FINANCIAL RESPONSIBILITY AGREEMENT

NAME ________________________________ S.S. # _______________________

DATE OF BIRTH ________________ ADDRESS __________________________

APT.#__________ CITY _______________STATE ________ ZIP ____________

HOME PHONE ________ WORK PHONE _________ CELL PHONE _________

This certifies that the above named individual agrees to pay in full for all professional services rendered at the time they are performed, unless other arrangements are made in advance of the set appointment. The below named guarantor understands a $ 10.00 returned check fee will be charged along with any appropriate collection or attorney's fee which may accrue upon collection of any outstanding balance.

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

Please Check one of the following:

Payment to this Office by:
ڤCash
ڤCheck
ڤCredit Card
ڤHealth Insurance
ڤAutomobile Insurance

<u>Privacy:</u>

The *Standards for Privacy of Individually Identifiable Health Information* ("Privacy Rule") establishes, for the first time, a set of national standards for the protection of certain health information. The U.S. Department of Health and Human Services issued the Privacy Rule to implement the requirement of the *Health Insurance Portability and Accountability Act* of 1996 ("HIPPA") A major goal of the Privacy Rule is to assure that individual's health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care and to protect the public's health and well being.

You can be assured that our clinic takes your privacy seriously and is in compliance with all HIPPA guidelines. Your health information will not be disclosed without your permission or will your name, address or telephone number be disclosed to any third party.

I have read and understand the foregoing.

_____________ _____________________

Date Policyholder/Guarantor

LifeForce CHIROPRACTIC

Jeff and Adriana MonteLeon. D.C.
5560 Babcock Street NE, Palm Bay, FL 32907
Phone: 321-409-0209 Fax: 321-409-0208

Doctor-Patient Relationship in Chiropractic

Chiropractic:

It is important to be an aware and an informed patient. We have found that an honest, open understanding of chiropractic care is helpful in order to bring about your potential for maximum health.

Your body has a potential to function at 100%. Our goal in chiropractic is to achieve better communication between the brain and the rest of the body through a fully functioning nervous system thus allowing the body the potential to function at 100%. We achieve this through chiropractic adjustments which correct spinal nerve interference called vertebral subluxations. When a vertebral subluxation is present in the spine the body is unable to function at 100% thus sickness and disease occurs.

When a chiropractic adjustment is provided by the chiropractor, the body is able to approach its potential to express optimum health. This is because of better communication though the nervous system by the reduction and correction of the vertebral subluxation and its related components. Rather that treat the resulting disease or your symptoms, chiropractors correct the spinal subluxation and the resulting nerve interference which is the number one cause of why the body functions at less than 100%. Instead of masking the symptoms with medications chiropractors look for the cause and correct the cause of your symptoms.

Analysis:

You will under go a chiropractic examination for the detection of vertebral subluxations and their related components. During the examination the chiropractor will evaluate how the spine moves, what it feels like and based upon the results of the examination findings X-rays of the spine may be performed. These X-rays will tell the doctor how far the vertebra is misaligned and in what direction. The X-rays will also help determine the most efficient chiropractic technique to effectively adjust and correct the spinal subluxations.

Diagnosis:

Only a chiropractor can determine if your case is a chiropractic case. Medical doctors diagnosis disease, chiropractors diagnose vertebral subluxations. Your diagnosis in this clinic will reflect spinal nerve interference which is caused by vertebral subluxations. Our doctors will work with any other health care provider for your benefit. Inversely, you should expect all other health care providers to work together with your chiropractor for your benefit. This team approach to your health care will benefit you the patient the best.

Chiropractic Adjustments:

The patient, in coming to the chiropractor, gives the chiropractor permission and authority to adjust the patient for spinal subluxations. In rare cases, under physical defects, deformities, or pathology may render the patient susceptible to injury. The chiropractor, of course, will not provide chiropractic adjustments if he is aware of any such conditions. If the patient is aware of any latent pathological defects, illness or deformities which would not otherwise come to the attention of the chiropractor, it is their responsibility to notify the chiropractor. The patient should not look to the

chiropractor for in depth diagnostic procedures. The chiropractor provides a specialized health service in the detection and correction of the vertebral subluxation and its related components. Any risks regarding chiropractic treatment will be explained upon request.

Although we use an OPEN ADJUSTING FORMAT, your confidential concerns can be handled appropriately, in specially designated private areas, for discussions with the Doctor, as long as a request is made in advance, and the sufficient time to handle your concern is scheduled.

Results

No doctor can promise a cure or guarantee results. The purpose of Chiropractic care is to promote natural health through the release of maximum nerve energy. Since there are so many variables, it is difficult to predict the time schedule or efficiency of chiropractic procedures. Sometimes the response is phenomenal. In most cases there is a more gradual, but quite satisfactory. In some it is only partial or not at all. Regardless of the disease,' the Chiropractor is not offering to heal, treat or cure it.

