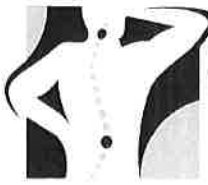


Sarasota Chiropractic
and Physical Therapy

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?	

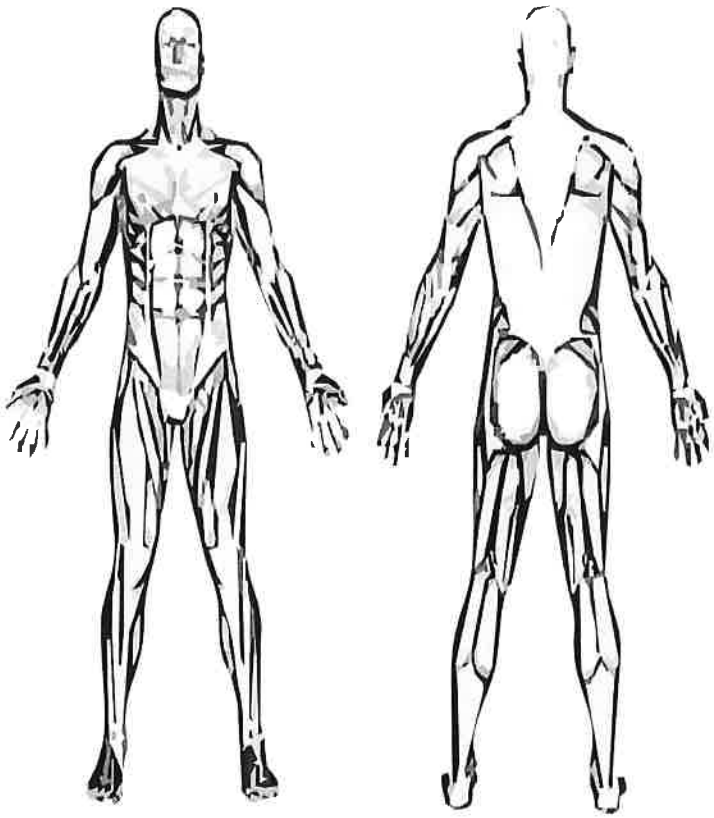
Habits	None	Light	Moderate	Heavy
Alcohol	○	○	○	○
Coffee	○	○	○	○
Tobacco	○	○	○	○
Drugs	○	○	○	○
Exercise	○	○	○	○
Sleep	○	○	○	○
Appetite	○	○	○	○
Soft Drinks	○	○	○	○
Water	○	○	○	○
Salty Foods	○	○	○	○
Sugary Foods	○	○	○	○
Artificial Sweeteners	○	○	○	○

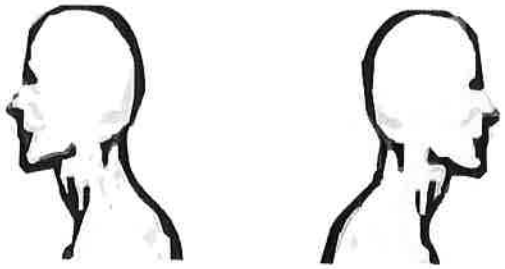
Have you ever suffered from:

- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Asthma
- ☐ Back Pain
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chest Pain/Conditions
- ☐ Cold Extremities
- ☐ Constipation
- ☐ Cramps
- ☐ Depression
- ☐ Diabetes
- ☐ Digestion Problems
- ☐ Dizziness
- ☐ Ears Ring
- ☐ Excessive Menstruation
- ☐ Eye Pain or Difficulties
- ☐ Fatigue
- ☐ Frequent Urination
- ☐ Headache
- ☐ Hemorrhoids
- ☐ High Blood Pressure
- ☐ Hot Flashes
- ☐ Irregular Heart Beat
- ☐ Irregular Cycle
- ☐ Kidney Infection
- ☐ Kidney Stones
- ☐ Loss of memory
- ☐ Loss of balance
- ☐ Loss of smell
- ☐ Loss of taste
- ☐ Lumps In Breast
- ☐ Neck Pain or Stiffness
- ☐ Nervousness
- ☐ Nosebleeds
- ☐ Pacemaker
- ☐ Polio
- ☐ Poor Posture
- ☐ Prostate Trouble
- ☐ Sciatica
- ☐ Shortness of breath
- ☐ Sinus Infection
- ☐ Sleep problems orInsomnia
- ☐ Spinal Curvatures
- ☐ Stroke
- ☐ Swelling of ankles
- ☐ Swollen Joints
- ☐ Thyroid Condition
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Varicose Veins
- ☐ Venereal Disease
- ☐ Other: _____

Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing.

