SPINAL HEALTH & REHAB
of punta gorda

Name: _____ **Date:** _____

Email: _____ **Phone Number:** _____

Please answer the questions below:

How did you learn about us? _____

Have you received chiropractic care before? _____

What brings you in today? _____

On a scale of **1-10**, rate your pain (*Circle one*); **0 1 2 3 4 5 6 7 8 9 10**

Is the pain:

○ **Constant** ○ **Intermittent** ○ **Sharp** ○ **Dull** ○ **Throbbing** ○ **Aching** ○ **Burning**

What aggravates your pain? _____

What relieves your pain? _____

If this problem were fixed, what do you want to be able to do?

_____

Are you on any medications? ○ Yes ○ No If yes, please list: _____

_____

Have you had any surgeries? ○ Yes ○ No If yes, please list: _____

_____

Do you smoke? ○ Yes ○ No ○ Previous smoker

Please mark any of the following conditions you may currently have:

○	Ankle/Foot pain	○	Sports Injury	○	Dizziness
○	Arm/Hand pain	○	Auto Accident	○	Cancer
○	Back Injury/Pain	○	Gut Issues	○	Heart Disease
○	Hip Pain	○	Osteoporosis	○	Diabetes
○	Knee Pain	○	Carpal Tunnel Syndrome	○	Allergies
○	Neck Pain	○	Headaches	○	Arthritis
○	Shoulder pain	○	High Blood Pressure	○	Other:

When was the last time you had an X-ray? _____

Pregnant? ○Yes ○No

Date of last menstrual cycle? _____

○ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient/Guardian Signature: _____

INFORMED CONSENT

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working toward the same objective. It is important that each patient understand both the objective and the method that will be used to attain this objective. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks, and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of health. Health is a state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of the nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

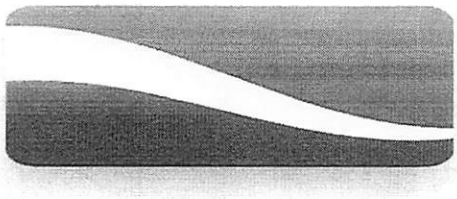
- All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction.
- The benefits, risks, and alternatives of chiropractic care have been thoroughly explained to me to my complete satisfaction.

"I have read and fully understand the above statement and therefore accept chiropractic care on this basis."

PRINT NAME:_____

SIGNATURE:_____

DATE:_____



Spinal Health
& Rehab
Integrative Medicine

OFFICE FINANCIAL POLICY

OUR POLICY IS TO EXTEND TO YOU THE COURTESY OF ALLOWING YOU TO ASSIGN YOUR INSURANCE BENEFITS DIRECTLY TO US. THIS POLICY REDUCES YOUR OUT-OF-POCKET EXPENSE AND ALLOWS YOU TO PLACE YOUR FAMILY UNDER CARE.

1. IF YOU DO NOT HAVE INSURANCE: All payments are expected at the time of service or by an authorized payment plan. Your personal balance may not exceed $100.00 at any time or care may be terminated. Our payment plans make chiropractic care an affordable part of your family's budget.

2. IF YOU DO HAVE INSURANCE: All deductibles and co-payments are expected at the time of service or by an authorized payment plan. Your co-insurance balance may not exceed $100.00 or care may be terminated. Our payment plans make chiropractic care an affordable part of your family's budget.

You are considered a cash patient until you bring in your completed insurance forms, and we qualify and accept your insurance coverage.

Our fees are considered usual, customary, and reasonable by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard of care in this area.

If your carrier has not paid a claim within sixty (60) days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid within ninety (90) days of submission, you then accept responsibility for payment in full of any outstanding balance and authorize us to use your credit card to collect full payment.

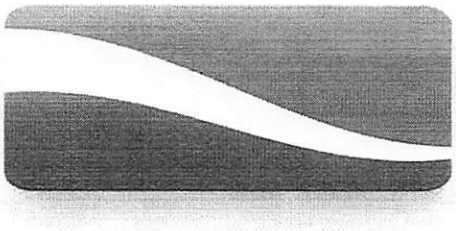
For self-pay patients with no major medical insurance, payment for rendered treatment is due at time of service. If a balance exceeds 3 days, **you authorize us to run the credit card on file for payment in full.**

When your schedule of visits is one per month or longer, you will not be eligible for insurance assignment if you have a Medicare policy. Charges for services rendered will be due as they are rendered or by an authorized payment plan.

If you discontinue care for any reason other than discharge by the doctor, all balances will become immediately due and payable in full by you, regardless of any claim submitted.

