WELCOME

Date: ______________

Patient Information

Name: ____
Last First MI

Email address: ____

Mailing Address: ______________________ City ________ State ______ Zip ______

Phone # (H)______________ (W) ______________ (Other) ______________

Can we call you at work? ❑ Yes ❑ No

Date of Birth: ______________ Sex: ❑ Male ❑ Female **SS#:** ______________

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Minor

Race ❑ Caucasian ❑ African American ❑ Asian ❑ Native American ❑ Latin American ❑ Other ____

Ethnicity ❑ Hispanic ❑ Latino ❑ Non-Hispanic / Non-Latino

Occupation: ______________________ Employer: ______________________

Employer Address: ______________________ Phone: ______________

May we contact you via text/phone regarding your appointment time and dates: Yes/No

Emergency contact: Name: ______________ Relation: ______________ Phone #: ______________

Phone #: (H) ______________ (W) ______________

Accident Information

Is this visit due to an accident? ❑ Yes ❑ No If yes, what type? ❑ Auto ❑ Work ❑ Other ________

Has it been reported? ❑ Yes ❑ No If yes, to whom? ______________________

Insurance Information

Policy Holder Name: ______________________ D.O.B. : ______________

Relationship to patient (if other than self): ______________ Phone # ______________

Do you have health insurance? ❑ Yes ❑ No Name of Carrier: ______________________

Do you have secondary insurance? ❑ Yes ❑ No Name of Carrier: ______________________

PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)

Assignment and Release (insured patients)

I certify that I (or my dependent) have insurance coverage with ______________________ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN/MEDICAL PRACTICE, INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

SIGNATURE (X) ______________________________ **DATE** ______________

Form 2

DOCTOR : Nicholas Belletto D.C.

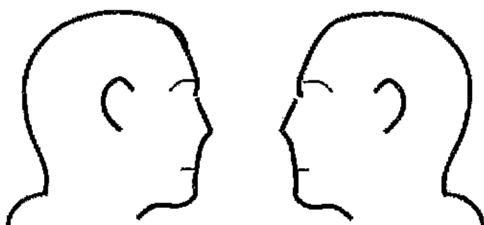
DATE OF VISIT* ___/___/20___ Patient________________________ Age________

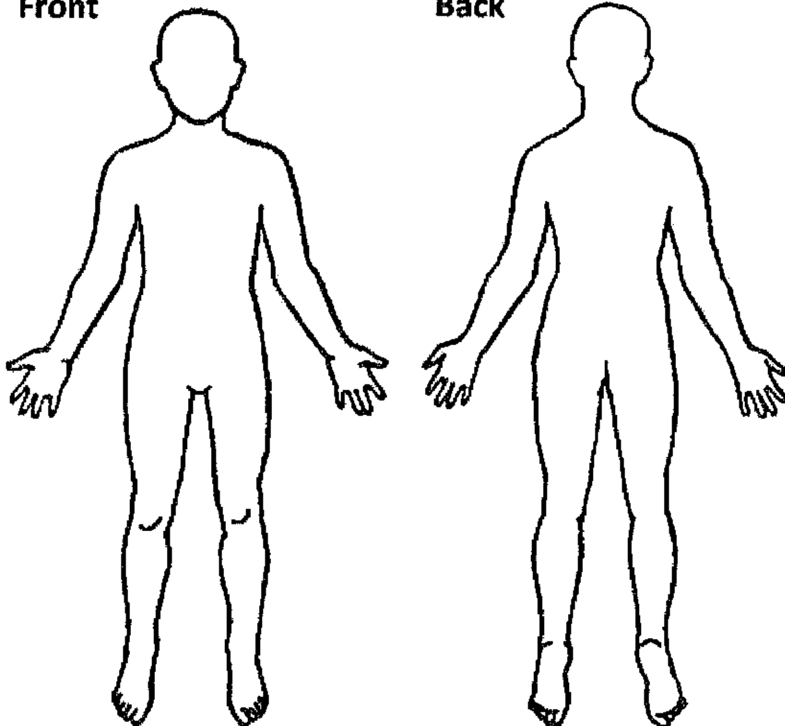
Check ONE: _____INITIAL EXAMINATION _____ OFFICE VISIT _____ NEW CONDITION

FOR INITIAL EXAMINATION OR NEW CONDITION, Please give first date you noticed symptoms ____________

FOR INITIAL EXAMINATION OR NEW CONDITION, What is your major complaint? ____________

SUBJECTIVE PAIN ASSESSMENT





RATE YOUR PAIN

Place an "X" on the drawings to the left wherever you have pain. Beside the "X" indicate the type of pain you are experiencing:

