Elyse Saltalamachia, D.C., DABCI
2910 Maguire Rd. Suite 1009
Ocoee FL 34761
P: 407.877.8707 *** F: 407.877.7464

Electronic Signature (e-Signature): You consent and agree that your use of a key pad, mouse or other device to select an item, button, icon or similar act/action while using any electronic service we offer; or in accessing or making any transactions regarding any agreement, acknowledgement, consent, terms, disclosures or conditions constitutes your signature, acceptance and agreement as if actually signed by you in writing. Further, you agree that no certification authority or other third party verification is necessary to validate your electronic signature; and that the lack of such certification or third party verification will not in any way affect the enforceability of your signature or resulting contract between you and Lakota Wellness, LLC. You understand and agree that your e-Signature executed in conjunction with the electronic submission of your paperwork shall be legally binding and such transaction shall be considered authorized by you.

Signature: _____ **Date:** _____

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Confidential Patient Information

Date: _____

First: _____ MI: ____ Last: _____
Address: _____
City: _____ State: ____ Zip: _____
Phone Home: _____ Cell: _____ Work: _____
Email: _____
Sex: _____ DOB: _____ SS#: _____ Lic#: _____
Marital Status: _____ Spouses Name: _____ DOB: _____
Referred By: _____

Chief Complaint

Main reason for visit: _____
Are your symptoms associated with an accident or injury? Yes No
If yes, please describe your injury: _____
How long has this been affecting you? _____
Is this condition interfering with your work? Yes No Sleep? Yes No Daily Routine? Yes No
How often are you experiencing symptoms? _____
What aggravates this condition? _____
What helps this condition? _____

Secondary Complaint

Are there any other concerns you would like the doctors to address? If so, please list:

_____

_____

Health History

Name: _____ Date: _____
Occupation: _____ Age: ____ Height: _____ Weight:_____
Sex: M F # of Children: __ Marital Status: _____
Are you recovering from a cold or flu? Yes No Are you pregnant? Yes No
List current health problems for which you are being treated: Click or tap here to enter text.

What types of therapies have you tried for these problem(s) or to improve your health over-all?
☐ Diet modification ☐Fasting ☐ Vitamins/Minerals ☐ Herbs ☐ Homeopathy
☐ Chiropractic ☐ Acupuncture ☐ Conventional Drugs ☐ Physical Therapy ☐ Massage
☐ Other _____

Do you experience any of these general symptoms EVERY DAY?
☐ Debilitating fatigue ☐ Shortness of breath ☐ Insomnia ☐ Constipation
☐ Chronic pain/inflammation ☐ Depression ☐ Panic attacks ☐ Nausea
☐ Fecal Incontinence ☐ Bleeding ☐ Disinterest in sex ☐ Headaches
☐ Vomiting ☐ Urinary incontinence ☐ Discharge ☐ Disinterest in eating
☐ Dizziness ☐ Diarrhea ☐ Low grade fever ☐ Itching/rash

Current medications taking (prescription or over the counter):
_____

Laboratory procedures performed (eg..stool analysis, blood and urine, hair analysis): _____

List any Major Hospitalizations, Surgeries, Injuries, complications (if any) and dates:

Year	***Surgery, Illness, Injury***	***Outcome***
_____	_____	_____
_____	_____	_____
_____	_____	_____

What is the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest): _____
Identify the major causes of stress (change in job, work, family, finances, or legal: _____
Do you consider yourself; ☐ underweight ☐ overweight ☐ just right Weight today ____
Have you had an unintentional weight loss or gain of 10 lbs or more in the last three months? Choose
Is your job associated with potentially harmful chemicals (pesticides, radioactivity, solvents) or health and/or life-threatening activities (fireman, etc)? _____
What are your current health goals: _____

