

**Advanced Injury & Rehab**  
**830 E. Hwy. 434, Suite 1, Longwood, FL 32750**  
**Phone 407-767-5700 \* Fax 407-339-7204**

**Terms of Acceptance**

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

**ADJUSTMENT:** An adjustment is the specific application of force to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

**HEALTH:** A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

**VERTEBRAL SUBLUXATION:** A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, \_\_\_\_\_, have read and fully understand the above statements.

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

I therefore accept chiropractic care on this basis.

Signature \_\_\_\_\_ Date \_\_\_\_\_

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**Payment Policy**

There are two forms of payment accepted by FCCF:

CASH each time you come in

or

INSURANCE ASSIGNMENT – copay, insurance reimbursement signed over to our clinic (as explained below).

PLEASE CHECK HOW YOU WISH TO PAY:

CASH \_\_\_\_\_ CHECK \_\_\_\_\_ CREDIT CARD \_\_\_\_\_

INSURANCE ASSIGNMENT PROGRAM

It is our desire to assist our patients whenever possible. The following insurance assignment program allows you, our patient, to receive the care you need without undue financial strain.

1. Waiting for insurance payment is a courtesy provided by this clinic. We reserve the right to withdraw this courtesy at any time. We will bill your insurance company and accept assignment of benefits during your corrective care period. Direct assignment will be discontinued when you have finished corrective care and a supportive health care program is recommended. We will notify you of the change.
2. All deductible amounts must be paid by you in advance of the first billing. Also, you must stay current with your percentage of responsibility (usually 20%). This must be paid at least weekly. Prepayments may also be made.
3. The insurance carriers are billed on specific 15-30 day cycles. It is your responsibility to supply this office with necessary forms to complete billing if needed.
4. If you receive payment from your insurance carrier during the period which the clinic has accepted assignment of benefits, you are to bring the check into this office within three days of receipt and endorse it over to the clinic. Failure to do this may result in collection action.
5. If you discontinue your care for any reason other than discharge by the doctor, you will be responsible for any unpaid balance, regardless of any claims submitted to your insurance company, at the time you discontinue care.
6. This clinic does not promise that an insurance company will pay. In the event that the insurance company disputes or rejects the claim, it will be the patient's responsibility to pay all the charges and pursue reimbursement from the insurance company on his/her own. The insurance company has 30 days from billing date to make this decision. Patient payment is expected on any fees over 30 days old.

I have read the above provisions and wish to participate in the insurance assignment program. I hereby agree to abide by the provisions as specified above.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

# URSHAN FAMILY CHIROPRACTIC

DR. JONATHAN URSHAN, D.C.  
830 EAST STATE ROAD 434, SUITE 1 - LONGWOOD, FL 32750  
PHONE : (407) 767-5700 - FAX : (407) 339-7204

Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Referred by: \_\_\_\_\_

Patient Name: First \_\_\_\_\_ Mi \_\_\_\_\_ Last \_\_\_\_\_

Parent/Guardian's Name (if patient is a minor): First \_\_\_\_\_ Last \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone #(\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone #(\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ E-mail: \_\_\_\_\_

Work Phone #(\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_ Female \_\_\_\_ Male \_\_\_\_ Social Security # \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Status: Minor \_\_\_\_ Single \_\_\_\_ Married \_\_\_\_ Divorced \_\_\_\_ Widowed \_\_\_\_ Separated \_\_\_\_

Chief Complaint or Reason for today's visit: \_\_\_\_\_

How long have you had this condition? \_\_\_\_\_ Date of Onset: \_\_\_\_/\_\_\_\_/\_\_\_\_

Have you had this condition before? Yes \_\_\_\_ No \_\_\_\_ If yes, when? \_\_\_\_\_

What doctors have you seen for this condition? \_\_\_\_\_

What did they do? \_\_\_\_\_

What surgeries have you had? \_\_\_\_\_

List drugs you now take (prescription and non-prescription): \_\_\_\_\_

Is this Injury/Illness due to: 1. Auto Accident Date of Accident: \_\_\_\_/\_\_\_\_/\_\_\_\_

2. Work Injury Date of Injury: \_\_\_\_/\_\_\_\_/\_\_\_\_

3. Other Injury/Illness Date Symptoms Appeared: \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient Resides With: Alone \_\_\_\_ Spouse \_\_\_\_ Parents \_\_\_\_ Children \_\_\_\_ Other \_\_\_\_\_

Do you own a vehicle? Yes \_\_\_\_ No \_\_\_\_ Any household family members that own vehicles? Yes \_\_\_\_ No \_\_\_\_

## AUTO INSURANCE INFORMATION

**Complete if you were recently in an auto accident.**

Auto Insurance Co. Name: \_\_\_\_\_ Insurance Phone # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Claim Number: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Relation to Insured: \_\_\_\_\_

Attorney Name: \_\_\_\_\_ Phone Number (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Attorney Address: \_\_\_\_\_

## HEALTH INSURANCE INFORMATION

If you have Health Insurance, please present your insurance card and ID to front desk.

