Korman Relief & Wellness Center
Laura R. Korman, DC, DACBN
16954 Toledo Blade Blvd.
Port Charlotte, Fl. 33954
Phone: (941) 629-6700, Fax: (941) 629-6805

PATIENT INFORMATION

Please print clearly:

Name_____ Date_____ SS#_____

Address_____ Unit #_____

City_____ State_____ Zip_____

Date of Birth _____ Age _____ Sex M / F Primary Language _____

Home Phone _____ Cell Phone _____

Work Phone _____ Email Address (print)_____

What is your preferred method of contact? _____

Emergency Contact _____ Relationship _____

Home Phone _____ Alternate Phone _____

Your Race (check all that apply) ____ White _____ American Indian or Alaskan Native _____ Asian

_____ Black or African American _____ Hispanic or Latino _____ Native Hawaiian or Other Pacific Islander

Marital Status Single / Married / Divorced / Separated / Widowed / Significant Other / Partner

Spouse / Partner Name _____

Currently living with Spouse / Alone / Other _____

Describe health of spouse Excellent / Very Good / Good / Fair / Poor / Other _____

Number of Children _____

Name of Child	**Age**	**Sex**	**Any physical condition / concern?**
_____	_____	M / F	_____
_____	_____	M / F	_____
_____	_____	M / F	_____
_____	_____	M / F	_____
_____	_____	M / F	_____

Your Occupation_____ Employer_____ Status_____

How, or by whom, were you referred to our office? _____

Patient / Guardian Signature _____ **Date** _____

PATIENT CONDITION

Overall health: (circle one) Excellent / Good / Poor / Other_____

Chief complaint / reason you are here (use separate sheet if more room is needed) _____

_____

_____

Cause of complaint or how complaint began_____

What type of pain are you experiencing? (Circle all that apply) Sharp / Burning / Dull / Tingling / Throbbing / Cramps

Numbness / Stiffness / Aching / Swelling / Shooting / Other _____

When did your symptoms first appear? _____

Is this condition getting progressively worse? Yes / No

How often do you have this pain / condition? _____

Is it constant, or does it come and go? _____

Does it interfere with (circle all that apply) Work / Sleep / Daily Routine / Recreation / Activities

Are any of these movements painful to perform? Sitting / Standing / Walking / Bending / Lying Down

Previous treatment for this complaint? _____

Are you currently under the care of a physician or other health professional? Yes / No

If "yes", please give name and date of last visit _____

Have you had Spinal X-rays, MRI, or CT Scan for your area(s) of complaint? Yes / No

List recent imaging or tests _____

At what facility was imaging / testing done? _____

Are you pregnant? Yes / No How many weeks? _____

Is this condition due to an accident? Yes / No If "yes", date of accident? _____/_____/_____

What type of accident did you have? Auto / Work Related / Home / Other _____

To whom have you reported the accident? Auto Insurance / Employer / Work Comp / Other

HEALTH HISTORY

Please check-mark below any health issues YOU currently have or have ever had, leaving blank if the condition does not apply to you.
If a condition applies to a family member, please indicate which family member using the following abbreviations:

M = Mother | **F** = Father | **S** = Sister | **B** = Brother | **MGM** = Maternal Grandmother

MGF = Maternal Grandfather | **PGM** = Paternal Grandmother | **PGF** = Paternal Grandfather

YOU			FAMILY	YOU			FAMILY
Past	**Present**	**Issue**		**Past**	**Present**	**Issue**	
_____	_____	Anemia	_____	_____	_____	High Blood Pressure	_____
_____	_____	Cancer	_____	_____	_____	High Cholesterol	_____
_____	_____	Diabetes	_____	_____	_____	Kidney Disease	_____
_____	_____	Heart Disease	_____	_____	_____	Stroke (date _____)	_____
_____	_____	Heart Failure	_____	_____	_____	Thyroid	_____
_____	_____	Rheumatoid Arthritis	_____				

Patient / Guardian Signature _____ **Date** _____

Korman Relief & Wellness Center

REVIEW OF SYSTEMS

Please circle "Yes" or "No" if you CURRENTLY have problems with the following. If yes, describe.

