Dr. Leone's Chiropractic Accident & Injury Center
Chiropractic-Massage Therapy-Physical Therapy
7003 NW 11 PL., Ste 5, Gainesville, FL 32605
GainesvilleInjuryCare.com
P: (352)374-0909

Dear New Patient,

From: Dr. Leone

We are looking forward to meeting you for your new patient Chiropractic appointment. Please bring the online new patient questionnaires and be sure to follow these instructions:

- Complete all, if something does not apply mark N/A for not applicable)
- **DO NOT DATE THE FORMS until you arrive at the office**
- take time to write legibly
- On the page titled "Pain Assessment":
    1. Mark only areas related to your recent trauma
    2. Mark any and all areas of pain numbness tingling cramping or other discomfort related to your recent trauma, even if that area has cleared up or has improved
    3. Please do not assign any numbers to your pain drawing. It is fine to Mark and X on the vertical line between 0 to 10 With 10 being so bad you prefer to be in the hospital and zero being no pain, five being moderate; should you decide to mark an X we are interested in the level that reflects your pain at its worst.

Here are some additional instructions for the day of your appointment:

Our doctor wants to get a sense of how your pain is affecting your daily routine so we ask that you **do not take any medicines for your pain or injuries that day**. Please bring the following:

- Photo Id, Health Insurance Card(s) primary and secondary
- Drivers Exchange, Police Report, or Incident Report
- Any Paperwork Given To you from Hospital/Urgent Care (Discharge Papers, Medical Testing and/or Test Results
- Your Primary Doctor's Card / information
- If being referred from a physician's office other than your Primary Doctor, bring the referral or provide referring physician's card/information
- Attorney's information and Contact Person at Attorney's Office
- Medication List

For Car/Bicycle/Scooter Accidents:

- Car Insurance Card
- List of coverages you purchased on your auto policy
- Any Written Correspondence From Both Your Auto Insurance Co. and The At Fault Insurance Company

Kindly provide 24-hour notice should you need to change your appointment. We look forward to seeing you at your scheduled time. Kindly come at your schedule time and not earlier as your forms will be already completed.

We accept Visa, MasterCard, or cash as forms of payment (sorry no checks or American Express).

PS We want you to have a pleasant experience with our office. This starts with easily finding our office, which is located behind Red Lobster. For easy landmarks and directions, that will make it a breeze to find us, see the "Contact Us" tab on our website: ***GainesvilleInjuryCare.com***. You'll also find special offers and free tips on how to feel better!

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Confidential Patient Information

Date:_____

First Name : _____ Middle Initial: _____ Last Name:_____

Address: _____

City: _____ State:_____ Zip Code:_____

Date of Birth:_____ Age:_____ Number of Children_____

SSN:_____-_____-_____ Are you **right** or **left** handed?_____

Spouse's Name:_____ Marital Status: Married Single Widow Divorced

Occupation: _____ Employer:_____

Email:_____@_____._____

Home #:( )_____-_____Work#: ( )_____-_____Cell# ( )_____-_____

Emergency Contact/relationship _____Contact #( )_____-_____

Car Insurance Company: _____**Date of Injury:**_____-_____-_____

Insurance Billing Address:_____

Policy Holder (If not patient):_____ date of birth_____ relationship_____

Claim Number: _____Policy #_____

PIP Claim Adjuster Name: _____ **Phone Number:**_____

Attorney Information:_____

Attorney Address:_____

Attorney Contact #: ( )_____-_____

Secondary Insurance Company: _____ Policy #, including letters_____

Policy Holder/Relationship (If different):_____Date of Birth:_____

Is this an employer plan/ Yes___ No___ If yes, list employer of policy holder _____

