Kenneth M. Kozlowski, D.C., P.A.
4200 4th Street North
St. Petersburg, FL 33703
727-823-7308

PATIENT CASE RECORD

PLEASE ANSWER ALL QUESTIONS AS ACCURATELY AS POSSIBLE

DATE_____

FOR OFFICE USE ONLY
#_____
BY:_____
INS:_____

NAME_____ **AGE:**_____

ADDRESS_____ CITY:_____ STATE:_____ ZIP:_____

TELEPHONE NO:_____ CELL NO:_____

BIRTHDATE:_____ **SEX:** M F MARITAL STATUS: S M D W

E-MAIL:_____ **SOCIAL SECURITY NO.**_____

EMPLOYER:_____ ADDRESS:_____

EMPLOYER'S TELEPHONE NO:_____ JOB TITLE:_____

NAME OF SPOUSE:_____ NO. OF CHILDREN_____

SPOUSE'S EMPLOYER:_____ ADDRESS:_____

DATE OF ACCIDENT:_____

Are the Symptoms: **A)** Improving **B)** Getting Worse **C)** About the same **D)** Intermittent *(come and go)*

Date Symptoms Appeared:_____

Which activities aggravate your condition? **A)** Standing **B)** Walking **C)** Sitting **D)** Lying **E)** Bending **F)** Lifting **G)** Twisting **H)** Coughing

Have you had any prior chiropractic treatment? *(Please Describe)*

_____
_____
_____

Current medical doctor

_____
_____
_____

Past Illnesses and dates

_____
_____
_____

Present Medications *(prescription & non-prescription)*

_____
_____
_____

Previous X-rays of areas injured:_____

_____

Previous operations and dates

1._____
2._____
3._____

Nutritional Supplements

1._____
2._____
3._____

SYMPTOM SURVEY

12) GENERAL SYMPTOMS: (Circle as many as apply)

A) Nervousness B) Irritability C) Fatigue D) Depression
E) Loss of Sleep F) Tension G) PMS H) Jaw Pain

13) HEAD: (Circle as many as apply)

A) Headache 1) Mild 2) Moderate 3) Severe
How often: (1 2 3 4 5 6) Per (Day / Wk. / Mo.)
Are they: 1) Sharp 2) Dull
Are they: 1) Constant 2) Intermittent
Where located: 1) Back of head 2) Forehead 3) Temples
4) Right Side 5) Left Side 6) Behind Eyes
B) Light Headed C) Memory Loss D) Fainting
E) Blurred Vision F) Double Vision G) Sensitivity to Light
H) Loss of Balance I) Hearing Loss J) Ringing in Ears

14) NECK: (Circle as many as apply)

A) Pain 1) Left Side 2) Right Side 3) Both
Pain Level: 1) Mild 2) Moderate 3) Severe
Pain Increased by: 1) Forward Movement 2) Backward Movement
3) Rotate head left 4) Rotate head right
5) Bend neck left 6) Bend neck right
B) Stiffness C) Muscle Spasm D) Grinding/Grating Sounds

15) SHOULDERS: (Circle as many as apply)

A) Pain in Joint	1) Left	2) Right	3) Both
B) Pain Across Shoulder	1) Left	2) Right	3) Both
C) Limitation of Movement	1) Left	2) Right	3) Both
D) Tension	1) Left	2) Right	3) Both

16) ARMS: (Circle as many as apply)

A) Pain in Upper Arm	1) Left	2) Right	3) Both
B) Pain in Elbow	1) Left	2) Right	3) Both
C) Pain in Forearm	1) Left	2) Right	3) Both
D) Pins & Needle in Arm	1) Left	2) Right	3) Both
E) Pins & Needles in Forearm	1) Left	2) Right	3) Both
F) Numbness in Arm	1) Left	2) Right	3) Both
G) Numbness in Forearm	1) Left	2) Right	3) Both

17) HANDS: (Circle as many as apply)

