WALK-IN CHIROPRACTIC, LLC

2001 N. Atlantic Ave, Cocoa Beach, FL, 32931

NOTICE REGARDING YOUR RIGHT TO PRIVACY continued …

Please complete the following where indicated and return to our front desk staff.

Patient initials: _____ **- retaining *page 1 of 2***

I hereby acknowledge I have read and received a copy of Walk-In Chiropractic, LLC Privacy Practices Notice.
I understand my rights as well as the practice's duty to protect my health information and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practices" at any time in the future and will make the new provisions effective for all information that it maintains past and present.
I am aware the practice will not use or share my information other than as described here unless I have provided written authorization stating otherwise. I understand I may change my mind at any time by providing written notification to the practice.
I am aware an extended detail version of this "Notice" is available to me upon request.
At this time, I do not have any questions regarding my rights or any of the information I have received.

If not signed by the patient, please indicate relationship:

_____ Parent or guardian of minor patient

_____ Guardian or conservator of an incompetent patient

_____ Beneficiary or personal representative of deceased patient

Name of Patient: _____

Signature: _____ Telephone: _____

HIPAA Personal Health Information Release

I, _____, hereby authorize Walk-In Chiropractic, LLC to discuss with and/or release information to the following people concerning my appointments, insurance, billing, and health treatment rendered.

- ○ Spouse Name: _____
- ○ Significant Other Name: _____
- ○ Parent/Legal Guardian Name: _____
- ○ Child(ren) Name(s): _____
- ○ Any Specified Person Name: _____
- ○ Information is not to be discussed with or released to anyone.

Restrictions:

- ○ No Restrictions
- ○ Only discuss my appointment time with the above-named individual(s).
- ○ Only discuss issues concerning my account, including insurance and/or billing with the above-named individual(s).
- ○ Only discuss the health treatment rendered to me with the above-named individual(s).

Messages:

Please call: ○ my home ○ my work ○ my cell phone Number: _____

If unable to reach me:

- ○ you may leave a detailed message
- ○ please leave a message asking me to return your call
- ○ _____

I understand I may terminate this consent at any time by giving written notice to [Insert Practice Name]. Any changes to this form will require a new consent form to be completed, signed, and dated.

Patient or Authorized Person's Signature _____ Date Completed _____

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INFORMED CONSENT REGARDING:
Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risks are most often minimal, complications such as sprain/strain injuries, irritation of a disc condition, dislocations of joints, and although very rare, fractures, and possible stroke (estimated to be related in one in one million to one in two million cervical adjustments), have been associated with chiropractic adjustments.

Treatment objectives, as well as the risks associated with chiropractic adjustments and all other procedures provided at [Insert Practice Name] have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

CONSTENT TO INITIATE CARE

I have one simple goal - I want to render the highest quality Chiropractic care at the lowest possible fee. To accomplish this goal, I have some business procedures to keep my fees reduced. Please read over these procedures below to understand how this office functions and decide if you wish to participate. If you have any questions, please ask.

- You may choose to submit receipts to your insurance company or other third-party health care programs, but payment for such services by insurance companies is neither implied nor agreed to by this office. We take no responsibility for non-payment by insurance companies for services rendered at our office.
- Our office will not respond to any requests for paperwork for insurance purposes or even acknowledge insurance requests for information on any patient's case. However, patients may request a copy of their records at no charge.
- No balances can be kept or run by patients at any time.
- All adjustment visits are paid immediately prior to the service being rendered.
- All initial visits are paid for upon completion of these services.
- Our office reserves the right to deny services to anyone for any reason, or if the doctor feels that the patient's health is not being best served. You will be given a list of other providers who may serve you better.

I wish to initiate care at this office. I understand that I am directly and fully responsible to WALK-IN CHIROPRACTIC, LLC and or Dr. Bret Glas, D.C. for all fees associated with chiropractic care I receive. I have read and understand the Consent to Initiate Care and agree to all terms. I understand that I am under no obligation to receive or continue care.

