Touch of Health Medical Center LLC
1405 W Colonial #B Orlando, FL 32804
Phone: (407) 237-0915, Fax: (407) 386-7332

Auto Accident Mechanism of Injury Form

Patient's Name: _____

Date of Collision: _____ | Hour of Accident: _____ AM / PM

Please describe how the collision happened: _____

_____

_____

_____

_____

_____

What was your position in the car? (Circle)**Driver** / **Front Passenger** / **Left Rear** / **Right Rear**

If "Driver", were your hands on the steering wheel? **Both** / **Left** / **Right**

Did the airbags deploy? **Yes** / **No**

Did you strike another vehicle? **Yes** / **No.**

Did another vehicle strike your vehicle? **Yes** / **No**

Angle of Impact: **Front** / **Back** / **Left** / **Right** / **Other**: _____

If Second Collision – Angle of 2nd impact: **Front** / **Back** / **Left** / **Right** / **Other**: _____

1) In relation to the back of your head, was your headrest set: **Low** / **Middle** / **High**

2) Were you surprised by the impact? **Yes** / **No**. If "NO", how did you brace? **With Hands** / **With Feet**

3) Where was your head facing at the time of impact? **Straight Ahead** / **Left** / **Right** / **Behind**

4) Were you leaning forward at the time of impact? **Yes** / **No**

5) What type and year of vehicle were you in? _____

5a) what was the approximate speed of your vehicle when the accident occurred? _____ mph

6) What type and year of vehicle struck yours?_____

6a) what was the approximate speed of the other vehicle when the accident occurred? _____ mph

7) Were you wearing a seatbelt? **Yes** / **No**

8) Did you feel pain immediately after the accident? **Yes** / **No**

9) Were you rendered unconscious as a result of the accident? **Yes / No**

Patient Signature _____ Date: _____

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Patient's Name:_____

Did you strike anything in the vehicle at the time of impact? **Yes** / **No**

If "YES", specify what part of your body struck what: (i.e. head, chest, chin, shoulder, knee, etc.)

□ Steering Wheel	□ Windshield
□ Dashboard	□ Roof
□ Left Side Door	□ Right Side Door
□ Left Window	□ Right Window
□ Other (specify)	

Did your seat break or bend? **Yes** / **No**

Immediately following the accident, how did you feel? (Circle all that apply)

Dizzy / **Dazed** / **Weak** / **Upset** / **Disoriented** / **Nervous** / **Nauseous** /

Other: _____

Police and Ambulance:

Was the accident reported to the police? **Yes** / **No**

Were traffic citations issued? **Yes** / **No** If "YES", to whom? _____

Did you go to the hospital? **Yes** / **No** If "YES", when? _____

If "YES", how did you get there? **Ambulance** / **Police Car** / **Private Transportation**

Were you admitted? **Yes** / **No** If "YES", how long? _____

The name of the hospital? _____ Attended by Dr. _____

What treatment given? (Circle all that apply)
None / **X-rays/ CT scan (Neck, Mid back, Low back, other_____)**
Pain Medication / **Stitches / Muscle Relaxants** / **Bandaged** / **Cervical Collar** / **Physical Therapy** / **Instructed Regarding Concussion** / **Instructed Regarding Sprains & Strains** / **Instructed to Call an Orthopedist** / **Instructed to Call a Private Physician** / **Referred to This Office** /
Other: _____

What other doctor have you seen as a result of this injury? _____

_____

Do you have difficulty in excessive: **Standing** / **Walking** / **Riding** / **Bending** / **Twisting**

Do you have difficulty in excessive lifting: **Light** / **Moderate** / **Heavy** / **Repetitive**

Symptoms other than above: _____

Patient Signature _____ Date: _____

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General Patient Information

Patient's Name: _____

Address: _____ **Care of: _____**
City:_____ State: _____Zip _____ **Phone (home): _____**
Driver's License #:_____ **Phone (work):_____**
E-Mail Address: _____ **Phone (cell):_____**
Spouse's Name:_____ **Spouse's Employer:**

Gender:( ) M () F **Age:**	() Single () Married () Divorced () Widowed	**Date of Birth:** _____	**Social Security Number:** _____
Patient's Employer:		**Student:** () Full-Time () Part-Time	