Y / N Skin _____
Y / N Ears / Nose / Throat _____
Y / N Cardiovascular_____
Y / N Gastrointestinal_____
Y / N Neurological_____
Y / N Psychiatric _____
Y / N Endocrine / Metabolic _____
Y / N Pacemaker _____
Y / N Musculoskeletal_____
Y / N Respiratory _____
Y / N Blood / Glands_____
Y / N Urinary _____
Y / N Reproductive _____
Y / N Eyes _____
Y / N Other _____

LIST ALL INJURIES **DATES**

_____ _____
_____ _____
_____ _____

LIST ALL SURGERIES **DATES**

_____ _____
_____ _____
_____ _____

LIST ALL HOSPITALIZATIONS **DATES**

_____ _____
_____ _____
_____ _____

LIST IMMUNIZATIONS **FLU SHOT? Y / N** **DATE** _____ **DATES**

_____ _____
_____ _____

CURRENT MEDICATIONS

MEDICATION **STRENGTH (MG, ML, ETC)** **TIMES PER DAY** **DATE BEGAN**

_____
_____
_____
_____
_____
_____

NUTRITIONAL SUPPLEMENTS (vitamins, calcium, fish oil, etc.)

_____
_____
_____

LIST ALLERGIES **ALLERGIC REACTION**

_____
_____
_____

Patient / Guardian Signature _____ **Date** _____

Korman Relief & Wellness Center

SOCIAL HISTORY

(Please circle all that apply to you)

Smoking - Never / Former / Current # Packs per day _____

Alcohol - None / Casual / Moderate / Heavy / Beer Only / Wine Only / # Drinks per week _____

Coffee / Caffeinated Drinks - None / Less than 3 drinks per day / 3-6 drinks per day / More than 6 per day

Drug Use - None / Recreational / Current or Former Addiction

Exercise - Never / Daily / Weekly / Walk only / Run / Swim

COMMUNICATION

I give permission for the following person(s) to discuss my health information with staff and physicians at Korman Relief & Wellness Center.

Name _____ Relationship _____

Name _____ Relationship _____

I give permission to be contacted by the following methods regarding messages, appointments, etc., for myself or my minor children.

(circle all that apply) Home Phone / Work Phone / Cell Phone / Email Address / Text Message

My email address at this time is (print) _____

I give permission to: (Check all that apply.)

_____ Leave messages on answering machine

_____ Leave messages with family member

INSURANCE

Name of Insurance Company _____

Authorization and Release: I authorize payment of insurance benefits, directly to Korman Relief & Wellness Center. I authorize the doctor to release all information necessary and to communicate with my personal physicians and other healthcare providers, and payers, and to secure the payment of benefits. I understand that I am responsible for all costs of care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this office to use their Patient Health Information for the purpose of treatment, payment, health care operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. 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. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's Signature_____ **Date**_____

Guardian's Signature Authorizing Care_____**Date**_____

Korman Relief & Wellness Center
Dr. Laura Korman, DC
16954 Toledo Blade Blvd Port Charlotte Fl 33954

PERSONAL INJURY QUESTIONNAIRE

Name _____ Main Phone _____ Other

_____ Address _____ City_____

State_____ Zip Code_____ Age_____ Birthdate _____ Sex_____ S.S.

#_____ Employer's Name_____

Address_____ Your Ins. Co. _____

Policy #_____ Agent's Name _____ Name on Policy (if other than self)

_____Policy # _____ Responsible Party's Name

_____

Address_____ City _____State _____ Zip Code _____

Policy Holder's Name _____ Policy # _____

ATTORNEY

Name_____ Phone _____

Address_____City_____State_____ Zip Code_____

Were there any witnesses? ( ) Yes ( ) No Name(s)_____

NATURE OF ACCIDENT

1. Date of accident _____ Time of day_____
2. Were you ( ) Driver ( ) Passenger ( ) Front seat ( ) Back seat
3. Number of people in your vehicle _____ Were you wearing a seat belts? _____
   What direction were you headed? ( ) North ( ) East ( ) South ( ) West
   on (name of street) _____
5. What direction was other vehicle headed? ( ) North ( ) East ( ) South ( ) West
   on (name of street) _____
6. Were you struck from ( ) Behind ( ) Front ( ) Left side ( ) Right side
7. Approximate speed of your car _____ mph Other car _____ mph.
8. Were you knocked unconscious? ( ) Yes ( ) No If yes, for how long? _____
9. Were police notified? ( ) Yes ( ) No
10. In your own words, please describe accident

_____

_____

_____

_____

11. Did you have any physical complaints BEFORE THE ACCIDENT? ( ) Yes ( ) No If "Yes", please describe in detail.

_____

_____

_____

12. Describe how you felt:

a. DURING the accident _____
b. IMMEDIATELY AFTER the accident _____
c. LATER THAT DAY _____
d. THE NEXT DAY _____

Korman Relief & Wellness Center

PERSONAL INJURY QUESTIONNAIRE

13. What are your PRESENT complaints and symptoms? _____

_____

_____

14.. Do you have any congenital (from birth) factors which relate to this problem? ( ) Yes ( ) No If "Yes", please describe.