A) Pain in Wrist	1) Left	2) Right	3) Both
B) Pain in Hand	1) Left	2) Right	3) Both
C) Pins & Needles in Hand	1) Left	2) Right	3) Both
D) Numbness in Hand	1) Left	2) Right	3) Both

18) MIDBACK: (Circle as many as apply)

A) Pain	1) Left	2) Right	3) Both
Pain Level:	1) Mild	2) Moderate	3) Severe
Pain Type:	1) Sharp/Stabbing		3) Dull Ache
B) Muscle Spasm	1) Left	2) Right	3) Both

19) CHEST: (Circle as many as apply)

A) Deep Chest Pain	1) Left	2) Right	3) Both
Pain Level	1) Mild	2) Moderate	3) Severe
C) Pain around Ribs	1) Left	2) Right	3) Both
D) Shortness of Breath	D) Irregular Heartbeat		

20) ABDOMINAL SYMPTOMS: (Circle as many as apply)

A) Pain	1) Mild	2) Moderate	3) Severe
B) Nervous Stomach	C) Nausea	D) Gas	
E) Constipation	F) Diarrhea	G) Heartburn	
H) Indigestion	I) Loss of Appetite		

21) LOWBACK: (Circle as many as apply)

A) Upper Lumbar Pain	1) Left	2) Right	3) Both*
B) Lower Lumbar Pain	1) Left	2) Right	3) Both*
C) Sacroiliac Pain	1) Left	2) Right	3) Both*
D) Muscle Spasm	1) Left	2) Right	3) Both
*Lowback Pain Level:	1) Left	2) Moderate	3) Severe

22) HIPS AND LEGS: (Circle many as apply)

A) Pain in Buttocks	1) Left	2) Right	3) Both
Pain Level:	1) Left	2) Moderate	3) Severe
B) Pain in Hip Joint	1) Left	2) Right	3) Both
Pain Level:	1) Left	2) Moderate	3) Severe
C) Pain Down Leg	1) Left	2) Right	3) Both
Location:	1) Front	2) Back	3) Side
Pain Radiates to:	1) Knee	2) Calf	3) Foot
D) Numbness Down Leg	1) Left	2) Right	3) Both
Location:	1) Front	2) Back	3) Side
E) Pins & Needles in Legs	1) Left	2) Right	3) Both
Location:	1) Front	2) Back	3) Side
F) Knee Pain Leg	1) Left	2) Right	3) Both
G) Cramps	1) Left	2) Right	3) Both

23) FEET: (Circle as many as apply)

A) Ankle Pain	1) Left	2) Right	3) Both
B) Swollen Ankle	1) Left	2) Right	3) Both
C) Foot Pain	1) Left	2) Right	3) Both
D) Numbness of Feet	1) Left	2) Right	3) Both
E) Swollen Feet	1) Left	2) Right	3) Both
F) Cramps	1) Left	2) Right	3) Both

CHECK THE FOLLOWING WHICH YOU HAVE HAD AND UNDERLINE ANY YOU HAVE NOW

GASTRO-INTESTIONAL
_____ Constipation
_____ Diarrhea
_____ Digestive Problems
_____ Stomach Pain
_____ Vomiting of Blood
_____ Gall Bladder Trouble
_____ Hemorrhorids
_____ Liver Trouble

SKIN
_____ Bruising
_____ Boils
_____ Dryness

GENIO-URINARY
_____ Frequent Urination
_____ Painful Urination
_____ Difficulty Starting Urine
_____ Inability Control Urine
_____ Blood in Urine
_____ Bed Wetting
_____ Kidney Infection
_____ Prostate Trouble

MUSCLES & JOINTS
_____ Foot Problems
_____ Swollen Joints
_____ Hernia

CARDIO VASCULAR
_____ High Blood Pressure
_____ Low Blood Pressure
_____ Previous Heart Trouble
_____ Previous Stroke

FOR WOMEN ONLY
_____ Cramps - Backache
_____ Excessive Flow
_____ Hot Flashes
_____ Irregular Cycles
_____ Pain Intercourse
_____ Pain Menstruation
_____ Vaginal Discharge

