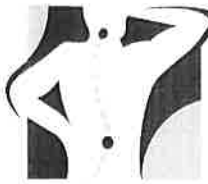


Sarasota Chiropractic
and Physical Therapy

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)I

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

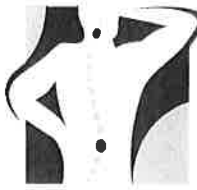
Have you ever:	No	Yes	Briefly Explain
Broken bones?	○	○	
Been hospitalized?	○	○	
Been in an auto accident?	○	○	
Had Sprains/Strains?	○	○	
Been struck unconscious?	○	○	
Had surgery?	○	○	

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?	

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:

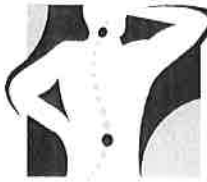
Name: _____
Name: _____

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

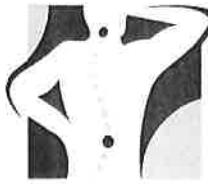
THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.

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: _____

EMSELLA®

GENERAL PATIENT RECORD

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

Diagnosis: _____

TREATMENT CONSIDERATIONS

You are scheduled for a series of non-invasive treatments with the BTL EMSELLA device.

BTL EMSELLA is intended to provide entirely non-invasive electromagnetic stimulation of pelvic floor musculature for the purpose of rehabilitation of weak pelvic muscles and restoration of neuromuscular control for the treatment of male and female urinary incontinence.

Initials: _____

Your treatment provider will discuss your specific treatment needs. Recommended number of treatments is 6. The treatment is typically about 30 minutes per session, with sessions separated by at least 2 days, depending on your needs. Completing a full treatment series is necessary to maximize treatment efficacy. You may need additional treatments depending on the severity of your condition. The results will typically continue to improve over the next few weeks.

Initials: _____

There is typically no pain associated with your treatment and there is no anesthetic required. You will experience gradually increasing tingling feeling and muscle contractions. These sensations in the pelvic area are normal and expected. You remain fully clothed during the treatment.

Initials: _____

On the day of the treatment, you are advised to wear comfortable clothes which allow flexibility for correct positioning and increased comfort during the treatment.

Initials: _____

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

- pregnancy ☐ YES ☐ NO
- cardiac pacemakers ☐ YES ☐ NO
- implanted defibrillators, implanted neurostimulators ☐ YES ☐ NO
- electronic implants ☐ YES ☐ NO
- pulmonary insufficiency ☐ YES ☐ NO
- metal implants ☐ YES ☐ NO
- drug pumps ☐ YES ☐ NO
- hemorrhagic conditions ☐ YES ☐ NO
- anticoagulation therapy ☐ YES ☐ NO
- heart disorders ☐ YES ☐ NO
- malignant tumor ☐ YES ☐ NO
- fever ☐ YES ☐ NO
- allergy to any medications, food or other substances ☐ YES ☐ NO
- taking prescription, herbal, or over the counter medication ☐ YES ☐ NO
- any surgeries ☐ YES ☐ NO
- any skin disease or sensitivity ☐ YES ☐ NO

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

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

- I am aware that pregnancy is contraindicated and pregnant women can't undergo the treatment. **Initials:** _____
- I am aware that I can't undergo the treatment when menstruating. **Initials:** _____
- I understand there are certain risks associated with BTL EMSELLA treatments and they include but are not limited to: muscular pain, temporary muscle spasm, temporary joint or tendon pain, local erythema or skin redness. 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 am willing to fill in forms and/or anonymous questionnaires if requested, as this will help for medical evaluation of the results of the treatment. Information will be acquired for medical records or marketing purposes. **Initials:**_____
- I understand the results may vary from person to person and that an exact result cannot be predicted. It is very unlikely but it is possible that you will not feel any recognizable result after the procedure. I acknowledge the results may not meet my expectations. **Initials:**_____
- I certify that I have read this entire document and that I 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 BTL EMSELLA procedure by the physician(s) in the below stated practice and his/her designated staff. **Initials:**_____

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

Patient signature:_____ **Date:**_____

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

Practice Name: _____

PELVIC HEALTH QUESTIONNAIRE

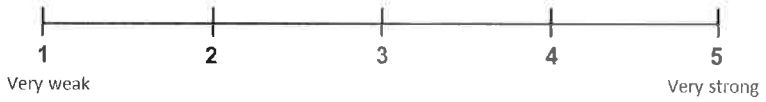
Patient's name:	**Date:**
Phone:	**Email:**
Sex: ☐ **Male** ☐ **Female**	**Date of birth:**

BASELINE

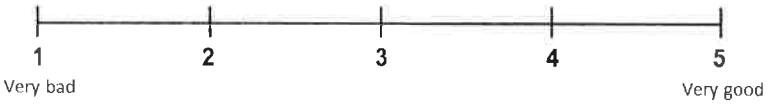
How would you describe your overall health at present?