Medical History

☐ Arthritis	☐ Neurological, Parkinson's, paralysis	☐ Surgical menopause	**EXERCISE**
☐ Allergies/hay fever	☐ Sinus problems	☐ Menopause	☐ 5-7 days per week
☐ Asthma	☐ Stroke	☐ Premenstrual syndrome PMS	☐ 3-4 days per week
☐ Alcoholism	☐ Thyroid trouble	☐ Date of last menstrual cycle	☐ 1-2 days per week
☐ Alzheimer's disease	☐ Obesity	Length of cycle ____days	☐ 45 mins or more duration per workout
☐ Autoimmune disease	☐ Osteoporosis	Interval of time between cycles __days	☐ 30-45 minutes duration per workout
☐ Blood Pressure Problems	☐ Pneumonia	Any recent changes in normal menstrual flow _e.g., heavier, large	☐ Less than 30 minutes
☐ Bronchitis	☐ Sexual transmitted disease	**FAMILY HEALTH HISTORY (PARENTS AND SIBLINGS)**	☐ Walk
☐ Cancer	☐ Skin problems	☐ Arthritis	☐ Run, jog, jump rope
☐ Chronic fatigue syndrome	☐ Tuberculosis	☐ Asthma	☐ Weight lift
☐ Carpal tunnel syndrome	☐ Ulcer	☐ Alcoholism	☐ Swim
☐ Cholesterol, elevated	☐ Urinary Tract infection	☐ Alzheimer's disease	☐ Box
☐ Circulatory problems	☐ Varicose Veins	☐ Cancer	☐ Yoga
☐ Colitis	Other _____	☐ Depression	**NUTRITION & DIET**
☐ Dental problems	**MEDICAL MEN**	☐ Diabetes	☐ Mixed food diet (animal and
☐ Depression	☐ Benign prostatic hyperplasia	☐ Drug addiction	☐ Vegetarian
☐ Diabetes	☐ Prostate Cancer	☐ Eating disorder	☐ Vegan
☐ Diverticular disease	☐ Decreased sex drive	☐ Genetic disorder	☐ Salt restriction
☐ Drug addiction	☐ Infertility	☐ Glaucoma	☐ Fat restriction
☐ Eating disorder	☐ Sexual transmitted disease	☐ Heart disease	☐ Starch/carbohydrate restriction
☐ Epilepsy	Other _____	☐ Infertility	☐ The Zone Diet
☐ Emphysema	**MEDICAL WOMEN**	☐ Learning disabilities	☐ Total calorie restriction
☐ Eyes, ears, nose throat problems	☐ Menstrual irregularities	☐ Mental Illness	Specific food restriction __dairy __wheat __egg __ soy __corn __all gluten
☐ Environmental sensitivities	☐ Endometriosis	☐ Migraine headaches	Other_____
☐ Fibromyalgia	☐ Infertility	☐ Neurological, Parkinson's, paralysis	**FOOD FREQUENCY**
☐ Food intolerance	☐ Fibrocystic breasts	☐ Obesity	Servings per day:
☐ Gastroesophageal reflux disease	☐ Fibroids/ovarian cysts	☐ Osteoporosis	☐ Fruits (citrus, melons, etc.) _____
☐ Genetic disorder	☐ Breast cancer	☐ Stroke	☐ Dark green or deep yellow/orange
☐ Glaucoma	☐ Pelvic inflammatory disease	☐ Suicide	☐ Grains (unprocessed) _____
☐ Gout	☐ Vaginal infections	Other _____	☐ Beans, peas, legumes _____
☐ Heart disease	☐ Decreased sex drive	**HEALTH HABITS**	☐ Dairy, eggs _____
☐ Infection, chronic	☐ Sexually transmitted disease	☐ Tobacco Chew	☐ Meat, poultry, fish _____
☐ Inflammatory bowel disease	☐ Other	☐ Cigarettes/Cigars: #/day	☐ Grains (unprocessed) _____
☐ Irritable bowel syndrome	☐ Age or first period	**Alcohol**	☐ Beans, peas, legumes _____
☐ Kidney or bladder disease	☐ Date of last GYN exam	☐ Wine: #glasses/d or wk _____	☐ Dairy, eggs _____
☐ Learning disabilities	☐ Date of last Mammogram	☐ Liquor: #ounces/d or wk_____	☐ Meat, poultry, fish _____
☐ Liver or gallbladder disease/stones	☐ Date of last PAP	☐ Beer: #glasses/d or wk_____	**EATING HABITS**
☐ Mental Illness	☐ Form of birth control	**Caffeine**	☐ Skip breakfast
☐ Migraine headaches	☐ # of children	☐ Coffee: #6 oz cups/d_____	☐ Two meals/day
	☐ # of pregnancies	☐ Tea: #6 oz cups/d_____	☐ One meal/day
	☐ C-section	☐ Soda w/caffeine: # cans/d_____	☐ Graze (small frequent metals)
		☐ Water: # glasses/d_____	☐ Food rotation

