

Sarasota Chiropractic

and Physical Therapy

Abraham Kozma, D.C., P.A.

2801 Fruitville Rd. Suite 180 Sarasota, Florida 34237

Office 941-924-9892 Fax 941-924-7283

www.sarasotaclinic.com

Patient Data

First Name Last Name Date Email*

* Your email will NOT be shared with any 3rd parties, and is used for occasional office announcements and promotions.

Mailing address

Address City State Zip

Telephone (Work) (home) Referred By

Age Birth Date Social Security # Number of Children

Occupation Employer

Marital Status Spouse's Name Spouse's Occupation

Spouse's Employer Spouse's Health Status

Emergency Contact Phone

Current Complaints

Nature of Injury: Automobile* Work Other

Please describe:

Date of Injury Date symptoms appeared

Have you ever had same condition? No Yes If yes, when?

List of other practitioners seen for this injury/condition

Have you ever been under chiropractic care? No Yes

If yes, please describe

Insurance Information

Name of party responsible for payment Phone

Do you have health insurance? No Yes, Name of company

*** If an auto accident, please provide:**

Insurance Company Name Contact Person

Phone: Claim #

Signatures

Name of the insured

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's signature Date

Spouse's or guardian's signature Date

Medical History

Have you been treated for any conditions in the last year? No Yes

If yes, please describe

Date of last physical exam

Is there a chance that you are pregnant? No Yes

Have you had X-rays taken? No Yes

If Yes, where?

What medications are you taking and for what conditions (Please list dosage and amounts, etc.)

What vitamins, minerals, or herbs do you currently take? (Please list for what conditions, dosage, and frequency).

Have you ever:

No Yes

Briefly Explain

Broken bones?

Been hospitalized?

Been in an auto accident?

Had Sprains/Strains?

Been struck unconscious?

Had surgery?

Family History

Family Members - Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc.)

Do you experience pain every day?

No Yes

Do your symptoms interfere with daily life?

No Yes

Does pain wake you up at night?

No Yes

Are your symptoms worse during certain times of the day?

No Yes

Do changes in weather affect your symptoms?

No Yes

Do you wear orthotics?

No Yes

Do you take vitamin supplements?

No Yes

What activities aggravate your symptoms?

No Yes

Habits

None

Light

Moderate

Heavy

Alcohol

Coffee

Tobacco

Drugs

Exercise

Sleep

Appetite

Soft Drinks

Water

Salty Foods

Sugary Foods

Artificial Sweeteners



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AUTHORIZATION FOR TREATMENT AND CONSENT FOR CARE

I hereby voluntarily consent to chiropractic care and/or diagnostic treatment by **Sarasota Chiropractic, Physical Therapy & Massage**, its physicians and employees as explained to me by the attending physician and whomever he/she may designate as their assistant. I am aware that the practice of chiropractic is not an exact science and that any procedure has an inherent risk. I acknowledge that no guarantees can be made to me as a result of any treatment or examination in this office.

I understand and agree that I am personally responsible for payment of all services rendered. Health and accident policies are an arrangement between an insurance carrier and myself, however, **Sarasota Chiropractic, Physical Therapy & Massage** may accept certain insurance assignments of benefits. The acceptance of insurance assignment is individually determined and prior authorization is required. I understand that upon termination of care, any outstanding charges for professional services rendered will be immediately due and payable. Fees incurred for any account turned over to a third party for the purpose of collections on your account is the patient's financial responsibility.

Patient Signature: _____ Date: _____

Relationship, if Guardian: _____

ALL FEMALE PATIENTS PLEASE COMPLETE THIS SECTION

In order to protect you, the patient, we need to be assured that if the Doctor orders x-rays, there is no possibility of you being pregnant.

I hereby release Sarasota Chiropractic, Physical Therapy & Massage and the staff from any responsibility for injury or complications to my fetus or myself should I be pregnant on this date.