Did you go to the hospital? ( ) Yes () No If yes, name of hospital: _____
What other doctor have you seen as a result of this injury? _____
Do you own a vehicle? () Yes ( ) No If yes, please provide us your vehicle automobile insurance policy _____
If you do not own a vehicle do you reside with a relative that owns a vehicle? ( ) Yes ( ) No
If yes, please provide us that auto insurance policy

Insurance Information

Auto Insurance Co: _____
Policy #: _____
Claim #: _____
Name of Insured: _____
Relationship to Insured: _____
Adjuster's Name: _____
Phone number: _____

Type of Health Ins: () HMO () PPO (fill out below if PPO)
Health Insurance Co: _____
Policy #: _____
Group #: _____
Phone #: _____
Claims
Address:_____
_____

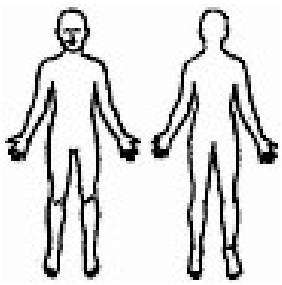
Attorney Information

Type of Accident: () Auto () Workers Comp. () Slip & Fall () Other: _____

Attorney's Name: _____

Phone #: _____

Date of Accident: _____



Please Shade Problem Areas:

I attest that the information given above is true and correct

Patient Signature _____ Date: _____

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Irrevocable Assignment of Benefits Authorization to Provide Copy of Updated PIP payout Sheet and Reserve the Right to Reserve Monies in Escrow for Bills Disputed

Patient's Name: _____

I, the undersigned patient hereby assign the rights and benefits of insurance to the applicable personal injury protection, medical payments, and other insurance **Touch of Health Medical Center LLC** ("Provider"), for services and supplies rendered for treatment of personal injuries sustained in any accident/incident, including but not limited to the accident/incident of _____(Date of accident/incident) to the undersigned patient and covered by Personal Injury Protection (PIP) Coverage or other insurance. I agree to pay any applicable deductible or co-payment not covered by the PIP or other insurance coverage. I authorize the Provider to release medical information as required.

This assignment includes but is not limited to all rights to collect benefits directly from the insurance company for services that I have received and all rights to proceed against the insurance company obligated to provide benefits in any action including legal suits for any reason the company fails to make payment to which I am due. As part of this assignment I authorize Provider to sign my name as an endorsement on any check made payable to myself and Provider for services or supplies rendered. This assignment also includes the right to collect payment for the reasonable costs for copying and mailing records. This assignment also includes any right to recover attorney's fees and costs for such action brought by the Provider as patient's assignee. I understand and agree that the attorney selected may be different than the attorney handling my personal injury/bodily injury claim or case.

I hereby instruct the insurance carrier that in the event the subject benefits are disputed for any reason, that the amount of benefits claimed is to be set aside and not disbursed until the dispute is resolved. As part of this assignment of benefits, I further instruct the insurance carrier to notify the Provider immediately after any dispute as to the payment so that it may preserve and exercise its legal rights. Also, in addition to notifying me and my legal representative, I instruct the insurance carrier to immediately notify the Provider of any scheduled examinations under oath or independent medical examinations. I authorize and instruct the insurance carrier to provide to Provider upon request any and all documents in my file, including but not limited to an up-to-date and unredacted and complete payout register and all medical records. I understand that any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement containing any false, incomplete, or misleading information is guilty of a felony of the third degree. I have read the information herein and it is true to the best of my knowledge and belief.

Patient Signature _____ Date: _____

Authorized Agent Representative _____ Date: _____

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APPLICATION OF "NO FAULT" BENEFITS

DATE	***YOUR POLICY HOLDER***	***DATE OF LOSS***	***CLAIM NUMBER***
_____		_____	

DETERMINATION OF BENEFITS DUE UNDER "NO FAULT" AUTO INSURANCE LAW, REQUIRES, THE ATTENDING PHYSICIAN TO COMPLETE THIS REPORT IT DIRECTLY

TO: _____

CLAIM DEPARTMENT
(Name of Insurance Company)

(Pursuant of Florida Statute §17.234, any person who knowingly and with intent to injure, defraud or deceive any insurance company by filing a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree.)

TO ENABLE US TO DETERMINE IF YOUR ARE ENTITLED TO BENEFITS UNDER THE PERSONAL INJURY PROTECTION LAW, PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY.