PATIENT'S PRINTED NAME:_____

SIGNATURE:_____ DATE:_____



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ASSIGNMENT OF BENEFITS AND MEDICAL RELEASE

Assignment of Benefits:

I, _____, hereinafter ASSIGNOR, hereby authorize

(Name of Insured Person)

_____ to pay directly to SPINAL HEALTH & REHAB of Punta Gorda.

(Insurance Company)

Hereinafter ASSIGNEE, the medical benefits otherwise payable to me for their services but not to exceed the charges of those services. I hereby ASSIGN to ASSIGNEE any benefits or causes of action under any policy of charges provided by ASSIGNEE. This Assignment of Benefits is given in exchange for ASSIGNEE agreeing to send request for payment to the above named insurance carrier for all payments due and payable pursuant to the ASSIGNOR'S contract of insurance. This Assignment of Benefits is IRREVOCABLE unless subsequent revocation is in writing and agreed to by both parties.

MEDICAL RELEASE

This document shall be sufficient to authorize any person having records of medical treatment, services, or supplies pertaining to me, to release true copies of the same to ASSIGNEE or any insurer providing coverage to me in connection with the processing of any claim for benefits made by the ASSIGNEE therein. A photocopy of this document shall be as binding as an original signature page.

IN WITNESS WHEREOF the undersigned ASSIGNOR and ASSIGNEE have hereunto set their hands-

Date:_____

Patient's Signature (ASSIGNOR):_____ Authorized ASSIGNEE:_____

Patient's Name (please print):_____

AUTO ACCIDENTS

* I authorize the release of PIP/Med payments to Spinal Health and Rehab.
* I authorize Spinal Health and Rehab the right to obtain my Declaration Page of my Auto Policy.

_____ _____

Patient Name (please print) Patient/Guardian Signature

Spinal Health & Rehab
Integrative Medicine

324 Cross St
Dr Kevin VanNostrand DC Dr Eric Chance DC Dr Jason Lawlor DC Dr Ed Degon DC Kevin Lille PA
Lilia Ballester LMT Richelle Sterling LMT Ed Roberts LMT

Acknowledgment Receipt of Privacy Practices
Disclosure of Protected Health Information (Updated 2026)

1. **COMMITMENT TO HIPAA AND OTHER FEDERAL GUIDELINES**: Protecting the privacy of your personal health information (PHI) is important to us. This acknowledgment is a summary of the full Notice of Privacy Practices which outlines in detail how information about you may be used and disclosed and how you can get access to this information. The full policy refers to guidelines outlined in federal mandates of the Health Information Portability and Accountability Act of 1996 (HIPAA), all updated HIPAA laws, and CARES Act. It is available upon request and can be found on our Practice's Website.
2. **USES & DISCLOSURES:** Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. HIPAA allows the use of PHI for treatment, payment, and healthcare operations. You are acknowledging that your PHI may be used for these HIPAA defined situations. You may request restrictions on disclosures. Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure.
3. **REQUESTING RECORDS:** A patient (or representative) may submit a records request in writing text or email explaining what records you are requesting and where you want them sent. Per the 21 St Century Cures Act and Information Blocking regulations these records will be made available to you as soon as possible and free of charge. Records may be released to other people or entities' however you must provide signed authorization. We limit what is shared based on your requests. Our practice has the right to accept, delay or deny your request according to Information Blocking Exceptions.
4. **RECORDS:** You may request changes to your records. We maintain a history of protected health information disclosures that are accessible to you. Your reproductive health information and any details you provide regarding substance abuse are part of your medical record and will be kept private according to all HIPPA regulations and may be released as part of your medical records as outlined above.
5. **AUTHORIZED REPRESENTATIVE:** I have the right to authorize any person to have the right to access my information for my benefit. This is often close family members such as parents or spouses. I authorize the release of information to personal acquaintances named below (and relationship if possible) or fill in none:

Name _____ Relationship: _____
Name _____ Relationship: _____

Effective Date of this Notice of Information Practices is 02/01/2026. Our practice is required to abide by this notice. We have the right to change this notice in the future as Federal guidelines are updated. Any revisions will be available upon request. You may file a complaint about privacy violations by contacting our Office Manager.

I acknowledge that I have access to the Notice of Privacy Practices for protected health information. I understand how to obtain access to my records, and I acknowledge the release of my PHI for the allowed uses under HIPAA for my treatment, payment, and healthcare operations.

_____
Patient's Name (Print) Patient's Signature

_____
Guardian signature Relationship if not signed by patient Date