Today’s Date: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_

Local Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_ Zip\_\_\_\_\_\_\_\_

Out of Town Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_\_

Marital Status\_\_\_\_\_\_\_\_\_ Sex\_\_\_\_\_\_\_ S.S.# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell. Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address/Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about our office?

Yellow Pages  Drive By  Walk-In  Internet  Referral

(Please tell us who) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health Insurance Information**

Primary Insurance \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder’s Relationship to Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder’s Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Current complaint:

Please list your **worst** complaint: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long have you had it? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did it start: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

A) **Is it**: Improving  Worsening  Staying the Same

B) **Is it**: Mild  Moderate  Severe

C) What worsens it: General activity  Moving Wrong  Bending  Lifting  Walking

Sports  Getting up from a chair  Using a computer/desk work

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

D) What makes it better: Rest  General Activity  Ice Packs  Heating Pad  OTC Meds

Rx Meds  Massage  Chiropractic  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E) Is it worse in the: AM  PM  After day wears on  Steady  Off and on

F) Is the symptom: Dull and Achy  Tight and Stiff  Sharp and Stabbing

Numb and Tingly  Shooting  Burning  Cramping

1. Please list your **2nd worst** complaint: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long have you had it? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did it start: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

A) **Is it**: Improving  Worsening  Staying the Same

B) **Is it**: Mild  Moderate  Severe

C) What worsens it: General activity  Moving Wrong  Bending  Lifting  Walking

Sports  Getting up from a chair  Using a computer/desk work

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

D) What makes it better: Rest  General Activity  Ice Packs  Heating Pad  OTC Meds

Rx Meds  Massage  Chiropractic  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E) Is it worse in the: AM  PM  After day wears on  Steady  Off and on

F) Is the symptom: Dull and Achy  Tight and Stiff  Sharp and Stabbing

Numb and Tingly  Shooting  Burning  Cramping

CURRENT HEALTH

Name and phone number of family doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CHIEF COMPLAINT (Why are you here to see the doctor): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MEDICAL HISTORY

Please indicate whether you have had or currently have any of the following illnesses.

Heart Disease  Chronic Lung Disease  Diabetes  Cancer  High Blood Pressure

Eye Disease  Hepatitis  Asthma  Stomach Problems  Kidney Problems

Bleeding Problems  Anemia

Excessive Scarring Other Please Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current or previous serious illnesses or injuries: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous surgeries: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any current loss of bowel or bladder control: Yes  No

Any current seizures, paralysis, speech, vision problems: Yes  No

Any unexplained recent weight loss: Yes  No  Current fever: Yes  No  Current nutritional problems: Yes  No

• Have you had spinal X-Rays within the past 5 years? If yes, when and where \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

• Do you have a pacemaker? Yes  No

If yes, please ALERT our doctor and/or assistant.

• Do you have any blood/lymph disorders? Yes  No  If yes, please list \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

• Do you have osteoporosis or rheumatoid arthritis? Yes  No

• Please list any other electrical device that you currently

wear\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

• Have you ever had chiropractic care? Yes  No

If yes, last date of treatment\_\_\_\_\_\_\_\_\_\_\_\_ By whom: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Similar or difference condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your overall expectations from your treatment with our doctor? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

• **WOMEN ONLY** I hereby declare that to the best of my knowledge **I am**  **I am not pregnant** . If there is a chance that I may be pregnant, I will inform the doctor prior to my examination.

I, the undersigned, voluntarily give my consent to receive medical and health care services by the doctor to examine and treat my condition as he deems appropriate using chiropractic care and/or medical care. I also give my consent for the doctor to take x-rays (if needed) or to perform other diagnostic aids as he deems appropriate.

Patient Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(Parent/Guardian signature if under 18 years of age)**

Required by Law: We may be required by law to report gunshot wounds, suspected abuse or neglect, or similar injuries and events. Research: We may use or disclose information for approved medical research.

**NOTICE OF PRIVACY PRACTICE**

**Patient Health Information:** Under federal law, your patient health information is protected and conﬁdential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing, and insurance information.