*YOUR NAME:*_____	*PHONE NUMBER:* _____	*BUSINESS:*
YOUR ADDRESS (NO. STREET, CITY OR TOWN, STATE AND ZIP CODE) PERMANENT ADDRESS, IF DIFFERENT, HOW LONG HAVE YOU LIVED IN FLORIDA?	*DATE OF BIRTH* _____	*SOCIAL SECURITY NO.* _____

DATE AND TIME OF ACCIDENT _____*P.M.AM*	*PLACE OF ACCIDENT (STREET, CITY. OR TOWN AND STATE)* ***SEE POLICE REPORT***

BRIEF DESCRIPTION OF ACCIDENT
SEE POLICE REPORT

DESCRIBE MOTOR VEHICLES TOO OWN: / *OTHER VEHICLES:* / *IN YOUR FAMILY:*	*VEHICLE*	*1.* _____ *2.* _____ *3.*	*OWNER2*	*1.* _____ *2.* _____ *3.*	*INSURER*	*1.* _____ *2.* _____ *3.*

AS A RESULT OF THIS ACCIDENT WERE YOU INJURED? ❑ *YES* ❑ *NO* *IF YOUR ANSWER IS YES COMPLETE THE REST OF THIS FORM, IF NO, SIGN HERE AND RETURN THIS FORM TO US.*

SIGNATURE: *DATE:*

DESCRIBE YOUR INJURY
FULL EXTENT OF INJURY IS NOT KNOWN; HOWEVER AT THE PRESENT TIME

WERE YOU TREATED BY A DOCTOR? *YES* ❑ *NO* ❑	*DOCTOR'S NAME AND ADDRESS* _____ ***Touch of Health Medical Center LLC1405WColonial # B Orlando, FL 32804***
IF YOU WERE TREATED IN A HOSPITAL WERE YOU *AN IN-PATIENT* ❑ *OUT-PATIENT* ❑	*HOSPITAL'S NAME AND ADDRESS*

AMOUNT OF MEDICAL BILLS TO DATE$ ***UNKNOWN***	*WILL YOU HAVE MORE MEDICAL EXPENSE? YES* ❑ *NO* ❑	*AT THE TIME OF ACCIDENT WERE YOU IN THE COURSE OF YOUR EMPLOYMENT? YES* ❑ *NO* ❑
DID YOU LOSE WAGES OR SALARY AS A RESULT OF YOUR INJURY? YES ❑ *NO* ❑	*IF YES, AMOUNT LOST TO DATES*	*WHAT IS YOUR AVERAGE WEEKLY WAGE OR SALARY? $*

DATE DISABILITY IF YOU LOST WAGES: FROM WORK BEGAN	*DATE YOU RETURNED TO WORK*
HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR PAYMENTS UNDER ANY WORKERS' COMPENSATION OR UNEMPLOYMENT LAW? IF YES: $ _____ *per week* $ _____ *per month* *Name of W/C insurer:* _____	*Have you received or are you eligible for benefits from the following sources:* *Medicaid* NO ❑ YES ❑ $_____ *Health ??? In any, (name):* *Medicaid* NO ❑ YES ❑ $_____ *Medicaid Benefits* NO ❑ YES ❑ $_____

LIST NAMES AND ADDRESSES OF YOUR PRESENT EMPLOYER(S) AND GIVE YOUR OCCUPATION AND DATES OF EMPLOYMENT FOR EACH

EMPLOYMENT AND ADDRESS	*OCCUPATION*	*FROM*	*TO*
EMPLOYMENT AND ADDRESS	*OCCUPATION*	*FROM*	*TO*

AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES? *YES* ❑ *NO* ❑ *IF YES, EXPLAIN ON REVERSE SIDE*

I hereby authorize release of medical information including, but not limited to, medical bills and reports, to such parties as the company may necessary to protect its rights of recovery under the No-Fault Act.

SIGNATURE: _____ ***DATE:*** _____

Touch of Health Medical Center LLC
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Notice of Initiation of Treatment

Claim Number: _____ **Date:** _____

Patient Name: _____

Practice/Provider Name: **Touch of Health Medical Center LLC**

First treatment Date**:** _____

To Whom It May Concern:

This document shall serve as our formal Notice of Initiation of Treatment pursuant to Fla. Stat. 627.736(5) (c). This notice is being sent, pursuant to Florida Statutes, within 21 days after this facility's first examination or treatment of the above referenced claimant. Because this notice has been timely provided, the law allows statements from this provider to include charges for treatment or services rendered up to, but not more than, 75 days before the postmark date of the statement sent.
Please take note and govern yourself accordingly.