☐ Very good
☐ Good
☐ Fair
☐ Poor
☐ Very poor

On a scale of 0-5, how would you rate your pelvic floor muscles strength?



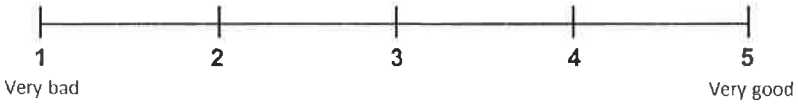
On a scale of 0-5, how would you rate your quality of sleep?



How many times per week do you exercise?

☐ 0
☐ 1-2
☐ 3-4
☐ 5+

On a scale of 0-5, how would you rate your sexual libido/desire?



During the last few months, have you accidentally leaked urine? (e.g. when laughing, jumping, sneezing) If yes, how often?

☐ No
☐ About once a week or less often
☐ Two or three times a week
☐ Daily

When does urine leak? (select all that apply)

☐ Leaks when you have finished urinating and are dressed
☐ Leaks when you cough or sneeze
☐ Leaks when you are asleep
☐ Leaks before you can get to the toilet
☐ Leaks when you are physically active/exercising
☐ Leaks for no obvious reason
☐ Leaks all the time

How much urine do you usually leak?

☐ A small amount
☐ A moderate amount
☐ A large amount

How many times per night do you wake up to use the restroom?

☐ 0
☐ 1-2
☐ 3-4
☐ 4+

Do you wear hygiene pads to keep dry?

☐ Never
☐ About once or twice a week
☐ Three to four times a week
☐ Daily

How much do you think your bladder problems affect your quality of life?

☐ Not at all
☐ A little
☐ Moderately
☐ A lot

Does your bladder problem limit your intimate relationship with your partner?

☐ Not at all
☐ A little
☐ Moderately
☐ A lot
☐ Not applicable

Does your bladder problem make you feel depressed/anxious?

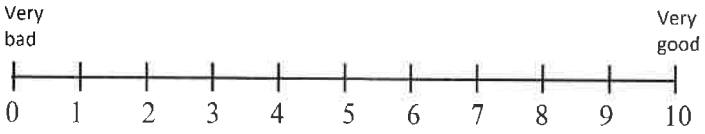
☐ Not at all
☐ A little
☐ Moderately
☐ Very much

Wellness Evaluation Questionnaire

Patient's name:	**Date:**
Phone:	**Email:**
Sex: ☐ **Male** ☐ **Female**	**Date of birth:**

1. On a scale of 0-10, how would you rate your core strength?

2. On a scale of 0-10, how would you rate your quality of sleep?



3. How many times per night do you wake up to use the bathroom? Please circle your answer.

0-1 2-4 4+

4. How many times per week do you exercise? Please circle your answer.

0 1-3 4-6 6+

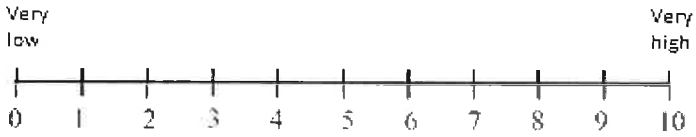
5. Which of the following sports and exercise activities do you participate in? Please circle all that apply.

Baseball Football Basketball Cycling Cross-fit Hockey Tennis Running Volleyball
Soccer Yoga Swimming Pilates Weightlifting Golf Skiing
Other: _____

6. During the last month, have you accidentally leaked urine? (e.g. when laughing, jumping, sneezing)

Yes No

7. On a scale of 0-10, how would you rate your sexual libido?



BTL EMSELLA® PATIENT FACT SHEET

SAY **NO** TO **INCONTINENCE**

ABOUT URINARY INCONTINENCE:

Urinary incontinence is defined as the involuntary leakage of urine. This might be a result of weak pelvic floor muscles since pelvic floor muscles play an important role in supporting pelvic organs and controlling continence.

