

# CHIROPRACTIC CENTER OF LAKE LAND

## New Patient Intake

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Ph: \_\_\_\_\_ Wk Ph: \_\_\_\_\_

Birthdate: \_\_\_\_\_ SSN: \_\_\_\_\_ Email: \_\_\_\_\_

Status: Single Married Divorced Widowed Children: Yes No How Many: \_\_\_\_\_

Are you considered a minor? Yes No If Yes, who is the responsible payer? \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Family Doctor: Yes No Name of Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Do you have insurance we will be using? Yes No Insurance Company: \_\_\_\_\_

### Past Medical History

For the conditions below, place a check in the "past" column if you have had the condition in the past.

If you presently have any condition listed below, please place a check in the present column.

Condition	Past	Present	Condition	Past	Present	Condition	Past	Present
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	General Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Muscular Incoordination	<input type="checkbox"/>	<input type="checkbox"/>
Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Visual Disturbances	<input type="checkbox"/>	<input type="checkbox"/>
Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Elbow/Arm Pain	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst	<input type="checkbox"/>	<input type="checkbox"/>
Wrist Pain	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination	<input type="checkbox"/>	<input type="checkbox"/>
Hand Pain	<input type="checkbox"/>	<input type="checkbox"/>	Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/>	Addiction Drug/Alcohol	<input type="checkbox"/>	<input type="checkbox"/>
Hip Pain	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Upper Leg Pain	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Bladder Ctrl	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
Knee Pain	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/>	Systemic Lupus	<input type="checkbox"/>	<input type="checkbox"/>
Ankle/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Wt Loss/Gain	<input type="checkbox"/>	<input type="checkbox"/>	Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>
Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Appetite	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Joint Pain/ Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>	Skin Conditions	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	<b>For Women:</b>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Birth Control	<input type="checkbox"/>	<input type="checkbox"/>
Tumor	<input type="checkbox"/>	<input type="checkbox"/>	Gall Bladder Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Hormone Replacement	<input type="checkbox"/>	<input type="checkbox"/>

List Treatments for Past Conditions: \_\_\_\_\_

List ALL Medications you are Currently Taking: \_\_\_\_\_

List any Allergies: (including food) \_\_\_\_\_

List any Surgeries: \_\_\_\_\_

### Family Medical History

Please indicate if you have any immediate family members with the following conditions:

- |   |                                   |  |
|---|-----------------------------------|--|
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lupus/Fibromyalgia  |
| <input type="checkbox"/> Heart Problems       | <input type="checkbox"/> Cancer   | <input type="checkbox"/> Multitole Sclerosis |

Other Family Medical history: \_\_\_\_\_

### Social History

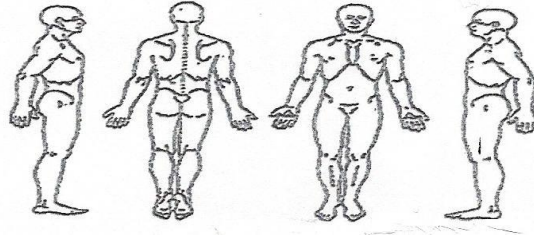
Do you smoke: Yes No How Much: \_\_\_\_\_ Drink Alcohol: Yes No How Much: \_\_\_\_\_

For Women Only: Pregnant? Yes No How Long: \_\_\_\_\_ Nursing?: Yes No

# CHIROPRACTIC CENTER OF LAKELAND

## New Patient Intake

Please indicate on the drawing below where you are experiencing your symptoms



1) Where does it hurt: \_\_\_\_\_ When Did It Start: \_\_\_\_\_

Pain Level (0= No Pain/10=Highest Pain) 0 1 2 3 4 5 6 7 8 9 10  
How often does it occur: Occasionally Intermittently Frequently Constantly  
(0-25% of the time) (26-50% of the time) (51-75% of the time) (76-100% of the time)

Please describe your pain: Aching Burning Dull Pulling Sharp  
Shooting Stabbing Stinging Throbbing

What aggravates your symptoms: \_\_\_\_\_

Doctor's Notes: \_\_\_\_\_

2) Where does it hurt: \_\_\_\_\_ When Did It Start: \_\_\_\_\_

Pain Level (0= No Pain/10=Highest Pain) 0 1 2 3 4 5 6 7 8 9 10  
How often does it occur: Occasionally Intermittently Frequently Constantly  
(0-25% of the time) (26-50% of the time) (51-75% of the time) (76-100% of the time)

Please describe your pain: Aching Burning Dull Pulling Sharp  
Shooting Stabbing Stinging Throbbing

