

Sarasota Chiropractic, Physical Therapy & Massage
Sensitive, Compassionate, Professional, Thoughtful and More

Abraham I. Kozma, D.C., P.A/ Patricia Vulopas, MSPT
NEW PATIENT PROFILE

Date: _____ Name: _____

Date of Birth: _____ Age: _____ Soc.Sec. No. ____ / ____ / ____ Marital Status _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: Home: (____) _____ - _____ Cell: (____) _____ - _____ Work: (____) _____ - _____

Permission to text appt reminder: Y or N – use Cell#(____)-____-____ My carrier _____

Ex: ATT, TMobile, etc

Spouse's Name: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

* E-MAIL: _____ @ _____ May we email your appt. reminders? Y or N

* Your email will NOT be shared with any 3rd parties, and is used for occasional office announcements and promotions.

Employer: _____ Occupation: _____

Address: _____ City: _____ State: _____ Zip: _____

Nature of Injury: Auto _____ Work _____ Other _____ Please describe below: _____

Date of injury _____ Date symptoms appeared _____

Have you ever had same condition? Yes ___ No ___ If yes, when? _____

List of physicians also seen for this injury/condition? _____

Have you ever been under chiropractic care: Yes ___ No ___ If yes, please describe _____

Method of Payment: Cash/Check: _____ Health Insurance: _____ Workers Comp: _____ Auto Accident: _____

Medicare: _____ Other: _____

Please Present Copy of Insurance Auto or Medical Card

Name of the insured: _____

I understand and agree that health/accident insurance policies are an arrangement between and insurance carrier and myself. I understand and agree that all services rendered to me and charges are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's Signature: _____ Date _____

Spouse's or Guardian's Signature: _____ Date _____

Revised 2/10/2021

Functional Rating Index

For use with Neck and/or Back Problems only.

In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities. For each item below, please circle the number which most closely describes your condition right now.

1. Pain Intensity

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain

0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Name _____

PRINTED

Signature _____

Date _____

Total Score _____

QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name _____

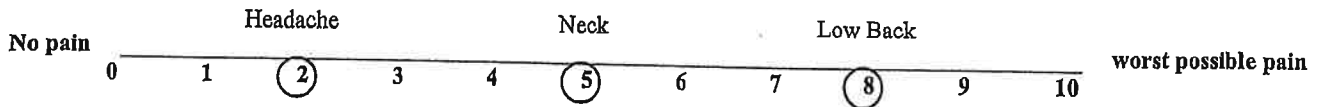
Date _____

Please read carefully:

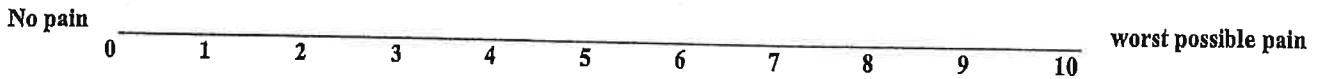
Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

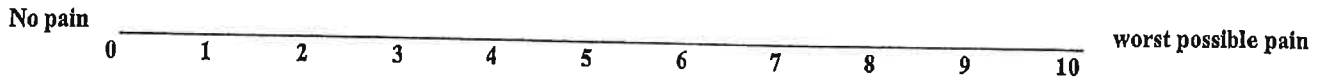
Example:



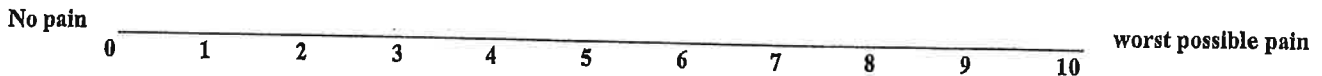
1 - What is your pain RIGHT NOW?



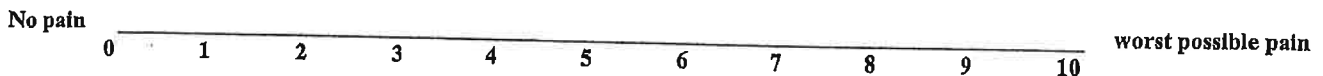
2 - What is your TYPICAL or AVERAGE pain?



3 - What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?



4 - What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?