_____ There is a possibility of my being pregnant.

_____ There is NO possibility of my being pregnant.

Signature of Patient _____ Date: _____

Relationship, if guardian: _____



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PATIENT CONSENT TO RECEIVE MAIL AND /OR TELEPHONE MESSAGES

PATIENT NAME: _____

DO WE HAVE YOUR PERMISSION TO:

Send an appointment reminder to your home? Yes No

Send test results to your home? Yes No

Leave the following information on your home answering machine/voice mail:

Appointment Information: Yes No

Billing Information: Yes No

Medical Information: Yes No

I give permission to share appointment information with the person(s) named below:

Name: _____

Name: _____

I give permission to share medical information with the person(s) named below:

Name: _____

Name: _____

I give permission to share billing information with the person(s) named below:

Name: _____

Name: _____

Signature of Patient _____

Date: _____



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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that 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 Patient's legal Representative

Signature

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.

List below the names and relationship of people to whom you authorize the Practice to release PHI



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Financial Policy

Sarasota Chiropractic, Physical Therapy & Massage is covered under many insurance plans. Most of our patients that have health or accident insurance will fall under one of the plans discussed in this policy. We ask that you read and understand our policy as it applies to your particular situation.

PATIENTS WITHOUT INSURANCE

We request that 100% of your visits be paid at the time of the visit. We are happy to accept payment with cash, check, credit card (no Diner's club) and PCD.

"ON THE JOB" INJURY (Worker's Compensation)

If you are injured on the job, your care should be paid for under your employer's Worker's Compensation Insurance. **You will need to inform your employer of the accident and obtain their permission to be seen at our office along with the name and address of their insurance carrier and your claim number. Without an authorization or referral to be seen here, we are not able to treat you.**

PERSONAL INJURY OR AUTOMOBILE ACCIDENTS

Please notify **YOUR auto insurance carrier of the accident immediately**. Even if you were not at fault as Florida is a no-fault state. If or when you retain legal representation (an attorney), please notify our office immediately. Although you are ultimately responsible for your bill, we will wait for settlement of your claim after your care is completed if you have an attorney. **Once the claim is settled or if you suspend or terminate care, any fees for services are due immediately by you as the patient.**

MANAGED CARE PLANS/ GROUP OR INDIVIDUAL INSURANCE – such as

[BC/BS, CIGNA, MEDICARE, TPA, UNITED HEALTH CARE and others]

Our office is on many different insurance provider lists. Please inquire about these plans at our front desk. As soon as possible, we will call to verify benefits on your insurance. However, the benefits quoted to us by your insurance company are not a guarantee of payment. **You are required to pay your co-pay and/ or deductible as required by the contract between you and your insurance company.** Payment will be due by you at the time of service for any non-covered services, deductibles or co-pays.

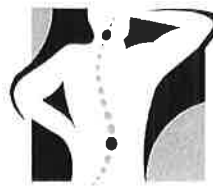
I have read and understand this financial policy for the Sarasota Chiropractic, Physical Therapy and Massage office. I understand that my insurance is a contract between myself and my insurance company and this office. I understand that if my insurance does not respond within 60 days, or if I suspend or terminate my schedule of care as prescribed by the doctors of this office, **those fees will be due and payable immediately by myself as the patient.**

Patient's signature (or guardian if patient is a minor)

Date

Front Desk Witness

Date



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No Show Policy

At Sarasota Chiropractic and Physical Therapy, we understand that unexpected events happen. However, to keep our schedule fair and efficient for all patients, we require a **24-hour notice** to cancel appointments.

If a patient arrives for their appointment but chooses to leave before completing the scheduled treatment, the full appointment fee will still be charged.

No-Show Fees:

- Chiropractic: \$75
- Physical Therapy: \$75
- BTL Services: \$100

If a patient has multiple services scheduled (Chiropractic, PT, or BTL), **all applicable fees will apply**. Missed appointments prevent others from being seen during that time.

