



Jeff and Adriana MonteLeon, D.C.

2200 Port Malabar Blvd. Suite #1, Palm Bay, FL 32905
Phone: 321-409-0209 Fax: 321-409-0208

CORRECTION

Today we are becoming more aware how current technological lifestyles and practices expose our children's nervous systems to continuous stresses. These result in Vertebral Subluxations.

Current scientific research is showing the direct relationship between the function of the nervous system and the immune system function. The integrity of the nerve system is therefore imperative to a healthy immune system in your growing child.

Today, your child has the opportunity to have a spinal analysis by a Doctor of Chiropractic, the only health care provider qualified to locate, analyze and correct the Vertebral Subluxation with the Chiropractic Adjustment. This is the beginning of greater health and well-being for your child.

AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize Dr. _____ to administer care as deemed necessary to my son/daughter.

Signed _____ Witnessed by _____

Dated this _____ day of 20____.

**Assignment and Instruction for Direct Payment to Doctor Private and Group
 Accident and Health Insurance**

Patient name: _____ SSN: _____ Birth date: _____

I hereby instruct and direct _____ Insurance Company to pay benefits by check made out and mailed to:

LIFEFORCE CHIROPRACTIC
 2200 PORT MALABAR BLVD. SUITE # 1
 PALM BAY, FL 32905

Or

If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows:

c/o LIFEFORCE CHIROPRACTIC
 2200 PORT MALABAR BLVD. SUITE # 1
 PALM BAY, FL 32905

the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional service rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY TO LIFEFORCE CHIROPRACTIC FOR PAYMENT OF PROFESSIONAL SERVICES RENDERED. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. I assign to said clinic all rights patient has under any contract of insurance for collection of same.

This is to certify that the above named patient authorizes the request of any records pertinent to the health care of same individual from but not inclusive of any insurance carrier, adjustor, attorney, or other health care provider.

This also authorizes this facility to release records, upon receipt of the above named patient's signature, or on an emergency basis, to, but not inclusive of, any insurance carrier, attorney, health care provider, hospital, or immediate family member.

This also certifies that the above named individual agrees to pay in full for all professional services rendered at the time they are performed, unless other arrangements are made in advance of the set appointment. The below named guarantor understands a \$10.00 returned check fee will be charged along with any appropriate collection or attorney's fee which may accrue upon collection of any outstanding balance.

A photocopy of this assignment shall be considered as effective and valid as the original.

Privacy: The *Standard5 for Privacy of Individually Identifiable Health Information* ("Privacy Rule") establishes, for the first time, a set of national standards for the protection of certain health information. The U.S. Department of Health and Human Services issued the Privacy Rule to implement the requirement of the *Health Insurance Portability and Accountability Act* of 1996 ("HIPAA") A major goal of the Privacy Rule is to assure that individuals' health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care and to protect the public's health and well being.

You can be assured that our clinic takes your privacy seriously and is in compliance with all HIPAA guidelines. Your health information will not be disclosed without your permission or will your name, address or telephone number be disclosed to any third party.

I have read and understand the foregoing.

_____/_____
 Date Policyholder/Guarantor Print Name SS#.



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Doctor-Patient Relationship in Chiropractic

Chiropractic:

It is important to be an aware and an informed patient. We have found that an honest, open understanding of chiropractic care is helpful in order to bring about your potential for maximum health.

Your body has a potential to function at 100%. Our goal in chiropractic is to achieve better communication between the brain and the rest of the body through a fully functioning nervous system thus allowing the body the potential to function at 100%. We achieve this through chiropractic adjustments which correct spinal nerve interference called vertebral subluxations. When a vertebral subluxation is present in the spine the body is unable to function at 100% thus sickness and disease occurs.

When a chiropractic adjustment is provided by the chiropractor, the body is able to approach its potential to express optimum health. This is because of better communication through the nervous system by the reduction and correction of the vertebral subluxation and its related components. Rather than treat the resulting disease or your symptoms, chiropractors correct the spinal subluxation and the resulting nerve interference which is the number one cause of why the body functions at less than 100%. Instead of masking the symptoms with medications chiropractors look for the cause and correct the cause of your symptoms.

Analysis:

You will undergo a chiropractic examination for the detection of vertebral subluxations and their related components. During the examination the chiropractor will evaluate how the spine moves, what it feels like and based upon the results of the examination findings X-rays of the spine may be performed. These X-rays will tell the doctor how far the vertebra is misaligned and in what direction. The X-rays will also help determine the most efficient chiropractic technique to effectively adjust and correct the spinal subluxations.

Diagnosis:

Only a chiropractor can determine if your case is a chiropractic case. Medical doctors diagnosis disease, chiropractors diagnose vertebral subluxations. Your diagnosis in this clinic will reflect spinal nerve interference which is caused by vertebral subluxations. Our doctors will work with any other health care provider for your benefit. Inversely, you should expect all other health care providers to work together with your chiropractor for your benefit. This team approach to your health care will benefit you the patient the best.