Respectfully,

Patient Signature _____ Date: _____

Account Manager Signature _____ Date: _____

OFFICE OF INSURANCE REGULATION
Bureau of Property & Casualty Forms and Rates

Standard Disclosure and Acknowledgement Form
Personal Injury Protection - Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

1. The services or treatment set forth below were **actually rendered.** This means that those services have **already been provided.**

_____

_____

2. I have the right and the **duty to confirm** that the services have already been provided.

3. I was **not solicited** by any person to seek any services from the medical provider of the services described above.

4. The medical provider has **explained** the services to me for which payment is being claimed.

5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to $500.

Insured Person (patient receiving treatment or services) or Guardian of Insured Person:

_____	_____	_____
Name *(PRINT or TYPE)*	Signature	Date

The undersigned licensed medical professional or medical director, if applicable, affirms the statement numbered 1 above and also:

A. I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.

B. The treatment or services rendered were explained to the insured person, or his or her guardian, **sufficiently** for that person to sign this form with informed consent.

C. The accompanying statement or bill is **properly completed** in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to **truthfully, accurately**, and in a **substantially complete** manner.

D. The coding of procedures on the accompanying statement or bill is proper. This means that **no service has been upcoded, unbundled**, or constitutes an invalid **or not medically necessary diagnostic test** as defined by Section 627.732(14) and (15), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Licensed Medical Professional Rendering Treatment/Services or Medical Director, if applicable *(Signature by his/ her **own hand**):*

_____	_____	_____
Name *(PRINT or TYPE)*	Signature	Date

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of Claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234(1)(b), Florida Statutes.

Note: The **original** of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may **not** be electronically furnished. Failure to furnish this form may result in non-payment of the claim.

OIR-B1-1571
Pub. 1/2004

Touch of Health Medical Center LLC
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Attorney Lien Letter

TO ATTORNEY: _____

RE: PATIENT: _____

DOB(MM/DD/YYYY): _____

SS#: _____

DATE OF ACCIDENT: _____

I hereby authorize ***Touch of Health Medical Center LLC*** to furnish you, my attorney, with a full report of the examination, diagnosis, treatment, prognosis, etc., of myself regarding the accident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly such sums as may be due and ***Touch of Health Medical Center LLC***, for professional services rendered to me both by reason of this accident and by reason of the other bill that are due his/her office and to withhold such sums from any settlements, judgments or verdict as may be necessary, and adequate to protect said doctor. I hereby further give a lien on my case to ***Touch of Health Medical Center LLC,*** against any and all proceeds of any settlements, judgments or verdict, which may be paid to you, my attorney, or myself as the results of the injuries for which I have been treated and/or injured in connection therewith.

I fully understand that I am directly and fully responsible to ***Touch of Health Medical Center LLC***, for all professional bills submitted for services rendered to me and that this agreement is made solely for ***Touch of Health Medical Center LLC*** additional protection and in consideration of this awaiting payment.

I also understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee(s).

I also authorize ***Touch of Health Medical Center LLC,*** the power of attorney to endorse on my behalf any checks that are made out to me for any services provided.

Patient Signature _____ Date: _____

The undersigned being attorney of record to the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect ***Touch of Health Medical Center LLC.***

Attorney Signature _____ Date: _____

You are entitled to a copy of this undersigned authorization.
A photocopy of this signed release form is a valid as the original

Touch of Health Medical Center LLC
1405 W Colonial #B Orlando, FL 32804
Phone: (407) 237-0915, Fax: (407) 386-7332

NOTICE OF DISCLOSURE

Touch of Health Medical Center is providing you with this written disclosure to inform you that Touch of Health Medical Center LLC is sharing office space, staff and/or billing and management services with, CFL Diagnostic LLC (MRI), and supply company CFL Medical Supplies LLC, and general medicine practice CFL MD LLC.

It is the express policy of Touch of Health Medical Center LLC to respect all patients' right to choose the providers of their health care services. You have the right to receive medical care from Touch of Health Medical Center LLC or from any other medical provider you choose. Similarly, you have the right to receive magnetic resonance imaging ("MRI") services from CFL DIAGNOSTIC LLC, or from any other MRI provider you choose. Similarly, you have the right to receive medical supplies from CFL medical supplies LLC, or from any other supply provider you choose; you can receive your EMC evaluation from CFL MD LLC or any other Florida Licensed physician of your choice.