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AUTO RELATED ACCIDENTS

PATIENT NAME:_____ DATE:_____

ACCIDENT INFORMATION

Accident date:_____ Time:_____
Was it? ☐Day Time ☐Night Time
Year, make and model of the vehicle you were occupying:_____
Did the police arrive to the site?
☐YES ☐NO
Was a police report filed? ☐YES ☐ NO
Was a traffic violation issued? ☐YES ☐NO
If yes, to whom?_____
Were there any witnesses? ☐YES ☐NO
Was your vehicle ☐stopped or ☐ moving at impact?
Did the impact to your vehicle come from the ☐Front ☐Rear ☐Driver Side ☐Passenger Side?
Did your vehicle strike another car or anything else? ☐YES ☐NO Please describe:_____
Make and model of the other vehicle:
_____
Describe the road condition: ☐Dry ☐Wet
In which direction were you traveling?
☐North ☐South ☐East ☐West
The other vehicle was traveling?
☐North ☐South ☐East ☐West
How many people were in your vehicle?_____
In your words, please describe the accident (use back if needed):_____
_____
_____
_____
Was the vehicle you were in equipped with air bags? ☐Y ☐N Were you struck by one? ☐Y ☐N
Was the vehicle you were occupying towed from the seen? ☐YES ☐NO
Describe the road condition: ☐Dry ☐Wet
Is this your first accident? ☐YES ☐NO If no, how many prior accidents have you had?_____

PERSONAL INFORMATION

Were you the ☐Driver ☐Front Passenger ☐Rear Passenger?
Did your head strike the head restraint?
☐YES ☐NO
Were you wearing your seat belt?
☐YES ☐NO
During the impact which direction was your head facing ☐Forward ☐Right ☐Left?
Where were your hands at the time of impact?
_____
Were you wearing ☐a hat ☐glasses ☐sunglasses? Did they fall off? ☐YES ☐NO
Did you have the brakes applied at impact?
☐YES ☐NO
Were you ☐aware of the impending collision or ☐surprised by the impact?
Did any other part of your body strike anything inside your vehicle? ☐YES ☐NO
If yes, please describe:_____
_____
Did you ☐Loose consciousness ☐Feel Dazed?
Did you have symptoms immediately after the accident? ☐YES ☐NO
Please Explain:_____
_____
Did paramedics examine you at the accident site? ☐YES ☐NO
Did you go to the hospital? ☐YES ☐NO
Which one? _____
Directly from the accident site? ☐YES ☐NO
How did you get to the hospital? ☐Ambulance ☐Driven by someone ☐Driven by self
At the hospital, what was performed?
☐X-rays ☐MRI ☐CT scan
☐Injection Other:_____
_____
If given a work excuse at the hospital, what date does it state for your return? _____

Work Information

What do you do for work?_____
Please indicate your daily job duties: ☐Standing ☐Sitting ☐Walking ☐Lifting ☐Driving ☐Twisting ☐Crawling ☐Bending ☐Operate Equipment ☐Work with arms above head ☐Typing ☐Stooping ☐Other_____
Have you missed any work due to the accident? ☐YES ☐NO If yes, how many days?_____
While in recovery, is there any light duty work you can request? ☐YES ☐NO

Dr. Leone's Chiropractic Accident & Injury Center
Dr. Angela Leone

7003 NW 11 PL Suite 5
Gainesville, Florida 32606
Office: 352-374-0909

Medical History:

Circle if you are currently suffering from:

- Headaches
- Arm hands pain numbness tingling
- Leg pain numbness tingling
- Restricted movement head/neck
- Neck pain
- Vision Hearing disturbances
- Poor posture
- Upper back pain
- Painful/stiff joints
- Restricted movement shoulder/arm/hand
- Pain around shoulder blade
- Pain around collar bone
- Mid back pain
- Chest pain
- Rib cage pain
- Pain around breast bone
- Scoliosis
- Low back pain
- Buttock pain
- Hip pain
- Restricted movement leg/foot
- Ankle problems
- Weakness
- Walking sitting standing problems

List any prior fractures/age_____

Circle if you have **you** had or suffer from:

asthma high blood pressure thyroid problems
diabetes ulcer or gastritis liver problems
tuberculosis kidney problem Heart failure
blood problem abnormal heart rhythm Heart attack
stroke cancer type_____
gout or other crippling arthritis
fibromyalgia chronic fatigue syndrome
other serious illness/hospitalization_____
_____

Family medical history, circle if either parent, sister, brother, child or grandparent ever had?

stroke heart trouble suicide mental illness diabetes
high blood pressure gout or crippling arthritis tuberculosis

Cancer list: _____
_____

Prior Injuries	Approx Date	Treatment Type

List Surgeries:_____
List Medications: We can copy a list if you have it today _____
_____
List Allergies:_____
Smoker/amount_____ Alcohol frequency_____

PATIENT'S AFFIRMATION OR RECEIPT OF PATIENT'S STATEMENT OF PRIVACY RIGHTS

ACKNOWLEDGEMENT FORM

I have received this office's Statement of Privacy Rights, provided on my behalf and in accordance with law, and have read and understand my rights to privacy and security of Personal Health Information, as a patient of this practice.