Chiropractic Adjustments:

The patient, in coming to the chiropractor, gives the chiropractor permission and authority to adjust the patient for spinal subluxations. In rare cases, under physical defects, deformities, or pathology may render the patient susceptible to injury. The chiropractor, of course, will not provide chiropractic adjustments if he is aware of any such conditions. If the patient is aware of any latent pathological defects, illness or deformities which would not otherwise come to the attention of the chiropractor, it is their responsibility to notify the chiropractor. The patient should not look to the

chiropractor for in depth diagnostic procedures. The chiropractor provides a specialized health service in the detection and correction of the vertebral subluxation and its related components. Any risks regarding chiropractic treatment will be explained upon request.

Although we use an OPEN ADJUSTING FORMAT, your confidential concerns can be handled appropriately, in specially designated private areas, for discussions with the Doctor, as long as a request is made in advance, and the sufficient time to handle your concern is scheduled.

Results

No doctor can promise a cure or guarantee results. The purpose of Chiropractic care is to promote natural health through the release of maximum nerve energy. Since there are so many variables, it is difficult to predict the time schedule or efficiency of chiropractic procedures. Sometimes the response is phenomenal. In most cases there is a more gradual, but quite satisfactory. In some it is only partial or not at all. Regardless of the disease, the Chiropractor is not offering to heal, treat or cure it.

A major premise in chiropractic is that the body is a self healing organism and by removing the vertebral subluxation, hence the nerve interference it can function as close to 100% as possible. However, you must remember that there is no process that does not take time, this includes the healing process. The longer the problems been in the body the longer healing process will take the body. The chiropractor's goal is to allow the body to express health at its optimum without nerve interference. This goal is accomplished through the chiropractic adjustment by the correction of the vertebral subluxation. In order to facilitate a more effective level of understanding of the Chiropractic approach, a **New Patient Orientation** has been developed, and it is a required component for all new patients to attend. This requirement can be fulfilled prior to, or after initiating care. The seminar is also open to family and friends seeking a better understanding of basic Chiropractic concepts.

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You can be assured that our clinic takes your privacy seriously and is in compliance with all HIPPA guidelines. Your health information will not be disclosed without your permission or will your name, address or telephone number be disclosed to any third party. Our privacy policy is posted in the reception area and is available at the front desk upon your request.

Questions

Just as in a good marriage, proper communication is an absolute necessity. We want to help you attain your goal of health. If at any time your response is not satisfactory, we will gladly assist you in choosing a referral doctor for another opinion. Your health is our number one priority.

Acknowledgement:

I have read and understand the foregoing.

Signature _____

Date _____

Witness _____



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Health Information Request Authorization

To Whom It May Concern:

I hereby authorize and request any person to whom this authorization is presented to furnish the doctors of LifeForce Chiropractic any X-rays, X-ray findings or information of any health records, which may be pertinent concerning my health.

Privacy:

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Signature

Today's Date

Print Name

Date of Birth

Social Security Number

PLEASE FILL IN BELOW

NAME _____ DATE _____

ADDRESS _____ APT.# _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ BUSINESS PHONE _____ MARITAL STATUS _____

SEX M ___ F ___ DATE OF BIRTH _____ HEIGHT _____ WEIGHT _____ DOM. HAND _____

SOCIAL SECURITY # _____ AGE _____ E-MAIL ADDRESS _____

Give reason for seeking chiropractic care: _____

Describe: _____

How long have you had this problem? _____ Please rate your symptoms (1-10, with 1 being least serious) _____

Are you under the care of any other physician? Yes ___ No ___

If yes, please list the doctors you are seeing, condition you are treated for, and progress of care to date: _____

Please list any medication you are presently taking and reason for taking it: _____

Please list all previous surgeries: _____

Please list any accidents or broken bones you have had: _____

List any x-rays you have had in the last two years: _____

Have you been to a chiropractor before? Yes ___ No ___

Date of last visit: _____ How long were you under care? _____

Condition treated for: _____ Name of Dr. _____

Occupation: _____ Name of Employer: _____

Duties you are required to perform regularly at work or home: _____

Habits:

Do you smoke: No ___ Yes ___ # of packs per day _____

Do you drink coffee: No ___ Yes ___ # of cups per day _____

Do you consume alcohol: No ___ Yes ___ Approximately how much daily _____

Do you exercise regularly: No ___ Yes ___ If so, what forms and how much: _____

Family Health History. Please describe health of:

Father _____ Mother _____

Spouse _____ Children, give ages _____

Who recommended this office to you: _____

Or, where did you hear about this office: _____

FEMALES: Is there a possibility of you being pregnant? Yes ___ No ___



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FINANCIAL RESPONSIBILITY AGREEMENT

NAME _____ S.S. # _____

DATE OF BIRTH _____ ADDRESS _____

APT.# _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

This certifies that the above named individual agrees to pay in full for all professional services rendered at the time they are performed, unless other arrangements are made in advance of the set appointment. The below named guarantor understands a \$ 10.00 returned check fee will be charged along with any appropriate collection or attorney's fee which may accrue upon collection of any outstanding balance.

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Please Check one of the following:

Payment to this Office by: Cash
 Check
 Credit Card
 Health Insurance
 Automobile Insurance

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Date

Policyholder/Guarantor