After **3 or more no-call/no-show appointments**, patients will only be allowed to schedule appointments on the same day as requested, unless approved by the Office Manager or Dr. Kozma.

Patient/Parent or Legal Guardian Signature: _____ Date: _____

Important Notice

Effective **June 1, 2024**, there will be a **\$30.00 fee** for the completion of all **FMLA, Handicap, or Disability forms** requested from the doctor.

Please note: This is **not considered a medical appointment**. The fee covers the time required for the doctor to review your chart and complete the form. There are **no exceptions** to this policy.

If you have any questions, please speak with the Office Manager.

Patient/Parent or Legal Guardian Signature: _____ Date: _____

Payment Policy

Unless prior arrangements have been made **in writing** with Dr. Abraham Kozma or the Office Manager, the balance on your statement is **due immediately upon issuance** and will be considered **past due** if not paid by the stated due date.

All payments for services rendered are **due in full on the day of service**.

There are **no exceptions** unless approved in advance by Dr. Kozma or the Office Manager.

Patient/Parent or Legal Guardian Signature: _____ Date: _____

EMSCULPT^{neo}®

PATIENT TREATMENT RECORD

Patient's name:	Date of birth:
Phone:	Email:

You are scheduled for a series of non-invasive treatments with the EMSCULPT NEO®.

EMSCULPT NEO is indicated to be used for:

- Improvement of abdominal tone, strengthening of the abdominal muscles, development of firmer abdomen.
- Strengthening, Toning and Firming of buttocks, thighs, and calves.
- Improvement of muscle tone and firmness, for strengthening muscles in arms.
- Non-invasive lipolysis (breakdown of fat) of the abdomen.
- Reduction in circumference of the abdomen.
- Non-invasive lipolysis (breakdown of fat) of the thighs.
- Reduction in circumference of the thighs.
- EMSCULPT NEO is intended for use with skin types I – VI.
- Non-invasive lipolysis (breakdown of fat) of the flanks limited to skin types I - IV.
- Non-invasive lipolysis (breakdown of fat) of the upper arms limited to skin types II and III and BMI 30 and under.

The EMSCULPT NEO device is intended to be used under medical supervision for adjunctive therapy for the treatment of medical diseases and conditions.

The EMSCULPT NEO device is indicated for use in stimulating neuromuscular tissue for bulk muscle excitation in the legs or arms for rehabilitative purposes.

Indications for Use for Muscle Stimulators:

- Relaxation of muscle spasms
- Prevention or retardation of disuse atrophy
- Increasing local blood circulation
- Muscle re-education
- Immediate post-surgical stimulation of calf muscles to prevent venous thrombosis
- Maintaining or increasing range of motion

Initials: _____

EMSCULPT^{neo}®

Please indicate your primary treatment goal:

- Sculpting
- Functional Wellness

Your treatment provider will discuss your specific treatment needs. The recommended number of treatments is four. Each treatment typically lasts about 20 to 30 minutes per session, with sessions separated by 5 to 10 days for the HIFEM+RF Advance/Gentle/Function preset or 2 to 3 days for the HIFEM Classic/Function preset. Completing a full treatment series is necessary to maximize treatment efficacy. You may need additional treatments depending on your goals.

Initials: _____

No unusual preparations are required before the treatment; however, it is strongly recommended to keep your body well-hydrated. On the day of the treatment, it's advisable to wear comfortable clothing that allows flexibility for proper positioning during the procedure. To prevent excessive sweating, the treatment area should be shaved or the hair trimmed beforehand. The treated area will also be wiped with alcohol wipes before the treatment to remove any moisture, perfume, moisturizers, or oils. You will be asked to remove all metallic accessories and electronic devices.

Initials: _____

I acknowledge that smoking, excessive alcohol consumption, eating disorders, and certain medications may affect the success of the treatment outcome. While no special diet is required, maintaining a healthy diet is encouraged to help promote and sustain results.