Affirmed,

_____ _____

Print Name Birth Date

_____

Signature

FINANCIAL RESPONSIBILITY STATEMENT

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this chiropractic office will be credited to my account upon receipt. This is an assignment of benefits to Gainesville Medspa, PA. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, against the Doctor's recommendation, my account balance will be immediately due and payable.

Patient's Signature:_____ **Date:**_____

Guardian or Spouse's Signature_____ **SSN:**_____

Print Name _____ Date:_____

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& Physical Therapy
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PAIN ASSESSMENT

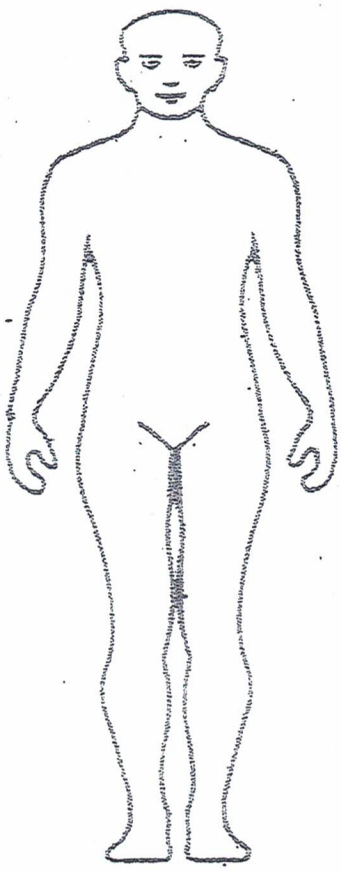
Aggravated by:

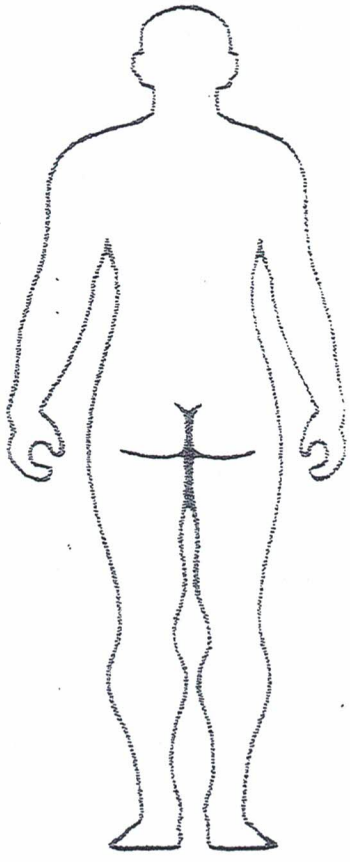
- ☐ Coughing
- ☐ Sneezing
- ☐ Straining
- ☐ Neck Movement
- ☐ Standing
- ☐ Reaching
- ☐ Lifting
- ☐ Bending
- ☐ Sitting
- ☐ Walking
- ☐ Other

Name _____ Date _____

Extreme Pain

No Pain





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AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION

TO RELEASE MOTOR VEHICLE CLAIMS INFORMATION, PIP INFORMATION, MEDICAL, PSYCHIATRIC, DRUG USE, ALCOHOL ABUSE, HIV TESTING, ARC, OR AIDS INFORMATION* IN THE RECORDS OF THE PATIENT NAMED BELOW.

I hereby authorize my provider(s)_____ to release my personal health information not already excepted by HIPPA or related statutes, or other information as noted below to the part of **GAINESVILLE MEDSPA, PA, 7003 NW 11th Place, Suite 5, Gainesville, Florida 32605** for the purpose of medical treatment for a period commencing on the date below and ending in five (5) years from that date. Release is executed to my current and future healthcare providers.

Review of_____

_____.

I reserve the right to cancel this authorization by notification in writing except to the extent that action has been taken in reliance on this authorization.