**How We use your Patient Health Information:** We use health information about you for treatment, to obtain payment, and for health care operations, including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances, we may be required to use or disclose the information even without your permission.

**Examples of Treatment, Payment, and Health Care Operations Treatment**: We will use and disclose your health information to provide you with medical treatment or services. For example, the physician and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, and to family members who are helping with your care. *Payment*: We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payment from your health plan. Health *Care Operations*: We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, and to assess the care and outcomes of your case and others like it.

**Special Uses**: We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives or other health-related beneﬁts and services that may be of interest to you.

**Other Uses and Disclosures:** We may use or disclose identiﬁable health information about you for other reasons, even without your consent. Subject to certain requirements, we are permitted to give out health information without your permission for the following purposes: *Public Health Activities*: As required by law, we may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities. *Health oversight*: We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities. *Judicial and administrative proceedings*: We may disclose information in response to an appropriate subpoena or court order. Law enforcement purposes: Subject to certain restrictions, we may disclose information required by law enforcement ofﬁcials. *Deaths*: We may report information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies. *Serious threat to health or safety*: We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. *Military and Special Government Functions*: If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes. *Workers Compensation*: We may release information about you for workers compensation or similar programs providing beneﬁts for work-related injuries or illnesses.

In any other situation, we will ask for your written authorization before using or disclosing any identiﬁable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

**Individual Rights:** You have the following rights regarding your health information. Please contact the person listed below to obtain the appropriate form for exercising these rights. *Request Restrictions*: You may request restrictions on certain uses and disclosures of your health information. We are not required to agree to such restrictions, but if we do agree, we must abide by those restrictions. *Conﬁdential Communications*: You may ask us to communicate with you conﬁdentially by, for example, sending notices to a special address or not using postcards to remind you of appointments. *Inspect and Obtain Copies*: In most cases, you have the right to look at or get a copy of your health information. There may be a small charge for the copies. *Amended Information*: If you believe that information in your record is incorrect, or if important information is missing, you have the right to request that we correct the existing information or add the missing information. *Accounting of Disclosures*: You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or health care operations.

**Our Legal Duty:** We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the Notice currently in effect.

**Changes in Privacy Practices:** We may change our policies at any time. Before we make a signiﬁcant change in our policies, we will change our Notice and post the new Notice in the waiting area and each examination room. You can also request a copy of our Notice at any time. For more information about our privacy practices, contact the person listed below.

**Complaints:** If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about your records, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for ﬁling a complaint.

**Contact Person** If you have any questions, requests, or complaints, please contact:

Hailey: 321-425-2519

Space Coast Advanced Health

401 N Wickham Road

Melbourne, FL. 32935

Effective Date: January 1, 2020

I hereby acknowledge receipt of the Notice of Privacy Practices given to me.

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If not signed, reason why acknowledgement was not obtained:

**GENERAL/FINANCIAL POLICY**

**By signing below, you confirm that you have read this policy and understand that**:

• It is your responsibility to inform our office of any address or telephone number changes.

• Your account is to be kept current. All self-pay or insurance copayments, co-insurances and deductibles will be collected at the time-of-service payable by cash, check, Visa, MasterCard, Discover, American Express or Care Credit.

• If you do not have your payment (s), your appointment may be rescheduled.

• If you are unable to keep a scheduled appointment, please notify us 24 hours before your appointment so that we may offer that time to another patient.

• A returned check will result in a $25.00 service charge and all future payments being required in the form of cash or credit card.

• If your account is turned over to a collection agency, you will be responsible for any costs incurred in collection of said balance, which may include collection agency fees up to 35% of your outstanding balance, court costs and attorney fees.

**IF YOU HAVE HEALTH INSURANCE COVERAGE**: As a courtesy to you, our office will attempt to pre-verify your primary insurance coverage for your Chiropractic care. Coverage information is obtained from your insurance company using information provided by you prior to your initial visit. We must emphasize that as medical providers, our relationship is with you, not your insurance company. Please be advised that the information provided by your insurance company is not a guarantee of payment, only an estimate of what might be covered under your policy at the time of inquiry.