You can find local providers of MRI and Supply services online.

https://www.floridahealthfinder.gov/facilitylocator/facloc.aspx

https://ahca.myflorida.com/

By signing below, you are acknowledging:

1. That you wish to obtain services provided by CFL Diagnostic LLC, CFL Medical Supplies LLC, and CFL MD LLC.

2. That you have read the above and acknowledge that you have received a copy of the Notice of Disclosure and have had all questions answered to your satisfaction.

Signature of Patient or Patient's Legal Guardian:

Patient/Guardian Signature _____ Date: _____

Patient's name: _____

Relationship to Patient (if applicable): _____

Touch of Health Medical Center LLC
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HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:

Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fundraising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Patient Signature _____ Date: _____

Touch of Health Medical Center LLC
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DISCLOSURE OF PROTECTED HEALTH INFORMATION

Information may be disclosed by: _____

Tel: ( ) _____ _____Fax: ( ) _____

Information to be disclosed to: ***Touch of Health Medical Center LLC***

PATIENT WHOSE PROTECTED HEALTH INFORMATION IS TO BE DISCLOSED

RE: PATIENT: _____ SS#: _____

DOB(MM/DD/YYYY): _____ DATE OF ACCIDENT: _____

INFORMATION TO BE DISCLOSED

	All Medical Records (Please Mail/Fax)		X-rays/CT Scan/MRI/Ultrasound (PLEASE FAX RESULTS)
	Progress Notes/Consultation		All Diagnostic Studies with Reports
	Final/ Dictated Report		

EXPIRATION DATE: This authorization will expire (insert date or event) 2 years from the above referenced date. I understand that I fail to specify an expiration date or event, this authorization will expire in six (6) months from the date on which was signed.

RE DISCLOSURE: I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

CONDITIONING: I understand that completing this authorization form in voluntary. I realize that treatment will not be denied if I refuse to sign this form.

REVOCATION: I understand that I have the right to revoke this authorization at any time by giving a written/verbal notice to the office listed above.

Patient Signature _____ Date: _____

You are entitled to a copy of this undersigned authorization.
A photocopy of this signed release form is an valid as the original

Touch of Health Medical Center LLC
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RELEASE OF INFORMATION

Patient name: _____

I, the above-named patient hereby authorizes **Touch of Health Medical Center LLC** to release any information pertinent to my case/automobile accident/incident/injury to any insurance company, adjuster, and/or attorney involved with my file, and hereby release **Touch of Health Medical Center LLC** of any consequences thereof.

PATIENT RECORD OF DISCLOSURE

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their Protected health Information (PHI). The individual is also provided the right to request confidential communications or that a communication PHI to made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

___Home/Portable Phone
___Ok to leave a message with detailed information
___Leave message with call back number only
___Written Communication
___Mail at home address
___Fax at: _____
___Email at: _____

Other: _____

Patient Signature _____ Date: _____

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I hereby acknowledge and affirm that no person nor entity, in an individual capacity or in the capacity as representative of the above referenced chiropractic/medical clinic, corporation, partnership, or association, including but not limited to the above referenced chiropractic/medical clinic, solicited me for the purpose of making a claim for personal injury protection or any other benefits under any policy of insurance including but not limited to automobile insurance as a result of the subject accident.

Further, I hereby acknowledge and affirm that I sustained injuries as a result of the above referenced accident, and I have not been requested nor forced to be treated at the above referenced clinic and that said clinic has not offered me money or any other remuneration for the purpose of retaining said chiropractic/medical clinic and that j chose said clinic on my own free will and was not directly solicited by phone or a representative from this clinic at my home.

Patient Signature _____ Date: _____

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PIP Deductible/Co-Insurance Payment Agreement

I,_____ understand that my auto insurance covers my medical expenses at _____ percent. I'm also aware that there is a _____ deductible.

Please read the following options and check the appropriate box.

____ I have medical coverage that will be used to satisfy the above deductible and/or co-insurance.

____ I have at Attorney on this case and will have a letter of protection signed with _____ to satisfy the above deductible and/or insurance.

____ I will satisfy the deductible personally.
Pay $ _____ is full.
Pay $ _____ per visit.
Pay $ _____ per week.
Pay $ _____ per month.