Alcohol and drug abuse information, if present has been disclosed from records whose confidentiality is protected by federal law. Federal regulations 42 CPR Part II prohibits making any further disclosure of it without the specific written consent of the undersigned, or as otherwise permitted by such regulations. HIV testing, ARC, and/or AIDS related diagnosis is further prohibited from further disclosure by state regulations without the specific written consent from the patient.

Affirmed by the patient,

PRINTED NAME_____

SIGNATURE _____

DATE _____

SOCAL SECURITY NUMBER _____-_____-_____

*Any of the categories above may be deleted my marking through. Please email records to: leoneINJURY@gmail.com or forward by postal mail to our office, see address above.

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.**

   Comprehensive Examination

   treatment (chiropractic adjustment/ physical therapy)

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):*

Dr. Angela Leone Name *(PRINT or TYPE)*	Angela Leone Signature	same date as above 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.

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Chiropractic ▪ Massage Therapy
& Physical Therapy
7003 NW 11th Place, Suite 5, Gainesville FL 32605
Located behind Red Lobster off Newberry Road
Phone: (352) 374-0909

MY CURRENT INSURANCE COVERAGE AND ANY FUTURE CHANGES

I understand that it is my responsibility to Dr. Leone, DC, and/or assigns (referred to as "Practice") with my most current insurance information. I also understand that if my insurance coverage changes that I must immediately inform the Practice. Failure to do so may result in a significantly higher patient responsibility.

I also understand that if the Practice does not participate with my current or future medical coverage I will be personally responsible for all charges incurred by myself

ASSIGNMENT OF BENEFITS

I authorize my insurer to make payments directly to my doctor. A copy or fax of this authorization may be used in place of the original and shall apply to all bills submitted by Angela Leone, DC and or their assigns.

FINANCIAL OBLIGATIONS & POLICIES

I understand and agree that all professional services rendered shall be charged directly to me and that I am personally responsible for payment. I understand and agree that the Practice will prepare forms to help me obtain benefits from my insurer but that I will be personally liable for my doctor bills unless my doctor notifies me in writing to the contrary.

I agree to make payment in full on all bills within 30 days of services rendered. I understand that any payment, which is 30 days, or more delinquent will be subject to late fees of $20, plus after such date interest at a rate 1.5% per month (or the highest percentage allowed by law) on the unpaid balance. If my doctor does not initially charge any late fees and/or interest I agree to pay all collection agency, credit bureau and/or attorney's fees and costs incurred in any attempt to collect the amount due. I agree to pay all attorney fees and cost incurred by my doctor in any attempt to collect the amount due. I understand that a $2.00 per month statement postage and handling fee will be charged to all unpaid balances.

MEDICAL RECORDS

I understand my original medical records will remain with the Practice as part of my permanent medical record for duration not less than that prescribed by law. I agree that if copies of my records are desired I will provide a written request, minimum of 72 hours advance notice and the prepayment of $1.00 per page.

WELCOMES AND REFERRALS

In an effort to make patients welcome and show our appreciation to patients for their referrals we do post a welcome and thank you board in our reception area. Unless I inform you to the contrary in writing I give the practice my full cooperation and allow them to use my name in this type of acknowledgment.

Print Name of Patient _____ Patient Signature _____ Date _____

GUARANTEE (MUST BE COMPLETED FOR ALL UNDERAGE PATIENTS)

The undersigned guarantor(s) guarantee(s) payment of all obligations owed by patient to the doctor.

Print Name of Guarantor	Relationship	Signature of Guarantor	Date
_____	_____	_____	_____

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FORM REQUEST POLICY

There is a $20 charge for forms to be filled out by our office.

Examples (not limited to):

- completed pip mileage forms
- school or work excuse/absence requests

Your required prepayment of $20.00 is non-refundable, non-reimbursable through insurance.

Completed forms are available two days post prepayment, for your pick up located at the office in the white mailbox.

Signature: _____ Date: _____

Printed name: _____

Circle preferred payment method: credit / cash

Received on: ____/____/_____

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AUTHORIZATION TO RELEASE SETTLEMENT AGREEMENT

If any one of my attorneys ask to reduce the final medical bills of Dr. Angela Leone and Gainesville MedSpa, P.A. for injuries on or about date of collision: _____. I hereby authorize my attorney(s) to release a true and complete copy of the financial disbursement sheet that shows the full amount offered or agreed upon at settlement as well as a listing of all attorney fees, lost wages, medical expenses and/or any other payee and amount(s) payable relating to my case. In addition, I order that my attorney(s) pay the above company within seven (7) calendar days of any agreed settlement. If, for any reason, my attorney refuses to release a true and complete copy of the disbursement sheet, I demand that my attorney pay my doctors bill in full.