There are three different types of urinary incontinence:

- **Stress incontinence:** is when there is exerted pressure on the bladder causing leakage. This can be caused by coughing, laughing, sneezing, or exercising.
- **Urge:** is the sudden, intense urge to urinate frequently.
- **Mixed incontinence:** is a combination of both stress and urge incontinence.

Physiological changes can contribute to the development of urinary incontinence; changes such as vaginal delivery, menopause, and aging can decondition pelvic floor muscles. In order to improve symptoms, it is important to strengthen these muscles. Possible ways to improve your condition may include lifestyle changes and Kegel exercises.

The diagram below shows the pelvic organs and pelvic floor muscles in men (left) and women (right).

MECHANISM OF ACTION:

BTL EMSELLA is the HIFEM® procedure, that utilizes electromagnetic energy, at a high frequency, to cause pelvic floor muscle stimulation completely non-invasively. Similar to the contractions you perform when doing a Kegel exercise. What makes this treatment effective is the in-depth penetration and stimulation of the entire pelvic floor area. A single session brings you thousands of intense contractions that you would not be able to do on your own. These contractions are very helpful when it comes to muscle strengthening and re-education.

WHAT TO EXPECT DURING THE TREATMENT?

During BTL EMSELLA treatment you will be completely clothed yet, we recommended loosely fitted clothing to help achieve best positioning during treatment. When the treatment starts you will feel slight tingling and vibrations in your pelvic floor muscles that will then turn into full contractions. This will be completely comfortable and tolerable. If not, please let your healthcare provider know and they will adjust accordingly. Take this 28-minute session to relax, read a magazine, or watch television. You will be able to return to normal activities after the treatment.

LEARN THE TERMS

- **Pelvic floor**: The bowl-shaped muscles in the pevlic area that support pelvic organs, including the uterus, bladder and rectum.
- **Pelvic floor muscle exercises (Kegels)**: Exercises that strengthen the pelvic floor. Regular excercising of the pelvic floor muscles can improve or prevent urinary leakage.
- **Bladder training**: Behavior therapy that helps you wait longer between bathroom trips so that you can go to the bathroom when it is convenient for you rather than the sudden urge.

BTL EMSELLA IS NOT FOR YOU IF:

METAL IMPLANTS

PREGNANCY

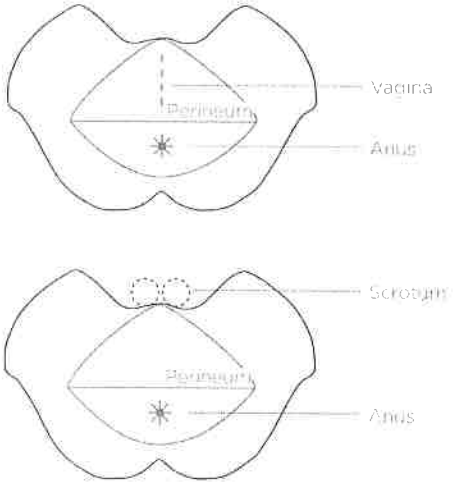
TUMOR

HEART DISORDERS

For the full range of contraindications, warnings and cautions, refer to your healthcare provider.

BTL EMSELLA® PATIENT POSITIONING

1. Sit comfortably at the center of the chair.
2. To achieve correct treatment position height of the chair can be set. Your health care provider will help you with this.
3. Your feet should be flat on the floor, shoulder width apart (which varies patient to patient).
4. Place your knees just above your feet at a 90-degree angle with slight outward rotation.
5. Angle your pelvic area closest to the center of the chair, you may have to tilt forward or backward to get the right angle.
6. Keep your spine straight and relax your hands on your thighs.
7. The first minute of therapy is there to help you gauge positioning. The tapping should be over the perineum (see figure below). Either adjust forward, back, or towards either side to find the target area.



ADDITIONAL PATIENT FACTS:

- Do not lean back on the chair.
- Do not hunch your back.
- Keep feet flat on the ground.
- Do not keep your legs together, crossed, or too spread out.
- Jewelry, belts, cards, coins, wallet, and watches should be removed before treatment. Also keep phones and other electronics away from the device. Wear comfortable clothing, nothing too tight that will prevent correct positioning.