OTHER COMMENTS:

Examiner _____

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

Medical History

Have you been treated for any conditions in the last year? No Yes

If yes, please describe:

Date of last physical exam: _____ Is there a chance that you are pregnant? No Yes

Have you had X-rays taken? No Yes If Yes, where? _____

What medications are you taking and for what conditions (Please list dosage and amounts, etc.)

What vitamins, minerals, or herbs do you currently take? (Please list for what conditions, dosage, and frequency).

Have you ever:	No	Yes	Briefly Explain
Broken bones?	<input type="radio"/>	<input type="radio"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Been hospitalized?	<input type="radio"/>	<input type="radio"/>	
Been in an auto accident?	<input type="radio"/>	<input type="radio"/>	
Had Sprains/Strains?	<input type="radio"/>	<input type="radio"/>	
Been struck unconscious?	<input type="radio"/>	<input type="radio"/>	
Had surgery?	<input type="radio"/>	<input type="radio"/>	

Family History

Family Members - Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc.)

Do you experience pain every day?	<input type="radio"/> No	<input type="radio"/> Yes
Do your symptoms interfere with daily life?	<input type="radio"/> No	<input type="radio"/> Yes
Does pain wake you up at night?	<input type="radio"/> No	<input type="radio"/> Yes
Are your symptoms worse during certain times of the day?	<input type="radio"/> No	<input type="radio"/> Yes
Do changes in weather affect your symptoms?	<input type="radio"/> No	<input type="radio"/> Yes
Do you wear orthotics?	<input type="radio"/> No	<input type="radio"/> Yes
Do you take vitamin supplements?	<input type="radio"/> No	<input type="radio"/> Yes
What activities aggravate your symptoms?	<input type="radio"/> No	<input type="radio"/> Yes

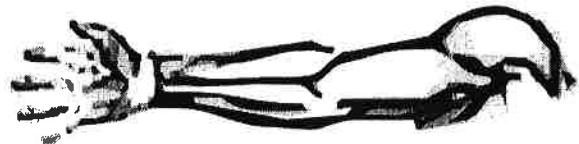
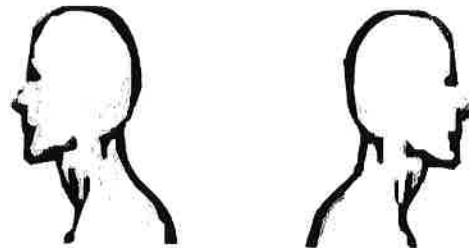
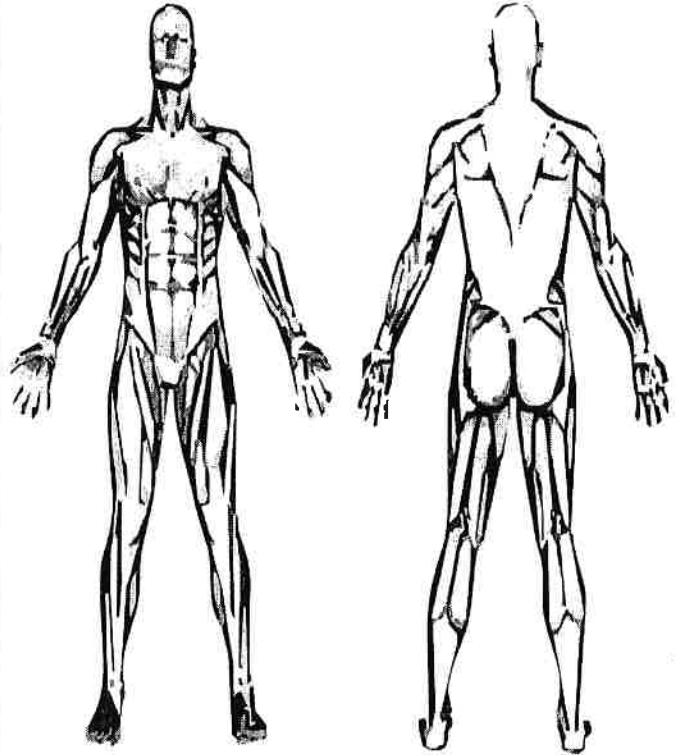
Habits	None	Light	Moderate	Heavy
Alcohol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Coffee	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Tobacco	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Drugs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Exercise	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Appetite	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Soft Drinks	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Water	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Salty Foods	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sugary Foods	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Artificial Sweeteners	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Have you ever suffered from:

- Alcoholism
- Allergies
- Anemia
- Arteriosclerosis
- Arthritis
- Asthma
- Back Pain
- Breast Lump
- Bronchitis
- Bruise Easily
- Cancer
- Chest Pain/Conditions
- Cold Extremities
- Constipation
- Cramps
- Depression
- Diabetes
- Digestion Problems
- Dizziness
- Ears Ring
- Excessive Menstruation
- Eye Pain or Difficulties
- Fatigue
- Frequent Urination
- Headache
- Hemorrhoids
- High Blood Pressure
- Hot Flashes
- Irregular Heart Beat
- Irregular Cycle
- Kidney Infection
- Kidney Stones
- Loss of memory
- Loss of balance
- Loss of smell
- Loss of taste
- Lumps In Breast
- Neck Pain or Stiffness
- Nervousness
- Nosebleeds
- Pacemaker
- Polio
- Poor Posture
- Prostate Trouble
- Sciatica
- Shortness of breath
- Sinus Infection
- Sleep problems or Insomnia
- Spinal Curvatures
- Stroke
- Swelling of ankles
- Swollen Joints
- Thyroid Condition
- Tuberculosis
- Ulcers
- Varicose Veins
- Venereal Disease
- Other:

Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing.

A=Ache **O=Other**
B=Burning **P=Pins & Needles**
N=Numbness **S=Stabbing**



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AUTHORIZATION FOR TREATMENT AND CONSENT FOR CARE

I hereby voluntarily consent to chiropractic care and/or diagnostic treatment by Sarasota Chiropractic, Physical Therapy & Massage, its physicians and employees as explained to me by the attending physician and whomever he/she may designate as their assistant. I am aware that the practice of chiropractic is not an exact science and that any procedure has an inherent risk. I acknowledge that no guarantees can be made to me as a result of any treatment or examination in this office.

I understand and agree that I am personally responsible for payment of all services rendered. Health and accident policies are an arrangement between an insurance carrier and myself, however, Sarasota Chiropractic, Physical Therapy & Massage may accept certain insurance assignments of benefits. The acceptance of insurance assignment is individually determined and prior authorization is required. I understand that upon termination of care, any outstanding charges for professional services rendered will be immediately due and payable. Fees incurred for any account turned over to a third party for the purpose of collections on your account is the patient's financial responsibility.

Patient Signature: _____ Date: _____

Relationship, if Guardian: _____

ALL FEMALE PATIENTS PLEASE COMPLETE THIS SECTION

In order to protect you, the patient, we need to be assured that if the Doctor orders x-rays, there is no possibility of you being pregnant.

I hereby release Sarasota Chiropractic, Physical Therapy & Massage and the staff from any responsibility for injury or complications to my fetus or myself should I be pregnant on this date.

_____ There is a possibility of my being pregnant.

_____ There is NO possibility of my being pregnant.

Signature of Patient _____ Date: _____

Relationship, if guardian: _____

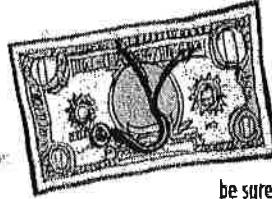
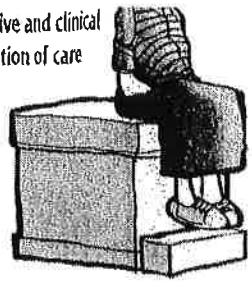
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Office 941-924-9892 ** Fax 941-924-7283 www.sarasotclinic.com

Revised 8/24/2020



with the best health care possible. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between physician assistant, nurse, physician and business office staff. In addition, we may share your health information with referring physicians, clinical and pathology laboratories, pharmacies or other health care personnel providing you treatment.

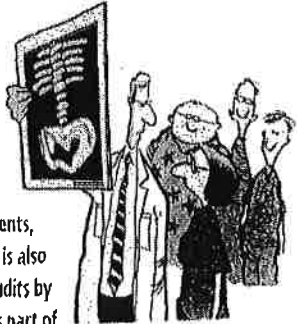


To Obtain Payment

We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health information.