A major premise in chiropractic is that the body is a self healing organism and by removing the vertebral subluxation, hence the nerve interference it can function as close to 100% as possible. However, you must remember that there is no process that does not take time, this includes the healing process. The longer the problems been in the body the longer healing process will take the body. The chiropractor's goal is to allow the body to express health at its optimum without nerve interference. This goal is accomplished through the chiropractic adjustment by the correction of the vertebral subluxation. In order to facilitate a more effective level of understanding of the Chiropractic approach, a **New Patient Orientation** has been developed, and it is a required component for all new patients to attend. This requirement can be fulfilled prior to, or after initiating care. The seminar is also open to family and friends seeking a better understanding of basic Chiropractic concepts.

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You can be assured that our clinic takes your privacy seriously and is in compliance with all HIPPA guidelines. Your health information will not be disclosed without your permission or will your name, address or telephone number be disclosed to any third party. Our privacy policy is posted in the reception area and is available at the front desk upon your request.

Questions

Just as in a good marriage, proper communication is an absolute necessity. We want to help you attain your goal of health. If at any time your response is not satisfactory, we will gladly assist you in choosing a referral doctor for another opinion. Your health is our number one priority.

Acknowledgement:

I have read and understand the foregoing.

Signature ____________________________________ Date _____________________

Witness ___________________

LifeForce CHIROPRACTIC
Jeff and Adriana MonteLeon, D.C.
5560 Babcock Street NE, Palm Bay, FL 32907
Phone: 321-409-0209 Fax: 321-409-0208

ASSIGNMENT, LIEN AND AUTHORIZATION

I hereby authorize you, my insurance company and/ or attorney to pay directly to LifeForce Chiropractic, Inc., such sums as may be due and owing ***Assignees*** for services rendered by me, both by reason of accident or illness, and by reason of any other bills that are due ***Assignees,*** and to withhold such sums for any disability benefits, medical payments, No Fault benefits, or any other insurance benefits obligated to reimburse or from any settlement, judgment, or verdict on my behalf as may be necessary to adequately protect said ***Assignees.*** I hereby further give a lien to said ***Assignees*** any and all insurance benefits named herein and any and all proceeds of any settlement, judgment, or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by ***Assignees.*** This is to act as an assignment of my right and benefits to extent of the ***Assignees*** services provided and in accordance with Florida Statute 627.736.5

In the event my insurance company obligated to make payments to me upon charges made by ***Assignees*** for services, refuses to make such payments, upon demand by me or ***Assignees***, I hereby assign and transfer ***Assignees*** any and all causes of action that I might have or that exists in my favor against such company and authorize ***Assignees*** to prosecute said causes of action either in my name or in ***Assignees*** name, and further I authorize ***Assignees*** to compromise, settle, or resolve said claim or cause of action as they see fit.
To avoid exhaustion of No Fault benefits while ***Assignees*** pursue its right under this assignment, I direct my insurance company to set aside and place in escrow any disputed amounts or reductions until the resolution of such dispute.

I authorize ***Assignees*** to release any information pertinent to my case to any insurance company, adjuster, or attorney to facilitate collection under this Assignment, Lien and Authorization.

_______________________________ ____________________

Signature of Claimant Date

Accepted by Authorized Representative of
Drs. Jeffrey MonteLeon and Adriana Quiroga-MonteLeon,
Chiropractic Physicians

Jeff and Adriana MonteLeon, D.C.
5560 Babcock Street NE, Palm Bay, FL 32907
Phone: 321-409-0209 Fax: 321-409-0208

RECORD REQUEST AUTHORIZATION AND FINANCIAL RESPONSIBILITY AGREEMENT

Patient name: ______________________________ SSN: _____________________

Birth date: _____________________ Billing Address: __________________________________

Home Phone: _______________ Work Phone: ______________ Cell Phone: _______________

This is to certify that the above named patient authorizes the request of any records pertinent to the health care of same individual from but not inclusive of any insurance carrier, adjustor, attorney, or other health care provider.

This also authorizes this facility to release records, upon receipt of the above named patient's signature, or on an emergency basis, to, but not inclusive of, any insurance carrier, attorney, health care provider, hospital, or immediate family member.

This also certifies that the above named individual agrees to pay in full for all professional services rendered at the time they are performed, unless other arrangements are made in advance of the set appointment. In the case of motor vehicle accidents involving personal injury claims, the patient will be ultimately responsible for deductibles and, or percentages of charges that the insurance company does not cover. The below named guarantor understands a $20.00 returned check fee will be charged along with any appropriate collection or attorney's fee which may accrue upon collection of any outstanding balance.

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You can be assured that our clinic takes your privacy seriously and is in compliance with all HIPP A guidelines. Your health information will not be disclosed without your permission or will your name, address or telephone number be disclosed to any third party.

I have read and understand the foregoing.

_______________	______________________________	___________________________
Date	Policyholder/Guarantor	Print Name

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.**

____

____

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**):*

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.

Text Alerts

PLEASE HELP US KEEP YOU UP TO DATE AND ON TIME FOR YOUR APPOINMENTS:

NAME: ______________________________

CELL PHONE: _____________________________

CARRIER: ________________________

I authorize LifeForce Chiropractic to send me text Message reminders for my future appointments I have scheduled.

____
Signature   Date

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RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

LIFEFORCE CHIROPRACTIC

I, __________________________________have read a copy of Lifeforce Chiropractic's
Patient Name

Notice of Patient Practices.

_________________________   ______________
Signature of Patient or Parent   Date
Legal Guardian