A=Ache **O**=Other
B=Burning **P**=Pins & Needles
N=Numbness **S**=Stabbing





QUADRUPLE VISUAL ANALOGUE SCALE

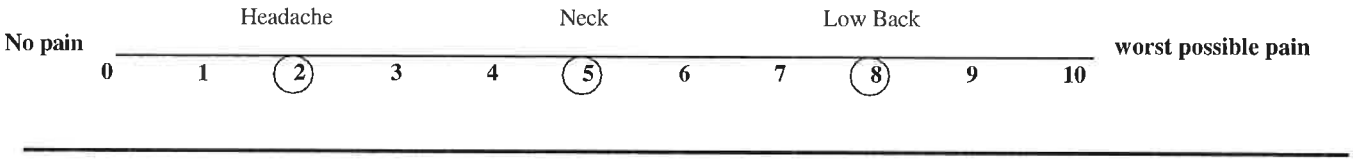
Patient Name _____ Date _____

Please read carefully:

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:



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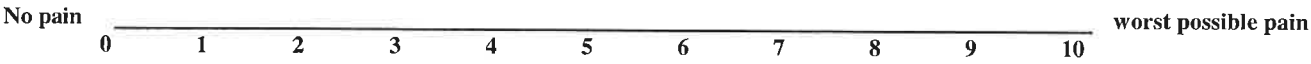
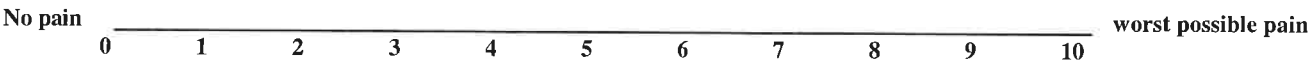
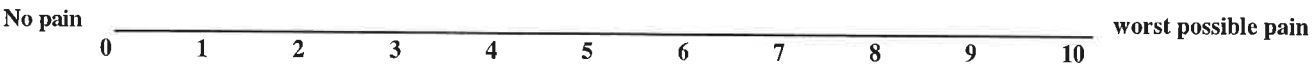
1 – What is your pain RIGHT NOW?



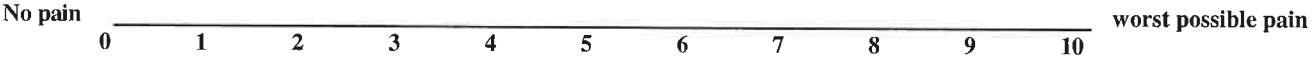
2 – What is your TYPICAL or AVERAGE pain?



3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?



4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?



OTHER COMMENTS:

_____

_____

_____

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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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AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

TO:

_____

_____

_____

_____

Patient Name: _____ Date of Birth: _____

I HEREBY REQUEST A COPY OF THIS PATIENT'S MEDICAL RECORDS:

INFORMATION REQUESTED:

_____ Patient X-Ray, CT, MRI Reports

_____ Patient X-Ray's, Patient MRI Films

_____ Patient Medical Records

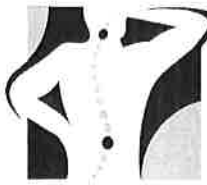
THE ABOVE RECORDS ARE TO BE RELEASED TO THE FOLLOWING:
Sarasota Chiropractic, Physical Therapy & Massage
2801 Fruitville Rd. Suite 180 Sarasota, FL 34237-5357
Fax: 941-924-7283 Office: 941-924-9892

THE RECORDS ARE REQUESTED FOR CONTINUED MEDICAL CARE

Signature of Patient _____ Date: _____

Patient, Parent or Legally Authorized Representative _____
Relationship to the Patient: _____

The information received on this fax is private medical information that is not to be viewed or distributed by anyone but the person listed on this cover letter. If you should receive this fax in error, please destroy immediately and contact this office at 941-924-9892 so we may correct our records. Thank you!



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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: _____

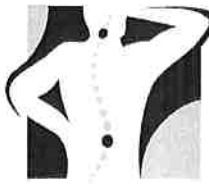
Payment Policy

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: _____



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PATIENT OPTIONS ACCESS PROGRAM
FREE PATIENT ENROLLMENT AGREEMENT

As a patient, you are a participant in a Discount Managed Care Organization provided by Patient Options. There is NO FEE for patients to participate, and it is provided free to the public for those who are uninsured or otherwise underinsured. This Agreement and its terms and conditions, is between you and Patient Options. This Agreement is effective as of the date you sign below and are electronically enrolled at www.PatientOptions.org by your Provider and shall continue for a period of exactly one year (12 months) from the date of signature below. You will automatically be reenrolled for successive one-year (12 month) periods unless request in writing.

There are no fees, dues, charges or other consideration required for participation.

DISCLOSURES:

The Program provides discounts to you from contracted healthcare providers for services rendered;

The Program participant is obligated to pay for all healthcare services directly as de facto 3rd party to provider but will receive a contractual discount from healthcare providers who have contracted with Patient Options;

This is NOT insurance or a qualified policy under the Affordable Care Act or any state regulated program. Patient agrees this program and the discounts offered by contracted Providers are not available in instances where another third-party insurance company is responsible for charges.

Patient absolves provider of wrongdoing in the event the patient chooses to bill insurance for discounted services rendered under this Agreement;

The name and address of the Discount Managed Care Organization is: Patient Options; 9435 Waterstone Blvd Suite #140, Cincinnati, Ohio 45249. (866) 275-5633

This Disclosure and its Benefit descriptions represent the entire agreement between you and Patient Options and supersedes all other prior representations, statements, or written agreements between you and Patient Options.

I have read and agree to the terms and conditions set forth above:

Name: _____ Signature: _____

Date: _____ Address: _____

_____

Additional Household participants may be enrolled free of charge under the same terms of this Agreement. To activate, please write their names below:

1_____ 2_____

3_____ 4_____

5_____ 5_____