A=Ache
B=Burning
ST=Stabbing
SP=Spasm
N=Numbness
P=Pins and Needles
T=Throbbing

(Example: XST between your shoulders mean you have stabbing pain between your shoulders)

PAIN SCALE: Please circle the number that best describes your overall pain:

0 1 2 3 4 5 6 7 8 9 10 10+

NONE LITTLE MEDIUM SEVERE EXCRUCIATING

PATIENT SIGNATURE **DATE**

Review of Systems

Name__________________________________ **Date**__________________

Please mark if you have experienced any of these symptoms within the last month:

Y	N	**Neurological**
___	___	Migraines
___	___	Headaches
___	___	Slurring of speech
___	___	Ringing in Ear
		Ear/Nose/Throat
___	___	Altered taste/smell
___	___	Night Blindness
___	___	Sore Throat
___	___	Gingivitis
___	___	Nose bleeds
		Cardiovascular
___	___	Chest pain
___	___	Palpitations-racing heart beat
___	___	Swelling in hands/feet
___	___	Anemia
		Respiratory
___	___	Recurrent Respiratory Infections
___	___	Asthma
___	___	Chest Congestion
___	___	Wheezing
___	___	Frequent Sneezing
		GI
___	___	Stomach Pains or Cramping
___	___	Constipation
___	___	Reflux or Heartburn
___	___	Bloating
___	___	Gas
___	___	Nausea or Vomiting
		Musculoskeletal
___	___	Joint Pain
___	___	Arthritis
___	___	Chronic pain
___	___	Muscle Aches

Y	N	**Skin**
___	___	Eczema
___	___	Dermatitis
___	___	Excessive Sweating
___	___	Rashes
___	___	Brittle Nails
___	___	Hair Loss
___	___	Easy Bruising
___	___	Increased Bleeding
___	___	Numbness/tingling
		Genitourinary
___	___	Uterine fibroids
___	___	Ovarian cysts
___	___	Cancer (breast, ovarian, prostate, uterine)
___	___	Prostate problems
		Emotional/Mental
___	___	Depression
___	___	Anxiety
___	___	Mood Swings
___	___	Irritability
___	___	Memory Loss
___	___	Confusion
		Energy
___	___	Fatigue
___	___	Hyperactivity
___	___	Restlessness
___	___	Insomnia
___	___	Decreased Libido
___	___	Stress
		Weight
___	___	Decreased Appetite
___	___	Weight Gain
___	___	Inability to Lose Weight
___	___	Food Cravings
___	___	Binge Eating
___	___	Water Retention

Nicholas Belletto D.C.

Assignment of Benefits and Direction to Pay Benefits Owed

I, the undersigned insured or beneficiary of an insurance policy, irrevocably assign to Nicholas Belletto D.C. P.A. whatever rights, interest, and benefits I have under any policy of insurance and under Florida law, including, without limitation, any and all claims for attorney's fees, injunctive, declaratory, and equitable relief, and costs, interest and/or damages, pursuant to common law, the Florida or US Constitution, and federal or Florida Statutes, including, but not limited to, § 624.155., *Fla. Stat.* This Assignment of Benefits (AOB) includes an assignment of any potential claim or cause of action 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 Nicholas Belletto D.C. P.A., to promptly make payment in the name of and directly to Nicholas Belletto D.C. P.A. or its chosen billing service.

In the event that any insurance company reduces or denies benefits for services or treatment that Nicholas Belletto D.C. P.A. rendered to me, pursuant to this AOB, Nicholas Belletto D.C. P.A. is authorized to file suit in the Provider's own name or on my behalf and prosecute causes of action or claim I might have or that may exist in my favor against the insurance company 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 further authorize Nicholas Belletto D.C. P.A. to compromise, settle or otherwise resolve any such claim or cause of action as it sees fit. 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 Nicholas Belletto D.C. P.A. 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 Nicholas Belletto D.C. P.A. 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. Nicholas Belletto D.C. P.A. reserves the right to seek the full amount of the bill submitted from the insurance company or from patient. 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 Nicholas Belletto D.C. P.A. in resolving all billing or other 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 Nicholas Belletto D.C. P.A. or its attorneys, employees or other representatives acting on behalf of Nicholas Belletto D.C. P.A. 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 the insurance company to speak to an attorney, employee or any other representative of Nicholas Belletto D.C. P.A. or anyone acting on its behalf over the phone and otherwise and to provide them with any and all information the insurance company 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 Nicholas Belletto D.C. P.A., regardless of the amount paid by the insurance company, unless ordered by a court of law. I fully understand that said services or treatment 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 on notice that the claims for services or treatment rendered by Nicholas Belletto D.C. P.A. are related to my accident (or my covered conditions) and should be paid directly to Nicholas Belletto D.C. P.A. pursuant to this assignment of benefits and applicable 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, INTEREST, AND BENEFITS I HAVE UNDER MY POLICY OF INSURANCE (LESS THE DUTY TO ATTEND AN EUO) AND UNDER FLORIDA LAW TO THIS PROVIDER. A photocopy of this assignment shall be considered as effective and valid as the original. **The rights of the Provider under this assignment shall not be extinguished upon my death, and my estate shall be subject to the terms and conditions of this AOB and my obligations and representations hereunder.**

