ACTIVITIES OF DAILY LIVING ASSESSMENT

Directions: This questionnaire has been designed to give the doctor information as to how your pain has affected your ability to manage in every day life. Circle as many numbers that apply to you or write out in the margin if you have a different description for your pain than is listed below.

Section 1 - Pain Intensity

1) I can tolerate the pain I have.
2) The pain is bad but I manage without taking pain killers.
3) Pain killers give complete relief from pain.
4) Pain killers give moderate relief from pain.
5) Pain killers give very little relief from pain.
6) Pain killers have no effect on the pain and I do not use them.

Section 2 - Personal Care (Washing, Dressing, etc.)

1) I can look after myself normally without causing extra pain.
2) I can look after myself normally but it causes extra pain.
3) It is painful to look after myself, but I am slow and careful.
4) I need some help at times, but I can manage most of my personal care.
5) I need help every day in most aspects of self care.
6) I do not get dressed usually staying in bed, and I wash with difficulty.

Section 3 - Lifting

1) I can lift heavy weights without extra pain.
2) I can lift heavy weights but it causes extra pain.
3) Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned.
4) I can lift only very light weights without extra pain.
5) I cannot lift or carry anything at all because of pain.

Section 4 - Walking

1) Pain does not prevent me walking any distance.
2) Pain prevents me walking more than 1 mile.
3) Pain prevents me walking more than $^1/_2$ mile.
4) Pain prevents me walking more than $^1/_4$ mile.
5) I can only walk using a cane or crutches.
6) I am in bed most of the time and must crawl to the toilet.

Section 5 - Sitting

1) I can sit in any chair without limitation and without causing extra pain.
2) Pain prevents me sitting more than 1 hour in any chair.
3) Pain prevents me from sitting more than $^1/_2$ hour in any chair.
4) Pain prevents me from sitting more than 10 minutes in any chair.
5) Pain prevents me from sitting at all.
6) I have no pain sitting, but only if I sit in my favorite chair.

Section 6 - Standing

1) I can stand without limitation without causing extra pain.
2) I can stand without limitation, it causes me extra pain.
3) Pain prevents me from standing for more than 1 hour.
4) Pain prevents me from standing for more than 30 minutes.
5) Pain prevents me from standing for more than 10 minutes.
6) Pain prevents me from standing at all.

Section 7 - Sleeping

1) Pain does not prevent me from sleeping well.
2) I can sleep well only by using medications.
3) I have less than six hours of sleep before the pain wakes me up.
4) I have less than four hours of sleep before the pain wakes me up.
5) I have less than two hours of sleep before the pain wakes me up.
6) Pain prevents me from sleeping at all.

Section 8 - Sex Life

1) My sex life is normal and causes no extra pain
2) My sex life is normal but causes some extra pain.
3) My sex life is nearly normal but is very painful.
4) My sex life is severely restricted by pain.
5) My sex life is nearly absent because of pain.
6) Pain prevents any sex life at all.

Section 9 - Social Life

1) My social life is normal and gives me no extra pain.
2) My social life is normal but increases the degree of pain.
3) Pain has no significant effect on my social life apart from Limiting my more energetic interests (e.g. dancing, exercise, yard work etc.)
4) Pain restricted my social life and I do not go out as often.
5) Pain has restricted my social life to my home.
6) I have no social life because of pain.

Section 10 - Traveling

1) I can travel anywhere without extra pain.
2) I can travel anywhere but it causes extra pain.
3) Pain is bad but I manage journeys over 2 hours.
4) Pain restricts me to journeys of less than one hour.
5) Pain restricts me to short necessary journeys less than 30 minutes.
6) Pain prevents me from traveling except to the doctors.

Patient Name: _____ Patient Signature _____

ASSIGNMENT OF BENEFITS, AUTHORIZATION TO SETTLE CLAIM

AND DIRECTION TO PAY MEDICAL PROVIDER DIRECTLY

By my signature below, for good and valuable consideration (including but not limited to the extension of credit to me), I hereby assign, transfer and convey to ***TAMPA SPINE AND WELLNESS*** (hereinafter "the Provider") all of my rights, title and interest in and to medical expense reimbursement in whatever form, including but not limited to any automobile liability medical expense payments or other health benefits indemnification and/or agreement otherwise payable to me. This payment shall not exceed my indebtedness to the above-named assignee and I acknowledge that I will timely pay any indebtedness owed by me to the assignee that is not otherwise satisfied by the above-mentioned assigned proceeds. I also acknowledge that any medical expenses not covered under my insurance policy will be my responsibility.

I further authorize the Provider to negotiate, collect and settle any claim with any insurance carrier or other third-party payor with regard to these services, which authorization shall include authority to:

(1) request and receive from any insurer or any other party all documentation and records that I am empowered to request regarding this claim, including, without limitation, a statement of coverage, policy declarations page and insurance policy pursuant to Section 627.4137. In addition, the provider has the authority to request and receive any Independent Medical Examination Reports, notices sent to me regarding appointments for Independent Medical Examinations and Examinations Under Oath (including proof of mail), Records Review Reports, coverage denial letters, Explanations of Benefits, and Benefit Payment Sheets or Logs (P.I.P. Payout Sheets), without regard as to whether such documentation has already been provided to me and,

(2) to endorse in my name any check issued for payment where benefits were assigned. By way of this assignment and notice, I further instruct you, the insurer, to furnish to Provider copies of all future notices affecting Provider's interest in this claim, including, without limitation, any notices of requested medical examinations or statements.

The Provider hereby objects to any reductions or partial payments. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by the provider shall be done so under protest, at the risk of the insurer, and the deposit *shall not* be deemed a waiver, *accord, satisfaction*, discharge, settlement or agreement by the provider to accept a reduced amount as payment in full.