**By signing below, you confirm you understand that**:

• It is your responsibility to inform us of any changes to your insurance policy so that your coverage can be re-verified.

• Not all services are covered by benefits with all insurance plans.

• It is your responsibility to be aware of what service (s) is being provided to you and if it is a covered benefit under your insurance.

• You are responsible for any non-covered charges not payable by your insurance policy.

• We will send all required claim forms and documentation to ensure your claims are processed in a timely manner.

• Final determination of benefits available is determined when the claim is sent to your insurance company, and we receive an explanation of benefits from them.

• After all co-pays, contracted plan reductions and insurance payment credits are applied to your account, any remaining portion will be your responsibility.

• If you are a MEDICARE PATIENT, please be advised that Medicare only covers Spinal Adjustments in a Chiropractor’s office. All services outside of the Spinal Adjustment in our office will be your financial responsibility.

* I am responsible for all attorney fees or collection fees related to the collection of my account.
* I agree to pay interest at the rate of 1.5% per month on any unpaid balance.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we urge you to contact us promptly for assistance in the management of your account. If you have any questions about the above information, please do not hesitate to ask us. WE ARE HERE TO HELP YOU.

I understand that services rendered by Dr. Steve Alukonis, DC, are NOT reimbursed by insurance and that the office does not provide or fill out forms for insurance purposes. I will be solely responsible for payment for these services.

By signing below, you have read and understand the above Financial Policy and agree to meet all financial obligations.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient/Legal Guardian Date

**CONSENT TO RELEASE INFORMATION**: In the event that you ever wish to have a family member or friend come to our office and get a copy of your medical records for whatever reason, we ask that you sign below allowing them to do so. By signing below, I hereby give my consent for Space Coast Advanced Health, Dr. Steve Alukonis, DC to release my medical records to:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Family Member/Friend

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient/Parent/Legal guardian Date

**CONSENT TO TREAT A MINOR**: I hereby authorize and give consent to Dr. Steve Alukonis, DC to examine, and if needed, treat my minor child \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Print Child’s Name Here

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Parent/Legal Guardian Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient/Legal Guardian Date

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please label the area of the body where you are experiencing symptoms:

B= Burning

T= Tingling

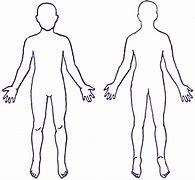
N= Numbness

S= Sharp

C= Cramping

D=Dull Pain

**Front Back**



Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_

**Informed Consent for Chiropractic**

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working toward the same objective. It is important that each patient understands both the objective and the method that will be used to attain it. This will prevent confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you make the decision whether to undergo chiropractic care or not, after being advised of the known benefits, risks, and alternatives.

Chiropractic is a science and art, which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and prevention of health. Health is a state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

The disturbance to the nervous system is called vertical subluxation. This occurs when one or more of the 24 vertebrae in the spinal column becomes misaligned and/or does not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely symptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments as well. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

We do not offer to diagnose or treat any disease or condition other than vertical subluxation. However, if during care, we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health provider.

All questions regarding the doctor’s objective pertaining to my care in the office have been answered to my complete satisfaction. The benefits, risks, and alternatives of chiropractic care have been explained to my satisfaction. I have read and fully understand that above statements and therefore accept chiropractic care on this basis.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name Signature Date

**Assignment of Benefits and Direction to Pay**

I hereby irrevocably assign to Space Coast Advanced Health, all benefits from my insurance carrier(s) due to me under No Fault, Medical Payments or any other applicable insurance coverage under any policy of insurance, for products, services and/or accommodations rendered by Provider as consideration for those products, services and/or accommodations rendered.

I hereby authorize and unequivocally instruct and direct my insurance company to issue payment directly to Provider for any and all products, services and/or accommodations rendered by Provider.

I have read the information herein and it is accurate to the best of my knowledge and belief.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Date Insurance Carrier

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Number

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Claim Number