_____

15. Do you have any previous illnesses which relate to this case? ( ) Yes ( ) No If "Yes", please describe

_____

16. Have you ever been involved in an accident before? ( ) Yes ( ) No If "Yes", please describe, including date(s) and type(s) of accidents, as well as injury/injuries received. _____

_____

_____

17. Where were you taken after the accident?

_____

18. Have you been treated by another doctor since the accident? ( ) Yes ( ) No If "Yes", please list doctor's name and address.

_____

What type of treatment did you receive? _____

_____

19. Since this injury occurred, are your symptoms ( ) Improving ( ) Getting Worse ( ) Same

20. **CHECK THE SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT.**

- ☐ Headache
- ☐ Neck Pain
- ☐ Neck Stiff
- ☐ Sleep Problems
- ☐ Back Pain
- ☐ Nervousness
- ☐ Tension
- ☐ Irritability
- ☐ Chest Pain
- ☐ Dizziness
- ☐ Head Seems To Heavy
- ☐ Pins & Needles in Arms
- ☐ Pins & Needles in Legs
- ☐ Numbness in Fingers
- ☐ Numbness in Toes
- ☐ Shortness in Breath
- ☐ Fatigue
- ☐ Depression
- ☐ Lights Bother Eyes
- ☐ Loss of Memory
- ☐ Ears Ring
- ☐ Face Flushed
- ☐ Buzzing in Ears
- ☐ Loss of Balance
- ☐ Fainting
- ☐ Loss of Smell
- ☐ Loss of Taste
- ☐ Diarrhea
- ☐ Feet Cold
- ☐ Hands Cold
- ☐ Stomach Upset
- ☐ Constipation
- ☐ Cold Sweats
- ☐ Fever
- ☐ _____

Symptoms other than above _____

21. Have you lost time from work as a result of this accident? ( ) Yes ( ) No If “Yes”, please complete this question.

a. Last Day Worked _____

b. Type of Employment _____

c. Present Salary _____

d. Are you being compensated for time lost from work? ( ) Yes ( ) No If “Yes”, pease state type of compensation you are receiving. _____

22. Do you notice any activity restrictions as a result of this injury? ( ) Yes ( ) No If “Yes”, please describe, in detail.

_____

_____

_____

23. Other pertinent information _____+_____

_____

_____

_____

Patient Signature _____ **Date** _____

Korman Relief and Wellness Center — Neck Disability Index

Patient name:_____ Signature:_____ Date: _____

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. **Please answer every section and mark in each section only ONE box** which applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box which MOST CLOSELY describes your problem.**

Section 1 – Pain Intensity

- ☐ I have no pain at the moment.
- ☐ The pain is mild at the moment.
- ☐ The pain comes and goes and is moderate.
- ☐ The pain is moderate and does not vary much.
- ☐ The pain is severe but comes and goes.
- ☐ The pain is severe and does not vary much.

Section 2 – Personal Care (Washing, Dressing, etc.)

- ☐ I can look after myself without causing extra pain.
- ☐ I can look after myself normally but it causes extra pain.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help, but manage most of my personal care.
- ☐ I need help every day in most aspects of self care.
- ☐ I do not get dressed, I wash with difficulty and stay in bed.

Section 3 – Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights, but it causes extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor but I can if they are conveniently positioned, for example on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4 – Reading

- ☐ I can read as much as I want to with no pain in my neck.
- ☐ I can read as much as I want to with slight pain in my neck.
- ☐ I can read as much as I want with moderate pain in my neck.
- ☐ I cannot read as much as I want because of moderate pain in my neck.
- ☐ I cannot read as much as I want because of severe pain in my neck.
- ☐ I cannot read at all.

Section 5 – Headaches

- ☐ I have no headaches at all.
- ☐ I have slight headaches which come infrequently.
- ☐ I have moderate headaches which come infrequently.
- ☐ I have moderate headaches which come frequently.
- ☐ I have severe headaches which come frequently.
- ☐ I have headaches almost all the time.

Section 6 – Concentration

- ☐ I can concentrate fully when I want to with no difficulty.
- ☐ I can concentrate fully when I want to with slight difficulty.
- ☐ I have a fair degree of difficulty in concentrating when I want to.
- ☐ I have a lot of difficulty in concentrating when I want to.
- ☐ I have a great deal of difficulty in concentrating when I want to.
- ☐ I cannot concentrate at all.