WORK-RELATED INJURIES, AUTOMOBILE ACCIDENT INJURIES OR PERSONAL INJURIES & PURPOSE OF AN ADJUSTMENT DISCLOSURE

By signing below, I acknowledge that I am aware that Walk-In Chiropractic, LLC and Bret Glas, D.C. reserves the right to not provide care for work related injuries, automobile accident injuries or personal injuries unless agreed upon in writing by the patient and Walk-In Chiropractic, LLC and Bret Glas, D.C. I also acknowledge that I must inform this office if I am in a work-related injury, automobile accident injury or personal injury and must seek care at my medical doctor's office or another healthcare provider for injuries or conditions sustained. I am also completely aware that Walk-In Chiropractic, LLC and Bret Glas, D.C. will not bill, submit claims nor prepare or submit reports for any work-related injury, automobile accident injury or personal injury claim. I also understand that I am responsible to pay each visit myself at the time of service.

Furthermore, I understand that chiropractic care is given to correct spinal misalignments called Subluxations. One of the benefits of a chiropractic adjustment is that you MAY feel better, but this is not the GOAL of an adjustment. The goal of a chiropractic adjustment is to correct SUBLUXATIONS, thereby removing the interference to the nervous system allowing the body to heal itself. As a result, Walk-In Chiropractic, LLC and Bret Glas, D.C. DOES NOT TREAT PAIN OR DISEASE; we remove subluxations, so the body is able to function properly and be better enabled to heal itself.

Patient Name (print)	Patient Signature	Date
Parent/Authorized Person Name (print)	Parent/Authorized Person Signature	Date

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INTAKE INFORMATION

PATIENT'S NAME: _____ DATE: _____

Birthdate: ____-____-____ Age: _____ ○ Male ○ Female Marital Status: ○ Single ○ Married ○ Widow

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

Home Phone: _____ Mobile Phone: _____ E-mail Address: _____

Are you willing to receive: Text alerts? ○ YES ○ No E-mail update? ○ YES ○ No Call alerts? ○ YES ○ No

Employer: _____ Occupation: _____

Spouse's Name _____ Spouse's Employer: _____

I depend on referrals to keep overhead low & pass the savings on to you who may I thank for referring you? _____

Have you seen a chiropractor before? Yes No Name _____ How long ago? _____

Are you here because your problem the result of ANY type of accident? ○ NO ○ Yes (When?) _____

Are you a Medicare recipient? ○ NO ○ Yes FEMALES: Could you be pregnant? ○ NO ○ YES Due Date:_____

What brings you in today? _____

Where is the worst of it? _____

How did this start?_____

When did the problem(s) begin?_____Was it ○ Gradual ○ All of a sudden EXPLAIN:_____

When is it at its worst? ○ AM ○ PM ○ mid-day ○ late PM ○ Other? _____

Do you have tingling, numbness or pain in your arms or legs? (Explain) _____

What does it feel like? *Sharp? Dull? Achy? Throbbing? Burning? Tightness? Soreness?* Other? _____

On a pain scale of 0 to 10, with 0 being the absence of pain and 10 being significant enough to seek emergency care, which number would describe your pain/discomfort severity, right now? _____/10 At its least?____/10 At its worst? ____/10

How long does it last? ○ Constant OR ○ On and off OR ○ Comes and goes

Has the pain been getting? ○ Better ○ Worse ○ Staying the same

What makes the pain worse?_____

What makes the pain better? _____

What activities are you unable to do because of these problems:_____

_____

List any other doctors you have seen for these problems: _____

List medications you are currently taking or provide a list: _____

_____

List any surgeries you have had and when: _____

List any work or auto accidents you have had: _____

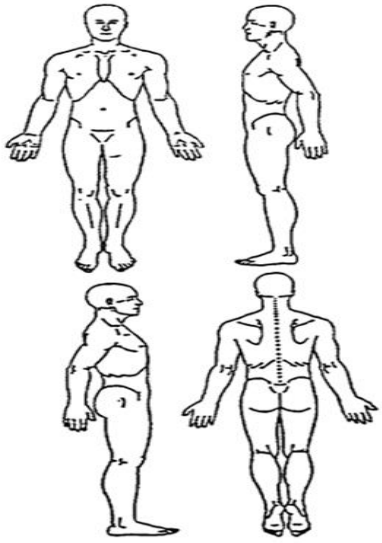
Do you have any dizziness? ○ NO ○ Yes _____

Do you have any communicable diseases: (List): _____

Have you had Covid-19 ○ NO ○ Yes

Have you had a Covid-19 Vaccination ○ NO ○ Yes Any Boosters ○NO ○ Yes

PLEASE MARK the ALL areas of complaint below



Patient or Authorized Person's Signature _____ Date Completed _____

Dr. Bret Glas Signature: _____ Date Reviewed _____