower Back Problems
Y N Heart Surg/Pacemaker
Y N Mitral Valve Prolapse
Y N Venereal Disease
Y N Shingles
Y N Emphysema/Glaucoma
Y N Psychiatric Problems
Y N Kidney Problems
Y N Sinus Problems
Y N Difficulty Breathing
Y N Artificial Bones/Joints
Y N Heart Murmur
Y N Artificial Valves
Y N Hepatitis
Y N Cancer
Y N Anemia
Y N Rheumatic Fever
Y N Ulcers/Colitis
Y N Asthma
Y N Chemotherapy
Y N Arthritis

Please list any **other serious medical condition(s)** you have or have ever had: ______________________________

Please list anything that you may be **allergic to**: ______________________________

List previous **surgeries**/treatments with dates: ______________________________

List any past serious **accidents** with dates: ______________________________

Family Health History: □Diabetes F/M □Heart Problems F/M □High Blood Pressure F/M □Cancer F/M
□Other______________________________ F/M *F/M: Father side/Mother side*

Do you: Take supplements or Vitamins? □No □Yes/ What kind? ____________ Exercise? □No □Yes/ How much? __________
Smoke? □No □Yes/How much? __________ How long? _______

Are you on a special diet: □No □Yes Since: _____/_____/_____

Are you wearing: □Heel lifts □Sole lifts □Inner soles □Arch supports

What is the age of your mattress? _____ Is it comfortable? □Yes □No

For **women**: Are you taking birth control? □Yes □No
Do you have children? □No □Yes/ How many? ___________ Ages: _____________
Are you pregnant? □No □Yes/ How long? _____ Nursing? □Yes □No

I understand the above information and guarantee this form was completed to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature ________________________________ Date____________________

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ACCOUNT INFORMATION

Person responsible for this account

Name: ____________________________________ Relation: ___________________________

Payment Method: ☐Cash ☐Check ☐Credit Card/ Type: _____________

INSURANCE INFORMATION

PLEASE COMPLETE THE ACCIDENT INJURY REPORT IF YOUR SYMPTOMS ARE A RESULT OF AN ACCIDENT

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

If insured is self, complete any information not listed above. If insured is someone other than yourself, please complete all information below.

Insured's Full Name ____ Insured's Date of Birth ____/____/____

Address ____ City __________________________ State _____ Zip ____________

Home Phone ____ Work Phone ___________________________ ext. ______________

Insurance Company ____ Phone ___________________________________

Group # ____ Insured's ID # ____

Employed by ____ Phone __________________________________

Additional Insurance Company ____ Phone _________________________________

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured's Full Name ____Insured's Date of Birth ______/______/_______

I understand that my insurance company states that this information is not a guarantee for payment and that my benefits could change or be denied. I also understand that my insurance company can take at least 60 days to respond to submitted claims and that it is my responsibility to inform this clinic of any changes in my policy. I agree to pay, in a current manner, any balance of said professional service charges over and above my insurance company's payments.

_______________________________________ ____ ___________________________

Name **Signature** **Date**

TERMS OF ACCEPTANCE, POLICIES, AND CONSENT FOR CARE

*When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same goal. Chiropractic has only one goal. It is important for each patient to understand this goal and the method that will be used to attain it. This will prevent confusion or disappointment.

"Vertebral Subluxations" are mechanical interferences, by the spinal bones, to the normal flow of mental impulses traveling over the nerve pathways. The goal of chiropractic is to locate, analyze and correct these vertebral subluxations. The method of correction is by specific adjustments to the spine. These adjustments are intended to reduce vertebral subluxations, thereby allowing the innate healing abilities of the body to work at maximum efficiency.

With a proper nerve supply restored through chiropractic adjustments, the body can begin the process of repair leading to health. In some patients this happens quickly; in others, more slowly. In some patients the repair and maintenance is complete; in others, only partial.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will so advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of the health care provider who specialized in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY GOAL IS TO ALLOW THE BODY TO DO ITS JOB. Our only method is the spinal adjustment of vertebral subluxations.

*All first visit charges are payable when services are rendered.

*At the completion of your first visit the doctor will inform you as to your examination results and whether or not your case has been accepted. You will be advised concerning treatment options, financial arrangements, and insurance coverage as appropriate. The doctor may advise as to a time you may return for a second consultation when the doctor will inform you of these arrangements as well.

*I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand Orlando Sports Chiropractic will prepare any necessary reports and forms to assist in making collections from the insurance company and that any amount authorized to be paid directly to Orlando Sports Chiropractic will be credited to my account upon receipt. HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT (fee schedule is available upon request).

*I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered to me will be immediately due and payable. I agree that I will be responsible for all attorney and legal fees if legal action becomes necessary to collect this account. I authorize Orlando Sports Chiropractic to obtain a credit report if deemed necessary.

*I authorize the taking of photographs and x-rays to be used for treatment purposes.
I authorize the performance of other diagnostic and therapeutic procedures for treatment purposes.

*I hereby give consent to have chiropractic adjustments performed in a semi-open room setting. I understand that a semi-open room setting does not ensure complete privacy and will inform the staff if I need to discuss any confidential information in private.

I, ____ have read and fully understand the above statements.
(Print Name)

____ _______________________________
Patient's Signature Date

Complete if Patient is a minor child.

I, ____ being the parent or legal guardian of the aforementioned child have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

________________________________ ________________________________ ________________
Child's Name Parent's Signature Date

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ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO PROVIDER

I ____ hereby instruct and direct my insurance company pursuant to Florida Statute F.S.627.422 to pay by check or draft made out to and mailed directly to the above named provider for professional or medical services, and any reimbursements otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered by them. The payment is not to exceed my indebtedness to the above named provider.

I hereby assign all rights and benefits that I have under any Group Health, HMO plan, Individual Health, PIP, Disability or any other health or medical plan or policy or reimbursement plan that may pay patient benefits for service and treatment that I have received or will receive from the above named provider.

This assignment includes but is not limited to all rights to collect benefits directly from my insurance company or HMO for those services and treatments that I have received and all rights to proceed against my insurance company or HMO in any action including legal suit if for any reason my insurance company or HMO fails to make payments of benefits that are due to the above named provider. This assignment also includes the right to recover any attorney's fees and costs for such an action brought by the provider as my assignee.

I also agree that the above mentioned provider be given Power of Attorney to endorse/sign my name on any and all checks for payment of services provided by them.

I also authorize the release of any information pertinent to my case or claim to the above named provider or any attorney involved in this case.

A photocopy of this assignment shall be considered as effective and valid as the original.

I hereby authorize the above named provider to file any formal or informal complaints that are necessary to the Insurance Commissioner's Office or any other agency or court they deem appropriate on my behalf.

____ ______________________________

Patient's (Claimant) Signature Date

IF POLICY HOLDER (INSURED) IS SOMEONE OTHER THAN PATIENT

____ ______________________________

Policy Holder Date