THIS ASSIGNMENT AND CONTRACTUAL LIEN IS IRREVOCABLE UNLESS BOTH THE PROVIDER AND I AGREE TO REVOKE IT IN WRITING.

By my signature, I acknowledge that I have carefully read and fully understand the above document and acknowledge that it is a valid and irrevocable AGREEMENT.

_____ _____

NAME **DATE**

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Patient Name (Printed):_____

_____

_____

_____

_____

Dear Sir/Madam:

When any settlement agreement or any payment is made for this case, please issue a **separate check** payable to Gainesville MedSpa P.A. and Dr. Angela Leone for the amount of my outstanding balance with their office and deliver such payment to **4715 NW 31ST Avenue, Gainesville, FL 32606**. I have previously agreed to this in writing and signed an irrevocable Assignment of Benefits and Contractual Lien when I began treatment with Gainesville MedSpa P.A. d/b/a Dr. Leone's Chiropractic Accident & Injury Center and Dr. Angela Leone.

Sincerely,

_____

Patient's Signature

Dr. Leone's Chiropractic Accident & Injury Center
Chiropractic-Massage Therapy-Physical Therapy
7003 NW 11 PL., Ste 5, Gainesville, FL 32605
GainesvilleInjuryCare.com
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Irrevocable Assignment of Benefits Authorization / Cause of Action

For good and valuable consideration, including the agreement of **GAINESVILLE MEDSPA, PA.** (assignee) ("GMS") to accept this assignment in lieu of demanding full payment for services from the undersigned on the date each service is rendered, the undersigned patient executes this document hereby assigning to GMS the right to receive insurance benefits, to me or on my behalf, for services rendered by GMS , unto me by both reason of accident or illness.

Any insurance company that may be obligated to pay any insurance benefits to me, or on my behalf, for the aforesaid accident for services provided by GMS, is hereby directed to issue payment for those benefits directly to and payable to GMS.

I also authorize and assign to GMS the right to file suit and pursue all legal remedies to obtain payment for services provided to me by GMS. This authorization to file suit is an assignment of my cause of action to obtain payment for services provided to me by GMS and includes the assignment to pursue declaratory relief or any other legal remedies. In the event my insurance company fails to pay Assignee the full amount owing to Assignee after proper statutory notice. I hereby also assign by this instrument, all rights and causes of action in tort, in contract and the laws of Florida, against the personal injury protection carrier for the above named insured / patient for it's failure to pay for services rendered unto me by Assignee in relation to my accident or illness.

Reservation of Benefits

GMS accepts the aforesaid assignment and hereby notifies any insurer issuing payment that GMS objects to any "repricing" or reduction of billed amounts unilaterally made by any insurer. Any such reduced payments issued by any insurer are accepted under protest and without waiving any right of the provider to pursue all legal remedies against the insurer. Please be advised that I am hereby placing you on notice pursuant to Florida case law that should you deny, reduce or fail to either a part or an entire bill, which was submitted on my behalf from this health care provider. I am requesting you reserve, or hold aside, that same amount until this dispute is resolved.

_____ _____

Patient's Signature (or Guardian's Signature) Date

_____

Print Patient's Name (or Print Guardian's Signature)

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Additional Authorization and Direction to Insurer

AUTHORIZATION FOR DISCLOSURE OF INSURANCE DECLARATION PAGE: I, the patient and insured further authorize and direct any insurance company that may be obligated to pay any insurance benefits to me, or on my behalf, to provide Gainesville Medspa PA ("GMS") a copy of any declaration page which reflects policy limits applicable at the time of the accident of any insurance policy that may provide any insurance benefits to me for this aforesaid accident.