What aggravates your symptoms: \_\_\_\_\_

Doctor's Notes: \_\_\_\_\_

3) Where does it hurt: \_\_\_\_\_ When Did It Start: \_\_\_\_\_

Pain Level (0= No Pain/10=Highest Pain) 0 1 2 3 4 5 6 7 8 9 10  
How often does it occur: Occasionally Intermittently Frequently Constantly  
(0-25% of the time) (26-50% of the time) (51-75% of the time) (76-100% of the time)

Please describe your pain: Aching Burning Dull Pulling Sharp  
Shooting Stabbing Stinging Throbbing

What aggravates your symptoms: \_\_\_\_\_

Doctor's Notes: \_\_\_\_\_

### Current Treatment of Symptoms

Have you seen anyone else for these symptoms: Yes No Who: \_\_\_\_\_

List any treatment given for these symptoms: \_\_\_\_\_

List any medications given for these symptoms: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# CHIROPRACTIC CENTER OF LAKELAND

## Auto Accident Questionnaire

Patient Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_ Accident Date: \_\_\_\_\_

Please give a brief description of your accident: (Where, What, When & How)

Where did it happen? \_\_\_\_\_

What happened? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Where were you in the vehicle?** Driver Passenger Rear Right Passenger Rear Left Passenger

**What type of vehicle were YOU in?** Compact Car Midsize Car Full Size Car Small Truck Full Size Truck

Small SUV Midsize SUV Large SUV Mini Van Full Size Van Motorcycle

**What type of vehicle collided with you?** Compact Car Midsize Car Full Size Car Small Truck Full Size Truck

Small SUV Midsize SUV Large SUV Mini Van Full Size Van Motorcycle

**Where was the impact on your vehicle?** Front Rear Driver Side Passenger Side

Front Driver Side Rear Driver Side Front Passenger Side Rear Passenger Side

**Were you wearing your seatbelt?** Yes No **Did the Airbag deploy?** Yes No

**Estimate the damage to your vehicle:** Minimal Moderate Extensive Totaled Unsure

**Were you anticipating the accident?** Expecting the collision Completely Unexpected

**What position were you sitting?** Straight ahead Rotated Right Rotated Left Unsure

**What position was your head?** Straight ahead Rotated Right Rotated Left Unsure

**Was your body thrown?** Yes No **In what direction?** Backwards Forwards Left Right Outside the vehicle

**How did your head move during the collision?** Forwards then backwards Backward then Forwards

Right to Left Left to Right Unsure of motion

**Did any part of your body strike anything in the vehicle?** Yes No **If Yes, please circle all body part involved:**

Head Upper Back Mid Back Lower Back Chest Left Shoulder Right Shoulder Left Arm Right Arm

Left Elbow Right Elbow Left Leg Right Leg Left Knee Right Knee Left Shin Right Shin

**How did you feel immediately following the accident?** Dazed Disoriented Headache Pain Unconscious None

# CHIROPRACTIC CENTER OF LAKE LAND

## Auto Accident Questionnaire

**Where did you feel pain immediately following the accident?** None Head Neck Upper Back Mid Back  
Lower Back Chest Left Shoulder Right Shoulder Left Arm Right Arm Left Elbow Right Elbow  
Left Leg Right Leg Left Knee Right Knee Left Shin Right Shin Other: \_\_\_\_\_

**Did you go to the hospital immediately following the accident?** Yes No **Where?** \_\_\_\_\_

**How were transported to the hospital?** Ambulance Drove self Driven there by friend/family member

**Were you admitted to the hospital?** Yes No **How many days in the hospital?** \_\_\_\_\_

**What was done at hospital? Xrays?** Yes No **Xrays of what?** Neck Mid back Low back Other: \_\_\_\_\_

**MRI?** Yes No **MRI of what?** Neck Mid back Low back Other: \_\_\_\_\_

**CT scan?** Yes No **CT of what?** Neck Mid back Low back Other: \_\_\_\_\_

**Given Medication?** Yes No **What Medication?** \_\_\_\_\_

**Later after the accident, where did you feel pain?** None Head Neck Upper Back Mid Back Lower Back  
Chest Left Shoulder Right Shoulder Left Arm Right Arm Left Elbow Right Elbow Left Leg  
Right Leg Left Knee Right Knee Left Shin Right Shin Other: \_\_\_\_\_

**Are you feeling numbness or tingling anywhere?** Yes No **Where?** \_\_\_\_\_

**Has the accident affected your sleep?** Yes No **How much sleep do you lose a night?** \_\_\_\_\_ hours of sleep.

**What other symptoms are you feeling now?** Nervousness Irritability General Fatigue Depression  
Cramping Unintentional Twitching Difficult Urination

**Have you experienced any weight changes?** Yes No Gain of \_\_\_\_\_ pounds Loss of \_\_\_\_\_ pounds

**Has this affected your daily quality of life?** Yes No **How much?** None Minimally Moderately Severely

**Please write down any other information that you feel is important for us to know:** \_\_\_\_\_

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## Chi ropacti c Center of Lakel and

### **Patient Health Information Consent Form**

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

**I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.**

---

Name of Patient

Date



# Chiropractic Center of Lakeland

## Term of Acceptance

When a patient care at the Chiropractic Center of Lakeland and we accept a patient for such care, it is essential for both to be working toward a common goal.