____ I will satisfy the deductible personally.
Pay $ _____ per visit.
Pay $ _____ per week.
Pay $ _____ per month

Patient Signature _____ Date: _____

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DISCLOSURE AND CONSENT FOR CHIROPRACTIC ADJUSTMENTS AND CARE

To the patient: Insurance is a contract between you and the Insurance company. We will gladly file the insurance but ultimately you are responsible for your account.

I hereby request and consent to the performance of chiropractic adjustments and other procedures, including various modes of physical therapy and diagnostic x-rays, on me (of the patient named below. For whom I am legally responsible) by the Doctor of Chiropractic and/or other licensed Doctors of Chiropractic or those working at the clinic or office who now or in the future treat me while employed by, working or associated with, or serving as a backup for the Doctor of Chiropractic.

I have had the opportunity to discuss with the Doctor of Chiropractic, my diagnosis, the nature and purpose of chiropractic adjustments and other procedures and alternatives.

I understand and I am informed that, in the practice there are some risks to exam and treatment including, but not limited to, fractures, disc injuries, strokes, dislocations, sprains and increased symptoms and pain or no improvement of symptoms or pain. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment.

I have read or have had read to me the above consent. I have also had an opportunity to ask questions, and all my questions have been answered fully and satisfactorily. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my present condition and for any further condition(s) for which I seek treatment.

To be completed by the Patient:

_____
Patient's signature

_____
Print Name Printed

_____
Date

To be completed by the Patient's representative if necessary:

_____
Patient Name Printed

_____
Patient Signature

_____
Patients Representative Name Printed

_____
Signature of Patients Representative

_____
Relationship to Patient

Touch of Health Medical Center LLC
1405 W Colonial #B Orlando, FL 32804
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PRIVACY PRACTICES ACKNOWLEDGMENT

ACKNOWLEDGEMENT FORM

I have received the' Notice of Privacy Practices and I have been provided an opportunity to review it.

Name: _____

D.O.B.: _____

Patient Signature _____ Date: _____

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Phone: (407) 237-0915, Fax: (407) 386-7332

EXPLANATION OF OFFICE PROCEDURES

This page will explain all the possible services that we may provide to you while you are treating with us. If you have any further questions regarding your treatment plan, please ask the doctor.

Examination (Exam) - This is when the doctor sits down with you and discusses your injuries/complains. Orthopedic and neurological tests are also done at this time. This is normally performed on the first visit. (ICD-9 codes - 99201-25, 99202-25, 99203-25, 99204-25 or 99205-25).

Reexamination (Re-exam) - This is usually performed every twelve to fifteen visits or every thirty days, whichever comes first. It is an assessment of the patient's progress and will determine the need for changes or referrals. (ICD-9 codes - 99211-25, 99212-25, 99213-25, 99214-25 or 99215-25).

Manual muscle Testing (MMT) - Throughout your care, the doctor will perform certain muscle tests. You will be asked to hold certain positions and resist the force of the doctor. A separate report will be filed out and sent to your insurance company and / or attorney. (ICD-9 code- 95831-59).

Range of Motion Test (ROM) - Throughout you care, the doctor will ask you to move you head and/or lower back in certain directions. This test will show any restriction in movement due to pain and / or anatomical reason. A separate report will be filled out and sent to you insurance company and/or attorney. (ICD-9 code -95851-59).

Adjustment (ADJ) - This is performed when the doctor finds a fixation/misalignment in your skeletal and corrects it. This can be performed with hands or Instrument(s). (ICD-9 codes -98940, 98941 or 98942).

Extremity Adjustment (EXT ADJ) - This is performed when the doctor finds **a** fixation/misalignment extra spinally (not in the spine). This can be performed with hands or Instrument(s). (ICD-9 code -98943).

Neuromuscular Re-education (NMR) - The purpose of this technique is to reeducate your body movement, balance coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing. This can be performed using various soft tissue or CBP (Chiropractic Biophysics) techniques. (ICD-9 code-97112).

Electrical Muscle Stimulation (EMS)/ Interferential Current (IF) - These electrical therapies are used to breakup muscular spasms, relax soft tissue, decrease pain and increase local circulation. (ICD-9 codes - 97014 (unattended) or 97032 (attended)).