RESPIRATORY
_____ Chest Pains
_____ Chronic Cough
_____ Difficulty Breathing
_____ Frequent Colds
_____ Spitting of Blood
_____ Allergies

GENERAL
_____ Weight Loss
_____ Nervousness
_____ Emotional Problems
_____ Diabetes

EYES-EARS-NOSE
_____ Eye Pains
_____ Earaches
_____ Ear Discharge
_____ Ringing in Ears
_____ Nasal Discharge
_____ Nose Bleeds
_____ Sinus Trouble
_____ Difficult Swallowing
_____ Hoarseness
_____ Asthma

DATE OF LAST:

_____ Spinal Exam _____ Blood Test _____ Physical Exam _____ Chest X-ray

_____ Spinal X-ray _____ Urine Test _____ Dental X-ray _____ Eye Exam

KENNETH M KOZLOWSKI, DC, PA

POWER OF ATTORNEY, MEDICAL RELEASE, ASSIGNMENT OF BENEFITS

POWER OF ATTORNEY TO ENDORSE CHECKS AND/OR TO SIGN ANY PIECE OF PAPER WHICH WILL ENHANCE OR EXPEDITE PAYMENT TO PROVIDER FOR SERVICES RENDERED, INCLUDING BUT NOT LIMITED TO A RELEASE OF MEDICAL RECORDS AND ASSIGNMENT OF BENEFITS/AUTHORIZATION TO PAY.

Know by all these present that: The undersigned has made, constituted and appointed, and by these presents does hereby make, constitute and appoint Kenneth M Kozlowski, DC, PA and any of his duly authorized agents and employees as and to be the undersigned's true and lawful attorney for and in the undersigned's name, place and stead to endorse any and all checks, drafts or money orders are made payable for services which have been made by Kenneth M Kozlowski, DC, PA, at the request or with the knowledge and approval of the undersigned and/or the maker of the check, draft, or money order.

Furthermore, the undersigned allows Kenneth M Kozlowski, DC, PA or any of his agents to sign any paper that will be necessary to enhance, expedite and/or allow payment to said provider. This may include affidavits of non-ownership of vehicles, insurance forms and other statements.

The undersigned by these presents does give and grant the said Kenneth M Kozlowski, DC, PA as attorney the full power and authority to do and perform all and every act whatsoever requisite and necessary to be done in and about the premises as fully to all intents and purposes as the undersigned might or cold do to personally present insofar as the endorsing and cashing of said checks are concerned as well as any other document.

MEDICAL RELEASE

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

The undersigned does hereby ratify and confirm any and all actions taken by the said attorney in accordance with this special power and which the said attorney shall do or cause to be done by virtue of these presents.

ASSIGNMENT OF BENEFITS

I, _____ hereby authorize my insurance company to
(Name of Insured/Patient)
make medical benefits payments otherwise payable to me for services rendered by Kenneth M Kozlowski, DC, PA but not to exceed the charges of those services, payable to and mailed directly to:

Kenneth M Kozlowski, DC, PA
4200 4th Street N.
St. Petersburg, FL 33703

Furthermore, I hereby IRREVOCABLY ASSIGN to Kenneth M Kozlowski, DC, PA the rights and benefits under any policy of insurance, indemnity agreement, or any other collateral source as defined in Florida Statutes for any service and/or charges provided by Kenneth M Kozlowski, DC, PA.

IN WITNESS WHEREOF the undersigned has hereunto set their hands,

this _____ day of _____, 20_____.

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

KENNETH M. KOZLOWSKI, D.C., P.A.

4200 4th Street North
St. Petersburg, FL 33703
Telephone (727) 823-7308
Fax (727) 521-0237

PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Restrictions
Please tell us with whom we **may not discuss your protected health information**
(Ex. ex-spouse (name), in-laws (name(s), children (name(s).

_____

_____

Please tell us with whom we **may discuss your protected health information**
(Ex. spouse (name), children (name(s), friend, relatives, or caregivers (names).