Chiropractic has only one goal: to eliminate misalignments within the spinal column which interferes with the expression of the body's innate wisdom. It is important all patients understand both the objective and the method used to attain our goal. The following definitions will help to educate each patient.

Health: Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

Adjustment: A specific application of forces to facilitate the body's correction of the spinal Subluxation. Our method of correction is performed by mechanical device as well as by hand.

Spinal Subluxation: A misalignment of one or more of the 24 vertebrae in the Spinal Column which causes alteration and interference with the transmission of information from the brain to all systems of the body, thus having a positive effect on the body's organs and systems, even down to the cellular level.

We do not offer to diagnose or treat any disease or condition other than vertebral Subluxation. However if during the course of chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will recommend our patients seek care fro a health care provider who specializes in that area. Regardless of the specific condition we cannot provide care of give advice on the care provided by other practitioners.

Our Practice objective is to eliminate major interference to the expression of the body's innate wisdom.

All questions regarding the doctor's objectives pertaining to my care in this office have been fully answered.

---

Print Name

---

Sign Name

---

Date

## Letter of Protection

To: \_\_\_\_\_

I herby authorize and direct my attorney to pay directly to **Chiropractic Center of Lakeland** such sums as may be due for services rendered to me by reason of the injury occurring on \_\_\_\_\_ and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect **Chiropractic Center of Lakeland**. And I herby further give a lien on my case to **Chiropractic Center of Lakeland** against any and all proceeds of any settlement, judgment or verdict which may be paid to my attorney or myself as a result of the injuries for which I have been treated or injuries in connection therewith.

I understand that I am directly and fully responsible to **Chiropractic Center of Lakeland** for all medical bills submitted for services rendered to me and that this agreement is made solely for **Chiropractic Center of Lakeland's** additional protection and in consideration of their awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

I authorize the office to release any information pertinent to my case to any insurance company, adjuster, or attorney to facilitate collection under this Assignment Lien and Authorization. I agree that the above mentioned office be given power of attorney to endorse/sign my name on any and all checks for payment of my doctor bills.

Dated \_\_\_\_\_ Patients Signature \_\_\_\_\_

Patient's name (print) \_\_\_\_\_

The undersigned attorney of record for the above patient does hereby agree to observe all of the terms of the above, and agrees to withhold sums from any settlement, judgment or verdict as may be necessary to adequately protect

Dated \_\_\_\_\_ Attorney's signature \_\_\_\_\_

Attorney 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 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. This means that no person has initiated contact with me and/or persuaded me to use the doctor or licensed professional, clinic, or medical institution that provided the services.
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.

The undersigned licensed medical professional 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. I have **explained** the services rendered 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 (15) and (16), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Insured Person (patient receiving treatment) or Guardian of Insured Person:

Name ( <i>PRINT or TYPE</i> )	Signature	Date
-------------------------------	-----------	------

Licensed Medical Professional Rendering Treatment (*Signature by his or her own hand*):

Name ( <i>PRINT or TYPE</i> )	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.



ASSIGNMENT OF BENEFITS, LIENS, DIRECT PAYMENT AUTHORIZATION, AUTHORIZATION TO RELEASE INSURANCE INFORMATION, AND AUTHORIZATION TO ESCROW UNPAID MEDICAL & PIP BENEFITS

Chiropractic Center of Lakeland, Inc.

INSURANCE CARRIER: \_\_\_\_\_ POLICY NUMBER: \_\_\_\_\_ DATE OF LOSS: \_\_\_\_\_

For and in consideration of Chiropractic Center of Lakeland, Inc. agreeing to pursue the responsible automobile insurance carrier for payment of benefits due and not requiring prepayment for services, I hereby irrevocably assign all rights and benefits to Chiropractic Center of Lakeland, Inc. for Personal Injury Protection, extended Personal Injury Protection, Medical Payment Coverage, and other benefits which I may have in accordance with Florida Statute §627.736. This includes any benefits from my insurance company and any other entity which may be responsible for medical expenses incurred. I further authorize Chiropractic Center of Lakeland, Inc. to collect payments & prosecute any necessary actions to collect payment for services as they see fit and allowable by law and contract. THIS DOCUMENT CONSTITUTES AN ASSIGNMENT OF RIGHTS AND BENEFITS.