EATING HABITS	CURRENT SUPPLEMENTS	WOULD YOU LIKE TO:	
☐ Skip breakfast	☐ Multivitamin/mineral	☐ Have more energy	
☐ Two meals/day	☐ Vitamin C	☐ Be stronger	
☐ One meal/day	☐ Vitamin E	☐ Have more endurance	
☐ Graze (small frequent metals)	☐ EPA/DHA	☐ Increase your sex drive	
☐ Food rotation	☐ Evening Primrose/GLA	☐ Be thinner	
☐ Eat constantly whether hungry or not	☐ Calcium, source	☐ Be more muscular	
☐ Generally, eat on the run	☐ Magnesium	☐ Improve your complexion	
☐ Add salt to food	☐ Zinc	☐ Have stronger nails	
	☐ Minerals, describe_____	☐ Have healthier hair	
	☐ Friendly flora (acidophilus)	☐ Be less moody	
	☐ Digestive enzymes	☐ Be less depressed	
	☐ Amino acids	☐ Be less indecisive	
	☐ CoQ10	☐ Feel more motivated	
	☐ Antioxidants (e.g., lutein, resveratrol, etc.)	☐ Be more organized	
	☐ Herbs-teas	☐ Think more clearly and be more focused	
	☐ Herbs-extracts	☐ Improve memory	
	☐ Chinese herbs	☐ Do better on tests in school	
	☐ Ayurvedic herbs	☐ Not be dependant on over-the-counter medications like aspirin, ibuprofen, antihistamines, sleeping aids, etc.	
	☐ Homeopathy	☐ Stop using laxatives or stool softeners	
	☐ Bach flowers	☐ Be free of pain	
	☐ Protein shakes	☐ Sleep better	
	☐ Superfoods (e.g., bee pollen, phytonutrient blends)	☐ Have agreeable breath	
	☐ Liquid metals	☐ Have agreeable body order	
	☐ Colloidal Silver	☐ Have stronger teeth	
		☐ Get less colds and flus	
		☐ Get rid of your allergies	
		☐ Reduce your risk of inherited disease tendencies (e.g., cancer, heart disease, etc.)	

Has your mother or father been diagnosed with any significant illness or disease? (e.g. cancer, diabetes, etc)

Mother: _____
Still Living: please circle YES NO

Father: _____
Still Living: please circle YES NO

AUTO/WORK RELATED ACCIDENT

ABOUT YOU

Today's Date:__/__/___File #:_____

Name:_____

WORK RELATED ACCIDENT

Date & Time of Accident:_____ ___A.M. ___P.M.

Was your accident directly related to your work? __Yes __No

Briefly describe the events that occurred just before and during your accident:_____

_____

_____

Give the address where the accident occurred: (If other than employer's address) _____

_____

Was anyone else present during your accident?... __Yes __No

Did you report your accident to your employer?....__Yes __No

What recommendations did your employer make just after your accident?_____

_____

Has this type of accident happened to you before?.....__Yes __No

To the best of your knowledge, has this accident occurred in your workplace before?.....__Yes __No

In general:

Is your job physically stressful?.....__Yes __No

Is your job mentally stressful?.....__Yes __No

Is your workplace noisy?.....__Yes __No

Have you changed jobs in the last year?.....__ Yes __No

AUTO RELATED ACCIDENT

Date & Time of Accident:_____ ___ A.M. ___ P.M.

Were you the:__Driver __Front Passenger __Rear Passenger

If a traffic violation was issued, to whom was it issued?

Number of people in accident vehicle?_____

Did the police come to the accident site?..._____ Yes _____ No

Was a police report filed?....._____ Yes _____ No

Were there any witnesses?....._____ Yes _____ No

Were you wearing your seatbelt?....._____ Yes _____ No

Was this vehicle equipped with airbags?...._____ Yes _____ No

If yes, did it/they inflate?....._____ Yes _____ No

In relation to the base of your skull, where was the headrest?....._____Above ___ Below ___At base of skull

What did your vehicle impact?___Another Vehicle __ Other

If other, explain:_____

Did any part of your body strike anything in the vehicle?....._____Yes _____ No

If yes, please describe:_____

_____

Make & model of the vehicle you were occupying?

_____

Name of the location/street on which you were travelling?

In which direction were you headed?....._____N __S __E __W

What was the approx. speed of your vehicle?_____

Did the impact to your vehicle come from the:

__Front __Rear __Right Side __Left Side __ Other

During impact, were you facing….. __Right __Left __Forward

Were you __aware or __surprised by the impact?