AUTHORIZATION FOR DISCLOSURE OF INSURANCE PAYMENT RECORD AND RELEASE OF INFORMATION: I further authorize and direct any insurance company that may be obligated to pay any insurance benefits to me, or on my behalf, to periodically as deemed necessary, provide to GMS a copy of any ledger, any PIP log, Initial and subsequent PIP Logs after initial log, or payment records reflecting any and all payments, and pending payments, made under any insurance coverage available to me, without redacting the names or payments of any other medical provider or entity to whom insurance been paid. I allow GMS to obtain any and all insurance and claim related information, and obtain copies of all correspondence regarding my claim.

DIRECTION NOT TO EXHAUST BENEFITS BY PAYMENT OF OTHER CLAIMS: I further authorize and direct any insurance company that may be obligated to pay any insurance benefits to me, or on my behalf, to not exhaust insurance benefits or coverage until all claims submitted by GMS have been paid in full, or at 80% if the insurance policy is limited to pay 80% coverage of medical claims. If any insurance company obligated to pay any insurance benefits to me, or on my behalf, has denied payment or a claim submitted by GMS, or made payment to GMS at any amount lesser than the amount billed, or lesser than 80% of the amount billed if my coverage is limited to 80% for medical claims. I direct the aforesaid insurance company to hold in escrow the amount in dispute, and if other claims would exhaust benefits of coverage by payment of the amount I have hereby requested be held in escrow. I further authorize and direct the aforesaid insurance company to notify GMS that benefits have been exhausted except the amount held in escrow, to enable GMS to attempt to resolve the disputed claim in a manner acceptable to GMS.

DIRECTION OF PAYMENT / RELEASE OF INFORMATION
I hereby authorize any insurance company or attorney to pay to Assignee the amount of this and/or any future bills, services rendered unto me. I also agree to pay in a current manner any differences between the total charges and the amount paid by the insurance company directly to Assignee. In the event that any payment is withheld by any insurance company, attorney, etc. I agree all of Assignee's attorney fee, costs and expenses incurred in connection with collecting the amount due, including any interpleader actions, settlement negotiations, collection efforts and/or litigation related to the amount due to be payable by PIP suit.

DIRECTION TO INSURER TO PROVIDE TO PROVIDER ADVANCE NOTICE OF IME OR EUO: I further authorize and direct any insurance company that may be obligated to pay any insurance benefits to me, or on my behalf, to provide at least 15 days in advance notice to GMS of any physical examination or examination under oath of myself that any insurance company may schedule.

_____ _____
Patient's Signature (or Guardian's Signature) Date

_____
Print Patient's Name (or Print Guardian's Signature)

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MEDICAL REPORTS, IRREVOCABLE LETTER OF REPRESENTION

& IRREVOCABLE PROVIDER LIEN

I do hereby authorize Dr. Angela Leone, DC to furnish you, my attorney, with a full report of her examination, treatment, prognosis, etc. of myself in regard to my accident/illness.

I hereby authorize my attorney's office to release any pertinent information to this health care provider as it relates to paying for services rendered. This is a Letter of representation/ letter instructing my attorney to satisfy the lien at the conclusion of my case, to which I am issuing to this health care provider. I am eliminating the need for my attorney to issue a separate document to this effect. I am instructing my attorney to satisfy the lien at the conclusion of my case. This lien is against any judgement, verdict, or pursuit settlement that may arise from my case. I also agree that regardless of the outcome of my case, I am still indebted for any unpaid balance for services rendered from this health care provider. A copy of this signed agreement is valid as the original. My attorney's signature is not needed on this agreement as I am issuing a valid health care provider lien against my proprietary right in any potential injury settlement that may arise. I have read and fully understand the above statements.

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that if my attorney does not wish to cooperate in assisting the doctor's office, the doctor will not await payment, but will require me to make my co-payments in full each visit.

_____ _____

Patient's Signature (or legal guardian) PRINT Patient's Name

Dated: _____

The undersigned, being attorney of record for the above patient does hereby acknowledge receipt of the above lien, and does agree to honor the same to protect adequately said above name attorney.

Attorney Name_____

Attorney's Signature_____ Dated _____

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IRREVOCABLE PROVIDER'S LIEN

PROVIDER INFORMATION

PROVIDER'S NAME: Dr. Angela Leone
ADDRESS: 7003 NW 11TH PL #5
Gainesville, FL 32605
PHONE: (353) 374-0909

I hereby authorize and direct my attorney pursuant to Florida Statute F.S.627.422 to pay directly to the above named provider such sums as may be due and owing them for professional services rendered to me by them. I also direct you to withhold any such sums or balance thereof that may be due to the above named provider from any settlement, judgment, payment, or verdict which may be paid to you, my attorney or myself as the result of the injuries for which I have been treated.

