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Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Age: _____ Sex: _____ Soc. Sec #_____

Phone Number: _____ Cell Phone: _____

E-mail Address: _____

Employer: _____ Occupation: _____

Work Number: _____ Marital Status (circle one) M S W D

In Case of Emergency Contact: _____ Phone: _____

Whom may we thank for referring you? _____

Medical History: Diabetes Heart Disease Epilepsy Pacemaker Strokes

Primary Complaints: _____

_____

Primary Doctor: _____ Phone: _____

Primary Insurance

Name of Insurance Company: _____

Insured Name: _____Relationship to insured: _____

Insured ID # _____ Group # _____

Patient Signature: _____Date: _____

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PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

By signing this form I acknowledge that Encompass Chiropractic Center has given me the opportunity to review or obtain the Notice of Privacy Practices.

Print Name: _____
(If you are a legal representative please print the patient's name and sign your name)

Signature: _____

Date: _____

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OFFICE POLICIES

1. It is our office policy that any patient and/or insurance company that pays up-front or in advance is entitle to and administrative discount.

2. The fee paid for treatment x-rays is for analysis only. The film itself is the property of this office. Once films are taken, they cannot be released, but may be copied. There may be a fee for copying of the x-rays.

3. If you have any out of pocket responsibility what will be you method of payment? (Please circle)

   Cash Check Credit Card/Debit Card Attorney/Letter of Protection

I understand and agree that health and accident insurance policies are an agreement between the insurance carrier and myself. Furthermore, I understand Encompass Chiropractic Center will prepare any necessary reports, and forms to assist in making collection from my insurance company and that any amount authorize to be paid directly to Encompass chiropractic Center will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me, are charge directly to me and that I am personally responsible for payment.

I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional service rendered to me will be immediately due and payable; I agree that I will be responsible for all attorney and legal action become necessary to collect this amount.

Patient's Name (Print): _____

Date: _____

Patients/ Guardian Signature authorizing care: _____

Date: _____

In case of emergency notify: _____

Relationship: _____

Address: _____

City _____ State _____

Phone Number: _____

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FINANCIAL DISCLOSURE POLICY

As a result of the changes to the 2003 Florida No Fault Statute (PIP statute) it is a third degree felony for any health care provider to agree to waive a deductible or to reduce or waive your co-payment (if applicable) as a routine business practice.

We therefore require payment of all balances due, whether co-payments or deductibles, after all attempts by us (including litigation) to collect from the PIP carrier and the at fault driver's carrier have been exhausted.

Two exceptions are permitted under the law:

1. Reduction of the balance in conjunction with a personal injury settlement.

2. Documented financial hardship.

Please speak with our billing manager if you have any questions or if your visits to our facility are due to the negligence of another party.

_____ _____

Patient's Signature Date

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X-rays Authorization

I, (Patient's Name) _____
give permission to Encompass Chiropractic Centers and its assigned associates to perform x-rays for the sole purpose of diagnosing a potential condition and/or for any possible injuries I may have sustained during my incident/accident.

FOR FEMALES ONLY:
The 10 days following onset of menstrual period are generally considered safe for x-ray examination.

Onset of Menstrual Period:

Date: _____ Today's Date: _____

I am pregnant YES _____ NO _____

I have had a hysterectomy YES _____ NO _____

I am aware that if I am pregnant and received radiation to the abdomen, there is a possibility of injuring to the fetus. However, I understand that the likelihood of such injury is slight and that my physician feels that the information to be gained from this examination is important to my health. I therefore wish to have this examination performed now.

Patient's Name: _____

Patient's Signature: _____

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Consent for Chiropractic Treatment

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures on me or on _____by **Dr. Victor Lasa/Dr. Suanette Torres** or other licensed doctors of Chiropractic who may be employed by or engaged in practice at **Encompass Chiropractic Centers, LLC**.

I have had the opportunity to discuss with the doctor or other clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that the practice of neither chiropractic nor medicine is an exact science and that my care may involve the making of judgments based upon the facts known to the doctor at the time, that it is not reasonable to expect the doctor to be able to anticipate or explain all risks and complications; that an undesirable result does not necessarily indicate an error in judgment; that no guarantee as to results has been made to nor relied upon me, and I wish to rely on the doctor to exercise judgment during the course of the procedure which he/she feels at the time, based upon the fact then known, is in my best interests.

I have also been advised that although the incidence of complications associated with chiropractic services is very low, anyone undergoing adjusting or manipulative procedures should known of possible complications which have been alleged. These include, but are not limited to fractures, disc injuries, strokes, dislocations, sprains, and those which relate to physical aberrations unknown or reasonably undetectable by the doctor.

I have read or have read to me the above consent. I have also had an opportunity to ask any questions about its contents, and by signing below, acknowledge my understanding of its contents.

Patient Name: _____ Date:___/____/___
Patient Signature: _____

If patient/insured is a minor, signature of parent/guardian
Parent/guardian Name: _____
Parent/guardian signature: _____ Date:___/___/___

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Today's Date_____

Request for Financial Assistance

By

_____

Patient's Name

In as much the patient has expressed a strong and willing desire to receive care in this office, and that current circumstances exist which greatly restrict their ability to pay the practice's standard fees for services and/or any co-pay and/or deductible amounts**. Encompass Chiropractic Centers** agrees to temporarily waive the patient's obligation to pay that portion they would otherwise be contractually or legally bound to pay for all services rendered in this clinic.

The reason for financial hardship is _____

_____

If, however, future discussion regarding their financial situation reveals that Mr. /Mrs. _____ circumstances have improved enough to enable them to assume a greater portion of their payment responsibility, the practice will immediately amend this agreement.

Approved by _____ Date _____

I understand that if my financial status or my ability to pay improves for any reasons, the services rendered from that time forward will be based on the practice's 'Standard, Usual, Customary' fees.

Patient's Signature _____ Date _____

Patient Name _____ Date _____