Health Insurance Name: \_\_\_\_\_ HMO \_\_\_ PPO \_\_\_

Health Ins. Address: \_\_\_\_\_

Health Ins. Phone # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Your ID # \_\_\_\_\_ Group # \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Relation to Insured: \_\_\_\_\_

### Please mark X for present conditions, O for past conditions

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Fractured Bones         | <input type="checkbox"/> Headaches                          | <input type="checkbox"/> Chest Pain              |
| <input type="checkbox"/> Auto Accidents          | <input type="checkbox"/> Pain/Stiff Neck R L                | <input type="checkbox"/> Asthma                  |
| <input type="checkbox"/> 0-1 year ago            | <input type="checkbox"/> Numbness, Tingling, Pain in        | <input type="checkbox"/> Lung Problems           |
| <input type="checkbox"/> 2-5 years ago           | Arms/Hands/Fingers R L                                      | <input type="checkbox"/> Difficulty Breathing    |
| <input type="checkbox"/> More than 5             | <input type="checkbox"/> Jaw Pain/TMJ R L                   | <input type="checkbox"/> Heart Problem           |
| <input type="checkbox"/> Other accidents & falls | <input type="checkbox"/> Head/Shoulders Feel Tired          | <input type="checkbox"/> Stroke                  |
| <input type="checkbox"/> Back Curvature          | <input type="checkbox"/> Difficulty in Excessive (Standing, | <input type="checkbox"/> High/Low Blood Pressure |
| <input type="checkbox"/> Arthritis               | Walking, Bending, Riding, Twisting                          | <input type="checkbox"/> Varicose Veins          |
| <input type="checkbox"/> Diabetes                | Lifting, Household Duties)                                  | <input type="checkbox"/> Liver Trouble           |
| <input type="checkbox"/> Swollen/Painful Joints  | <input type="checkbox"/> Shoulder Pain R L                  | <input type="checkbox"/> Gall Bladder Trouble    |
| <input type="checkbox"/> Convulsions, Epilepsy   | <input type="checkbox"/> Dizziness                          | <input type="checkbox"/> Digestive Problems      |
| <input type="checkbox"/> Skin Problems           | <input type="checkbox"/> Ringing in Ears R L                | <input type="checkbox"/> Heartburn               |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Hearing Loss R L                   | <input type="checkbox"/> Ulcers                  |
| <input type="checkbox"/> Frequent Colds/Flu      | <input type="checkbox"/> Fainting                           | <input type="checkbox"/> Diarrhea/Constipation   |
| <input type="checkbox"/> Depression              | <input type="checkbox"/> Loss of Balance                    | <input type="checkbox"/> Colon Trouble           |
| <input type="checkbox"/> Irritable               | <input type="checkbox"/> Blurred Vision R L                 | <input type="checkbox"/> Hemorrhoids             |
| <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Double Vision R L                  | <input type="checkbox"/> Prostate Problems       |
| <input type="checkbox"/> Tremors                 | <input type="checkbox"/> Upper Back Pain/Stiffness          | <input type="checkbox"/> Impotence               |
| <input type="checkbox"/> Allergies               | <input type="checkbox"/> Mid Back Pain/Stiffness            | <input type="checkbox"/> Kidney Trouble          |
| <input type="checkbox"/> Sinus Problems          | <input type="checkbox"/> Low Back Pain/Stiffness            | <input type="checkbox"/> Menstrual Problems/PMS  |
| <input type="checkbox"/> Eating Disorders        | <input type="checkbox"/> Numbness, Tingling or Pain in      | <input type="checkbox"/> Menopausal Problems     |
| <input type="checkbox"/> Trouble Sleeping        | buttocks, thighs, legs, feet, toes                          | <input type="checkbox"/> Pregnant (currently)    |
| <input type="checkbox"/> Trouble Concentrating   | <input type="checkbox"/> Pain with cough/sneeze             | <input type="checkbox"/> Bed Wetting             |
| <input type="checkbox"/> Learning Disability     | <input type="checkbox"/> Hip Pain R L                       | <input type="checkbox"/> Ear Infections          |
| <input type="checkbox"/> Mood Changes            | <input type="checkbox"/> Foot Trouble R L                   | <input type="checkbox"/> AIDS/HIV                |

For the provider only: Diagnosis Codes: 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_