Section 7 – Work

- ☐ I can do as much work as I want to.
- ☐ I can only do my usual work, but no more.
- ☐ I can do most of my usual work, but no more.
- ☐ I cannot do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I cannot do any work at all.

Section 8 – Driving

- ☐ I can drive my car without neck pain.
- ☐ I can drive my car as long as I want with slight pain in my neck.
- ☐ I can drive my car as long as I want with moderate pain in my neck.
- ☐ I cannot drive my car as long as I want because of moderate pain in my neck.
- ☐ I can hardly drive my car at all because of severe pain in my neck.
- ☐ I cannot drive my car at all.

Section 9 – Sleeping

- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed (less than 1 hr. sleepless).
- ☐ My sleep is mildly disturbed (1-2 hours sleepless).
- ☐ My sleep is moderately disturbed (2-3 hours sleepless).
- ☐ My sleep is greatly disturbed (3-5 hrs. sleepless).
- ☐ My sleep is completely disturbed (5-7 hrs. sleepless).

Section 10 – Recreation

- ☐ I am able to engage in all recreational activities with no pain in my neck at all.
- ☐ I am able to engage in all recreational activities with some pain in my neck.
- ☐ I am able to engage in most, but not all recreational activities because of pain in my neck.
- ☐ I am able to engage in a few of my usual recreational activities because of pain in my neck.
- ☐ I can hardly do any recreational activities because of pain in my neck.
- ☐ I cannot do any recreation activities at all.

Korman Relief and Wellness Center — Oswestry Low Back Questionnaire

Patient name:_____ Signature:_____ Date: _____

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage in everyday life. **Please answer every section and mark in each section only ONE box** which applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box which MOST CLOSELY describes your problem.**

Section 1 – Pain Intensity

□ The pain comes and goes and is very mild.
□ The pain is mild and does not vary much.
□ The pain comes and goes and is moderate.
□ The pain is moderate and does not vary much.
□ The pain comes and goes and is severe.
□ The pain is severe and does not vary much.

Section 2 – Personal Care (Washing, Dressing, etc.)

□ I would not have to change my way of washing or dressing in order to avoid pain.
□ I do not normally change my way of washing or dressing even though it causes some pain.
□ Washing and dressing increase the pain but I manage not to change my way of doing it.
□ Washing and dressing increase the pain and I find it necessary to change my way of doing it.
□ Because of the pain I am unable to do some washing and dressing without help.
□ Because of the pain I am unable to do any washing and dressing without help.

Section 3 – Lifting

□ I can lift heavy weights without extra pain.
□ I can lift heavy weights but it gives extra pain.
□ Pain prevents me from lifting heavy weights off the floor.
□ Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned, e.g. on a table.
□ Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
□ I can only lift very light weights at the most.

Section 4 – Walking

□ I have no pain on walking.
□ I have some pain with walking but it does not increase with distance.
□ I cannot walk more than One Mile without increasing pain.
□ I cannot walk more than 1/2 Mile without increasing pain.
□ I cannot walk more than 1/4 Mile without increasing pain.
□ I cannot walk at all without increasing pain.

Section 5 – Sitting

□ I can sit in any chair as long as I like.
□ I can only sit in my favorite chair as long as I like.
□ Pain prevents me from sitting more than one hour.
□ Pain prevents me from sitting more than 30 minutes.
□ Pain prevents me from sitting more than 10 minutes.
□ I avoid sitting because it increases pain straight away.

Section 6 – Standing

□ I can stand as long as I want without pain.
□ I have some pain on standing but it does not increase with time.
□ I cannot stand for longer than one hour without increasing pain.
□ I cannot stand for longer than 1/2 hour without increasing pain.
□ I cannot stand for longer than 10 minutes without increasing pain.
□ I avoid standing because it increases pain straight away.

Section 7 – Sleeping

□ I get no pain in bed.
□ I get pain in bed but it does not prevent me from sleeping well.
□ Because of pain my normal nights sleep is reduced by less than 1/4.
□ Because of pain my normal nights sleep is reduced by less than 1/2.
□ Because of pain my normal nights sleep is reduced by less than 3/4.
□ Pain prevents me from sleeping at all.

Section 8 – Social Life

□ My social life is normal and gives me no pain.
□ My social life is normal but increases the degree of my pain.
□ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing, etc.
□ Pain has restricted my social life and I do not go out very often.
□ Pain has restricted social life to my home.
□ I have hardly any social life because of the pain.