I further direct my insurer to direct all payments for services rendered by the Provider directly to Provider at the billing address contained on Provider's medical bills.

THIS IS A DIRECT AND IRREVOCABLE ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER MY POLICY OF INSURANCE.

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

I have read the foregoing and understand and agree to each of the above provisions:

_____ _____

Patient's signature Date

Tampa Spine & Wellness
205 W. Martin Luther King Blvd
Suite 103
Tampa, FL 33603
O: (813) 331-5753 F: (813) 330-3022

Informed Consent to Chiropractic Adjustment and Care

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

I have had the opportunity to discuss with the Doctor of Chiropractic named below and/or with the other office or clinical personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that the results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks of treatment, including, but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate or explain all risks and complications, and I wish to rely on the doctor to exercise judgement during the procedure which the doctor feels at the time, based upon the facts then known, is in my best interest.

I have read or have had read to me the above consent. I have also had an opportunity to ask questions about this consent, and by signing below I agree to the above-mentioned procedures. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any future condition(s).

_____
Print Patient's Name

_____
Signature of Patient

_____
Date

_____
Print Name of Patient

_____
Print Name of Patient's Representative

_____
Signature of Patient's Representative

As: _____
Relationship or Authority of Patient's Representative

_____
Date

To be completed by doctor or staff

A copy of this form is as valid as the original

Witness to Patient's signature

_____

_____
Translated by

Print name of doctor(s) treating this patient

_____

Tampa Spine & Wellness
205 W. Martin Luther King Blvd
Suite 103
Tampa, FL 33603
O: (813) 331-5753 F: (813) 330-3022

PRIVACY PRACTICES ACKNOWLEDGEMENT

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

Name: _____

Date of Birth: _____/ _____/ _____

Signature: _____ Date: _____

Tampa Spine & Wellness
205 W. Martin Luther King Blvd
Suite 103
Tampa, FL 33603
O: (813) 331-5753 F: (813) 330-3022

Confidentiality Agreement

To our valued Patients:

We at Tampa Spine and Wellness have always made your privacy one of our top priorities. We would like to inform you of the measures our office has taken to insure your rights of patient privacy. (In accordance with HIPPA)

We communicate with our patients through email and by phone. Below is a list of ways in which our office corresponds with you. Please indicate any items that you do **NOT** wish to receive.

Mailer in Office:

1) _____ Birthday Greeting
2) _____ Health care maintenance reminders
3) _____ Holiday Cards
4) _____ Thank you cards for your referrals
5) _____ Health Newsletter

I prefer all mailed correspondence to be sent to my: Home _____ Office _____ (Please check one)

Address: _____ Email: _____

City: _____ State: _____ Zip: _____

Phone Calls: Home _____ Mobile: _____

6) _____ Health care maintenance reminders
7) _____ Appointment reminders
8) _____ Missed appointment rescheduling

In the event we are unable to speak with you directly, please indicate the ways in which it is acceptable for our office to leave a courtesy message for you.

_____ On your home answering machine or with family

_____ Office voicemail with receptionist

_____ Okay to leave detailed message with information

_____ Please leave message with call back number only

We do our best to always honor your request when communicating with you.

Yours in Health,

Tampa Spine & Wellness

_____ _____

Patient Signature Date

Tampa Spine & Wellness
205 W. Martin Luther King Blvd
Suite 102
Tampa, Florida 33603
O: (813) 331-5753 F: (813) 330-3022
doctor@tampaspineandwellness.com
www.tampaspineandwellness,com

RECORD RELEASE AUTHORIZATION

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION UNDER HIPAA 164.508

To: _____
Doctor or Hospital

_____
Address

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE TO:

Tampa Spine Wellness

F: (813) 330-3022
doctor@tampaspineandwellness.com

THE COMPLETE RECORDS AND X-RAYS IN YOUR POSSESSION CONCERNING THE PATIENT'S ILLNESS AND/OR TREATMENT DURING THE PERIOD OF _____ TO _____

NAME: _____

DATE OF BIRTH: ___/___/___

SOCIAL SECURITY NUMBER: _____-_____-_____

ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____

SIGNATURE: _____ DATE: ___/___/___

Please send the above patient's medical records, x-rays, MRI's, and all other tests as soon as possible, since it is necessary for the doctor to review them prior to the patient's next visit. Thank you.

This authorization will expire one year after the date signed. Your are authorized to accept a copy of this form in lieu of the original. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524.

All information transmitted hereby is intended only for the addressee named above. If the reader of this message is not the intended recipient or the employee or agent responsible for delivering the message to the intended recipient, please note that any distribution or copying of this communication is strictly prohibited. Anyone who received this communication in error should notify us immediately by telephone and return the original message to us at the above address by U.S. mail.

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.**

Initial Examination

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**)*:

Seth M. Lott D.C. 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.

Tampa Spine & Wellness
205 W. Martin Luther King Blvd
Suite 102
Tampa, Florida 33603
813-331-5753

24 hour Cancellation Policy

Thank you for providing this personal information. It will enable us to more completely understand your individual pattern and come up with the most accurate diagnosis for your condition. Everything you disclose will be held in the utmost confidentiality, and will not be shared in any circumstances without the patient's expressed, written consent.

We find that communicating our office policies will assist us in providing you with optimal service. Should you need to reschedule an appointment, a **24 hour notice is required**. If you fail to notify us 24 hours in advance, you will be charged a $35.00 dollar fee for your missed appointment. A missed appointment is a loss for everyone. For a Monday cancellation, please call on Saturday.

_____
Patient's Signature

_____
Parent's Signature if patient is a minor

_____
Date