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

Today's Date: \_\_\_\_\_

List your Pains/Complaints from Most Severe (1) to Least Severe (4)

	1.	2.	3.	4.
Today, I have the following physical complaints:	_____	_____	_____	_____
Is this Complaint Sharp, Dull, Achy, Throbbing, Numb, Shooting or Other (explain)?	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Achy <input type="checkbox"/> Throbbing <input type="checkbox"/> Numb <input type="checkbox"/> Electric / Shooting	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Achy <input type="checkbox"/> Throbbing <input type="checkbox"/> Numb <input type="checkbox"/> Electric / Shooting	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Achy <input type="checkbox"/> Throbbing <input type="checkbox"/> Numb <input type="checkbox"/> Electric / Shooting	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Achy <input type="checkbox"/> Throbbing <input type="checkbox"/> Numb <input type="checkbox"/> Electric / Shooting
How often do you feel this Complaint? Constant, Daily, "Off & On" or Weekly?	<input type="checkbox"/> Constant <input type="checkbox"/> Daily <input type="checkbox"/> Off & On <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other _____	<input type="checkbox"/> Constant <input type="checkbox"/> Daily <input type="checkbox"/> Off & On <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other _____	<input type="checkbox"/> Constant <input type="checkbox"/> Daily <input type="checkbox"/> Off & On <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other _____	<input type="checkbox"/> Constant <input type="checkbox"/> Daily <input type="checkbox"/> Off & On <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other _____
How long have you had this complaint?	_____	_____	_____	_____
Is it getting better, worse, or staying the same?	<input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> Same	<input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> Same	<input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> Same	<input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> Same
What makes it better?	_____	_____	_____	_____
What makes it worse?	_____	_____	_____	_____
On a scale of 1 to 10 Rate your discomfort.	<u>Circle one:</u> 10 9 8 7 6 5 4 3 2 1  10 = Excruciating 0 = No discomfort	<u>Circle one:</u> 10 9 8 7 6 5 4 3 2 1  10 = Excruciating 0 = No discomfort	<u>Circle one:</u> 10 9 8 7 6 5 4 3 2 1  10 = Excruciating 0 = No discomfort	<u>Circle one:</u> 10 9 8 7 6 5 4 3 2 1  10 = Excruciating 0 = No discomfort
How have you taken care of this in the past? How has it worked for you?	_____	_____	_____	_____
This issue is affecting my:	<input type="checkbox"/> Job <input type="checkbox"/> Childcare <input type="checkbox"/> Marriage <input type="checkbox"/> Sex <input type="checkbox"/> Golf <input type="checkbox"/> Finances <input type="checkbox"/> Playing with Kids <input type="checkbox"/> Bowels <input type="checkbox"/> Urine	<input type="checkbox"/> Job <input type="checkbox"/> Childcare <input type="checkbox"/> Marriage <input type="checkbox"/> Sex <input type="checkbox"/> Golf <input type="checkbox"/> Finances <input type="checkbox"/> Playing with Kids <input type="checkbox"/> Bowels <input type="checkbox"/> Urine	<input type="checkbox"/> Job <input type="checkbox"/> Childcare <input type="checkbox"/> Marriage <input type="checkbox"/> Sex <input type="checkbox"/> Golf <input type="checkbox"/> Finances <input type="checkbox"/> Playing with Kids <input type="checkbox"/> Bowels <input type="checkbox"/> Urine	<input type="checkbox"/> Job <input type="checkbox"/> Childcare <input type="checkbox"/> Marriage <input type="checkbox"/> Sex <input type="checkbox"/> Golf <input type="checkbox"/> Finances <input type="checkbox"/> Playing with Kids <input type="checkbox"/> Bowels <input type="checkbox"/> Urine
Helping this issue would increase my Quality of life by:	<input type="checkbox"/> 10-20% <input type="checkbox"/> 30-40% <input type="checkbox"/> 50-60% <input type="checkbox"/> 70-80% <input type="checkbox"/> 90% <input type="checkbox"/> 100%	<input type="checkbox"/> 10-20% <input type="checkbox"/> 30-40% <input type="checkbox"/> 50-60% <input type="checkbox"/> 70-80% <input type="checkbox"/> 90% <input type="checkbox"/> 100%	<input type="checkbox"/> 10-20% <input type="checkbox"/> 30-40% <input type="checkbox"/> 50-60% <input type="checkbox"/> 70-80% <input type="checkbox"/> 90% <input type="checkbox"/> 100%	<input type="checkbox"/> 10-20% <input type="checkbox"/> 30-40% <input type="checkbox"/> 50-60% <input type="checkbox"/> 70-80% <input type="checkbox"/> 90% <input type="checkbox"/> 100%