I hereby further give a lien to Chiropractic Center of Lakeland, Inc. against 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 Chiropractic Center of Lakeland, Inc. as a result of the above stated loss date. This document acts as an irrevocable absolute assignment of my rights and benefits to the extent of the charges for services provided. I agree to cooperate with Chiropractic Center of Lakeland, Inc. and their attorney's (at their choosing), and to do all things reasonable to effect payment of the bills by the insurance company or other entity to Chiropractic Center of Lakeland, Inc. including, but not limited to, disclosing my medical condition, being available for factual discovery or other cooperation.

This assignment concerns only the bills for Chiropractic Center of Lakeland, Inc. and those costs including, but not limited to, attorney's fees, other costs, and interest necessary in procuring payment from the above-named insurance company and/or other entities. This assignment is not intended to assign any other causes of action that may belong to the undersigned patient. I agree to pay any applicable deductible or co-payment not covered by any policy of insurance cited above. I understand that as a benefit and convenience to me, Chiropractic Center of Lakeland, Inc. will bill and pursue collection against the insurance company or other responsible entity on my behalf. I hereby instruct and direct my insurance company to pay my benefits directly to Chiropractic Center of Lakeland, Inc. at the address provided on the bill. If my current policy prohibits direct payment to doctors, then I hereby instruct and direct my insurance company or other responsible entity to make the check payable to me and mail it to Chiropractic Center of Lakeland, Inc. at the address on the bill. Chiropractic Center of Lakeland, Inc.'s medical care is being provided for a reasonable fee for treatment causally related to the above loss date and is medically necessary. I instruct my insurance carrier or other responsible entity to pay these bills to the full extent of my available benefits under the insurance policy and Florida law. If any portion of the charge for these services is either reduced or denied in whole or in part, my insurance company or other entity is to place funds equal to the amount of the reduced or denied charges into escrow and hold the escrowed funds until agreement or resolution of legal action by Chiropractic Center of Lakeland, Inc.. I further instruct my insurance company to make payment for charges submitted by Chiropractic Center of Lakeland, Inc. in priority to any other requests to escrow benefits, including a request by myself to reserve benefits for pending disability claims. I hereby give Chiropractic Center of Lakeland, Inc. limited power of attorney to endorse and sign my name on any draft for payment to either Chiropractic Center of Lakeland, Inc. or myself if said draft represents payment for charges related to services rendered by Chiropractic Center of Lakeland, Inc..

I further direct my insurance carrier or responsible other entity to provide information to Chiropractic Center of Lakeland, Inc. which is otherwise available to me including but not limited to a copy of any applicable insurance policy, declaration page, all applicable endorsements, transcripts and/or copies of any recorded statements, examinations under oath and requests for same, independent medical evaluations and requests for same, peer review reports, and a listing of all PIP benefits paid to date which shall include when claims were made, when the claims were received, the payment or denial of each claim, the amount of the deductible and the claims applied thereto, and whether benefits have been exhausted and the amount of PIP benefits available, commonly known as a "PIP log". This request includes the name of other medical providers to whom payments have been under my policy of insurance. This agreement is intended to serve as an assignment of rights and benefits under my policy of insurance in favor of Chiropractic Center of Lakeland, Inc.. If any language within this agreement has the effect of invalidating this agreement, that language shall be deemed void and the remainder of the assignment shall maintain full force and effect. A photocopy of this assignment shall be considered as effective and valid as the original.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Name

*If patient is incapacitated or under the age of 18, please indicate the patient name, guardian name and relation to patient, and obtain guardian signature.*

# Chiropractic Center of Lakeland

We want to thank you for choosing us as your chiropractic health provider. In order to provide you and our other patients with the best optimal spinal care, we request that you follow our guidelines regarding broken and/or canceled appointments. Please remember that we have reserved appointment times especially for you. Therefore, we request at least 24 hours notice in order to reschedule your appointment. This will enable us to offer your canceled time to other patients that desire to get their treatment completed. When you cancel your appointment at the last minute, everyone loses—you, the doctor and other patients that would like to have utilized your appointment time.

Since our office does not charge for broken or canceled appointments, please realize how important it is to keep your reserved time. However, if you are scheduled for a Massage, a \$25 cancellation fee is enforced for the inconvenience of others. Thank you for your consideration of our policies and the opportunity to be your chiropractic office of choice.

---

Signature

---

Date