Section 9 – Traveling

□ I get no pain while traveling.
□ I get some pain while traveling but none of my usual sorts of travel make it any worse.
□ I get extra pain while traveling but it does not compel me to seek alternative forms of travel.
□ I get extra pain while traveling which compels me to seek alternative forms of travel.
□ Pain restricts all forms of travel.
□ Pain prevents all forms of travel except that done lying down.

Section 10 – Changing Degree of Pain

□ My pain is rapidly getting better.
□ My pain fluctuates but overall is definitely getting better.
□ My pain seems to be getting better but improvement is slow at the present.
□ My pain is neither getting better or worse.
□ My pain is gradually worsening.
□ My pain is rapidly worsening.

Korman Relief & Wellness Center

Exam Form

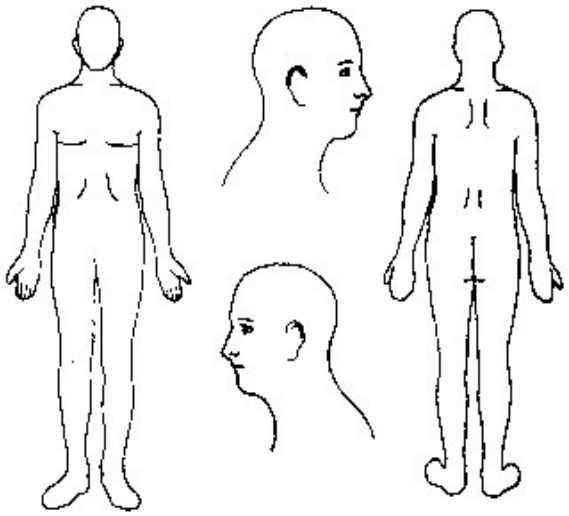
Date of Visit: ___/___/___ Patient: _____ Age: _____

What brought you here today?_____

_____

Place an "X" on the drawings below on areas causing you pain and include a letter (from box on right) describing the pain.

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



PAIN SCALE

Please circle the number that best describes your pain.

0 1 2 3 4 5 6 7 8 9 10

NONE LITTLE MEDIUM SEVERE

Describe your past health history:

Prior Illness: _____

_____

Past Hospitalizations: _____

_____

Surgeries: _____

_____

Medications: _____

Patient Signature: X _____

PATIENT: DO NOT WRITE BELOW THIS LINE OR ON THE NEXT PAGE - PHYSICIAN USE ONLY

EXAMINATION

Range of Motion

Cervical	Normal		Pain
Flexion	50		
Extension	60		
Left Lat Flex	45		
Right Lat Flex	45		
Left Rotation	80		
Right Rotation	80		
Lumbar	**Normal**		**Pain**
Flexion	60		
Extension	25		
Left Lat Flex	25		
Right Lat Flex	25		
Left Rotation	30		
Right Rotation	30		

Health HX Notes:

_____

_____

_____

_____

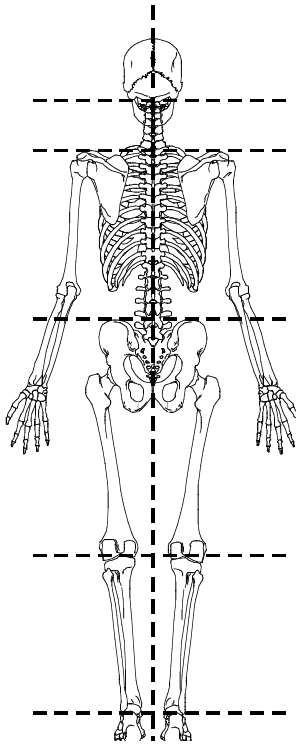
_____

_____

Asymmetry

C0
C1
C2
C3
C4
C5
C6
C7

L1
L2
L3
L4
L5
SAC
L-IL
R-IL

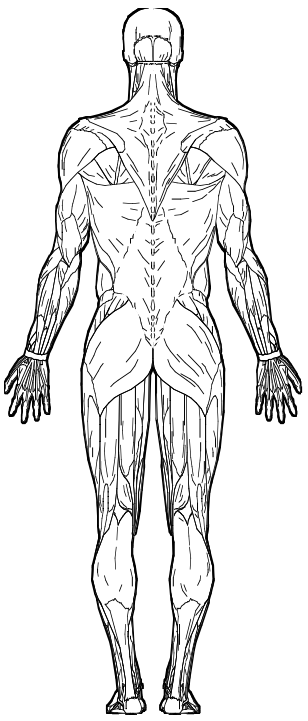


Using arrows (↑ ↓ → ←) mark the misaligned vertebrae

T1
T2
T3
T4
T5
T6
T7
T8
T9
T10
T11
T12

Using arrows (↑↓), mark postural asymmetry

Tissue



Mark tissue abnormalities
TP, LG, TN, SK, FS

TP=Trigger Points; LG=Ligaments (swollen or tender)
TN=Tendons; SK=Skin; FS=Fascial Restrictions