_____

_____

**Non-sensitive messages or appointment reminders:
May we leave a message at your home using practitioner's/practice's name? Yes { } No { }
May we leave a message at your work using practitioner's /practice's name? Yes { } No { }
May we send practice information, and or patient appreciation communications? Yes { } No { }

I understand that protected health information may be disclosed or used for the treatment, payment, or health care operations. I consent to such disclosers as permitted by law.

I fully understand and accept / decline (please circle one) the information of this Consent.

_____ Date_____
Patient/Guardian Signature

_____
Print Name of Person Signing

If someone other than the patient is signing, are you the legal guardian Yes { } No { }

KENNETH M. KOZLOWSKI, D.C., P.A.

4200 4th Street North
St. Petersburg, FL 33703
Telephone (727) 823-7308
Fax (727) 521-0237

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

By checking the lines below, I authorize being contacted for appointment reminders by (**check all that apply**):

Mail: _____
~~Email: _____ at email address~~
_____
Telephone numbers: _____
_____
By voicemail: _____
~~By text message: _____~~
~~By Facebook address~~: _____

By checking the lines below, I authorize being contacted for birthday greetings or promotions about the practice by (**check all that apply**):
Mail: _____
~~Email: _____ at email address~~
_____
Telephone numbers: _____
_____
By voicemail: _____
~~By text message: _____~~
~~By Facebook address~~: _____

By checking the lines below, I authorize the doctor to personally discuss with me products that may benefit my health or condition. _____

_____ _____
Patient name (please print) Date

_____
Signature of Patient, Guardian or Patient's legal representative

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.

List below the names and relationships of people to whom you authorize the Practice to release PHI.

_____ _____

_____ _____

_____ _____

KENNETH M. KOZLOWSKI, D.C., P.A.

4200 - 4th Street North, St. Petersburg, FL 33703

Electronic Health Records Intake Form

This form complies with CMS EHR incentive program requirements

Name:_____

Email address: _____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ **Gender:** Male / Female **Preferred Language:** English / other: _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Smoking Start Date: _____

Family Medical History ***(Record one diagnosis in your family history and the affected relative)***						
Diagnosis:	Father	Mother	Brother	Sister	Son	Daughter
Heart Disease						
Stroke						
Diabetes						
Cancer						
High Blood Pressure/Hypertension						

Race (Circle one): American Indian or Alaska Native / *Asian* / Black or African American / *White (Caucasian)* / Native Hawaiian or Pacific Islander / *I Decline to Answer*

Ethnicity (Circle one): Hispanic or Latino / *Not Hispanic or Latino* / I Decline to Answer

Are you currently taking any medications? *(Include regularly used over the counter medications)*	
Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?			
Medication Name	Reaction	Onset Date	Additional Comments

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

Patient Signature: _____ ***Date:*** _____

For office use only

Height: _____ Weight: _____ Blood Pressure: _____ / _____ Pulse: _____

Patient's Name_____ Number_____ Date_____

NECK DISABILITY INDEX

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 very mild at the moment.
☐ The pain is moderate at the moment.
☐ The pain is fairly severe at the moment.
☐ The pain is very severe at the moment.
☐ The pain is the worst imaginable at the moment.

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

☐ I can look after myself normally 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 gives extra pain.
☐ Pain prevents me from lifting heavy weights off the floor, but I can manage 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.
☐ I can't read as much as I want because of moderate pain in my neck.
☐ I can hardly read at all 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 slight headaches which come frequently.
☐ I have moderate headaches which come infrequently.
☐ I have severe headaches which come frequently.
☐ I have headaches almost all the time.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered a significant activities of daily living disability.
(Score___ x 2) / (____Sections x 10) = _____ %ADL_____

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 can't do any work at all.

Section 8 – Driving

☐ I drive my car without any 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 can't 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 can't 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 moderately disturbed (1-2 hrs. sleepless).
☐ My sleep is moderately disturbed (2-3 hrs. sleepless).
☐ My sleep is greatly disturbed (3-4 hrs. sleepless).
☐ My sleep is completely disturbed (5-7 hrs. sleepless).