_________________________ _________________________ __________

PATIENT NAME ***PATIENT SIGNATURE*** ***DATE***

Informed Consent to Care

A patient coming to the doctor gives him/her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare case, underlying physical defects, deformities or pathologies may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician. This office does not perform breast, pelvic, prostate, rectal, or full skin evaluations. These examinations should be performed by your family physician, GYN, and dermatologist to exclude cancers, abnormal skin lesions that should undergo biopsy/removal or other treatments. This clinic does not provide care for any condition (such as high blood pressure, diabetes, high cholesterol) other than those addressed in your physical medicine care plan. We also do not prescribe or refill ANY controlled substances. All prescriptions should be refilled by your original prescriber and any new prescriptions should be issued by your primary care provider.

The patient assumes all responsibility/liability if the patient does not report on health forms any past medical history, illnesses, medicines, or allergies.

I agree to settle any claim or dispute I may against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

Patient's Signature ______________________ Date ________

Chiropractic care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke.

Prior to receiving chiropractic care this Chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spine health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies needed. In addition, they will help us determine if there is any reason to modify your care of provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care. I understand and accept that there are risks associated with chiropractic care and give consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment.

This notice is effective as of the date it is signed and will expire seven years after the date on which you last received servies from us.

______________________ Patient Signature Date

NOTICE TO ALL PATIENTS

By FLORIDA STATUE 817.234 – False and Fraudulent Insurance Claims.

(7)(a) It shall constitute a material omission and insurance fraud for any physician or other provider, other than a hospital, to engage in a general business practice of billing amounts as its usual and customary charge, if such provider has agreed with the patient or intends to waive deductibles or co-payments, or does not for any other reason intend to collect the total amount of such charge. With respect to a determination as to whether a physician or other provider made a good-faith attempt to collect such a deductible or co-payment.

Therefore, waiver of collection of co-pay and deductibles makes it a third degree felony if done as general business practice, unless it is shown that the provider makes/made a good faith attempt to collect the deductible or co-payment, such as writing the patient one or more letters asking for payment.

Due to this new law enacted upon us, we are giving you this copy, as well as, placing one in your file of the Florida statue. By signing this, we have explained to you and that you understand the new law. This is also an attempt to collect a portion of the deductible or co-payment at this time and will attempt to collect each time that you come in for treatment until your deductible has been met determined by your insurance policy. If no deductible or co-payment need to be paid, then none will be collected.

____

Print Patient Name

________________________________ Date____________

Patient Signature

________________________________ Witness____________

PATIENT MISSED APPOINTMENT POLICY

DEFINITIONS

POLICY- a way of managing affairs so as to achieve some purpose.

APPOINTMENT- a meeting with someone at a certain time and place.

MISSED- fail to keep, do, or be present at.

It is our wish that each and every one of our patients receive the very best care and service possible. **Your Treatment Program** consists of a specific series of treatment given over a pre-planned time span. If you do not follow this plan, then you will not receive the desired results.

If we did not insist that you meet all your appointments, we would be doing you a disservice and it would be indicative that we did not care. We do not want to do you a disservice and we do care about you and the success of your program here. Therefore, we have a few simple rules that we insist you follow:

1. Meet all your appointments. Arrange the activities in your life so that this can occur.
2. If you become ill, we still want you to come in, because **Treatments** will help you recover.
3. If you are unable to make it in due to an emergency, please call us and let us know so we can reschedule your appointment.
4. With the exceptions of unexpected emergencies, we require that you notify us at least 24 hours in advance as to any appointment changes.
5. **All cancelled or missed appointments must be rescheduled and made up within one week.**

I have read, understand, and agree to follow the above policy.

Patient's Name: ______________________________

Signature: ______________________________

Staff Witness: ______________________________

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