If accident vehicle made impact with another vehicle……

Make and model of that other vehicle?_____

_____

Direction other vehicle was headed?.....__N __S __E __W

Speed of the other vehicle?_____

In your words, please describe the accident:_____

_____

_____

_____

ABOUT YOU

Name:_____ File #:_____

What is your current weight:_____lbs., and height, _____Ft._____In.

Please describe your condition:_____

_____

_____

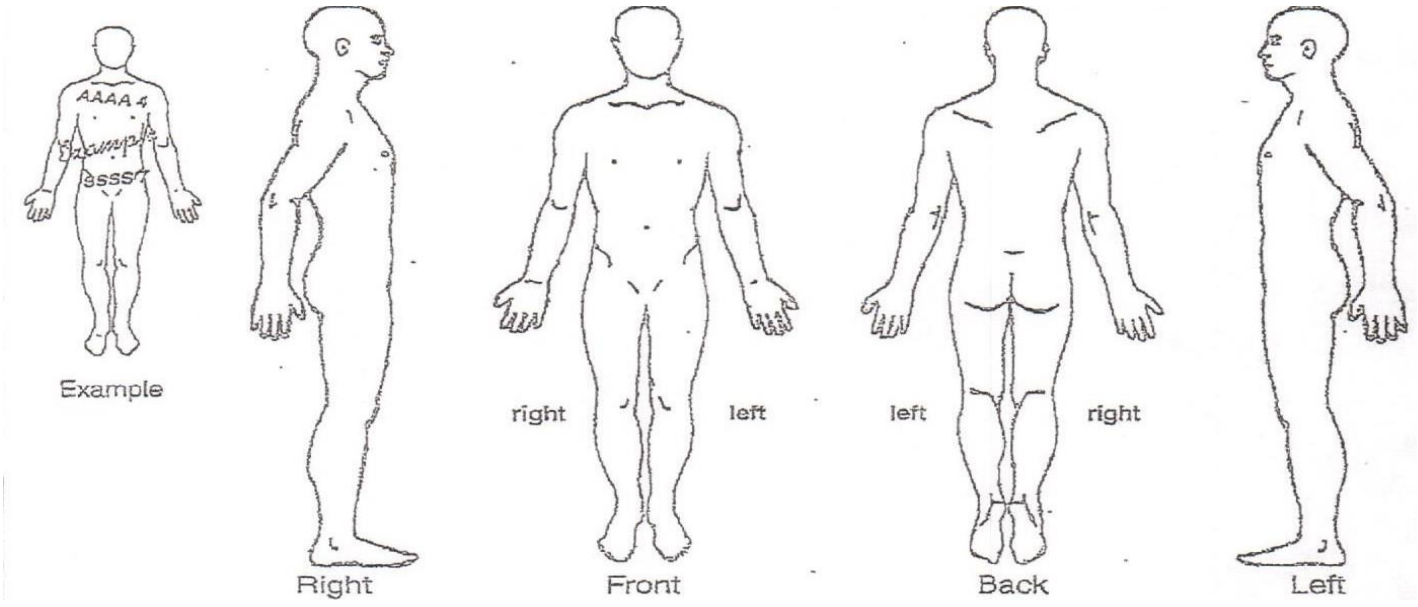
Signature:_____ Date:___/___/____

SHOW US WHERE IT HURTS

Please mark area(s) of injury or discomfort as shown in the example below. Mark all areas with the appropriate symbols and indicate the degree of pain using a scale from 1 (discomfort) to 10 (extreme pain).

Description:	Numbness	Pins & Needles	Burning	Aching	Stabbing
Symbol:	NNNN	PPPP	BBBB	AAAA	SSSS

Circle any area of pain not represented by a symbol.



DOCTOR'S NOTES

_____

_____

_____

_____

_____

AFTER INJURY

Did the accident render you unconscious?.....__Yes __No
If yes, for how long?_____
Please describe how you felt immediately after the accident: _____

_____

Have you gone to a Hospital or seen any other Doctor?..... __Yes __No
When did you go? __Just after accident __The next day __Two days plus
How did you get there?.... __Ambulance __Private transportation
Name of Hospital and/or Attending Doctor:_____

_____

Were they a: __D.C. __M.D. __D.O. __D.D.S
Describe any treatment you received:_____

_____

Were X-rays/MRI/CT SCAN taken?.....__Yes __No
Was medication prescribed?.....__Yes __No
Have you been able to work since the injury?.....__Yes __No
Are your work activities restricted as a result of this injury?...__Yes __No