I fully understand that I am directly and fully responsible to the above named provider for all bills submitted by them for services rendered to me by them. And that this agreement is made solely as additional protection for any balance owed to them. I further understand that such payment is not contingent on any settlement, judgment, payment or verdict by which I may recover said payment.

I hereby acknowledge that this Provider's Lien is irrevocable and may not be terminated, ignored nor subjectively complied to without the expressed written consent of the Provider.

I agree never to resend this document and that a rescission will not be honored by my attorney. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney will honor this lien as inherent to the settlement and enforceable upon the case if it were executed by him.

The undersigned hereby acknowledges that I have read and understand the above information. I am signing without any threat of coercion, force or against my will. I am signing freely, voluntarily and with my full consent.

Patient Signature: _____

Patient Printed Name: _____

Date: _____

Dr. Leone's Chiropractic Accident & Injury Center
Chiropractic-Massage Therapy-Physical Therapy
7003 NW 11 PL., Ste 5, Gainesville, FL 32605
GainesvilleInjuryCare.com
P: (352)374-0909

INFORMED CONSENT

Every type of health care is associated with some risk of a potential problem. This includes chiropractic health care and diagnostic testing. Generally, both are very safe. Thousands of people die every year from prescribed drug complications, while only a handful of notable complications arise in the millions of people treated with chiropractic health care. We want you to be informed about potential problems associated with chiropractic health care before consenting to treatment. This is called **"INFORMED CONSENT."**

Chiropractic adjustments (manipulations) are the moving of bones with the physician's hands or an instrument. Frequently, adjustments make a "pop" or "click" sound in the area being adjusted. In this office, we have trained personnel to assist the physician with portions of your consultation, examination, physical therapy application, exercise instruction, etc. Staff members are always under the direct supervision of the physician. Occasionally, when the Dr. Leone is unavailable, another physician will treat patients.

STROKE: A stroke is the most serious problem associated with spinal manipulation. A stroke means that a portion of the brain does not receive enough oxygen from the bloodstream. The results are usually temporary (but can be permanent) dysfunction of the brain with an extremely rare complication of death. Spinal manipulations have been associated with strokes that arise from the vertebral artery only; this is because the vertebral artery is actually found inside the neck vertebrae. This is called a basilar stroke. In many of these cases, the spinal manipulation was performed by an inexperienced, untrained, or non-chiropractor person. The spinal manipulation that is related to vertebral artery stroke is called "extension-rotation-thrust atlas adjustment." This office does not perform this manipulation. Other types of neck manipulations may also potentially be related to vertebral artery stroke, but no one knows for certain. One study (journal of CCA, Volume 37, June 1993 and others) estimated that the frequency of this type of stroke is one per every 3 million upper neck manipulations, while a more recent study in 2001 (CMAJ *10/2/01* vol 165 n07) estimated 1 in 5.85 million adjustments. **This means that an average chiropractor would have to be in practice for 1430 years before they statistically be associated with a single patient stroke.** Less reliable survey studies of neurologists between 1994 and 2000 estimated an incidence of 1 in 500,000 to 1 million Dr. Leone routinely screens patients prior to cervical manipulation to minimize any risk even further.

DISC HERNIATIONS: Disc herniations that create pressure on the spinal nerve or on the spinal cord are frequently successfully treated by chiropractors and chiropractic manipulations, traction, etc. This includes both the neck and the back. Yet, occasionally manipulations, traction, etc. will aggravate the problem and rarely surgery may become necessary for correction. In extremely rare cases, chiropractic manipulations may also cause a disc problem, if the disc is in a weakened condition. These problems occur so rarely that there are few available statistics; a 2004 study (JMPT 2004 (Mar); 27(3» estimated an incidence of disc herniation occurring in less than 1 in 3.7 million manipulations.

SOFT TISSUE INJURY: Soft tissue primarily refers to muscles and ligaments. Muscles move bones and ligaments limit joint movement. Rarely, a spinal manipulation, traction, etc. may tear some muscle or ligament fibers. The result is a temporary increase in pain, but there are not long-term effects for the patient. These problems occur so rarely that to date, there are no available statistics to measure their occurrence.