Korman Relief & Wellness Center **Patient Name** _____ **Date** _____

HISTORY OF PRESENT COMPLAINT

Complaint: _____

Qual & Chara: _____

On, Dur, Intens, Freq, Loc, Rad: _____

_____

_____

Better or worse: _____

_____

Prior TX, meds, other: _____

_____

EXAMINATION

Reflexes
(Wexler Scale)

Biceps ____
Triceps ____
Brac/rad____
Patella ____
Achilles ____

B/P: _____/_____ **L / R** **PULSE:** _____ **O2:** _____ **HT:** _____ **WT:** ____ **GRIP: (R)** ____ **(L)**___

Sensory: C5: _____ C6: _____ C7: _____ C8: _____ T1: _____
L3: _____ L4: _____ L5: _____ S1: _____

D= Deficit **N= Normal** **(R) or (L)**

General Orth/Neuro Examination:

Spinous Percus: _____ Valsalva: _____

Dejerine Triad: _____ Rhomberg: _____ **(+) or (-), (R) or (L)**

Notes: _____

Test	(+)	(-)	R	L	Indication
Distraction					nerve root compression
Jackson					nerve root compression
Max Cerv Rot Comp					nerve root compression
Cerv Comp					nerve root compression
Soto Hall					(cerv) (thor) vertebral trauma
Spurlings					nerve root irritation
Shoulder Depress					nerve root compression

Test	(+)	(-)	R	L	Indication
Libman's					(low) (normal) (high) pain threshold
Burn's Bench					(hysteria) (malingering)
Hoover's					(hysterical paralysis) (malingering)

Test	(+)	(-)	R	L	Indication
Bechterew					sciatic disc compression
Beevor's					abdominal muscle weakness
Minors Sign					radicular disc pain
Ely					upper lumbar lesion
Fajersztajn					intervertebral disc syndrome
Nachlas					upper lumbar lesion
Gluteal punch					spinal lesion
Goldthwaite					lumbar differentiation
Heel walk					5th lumbar motor deficit
Kemps					intervertebral disc rupture
Lasague					(muscle) (disc) (nerve) irritation
Braggards					lumbar antalgic spasm
Supported Adam's					lumbosacral differentiation

MUSCLE TESTS

Level	Muscle	Muscle Grade	
C5	Deltoids	L:	R:
C6	Biceps	L:	R:
	Wrist extensors	L:	R:
C7	Triceps	L:	R:
	Wrist flexors	L:	R:
	Finger extensors	L:	R:
C8	Finger flexors	L:	R:
T1	Finger abductors	L:	R:
L2-L3	Hip flexors	L:	R:
L4-L5	Hip extensors	L:	R:
L3-L4	Knee extensors	L:	R:
L5-S1	Knee flexors	L:	R:
L4-L5	Ankle extensors	L:	R:
S1-S2	Ankle flexors	L:	R:

TREATMENT PLAN

Initial TX on: ____ /___ /___

Level of Care: (include duration and frequency of visits)

_____

_____

_____

Specific Treatment Goals: _____

_____

Specific Objective Eval: _____

_____

_____

DIAGNOSIS: _____

_____

_____

Doctor Signature:_____ **Date:** ____ /___ /___

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 (15) and (16), 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.

OIR-B1-1571
Pub. 1/2004

Laura R. Korman, DC, DACBN
CHIROPRACTIC PHYSICIAN
Board Certified in Nutrition
16954 Toledo Blade Blvd. Port Charlotte, Fl. 33954.
Phone 941-629-6700 Fax 941-629-6805

AUTHORIZATION TO OBTAIN PIP BENEFITS PAYOUT INFORMATION

Date: _____ /_____ /_____

Name of Insurance Carrier: _____

PIP Policy#: _____

Name of Insured: _____

Name of Patient: _____

Date of Accident: _____ /_____ /_____

I, _____, hereby authorize and direct the above referenced insurance carrier to send Dr. Laura R. Korman (fax #: 941-629-6805) an accounting of all payouts made, for all claims submitted for payment, under the above referenced policy to the motor vehicle collision (MVC) occurring on the above referenced date.
Thank you.