Indicate the symptoms that are a result of this accident:
__Dizziness __Difficulty sleeping __Jaw Problems __Nausea __Memory Loss __Irritability __Back Pain __Arms/Shoulder Pain __Headache(s) __Fatigue __Numb Hands/Fingers __Lower back pain __Blurred vision __Tension __Chest pain __Back stiffness __Buzzing in ear __Neck Pain __Shortness of breath __Leg pain __Ears ringing __Neck stiff __Stomach upset __Numb _Feet/Toes
__Other:_____
Is your condition getting worse?
__Yes __No __Constant __Comes and goes

Indicate your degree of comfort while performing the following activities:

	Comfortable	Uncomfortable	Painful
Lying on back	__	__	__
Lying on side	__	__	__
Lying on stomach	__	__	__
Sitting	__	__	__
Standing	__	__	__
Stretching	__	__	__
Intercourse	__	__	__
Walking	__	__	__
Running	__	__	__
Sports	__	__	__
Working	__	__	__
Lifting	__	__	__
Bending	__	__	__
Kneeling	__	__	__
Pulling	__	__	__
Reaching	__	__	__

Have you retained an attorney: __Yes __No
If yes, whom:_____
Their Phone #:_____

RECOVERY

To evaluate the effect that continuing work will have on your recovery please complete the following:
How many hours are in your normal work day? ___
Please indicate your daily job duties and any activities which you are occasionally asked to perform:
__Standing __Driving __Operating equipment __Sitting __Twisting __Work with arms above head __Walking __Crawling __Typing __Lifting __Bending __Stooping __Other:_____
What positions can you work in with minimum physical effort and for how long?_____ __N/A
Prior to the injury were you capable of working on an equal basis with others your age?.....__Yes __No __N/A
Do you work with others who can help you with any heavy lifting?.....__Yes __No __N/A
While in recovery, is there any light duty work you could request?.....__Yes __No __N/A

ADDITIONAL INSURANCE

2nd Insurance Source or Auto Insurance

Type of Insurance:_____
Co. Name:_____
Address:_____
Phone #:_____
Insured's Name:_____
Policy #:_____ Claim #:_____
Insured's SS #:_____ D.O.B.___/__/__
Insured's Employer:_____
Agent's Name: _____

If any of your medical or account information has changed, please inform our front desk personnel.

Please remember you are ultimately responsible for your account.

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(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**):*

Elyse Saltalamachia, DC, DABCI		
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.

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Difficulty in Performing Activities of Daily Living

Patient name: _____ Date: _____

Please check each of the activities which you have difficulty performing and/or can perform only with pain. (There is no priority in the order presented).

Housework
___ Doing laundry
___ Making beds
___ Vacuuming
___ Washing dishes
___ Ironing
___ Carrying groceries
___ Caring for pets
___ Cooking
___ Other_____

Yardwork
___ Mowing lawn
___ Shoveling
___ Raking
___ Gardening

General
___ Walking
___ Standing
___ Running
___ Sitting
___ Lifting children
___ Bending
___ Climbing stairs
___ Reading
___ Lying in bed
___ Chewing
___ Sports: List _____

Personal Grooming
___ Combing hair
___ Shaving
___ In/Out bathtub
___ Brushing teeth
___ Other_____

Travel
___ Driving
___ Riding (Passenger)
Minutes per day_____

Type of vehicle
___ Auto ___ Truck
___ Train ___ Airplane
___ Bus

___ In/out of auto
___ Playing piano
___ Using computer
___ Kneeling
___ Sexual intercourse
___ Exercise
___ Using phone
___ Sitting in recliner
___ Sleeping

Other: Please list any other difficulties you are experiencing with activities you have engaged in since your condition arose:

Signed_____ Date_____

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INFORMED CONSENT

Every type of health is associated with some risk of potential problem. This includes chiropractic health care and diagnostic testing. Generally, both are very safe. Thousands of people die every year from prescribed drug complication while only as handful of notable complications arise in the millions of people treated with chiropractic health care. We want you to be informed about the potential problems associated with chiropractic health care before consenting to treatment. This is called "**INFORMED CONSENT".**

Chiropractic adjustments (manipulations) are moving of bones with the physician's hands or an instrument. Frequently, adjustments make a "pop" or "click" sound sensation in the area being adjusted. In the office, we have trained staff personnel to assist the physician with portions of your consultation, examination, physical therapy application, exercise instruction, etc. Staff members are always under the direct supervision of the physician. Occasionally, when the physician is unavailable, another physician will treat patients.