Inter-segmental Traction (Traction) - This therapeutic procedure utilizes either the spinalator table or the flexion/distraction table for Fifteen minutes. The goal is to gently stretch the spine. (ICD-9 code -97012).

Gait Training - Gait training entails retraining your proprioception by performing step exercises or certain style of walking, including rhythm and or speech. (ICD-9 code - 97116).

Activities of Daily Living Home or Work (ADL - home/work) - This is when the doctor finds out about your home *or* work activities and modifies them to accommodate your present- state of health. The doctor may give instructions on how to use ice or heat; the amount of water' you should drink; certain stretches you should do (depending on the chief complaint), etc. (ICD-9 codes - 97535 (home ADL) or 97537 (work ADL)).

Manual Therapy / Myofascial release (MT/MyoRel) - This treatment is used in increase lymphatic drainage and to decrease muscle spasms. (ICD-9 code -97140-59).

The TQ Solo is a safe high-power pulsing cold laser with state-of-the-art multi-frequency emitters in a compact rechargeable portable unit. It combines 3 proven technologies into one device: A Super-pulsed 15,000 mW (15 watt Peak @ 905 nm) laser, 60 mW (875 nm) infrared LED, and a 7.5 mW (660 nm) red LED. It is commonly used to treat Cervical Pain, Temporomandibular Arthrosis (Arthritis), Rotator Cuff Tendonitis, Shoulder Joint Injuries, Tennis Elbow, Elbow Joint Injuries, Wrist Injuries, Lumbar Spine: Pain, sprain, and strain, Hip Sprain, Hip Tendonitis (Iliopsoas), Knee Sprain, Acute Patellar Tendonitis, Achilles Tendonitis, and Calcaneal Spurring. more information is available at www.coldlasers.org.

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Therapeutic Exercises (THER. EX.) - Therapeutic exercises involve increasing the quality of the muscle. This includes increasing flexibility, range of motion and/or endurance. (ICD-9 code -97039).

Therapeutic Activities (THER.ACT.)- Therapeutic activities involve increasing the quality of the muscle. This includes throwing, catching, swinging or strengthening exercises. (ICD-9 code - 97110).

Disposable Pads (Disp. Pads) - These pads are used when utilizing EMS or interferential current. They are single use electrodes.'(ICD-9 - A4556).

Trigger Point Therapy (Trigger Pt.) - A manual therapy technique that locates pockets of lactic build up in the muscles that can cause radiation of pain to specific areas. By manually applying pressure to these points, the trigger points are broken up and reabsorbed into the blood stream and usually relieves the symptoms in the area of involvement. (ICD-9 code-97139).

Computerized Posture Analysis (Comp Analy) - Computerized Posture Analysis is a physical performance test or measurement made upon the analysis form the patient's photo (e.g. muscle-skeletal, fractional capacity), with write report. (ICD-9 code -97750).

Surface Electromyography (sEMG) is the electrophysiological technique for quantifying motor activity (muscle contraction) in specific muscle groups as determined by electrode placement.

Iontophoresis - Is a medical treatment used to drive positive or negative ions into a tissue, in which two electrodes are placed in contact with tissue, one of the electrodes being a pad of absorbent material soaked with a solution of the material to be administered, and a voltage is applied between the electrodes. (ICD-9 code - 9927)

Electromyography (EMG) and nerve conduction velocity (NCV) testing helps evaluate and treat problems related to your nerves or muscles.
EMG simply means measuring the electrical activity of the muscles. Normal muscles give off a certain size, shape and sound of electrical signal. Muscles that have a damaged nerve simply give off very different electrical signals. Therefore, analyzing the abnormal electrical signals in your muscles will help your doctor locate the specific site, nature and extent of nerve damage, if any. **NCV** testing is almost always done along with the EMG exam. In fact, when doctors say “EMG”, it is short for EMG and NCV testing together. This test evaluates nerves by measuring how fast the electrical impulse travels through them.

Biofeedback is a process that enables an individual to learn how to change physiological activity for the purposes of improving health and performance. Precise instruments measure physiological activity such as brainwaves, heart function, breathing, muscle activity, and skin temperature. These instruments rapidly and accurately 'feed back' information to the user. The presentation of this information — often in conjunction with changes in thinking, emotions, and behavior — supports desired physiological changes. Over time, these changes can endure without continued use of an instrument.

By signing below I acknowledge that I have read and understand the above procedures

Patient Signature _____ Date: _____

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