Signature of Insured:_____ Date: _____/_____/_____

Korman Relief & Wellness Center
Laura R. Korman, DC, DACBN,
16954 Toledo Blade Blvd. Port Charlotte, Fl. 33954

Attending Physician's Report

Date _____ Policy Holder _____ Date of Accident _____

TO ASSIST US IN DETERMINING BENEFITS DUE UNDER THE AUTOMOBILE PERSONAL INJURY PROTECTION LAW, THE ATTENDING PHYSICIAN MUST COMPLETE THIS REPORT AND RETURN IT DIRECTLY.

Physician's Name _____ Hospital / Office Name _____

Address _____ City_____ State _____ Zip _____

Patient's Name _____ Date of Birth _____ Sex: Male / Female

Patient's Address _____ City _____ State_____ Zip _____

Patient's Occupation _____

AUTHORIZATION TO RELEASE INFORMATION: PLEASE FURNISH THE FOLLOWING REPORT REGARDING MY CONDITION AS A RESULT OF THIS ACCIDENT WHICH OCCURRED ON _____, 20_____

Signature _____ **Date** _____

TO BE COMPLETED BY ATTENDING PHYSICIAN

History of occurrence as described by the patient _____

_____

Diagnosis and current conditions _____

_____

Were X-Rays Taken? Yes / No If Yes, where? _____

When did symptoms first appear? _____

When did the patient first consult you for this conditions? _____

Has the patient ever had same or similar conditions? Yes / No If Yes, state when and describe below.

_____

Is conditions solely a result of this accident? Yes / No If No, explain. _____

_____

Nature of surgical procedures and dates (if any). _____

Charge to patient for this procedure including post care $_____ Location of Procedure _____

Is condition due to injury or sickness arising out of patient's employment? Yes / No

Will injury result in permanent disfigurement or disability? Yes / No If Yes, describe below.

_____

Patient was disabled (unable to work) from _____ through _____.

If still disabled, date patient should be able to return to work _____

Other medical services and charges: Service _____ Charge $_____

Service _____ Charge $_____

Total Charges to date $_____

Is patient still under your care for this condition? Yes / No Estimated Future Charges $ _____

Physician Name (print) _____ IRS Identification # _____

Physician Address _____ City _____ State _____ Zip_____

Physician's signature _____ Date _____/_____/_____

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PROMISE TO PAY FOR TREATMENTS

I, _____, am seeking treatment from Laura R. Korman, DC, for injuries sustained in an automobile accident occurring on (date) _____.

I am responsible for paying Laura R. Korman, DC, for that treatment, and any treatments left unpaid are due and owing by me to Laura R. Korman, DC. I hereby promise and assure Laura R. Korman, DC, that any payment by check or any other form from any health insurance company, automobile insurance company, or any other source as compensation or reimbursement for treatment of the aforementioned injuries by Laura R. Korman, DC, shall be preserved and submitted to Laura R. Korman, DC, for payment of any balance due on the aforementioned treatments.

I understand that I remain liable to Laura R. Korman, DC, for any unpaid aforementioned treatments should I cash any check or accept any payment from any health insurance company, automobile insurance company, or any other source as compensation or reimbursement for treatment of the aforementioned injuries.

Signed this _____ day of _____, 20_____.

Patient's printed name _____

Patient's signature _____

Witness printed name _____

Witness signature _____

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www.drlaurakorman.com

PATIENT LIEN NOTIFICATION

To Attorney _____

Medical Provider's Name _____

I do hereby authorize this doctor's office to furnish you, my attorney, with a full report of the examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was involved on _____.

I hereby authorize and direct you, my attorney, to pay directly to said doctor, sums as may be due and owning to him/her for medical services rendered to me by reason of this accident, and to withhold such sums from any settlement, judgement or verdict as may be necessary to adequately protect said doctor.

I hereby authorize and direct you, my attorney, to furnish any and all payment logs, PIP print out logs, and settlement disbursement logs. I hereby further give a lien on my case to you, my attorney, as the result of the injuries for which I have been treated, or injuries in connection therewith.

I hereby instruct that in the event another attorney is substituted in this manner, the new attorney honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by any new attorney.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by said doctor for services rendered me and that this agreement is made solely for said doctor's awaiting payment. I further understand that such payment is not contingent on any settlement, judgement, or verdict by which I may eventually recover said fee(s).