Section 10 – Recreation

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

Comments_____ %ADL

Reference: Vernon, Mior. JMPT 1991; 14(7): 409-15

Patient's Name_____ Number_____ Date_____

LOW BACK DISABILITY QUESTIONNAIRE (REVISED OSWESTRY)

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

☐ I can tolerate the pain without having to use painkillers.
☐ The pain is bad but I can manage without taking painkillers.
☐ Painkillers give complete relief from pain.
☐ Painkillers give moderate relief from pain.
☐ Painkillers give very little relief from pain.
☐ Painkillers have no effect on the pain and I do not use them.

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

☐ I can look after myself normally 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 gives extra pain.
☐ Pain prevents me from lifting heavy weights off the floor, but I can manage 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 – Walking

☐ Pain does not prevent me from walking any distance.
☐ Pain prevents me from walking more than one mile.
☐ Pain prevents me from walking more than one-half mile.
☐ Pain prevents me from walking more than one-quarter mile
☐ I can only walk using a stick or crutches.
☐ I am in bed most of the time and have to crawl to the toilet.

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.
☐ Pain prevents me from sitting almost all the time.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered significant activities of daily living disability.
(Score___ x 2) / (____Sections x 10) = _____ %ADL

Section 6 – Standing

☐ I can stand as long as I want without extra pain.
☐ I can stand as long as I want but it gives extra pain.
☐ Pain prevents me from standing more than 1 hour.
☐ Pain prevents me from standing more than 30 minutes.
☐ Pain prevents me from standing more than 10 minutes.
☐ Pain prevents me from standing at all.

Section 7 -- Sleeping

☐ Pain does not prevent me from sleeping well.
☐ I can sleep well only by using tablets.
☐ Even when I take tablets I have less than 6 hours sleep.
☐ Even when I take tablets I have less than 4 hours sleep.
☐ Even when I take tablets I have less than 2 hours sleep.
☐ Pain prevents me from sleeping at all.

Section 8 – Social Life

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

Section 9 – Traveling

☐ I can travel anywhere without extra pain.
☐ I can travel anywhere but it gives me extra pain.
☐ Pain is bad but I manage journeys over 2 hours.
☐ Pain is bad but I manage journeys less than 1 hour.
☐ Pain restricts me to short necessary journeys under 30 minutes.
☐ Pain prevents me from traveling except to the doctor or hospital.

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 nor worse.
☐ My pain is gradually worsening.
☐ My pain is rapidly worsening.

Comments_____

Reference: Fairbank, Physiotherapy 1981; 66(8): 271-3, Hudson-Cook. In Roland, Jenner (eds.), Back Pain New Approaches To Rehabilitation & Education. Manchester Univ Press, Manchester 1989: 187-204

KENNETH M. KOZLOWSKI, D.C., P.A.

4200 4th Street North
St. Petersburg, FL 33703
Telephone (727) 823-7308
Fax (727) 521-0237

Informed Consent for Chiropractic Treatment

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by Dr. Kenneth Kozlowski (doctor of chiropractic) and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed above or any other office or clinic.

I have had an opportunity to discuss with Dr. Kenneth Kozlowski (doctor of chiropractic) and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature_____ Date _____

Witness Signature _____ Date_____

KENNETH M. KOZLOWSKI, D.C., P.A.

4200 4th Street North
St. Petersburg, FL 33703
Telephone (727) 823-7308
Fax (727) 521-0237

COVID-19 Treatment Consent Form

Due to the desire to halt the spread of the COVID-19 virus, it has been ordered and directed that there be a temporary suspension of all elective procedures that can be delayed without undue risk to the patient as determined by you treating physician.

I hereby acknowledge and understand that there may be an increased risk that COVID-19 may be transmitted in any place of public accommodation, which includes my physician's office. I have been informed by my physician of their desire to protect their patients, staff and the community at large.