RIB FRACTURES: The ribs are found only in the thoracic spine or middle back. They extend from your back to your front chest area. Rarely a chiropractic manipulation can crack a rib, and this is referred to as a "fracture." This occurs primarily in patients that have weakened bones from such things as osteoporosis. But, it can occur in perfectly healthy people as well. Osteoporosis may be noted on your x-rays, if they are medically necessary.

We adjust all patients very carefully, and especially those who have osteoporosis (on x-rays or bone density tests), or are likely to have undiagnosed osteoporosis by history. These problems occur so rarely that to date, there are no available statistics to measure their occurrence.

PHYSICAL THERAPY BURNS: Some of the machines we use generate heat. We also use both heat and ice, and recommend them for home care on occasion. Everyone's skin has sensitivity to these modalities, and rarely, either heat or ice can burn or irritate the skin Rarely, side effects include temporary increase in skin pain, and there may even be some blistering. We also occasionally use electrical modalities which may occasionally shock and/or burn the skin. Long term complications are rare. These problems occur so rarely that there are no available statistics to quantify their probability

SORENESS: It is common for patients to experience a temporary soreness or increase in soreness in the region being treated by manipulation, traction, etc. This is a normal physiological response while your body is undergoing therapeutic changes and is nearly always temporary, and let Dr. Leone know should this occur.

HIP PROSTHESIS: Generally a hip prosthesis is very stable. However, it is possible that the hip can dislocate during some maneuvers. This can typically be easily reduced, but could result in surgery to repair. Older prostheses are more vulnerable. This happens very rarely, so no statistics are available to quantify their probability. The techniques used further minimize the possibility of hip dislocation.

BREAST IMPLANTS: Most breast implants are very durable, but they can rupture, especially those that are over 10 years old. They typically rupture spontaneously, but it is possible that they could rupture during a manipulation This could require surgical intervention. This happens so rarely that no statistics are available. The techniques used further minimize the possibility of implant rupture.

OTHER PROBLEMS: There may be other problems or complications that might arise from chiropractic health care or diagnostic testing other than those noted above. These other problems or complications occur so rarely that it is not possible to anticipate and/or explain them all in advance of care. If you have any questions, always feel free to consult your physician.

Chiropractic medicine is a system of health care delivery; therefore, as with any other health care delivery system, we cannot promise a cure for any symptom, disease, or condition as a result of care in this office. We will always give you our best care, and if results are not acceptable, we will refer you to another physician/provider who we feel will assist your situation. **Should you experience any of these reactions, always let Dr. Leone know right away.**

If you have any questions regarding the above, please ask the physician prior to signing. When you have a full understanding, please sign below, attesting that all questions have been answered to your satisfaction.

Print name_____

Signature_____

Date_____

Witness Signature Dr. Leone

Printed Name: Dr. Angela Leone
Date: As above

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EMAIL APPOINTMENT REMINDER/ Cancellation policy

I provide consent to receive email notifications including appointment reminders, and office practice updates which may be in newsletter form (less than six per year). **Please initial** the items below stating that you understand how you will see our medical practice name as it relates to your visits.

_____ I understand that all emails sent to me will be from **GAINESVILLE MEDSPA.**

_____ I understand that all receipts, billings & medical records will read **GAINESVILLE MEDSPA.**

____ I understand that all insurance correspondence will show **GAINESVILLE MEDSPA.**

Chiropractic/ Manuel Therapy Soft Tissue Mobilization / Massage / Acupuncture

Appointment Cancellation Policy

A 24-hour notice is required to change or cancel an appointment. Should 24-hour notice not be provided, your credit card will be billed $25.00 for a missed appointment fee.

_____
(Initial)

Manuel therapy soft tissue mobilization, massage and acupuncture *appointments are held* with a **Visa or MasterCard** credit card – no debit cards. No other credit cards or checks are accepted.

_____
(Initial)

This fee is not payable by insurance. I authorize my **Visa or MasterCard** to be billed, in the event that I do not provide 24-hour Notice of Cancellation, in the amount of $25.00.

_____
(Initial)

_____ _____
Signature Date