STROKE: A stroke is the most serious problem associated with spinal manipulation. A stroke means that a portion of the brain does not receive oxygen from the bloodstream. The results are usually temporary (but can be permanent) dysfunction of the brain with an extremely rare complication of death. Spinal manipulations have been associated with strokes that arise from vertebral artery only; this is because the vertebral artery is found inside the neck vertebrae. This is called basilar stroke. In many of these cases the spinal manipulation that is related to vertebral artery stroke is called "extension-rotation-thrust atlas adjustment". This office does not perform this manipulation. Other types of neck manipulations may also potentially be related to vertebral artery stroke, but no one knows for certain. One study (journal of CCA, Volume37, June 1993 and other) estimated that the incident of this type of stroke is one per every 3 million upper neck manipulations. This means that an average chiropractor would have to be in practice for 1430 years before they statistically be associated with a single patient stroke. Less reliable surrey studied of neurologists between 1994 and 2000 estimated an incidence of 1 in 500,000 to 1 million. Dr. Saltalamachia routinely screens patients prior to cervical manipulation to minimize any risk any further.

DISC HERNIATION: Disc herniations that create pressure on the spinal nerve, or the spinal cord are frequently successfully treated by chiropractors and chiropractic manipulations, traction, etc. This includes both the neck and the back. Yet occasionally manipulations, traction, etc. will aggravate the problem and rarely surgery may become necessary for correction. Rarely chiropractic manipulations may also cause a disc problem; if the disc is in a weakened condition these problems occur so rarely that there are few available statistics to quantify their probability. A 2004 study (JMPT2004 (MAR);27(3)) estimated an incidence of disc herniation occurring in less than 1 in 3.7 million manipulations.

SOFT TISSUE INJURY: Soft tissue primarily refers to muscles and ligaments. Muscles move bones, and ligaments limit joint movement. Rarely a spinal manipulation, traction, etc. may tear some muscle or ligament fibers. The results are a temporary increase in pain and necessary treatments for resolution, but they are not long-term effects for the patient. These problems occur so rarely that there are no available statistics to quantify their probability.

RIB FRACTURES: The ribs are found only in thoracic spine or middle back. They extend from your back to your front chest area. Rarely a chiropractic manipulation will crack a rib, and this is referred to as a "fracture". This occurs primarily on patients that have weakened bones from such things as osteoporosis but can occur in perfectly well people. Osteoporosis may be noted on your x-rays if they are indicated. We adjust all patients very carefully, and especially those who have osteoporosis on their x-rays or DEXA scans or are likely to have undiagnosed osteoporosis by history. These problems occur so rarely that there are no available statistics to quantify their probability.

PHYSICAL THERAPY BURNS: Some of the machines we use generate heat. We also use both heat and ice and recommend them for home care on occasion. Everyone skin has sensitivity to these modalities, and rarely, either heat or ice can burn or irritate the skin. The result is a temporary increase in skin pain, and there may even be some blistering of the skin. We also occasionally use electrical modalities which may occasionally shock and/or burn the skin, long term complications are rare. The problems occur so rarely that there are no available statistics to quantify their probability.

SORENESS: It is common for patients to experience a temporary soreness or increase in soreness on the region being treated by manipulation, traction, etc. This is a normal physiological response while your body is undergoing therapeutic changes and is nearly always temporary, It is not dangerous, but let your physician know of your concerns.

HIP PROSTHESIS: Generally, a hip prosthesis is very stable. However, it is possible that the hip can dislocate during some maneuvers. This can typically be easily reduced but could result in surgery to repair. Older prostheses are more vulnerable. This happens very rarely, so no statistics are available to quantify their probability. The techniques used, further minimize the possibility of hip dislocation.

BREAST IMPLANTS: Most breast implants are exceptionally durable, but they can rupture, especially those that are over 10 years old. They typically rupture spontaneously, but it is possible that they could rupture during a manipulation. This could require surgical intervention. This happens very rarely, that no statistics are available.
The techniques used further minimize the possibility of implant rupture.

OTHR PROBLEMS: There may be other problems or complications that might arise from chiropractic health care or diagnostic testing other than those noted above. These other problems or complications occur so rarely that it is not possible to anticipate and/or explain them all in advance of care. If you have any further questions, always feel free to consult your physician.