As a prerequisite to obtaining the treatment proposed, I am confirming that I have none of the current commonly known symptoms of COVID-19 (fever, cough, shortness of breath, sore throat, loss of taste and/or smell sensation) and that I have not traveled by airplane or cruise ship, in the past 14 days. Further, I have been practicing all current CDC guidelines with respect to "social distancing" and have NOT been in contact with a person who has a positive test for COVID-19 or suspected to be positive.

I hereby consent to the treatment proposed by my physician.

Patient Name: _____

Patient Signature: _____

Date: _____

Physician Name: Dr. Kenneth M. Kozlowski, DC

Physician Signature: _____

Date: _____

KENNETH M. KOZLOWSKI, D.C., P.A.

4200 4th Street North
St. Petersburg, FL 33703
Telephone (727) 823-7308
Fax (727) 521-0237

Form Fee Sheet

The completion of informational/insurance form represents an administrative service to our patients above and beyond the provision of medical care. Recent changes in health care have resulted in tremendous increase in the volume of information requests to our practice. The time and effort involved in providing this detailed information results in significant costs. The refusal of insurance companies and requesting agencies to cover the costs requires us to institute a policy of charges (effective August 15, 2019) for the completion of the forms as follows:

No Charge:

- Worker's Compensation requested Disability & Work Status forms
- Auto Insurance Carrier requests for Work Status & Treatment Plans
- School Educational Disability or Limitation Forms

$20.00:

- Disabled Parking Applications

$50.00:

- Credit Card Deferment Forms
- Private Disability Insurance Forms
- Family Medical Leave Act (FMLA) forms

$50-$200:

- For any narrative report detailing diagnosis, treatment, and future medical care.
- For completion of any letter describing medical care and limitations.

_____ _____ _____

Patient Name (Print) Signature Date

KENNETH M. KOZLOWSKI, D.C., P.A.

4200 4th Street North
St. Petersburg, FL 33703
Telephone (727) 823-7308
Fax (727) 521-0237

Office and Financial Policy

We have found that a clear agreement on finances BEFORE treatment begins results in fewer misunderstandings. With that in mind, we have carefully developed the following financial information. At the end of this document, you will be asked to sign an agreement and understanding of this document. You will be provided a copy for your records if requested. Please notify us if you have a change in address, phone number, or insurance.

APPOINTMENTS AND CANCELLATIONS:
Missed appointments are a loss for everyone! Please understand that when an appointment is made, that time is reserved especially for you. If your appointment is broken or cancelled less than 24 hours prior to the appointment time, we find it necessary to **charge a fee equal to the fee allotted to that appointment time**. It is your responsibility to keep or cancel your appointment, whether or not we are able to contact you for confirmation. We will be unable to reschedule appointments if you have three or more broken appointments, without the proper notice.

INSURANCE:
We will gladly file your insurance claim for you, and accept assignment of benefits. However, if the insurance company does not pay after **30 days**, it will be **your** responsibility to pay **Kenneth M. Kozlowski, DC, PA** for all services rendered on your behalf.

PAYMENT:
We accept cash, personal checks, and all major credit cards at this time.

PAYMENT ARRANGEMENTS:
All services are **PAYABLE IN FULL AT TIME OF TREATMENT,** unless other arrangements are made in advance.

CONCERNING INSURANCE:
Insurance coverage is a CONTRACT BETWEEN THE PATIENT AND THE INSURANCE CARRIER. It is a benefit to the patient and should be considered only an adjunct to chiropractic treatment. It does NOT and never was INTENDED to pay for all of your chiropractic treatment. As a convenience to our patients, we will file your insurance claims with your carrier. We will determine, to the best of our ability, from your insurance company the amount of coverage for your procedure. You will be responsible for payment of your co-insurance and deductible amount. This may be collected at time of service if known or billed once insurance company makes their determination.

OTHER CHARGES:
There is a $35.00 charge for all returned checks.

Should your account be turned over to our collection agency for non-payment, the patient is responsible for all collection / attorney fees incurred by **Kenneth Kozlowski, DC, PA**.

I have read, understand and agree with the above information.

_____	_____	_____
Patient / Responsible Party	Witness	Date