To Conduct Health Care Operations

Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care at our office. As a result, health information may be included in training programs for students, interns, associates, and business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, licensing or credentialing activities.



Dear Patient:

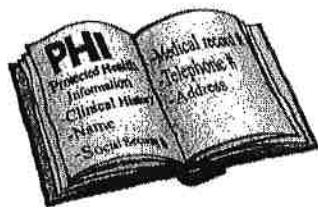
This is not meant to alarm you! Quite the opposite! It is our desire to communicate to you that we are taking the new Federal (HIPAA - Health Insurance Portability and Accountability Act) laws written to protect the confidentiality of your health information seriously. We do not ever want you to delay treatment because you are afraid your personal health history might be unnecessarily made available to others outside of our office.

So what has changed?
Why a privacy policy now?
Very good questions!

The most significant variable that has motivated the Federal government to legally enforce the importance of the privacy of health information is the rapid evolution of computer technology and its use in healthcare. The government has appropriately sought to standardize and protect the privacy of the electronic exchange of your health information. This has challenged us to review not only how your health information is used within our computers but also with the Internet, phone, faxes, copy machines, and charts. We believe this has been an important exercise for us because it has disciplined us to put in writing the policies and procedures we use to ensure the protection of your health information everywhere it is used.

We want you to know about these policies and procedures which we developed to make sure your health information will not be shared with anyone who does not require it. Our office is subject to State and Federal law regarding the confidentiality of your health information and in keeping with these laws, we want you to understand our procedures and your rights as our valuable patient.

We will use and communicate your HEALTH INFORMATION only for the purposes of providing your treatment, obtaining payment and conducting health care operations. Your health information will not be used for other purposes unless we have asked for and been voluntarily given your written permission.



In Patient Reminders

Because we believe regular care is very important to your general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family.



These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best preventive and curative care modern medicine can provide. They may include postcards, folding postcards, letters, telephone reminders or electronic reminders such as email (unless you tell us that you do not want to receive these reminders).

Abuse or Neglect

We will notify government authorities if we believe a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only when we are compelled by our ethical judgment, when we believe we are specifically required or authorized by law or with the patient's agreement.

Public Health and National Security

We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or to national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.



Rights



Family, Friends and Caregivers

We may share your health information with those you tell us will be helping you with your home hygiene, treatment, medications, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want we will use our very best judgment when sharing your health information only when it will be important to those participating in providing your care.

To Coroners, Funeral Directors and Medical Examiners

We may be required by law to provide information to coroners, funeral directors and medical examiners for the purposes of determining a cause of death and preparing for a funeral.

Medical Research

Advancing medical knowledge often involves learning from the careful study of the medical histories of prior patients. Formal review and study of health histories as a part of a research study will happen only under the ethical guidance, requirements and approval and of an Institutional Review Board.

Authorization to Use or Disclose Health Information

Other than is stated above or where Federal, State or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

This new law is careful to describe that you have the following rights related to your health information.

Restrictions

You have the right to request restrictions on certain uses and disclosures of your health information. Our office will make every effort to honor reasonable restriction preferences from our patients.

Confidential Communications

You have the right to request that we communicate with you in a certain way. You may request that we only communicate your health information privately with no other family members present or through mailed communications that are sealed. We will make every effort to honor your reasonable requests for confidential communications.

Inspect and Copy Your Health Information

You have the right to read, review, and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable fee to duplicate and assemble your copy.



Amend Your Health Information

You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe your reason for the change.

Your request may be denied if the health information record in question was not created by our office, is not part of our records or if the records containing your health information are determined to be accurate and complete.

Documentation of Health Information

You have the right to ask us for a description of how and where your health information was used by our office for any reason other than for treatment, payment or health operations. Our documentation procedures will enable us to provide information on health information usage from April 14, 2003 and forward. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. We may need to charge you a reasonable fee for your request.

Request a Paper Copy of this Notice

You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail or email a copy to you.

We are required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practices we will be sure all of our patients receive a copy of the revised Notice.