Chiropractic medicine is a system of health care delivery: therefore, as with any other health care delivery system, we cannot promise a cure for any symptom, disease, or condition as a result of care in this office. We will always give you our best care, and if results are not acceptable, we will refer you to another physician/provider who we feel will assist your situation.

If you have any questions regarding the above, please ask the physician prior to signing. When you have a full understanding, please sign below, attesting that all questions have been answered to your satisfaction.

Signature: _____ **Date:** _____

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Patient Consent to Telehealth Services and Digital Correspondence

Telehealth services involve the use of electronic communications to enable health care providers to deliver health care services to patients using interactive video and audio communications. This document outlines the potential benefits and risks associated with telehealth services and confirms your consent to the use of telehealth services in your health care.

I understand the following:

1. The laws that protect the confidentiality of my personal information also apply to telehealth.
2. I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.
3. The same standard of care that would apply to an in-person visit also applies to telehealth.
4. My health care information may be shared with other individuals for scheduling and billing purposes.
5. There are certain risks associated with telehealth, including delays in treatment occurring due to deficiencies or failures of equipment, interruptions of service or other technical difficulties, or the breach of privacy of personal health information caused by failure of security protocols.
6. Certain technical failures may necessitate the rescheduling of my appointment or the continuation of my visit by alternative means.
7. I am responsible for any out-of-pocket costs such as copayments or coinsurances that apply to my telehealth visit, and I understand that health plan payment policies for telehealth visits may be different from policies for in-person visits.
8. This document will become a part of my health record.

I hereby give my informed consent for the use of telehealth services in my health care. I have personally read this form (or had it explained to me) and fully understand and agree to its contents. My questions about telehealth services have been answered to my satisfaction, and the risks, benefits, and alternatives to telehealth services have been shared with me in a language I understand. I am in and will remain in the state of **Florida** during my telehealth encounter(s).

_____	_____
Patient Signature	**Date**
_____	_____
Parent/Guardian Signature (if applicable)	**Date**
_____	_____
Witness Signature	**Date**

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P: 407.877.8707 *** F: 407.877.7464

Acknowledgement of Patient Digital Communication Correspondence

I hereby consent and state my preference to have Dr. Elyse Saltalamachia and staff of Lakota Wellness to communicate with me by email or standard SMS (text) messaging regarding various aspects of my medical care, which may include, but shall not be limited to, test results, supplementation, appointments, billing and past/present conditions.

I understand that email and standard SMS (text) messaging are not secure confidential methods of communication and may be insecure. I further understand that because of this there is a risk that email and SMS (text) standards regarding my medical care might be intercepted and read by a third party.

Signature: _____ **Date:** _____

Affirmation of Receipt of Patients Notice of Privacy Rights

I hereby acknowledge receipt of this offices Patient Notice of Privacy Rights provided on my behalf and in accordance with law and have read and understand my rights to privacy and security of personal health information as a patient of this practice.

Affirmed,

Signature: _____ **Date:** _____

Elyse Saltalamachia, D.C., DABCI
2910 Maguire Rd. Suite 1009
Ocoee FL 34761
P: 407.877.8707 *** F: 407.877.7464

HIPAA Acknowledgement and Authorization

I hereby authorize my insurance company or any other third-party payer to pay directly to Lakota Wellness for all charges submitted for services incurred by me. I understand that I will be responsible for all charges not paid by my insurance company or third-party payer. I authorize Lakota Wellness to release information concerning my chiropractic/medical condition to my insurance company, employer, attorney, or multiple health care providers who may be involved in the treatment directly or indirectly and hereby release this office of any consequence thereof. Furthermore, any risks regarding chiropractic treatment will be explained to me by request. I assign payment directly to Lakota Wellness which may cover in whole or part of the services that I have received. the authorization shall be valid until I notify Lakota Wellness in writing of a cancellation. A photocopy of the authorization shall be valid as the original copy.

I hereby acknowledge that I have read the HIPAA Privacy Policy and understand my rights contained in the notice. By way of my signature, I provide Lakota Wellness with my authorization and consent to use and disclose my protected chiropractic/medical care information for the purposes of treatment, payment and health care operations as described in the HIPAA Privacy Policy.