Initials: _____

The treatment does not require anesthesia. During the procedure, you may feel intense muscle contractions and a warming sensation in the treated area. It's important to note that while the warming sensation may be intense, it should never be painful. If you experience any pain or discomfort, please ask your provider to adjust the intensity. The procedure requires no recovery time, and you can typically return to your daily routine immediately afterward.

Initials: _____

EMSCULPT^{neo}®

I am aware that I MUST NOT wear any metallic accessories (such as jewelry, watches, or clothing with metallic threads or accessories) during the treatment. I also confirm that I do not have any metallic or electronic implants (such as pacemakers, defibrillators, metallic IUDs, etc.).

Initials: _____

Please answer whether you currently have or had any of the following in the past*:

- Electronic implants (such as cardiac pacemakers, defibrillators and neurostimulators) YES NO
- Metal implants YES NO
- Drug pumps YES NO
- Malignant tumor YES NO
- Pulmonary insufficiency YES NO
- Muscles in acute phase of injury YES NO
- Cardiovascular diseases YES NO
- Disturbance of temperature or pain perception YES NO
- Hemorrhagic conditions YES NO
- Septic conditions and empyema YES NO
- Acute inflammations YES NO
- Systemic or local infection such as osteomyelitis and tuberculosis YES NO
- Contagious skin disease YES NO
- Elevated body temperature YES NO
- Pregnancy, postpartum and nursing period YES NO
- Graves' disease YES NO
- Metallic IUD YES NO
- Recent surgical procedures (muscle contraction may disrupt the healing) YES NO
- Areas of the skin which lack normal sensation YES NO

*For the full range of contraindications, warnings, and cautions, consult your treatment provider.

EMSCULPT^{neo}®

If you answer YES to any of these questions, please specify:

Treatment considerations

- I am aware that the treatment cannot be applied over the head, neck, spinal cord, heart, or testes.

Initials: _____

- I am aware that the treatment cannot be applied over swollen or neoplastic tissues, space-occupying lesions, or skin eruptions.

Initials: _____

- I am aware that pregnancy is contraindication, and pregnant women cannot undergo the treatment.

Initials: _____

- I am aware that with any heat-based therapy, in rare cases, burns can occur.

Initials: _____

- I am aware that the applicators must always be in direct contact with the skin. **I am aware that treatment must not be applied over clothing or scar tissue.**

Initials: _____

- I understand that there are certain side effects associated with EMSCULPT NEO treatments. The side effects may include, but are not limited to muscular pain, intramuscular fat decrease, temporary muscle spasm, temporary joint or tendon pain, local erythema or skin redness, increased menstrual flow in female patients and panniculitis.

Initials: _____

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- I understand that the treatment over muscles in the acute phase of injury is contraindicated.

Initials: _____

- I understand that the treatment may involve risks of complications or injury from both known and unknown causes, and I freely assume these risks.

Initials: _____

- I agree to before and after treatment photographs, measurements, and weighing, as this will aid in the medical evaluation of the results of the treatment. This information will be collected for medical records or marketing purposes.

Initials: _____

- I understand results may vary from person to person and that an exact result cannot be predicted. Completing a full treatment series is necessary to maximize treatment efficacy. It is very unlikely, but I acknowledge that it is possible not to experience any noticeable results after the procedure. I understand that the results may not meet my expectations.

Initials: _____

- I certify that I have read this entire document and agree with all provisions. I certify that I have had the opportunity to ask questions and these questions have been answered in full to my satisfaction. I fully understand the treatment conditions, the procedure, and possible side effects.

Initials: _____

- I have read the above information, and I request and give my consent to be treated with the EMSCULPT NEO by the physician(s) at this practice and their designated staff.

Initials: _____

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My signature below indicates that the above information is accurate and current.

Patient's signature: _____ **Date:** _____

Witness (in print): _____ **Signature:** _____ **Date:** _____

Practice Name: _____