You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. Please let us know of your concerns or complaints in writing.

Patient Acknowledgment

Patient Name(s): _____

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions we want to hear from you. If not we would appreciate very much your acknowledging your receipt of our policy by signing and returning this card. We look forward to seeing you again soon!



Patient Signature

Date: _____ / _____ / _____

Sarasota **C**hiropractic, **P**hysical **T**herapy & **M**assage

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Abraham Kozma, D.C., P.A.

2801 Fruitville Rd. Suite 180 * Sarasota, Florida * 34237-5357

Office 941-924-9892 ** Fax 941-924-7283

PATIENT CONSENT TO RECEIVE MAIL, TELEPHONE/VOICEMAIL, EMAIL*, AND/OR TEXT MESSAGES

PATIENT NAME: _____

DO WE HAVE YOUR PERMISSION TO:

Send an appointment reminder to your home? Yes No

Send test results to your home? Yes No

Leave the following information on your home answering machine/voice mail and/or in your email inbox*:

Appointment Information: Yes No

Billing Information: Yes No

Medical Information: Yes No

I give permission to share appointment information with the person(s) named below:

Name: _____

Name: _____

I give permission to share medical information with the person(s) named below:

Name: _____

Name: _____

I give permission to share billing information with the person(s) named below:

Name: _____

Name: _____

Signature of Patient _____

Date: _____

* Your email will NOT be shared with any 3rd parties, and is used for occasional office announcements and promotions.

Sarasota Chiropractic, Physical Therapy & Massage
ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

Patient Name (please print)

Date

Parent, Guardian or Patient's legal representative

Signature

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.

List below the names and relationship of people to whom you authorize the Practice to release PHI.

Sarasota Chiropractic, Physical Therapy & Massage

Sensitive, Compassionate, Professional, Thoughtful and More

2801 Fruitville Rd. Suite 180 * Sarasota, FL * 34237

FINANCIAL POLICY

In an effort to maintain compliance with various state and federal regulations, managed care and preferred provider agreements, as well as billing and coding guidelines, we have adopted the following financial policies: Our clinic has established a single fee schedule that applies to all patients for each service provided.

PATIENTS WITHOUT INSURANCE

We request that 100% of your visits be paid at the time of the visit. We are happy to accept payment with cash, check, credit card (no Diner's club) and **Discount Medical Plan Organization**.

"ON THE JOB" INJURY (Worker's Compensation)

If you are injured on the job, your care should be paid for under your employer's Worker's Compensation Insurance. You will need to inform your employer of the accident and obtain their permission to be seen at our office along with the name and address of their insurance carrier and your claim number. Without an authorization or referral to be seen here, we are not able to treat you.

PERSONAL INJURY OR AUTOMOBILE ACCIDENTS

Please notify **YOUR auto insurance carrier of the accident immediately**. Even if you were not at fault as Florida is a no-fault state. If or when you retain legal representation (an attorney), please notify our office immediately. Although you are ultimately responsible for your bill, we will wait for settlement of your claim after your care is completed if you have an attorney. **Once the claim is settled or if you suspend or terminate care, any fees for services are due immediately by you as the patient.**

MANAGED CARE PLANS/ GROUP OR INDIVIDUAL INSURANCE – such as [BC/BS, CIGNA, MEDICARE, TPA, UNITED HEALTH CARE and others]

Our office is on many different insurance provider lists. Please inquire about these plans at our front desk. As soon as possible, we will call to verify benefits on your insurance. However, the benefits quoted to us by your insurance company are not a guarantee of payment. You are required to pay your co-pay and/ or deductible as required by the contract between you and your insurance company. Payment will be due by you at the time of service for any non-covered services, deductibles or co-pays.

I have read and understand this financial policy for the Sarasota Chiropractic, Physical Therapy and Massage office. I understand that my insurance is a contract between myself and my insurance company and this office. I understand that if my insurance does not respond within 60 days, or if I suspend or terminate my schedule of care as prescribed by the doctors of this office, those fees will be due and payable immediately by myself as the patient.

Patient's signature indicates they read and understand this financial policy (or guardian if patient is a minor)

Date

Front Desk Witness

Date

Revised 8/24/2020