Signature: _____ **Date:** _____

Office Policy

There will be a **$50** fee for same day or short notice cancellations and missed appointments. There is no charge for cancellations that are made at least **24** business hours before the day of the scheduled appointment. **These fees are not covered by insurance carriers; I agree to be responsible for payment in full.** Payment in full is required before any future appointments can be scheduled. Patients with a chronic history of failed or broken appointments will have to call the day of to see if times are available since our office will no longer be able to reserve a appointment in advance for you. Our normal business hours are Monday thru Thursday 9:00am – 6:00pm, Friday 9:00am – 4:00p and Saturday 9:00am – 3:00pm. Our office is closed Sunday.

Signature: _____ **Date:** _____

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Insurance

In order to meet the needs of our patients, we have enrolled in various insurance programs. As you can imagine keeping up with all the individual requirements for each of the insurance companies can be practically impossible. Each program may have different requirements or stipulations that dictate which services can be provide and how often they can be provided. These rules can vary even in the same company with various programs being offered. At Lakota Wellness providing the highest quality in chiropractic/medical care to our patients in an atmosphere of genuine caring is our primary concern. It is possible that your insurance provider may **NOT** cover every service we provide in our office and in these cases, we will have no choice but to bill you for the services provided. It is not our sole responsibility to know every detail of your insurance company, so if we work together, both doing our parts and familiarizing ourselves with your specific policy, we can focus on what we do best – take care of you.

I understand that my insurance company may disallow and not pay fees related to certain procedures and services that I may receive at this office. If these are disallowed, I understand that I am responsible for payment. I understand that I am also responsible for any balance this is not paid by my insurance company after 30 days.

Signature: _____ **Date:** _____

Assignment of Benefits

I hereby instruct and direct my insurance company to pay by check make out and mailed directly to this office for medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges or professional services rendered by this office. If in the event my current policy prohibits direct payment to doctor, then I hereby also authorize and direct you to pay directly to:

Lakota Wellness 2910 Maguire Rd. Suite 1009 Ocoee FL 34761

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

Signature: _____ **Date:** _____

This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay in a current manner and balance of said professional service charges over and above this insurance payment.

Elyse Saltalamachia, D.C., DABCI
2910 Maguire Rd. Suite 1009
Ocoee FL 34761
P: 407.877.8707 *** F: 407.877.7464

Release of Information

I authorize this office to release any information pertinent to my case to any insurance company, adjuster, and attorney involved in this case and hereby release this office of any consequence thereof. I understand that if the Lakota Wellness accepts me as a patient that I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risks regarding chiropractic/medical treatment will be explained to me upon my request.

Signature: _____ **Date:** _____

Financial Responsibility

I agree to be financially responsible for all charges incurred at this office including my insurance deductibles, copayments and any services or balance **NOT** covered by my insurance company. I also acknowledge, understand and agree that any purchase of supplements at Lakota Wellness is non-refundable and cannot be returned.

Signature: _____ **Date:** _____

Waiver of X-rays

I understand that should I require X-rays per Dr. Saltalamachia recommendation I shall be referred to a free-standing facility where X-ray can be performed. I understand that X-rays are not performed at Lakota Wellness and agree to treat my present problem (illness) to the best ability by Dr. Saltalamachia without the complete analysis of an X-ray.

Should any untoward effects develop or any further illness or injury develop directly or indirectly as a result of such treatment, I shall assume full responsibility and in consideration of Dr. Saltalamachia treating me at my request without the benefit of a complete X-ray study and analysis, I do hereby release Dr. Saltalamachia from all causes of action, damages and liabilities arising by reason of said treatment, whether now or here after occurring, and whether now known or unknown between the parties hereto.

Signature: _____ **Executed this Date:** _____

Witness: _____

Elyse Saltalamachia, D.C., DABCI
2910 Maguire Rd. Suite 1009
Ocoee FL 34761
P: 407.877.8707 *** F: 407.877.7464

Records Release Authorization

Should you have records that we may need to request, please fill out this form and sign

Clinic Name: _____
Clinic Address: _____
Clinic Phone#: _____
Clinic Fax#: _____

Patient Name: _____
Date of Birth: _____
Date of Service: _____

I Name: _____ hereby authorize the release of a copy of my complete medical records, X-rays, MRIs, CT Scans, Test Results Doctor Notes, Prescription History, and/or ER Records to **Lakota Wellness**.
This authorization is given pursuant to Florida Statute 456.057 and HIPAA Regulations. I hereby understand that any third party to whom records are disclosed is prohibited from further disclosing any information in the medical record without the expressed written consent of the patient or the patient's legal representative.

Signature: _____ **Date:** _____