Date: _____ Print Name _____

Signature_____

Date:_____ Attorney Name _____

Signature_____

Korman Relief and Wellness Center
Laura R. Korman, DC, DACBN
16954 Toledo Blade Blvd.
Port Charlotte, FL 33954
Ph# (941) 629-6700

OFFICE & PAYMENT POLICY INFORMATION

FINANCIAL POLICY:
Payments for Healthcare Services provided in this office are due the day that services are rendered, unless other arrangements have been made prior to seeing the doctor. Patients are personally responsible for all charges.

OUR GOAL:
We believe that a clear definition of our office policies will allow you, the patient, and us, the doctor, to concentrate on the big issue - REGAINING AND MAINTAINING YOUR HEALTH. It is the goal of this office to provide you with the finest quality healthcare available. If you have any questions regarding your healthcare, or any of our policies, please let us know. We welcome your referrals and look forward to a mutually rewarding doctor-patient relationship.

INSURANCE POLICY:
I understand, and agree, that health and accident insurance policies are an arrangement between my insurance company and myself, and ***not*** between my insurance company and this office.

Assignment of Insurance benefits will be accepted upon proper verification of coverage and at the discretion of this office, however **benefits quoted are not a guarantee of payment.** Benefits are determined at the time of processing. In the event that an "Explanation of Benefits" comes back stating patient responsibility, the patient will be sent a bill.

This office does not file for, or accept assignment for, out-of-network or secondary insurance benefits. We will, however, provide you with documentation to assist you in collecting from your insurance carriers.

APPOINTMENT POLICY:
We want to thank you for choosing us as your healthcare provider. Please remember that we have reserved appointment times especially for you, and we attempt to honor all appointments at the scheduled time. Therefore, in the event you are unable to keep an appointment for any reason, we request that you call immediately to reschedule your visit. This will enable us to schedule other patients for that time.

When you cancel your appointment at the last minute, everyone loses - you, the doctor, and other patients who would like to have utilized your appointment time. ***In the event that you do not contact our office to cancel or reschedule your appointment, at least 2 hours prior to your scheduled time, you may be billed a $20 missed appointment fee. Failure to comply may result in dismissal of care.***

I have read and understand the above policies. Any questions I had have been answered to my satisfaction, and I understand my responsibility as a patient. I also understand that if my insurance does not respond within 90 days, or if I suspend or terminate my schedule of care as prescribed by Korman Relief & Wellness Center, all fees will be due and payable immediately.

Should there be any instance of a bounced or returned check, I acknowledge that I will be charged a fee of $**10 per bounced check.**

PATIENT SIGNATURE: _____ **DATE:**_____

Korman Relief & Wellness Center
Laura R. Korman, DC, DACBN
16954 Toledo Blade Blvd.
Port Charlotte, FL 33954
941-629-6700

INFORMED CONSENT FOR THERAPY TREATMENT

Physicians and physical therapists who perform soft tissue therapies and spinal manipulations are required by law to obtain your informed consent before starting treatment.

I, _____, do hereby give my consent to the performance of conservative, non-invasive treatments to the joints and soft tissues. I understand that the procedures may consist of soft tissue and/or spinal manipulations involving movement of the joints and soft tissues.

Physiotherapies and exercises which may be used by this office include:

1. Class IV Deep Tissue Laser
2. Infrared Light Therapy
3. Vibration Plate and/or Whole Body Vibration
4. Back on Trac (Low Back Decompression and/or Cervical Decompression)
5. Knee Trac (Knee Decompression)
6. EMS
7. Ultrasound
8. Rebuilder
9. Specialized Myoneural Therapy

Although these treatments are considered to be safe for neuromuscular problems, I realize that there are possible risks and complications associated with these procedures, as follows:

- **Soreness:** I am aware that, like exercise, it is common to experience muscle and/or joint soreness after the first few treatments.
- **Physiotherapy Burns:** Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase of pain and possible blistering.
- **Bruising:** Mild bruising may occur as a result of the soft tissue therapies.
- **Joint Injury:** I further understand that, in isolated cases, underlying physical defects, deformities, or pathologies, such as weak bones from osteoporosis, may render a patient susceptible to injury. When osteoporosis, degenerative disc(s), or any other abnormality is detected, this office will proceed with caution.

TREATMENT RESULTS

I also understand there are beneficial effects associated with these treatment procedures, including decreased pain and inflammation, increased circulation, and mobility. However, I appreciate that there is no certainty that I will achieve these benefits.

I have read, or have had read to me, the above explanation of soft tissue treatment. Any questions have been answered to my satisfaction. I made this decision freely and voluntarily.

Signature_____ Date _____