Dr. Barry W. Levitt, D.C., P.A.
Dr. Erick A. Daes, D.C., P.A.
8955 S.W. 87th Court
Miami, Florida 33176
305-233-5700 305-279-2222

PATIENT INFORMATION

(IF THIS IS RELATED TO AN AUTO ACCIDENT OR WORK INJURY PLEASE TELL THE FRONT DESK.)

NAME____ DATE_______________________________

ADDRESS__________________________________CITY_____________STATE_______ZIP___________

TELEPHONE__________________________ CELL______________________

E-MAIL____

Please print clearly email address..{Your email will not be shared with 3rd parties. It will be used to communicate with you from our office and to send periodic reminders, newsletters and information of interest}

BIRTHDATE__________________AGE_________SEX_______ STATUS---M S W D

HEIGHT___________ WEIGHT__________

OCCUPATION___________________________________EMPLOYER_____________________________

WORK TELEPHONE_____________________________

SPOUSE'S NAME____BIRTHDATE_____________________

SPOUSE'S EMPLOYER & PHONE____

NAMES & AGES OF CHILDREN____

NAME AND PHONE OF EMERGENCY CONTACT____

WHO MAY WE THANK FOR REFERRING YOU____

INSURANCE INFORMATION

NAME OF COMPANY____

INSURED NAME AND DATE OF BIRTH ____

GROUP #__________________________________ IDENTIFICATION #____________________________

*** PLEASE REMEMBER TO GIVE THE FRONT DESK A COPY OF YOUR INSURANCE CARD AND DRIVERS LICENSE**

Dr. Barry W. Levitt, D.C., P.A.
Dr. Erick A. Daes, D.C., P.A.
8955 S.W. 87th Court
Miami, Florida 33176
305-233-5700 305-279-2222

PATIENT HISTORY FORM

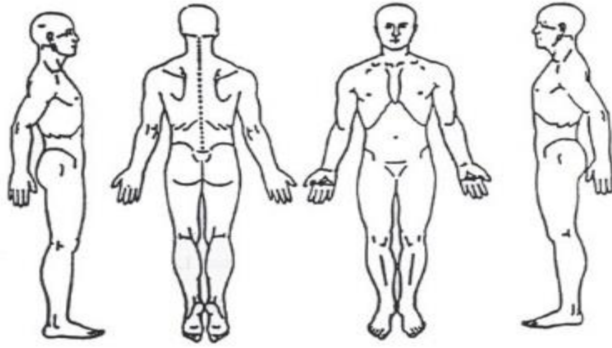
Patient's Name____ **Date**______________________

REASON(S) FOR VISIT

Please circle all that apply: Work, Sport, Auto Accident, Spinal Pain, Spinal Curvature correction (including Scoliosis), Headaches, Arm and/or Leg pain/sciatica, Back Pain, Muscle Spasms, Preventive Checkup/Care, Misaligned Vertebrae, "Slipped disc" [bulge or herniation], Loss of Strength or feeling in the arm/hand or thigh/leg.

When did the condition begin? ____
Explain what happened ____

How often do you experience your symptoms? Please check one:
Constantly ________(76-100% of the day) Frequently ________ (51-75% of the day)
Occasionally ______ (26-50% of the day) Intermittently ______ (0-25% of the day)
What describes the nature of your symptoms?
Sharp ______ Shooting ______ Dull Ache ______ Burning ______ Numb______ Tingling_____
Mark the appropriate symbol on the picture where you are having pain.
Aching ****** Stabbing ///////// Numbness --------- Burning XXXXXX Pins and Needles 000000



Indicate the average intensity of your symptoms: (least pain) 0 1 2 3 4 5 6 7 8 9 10 (severe pain)

How are your symptoms getting? Better_____ Worse_____ Not Changing_____

Has it interfered with your: Work_____ Sleep_____ Daily Routine_____ Recreation_____

Have you ever been treated by a medical physician for this condition? YES ___ NO ___

Have you ever been treated by a chiropractor? YES ___ NO ___

List all medical conditions: ____

List medications/birth control: ____

List major surgeries: ____

Do you have any allergies/asthma? YES ___ NO ___ If so, please list: ___________________________________

If female, are you pregnant? YES ___ NO ___ Date of last menstruation____________________

Do you smoke? YES ___ NO ___ How much__________________________

Do you use other substances? YES ___ NO ___

Do you consume alcohol? Never_____ Rarely_____ Occasionally_____ Frequently _____

Signature ____

Dr. Barry W. Levitt, D.C., P.A.
Dr. Erick A. Daes, D.C., P.A.
8955 S.W. 87th Court
Miami, Florida 33176
305-233-5700 305-279-2222

Medical History

Please Check and Describe Below any of the following you have had in the last 12 months and/or ever received treatment for:

MUSCULO-SKELETAL Describe Checked Item:

____Low Back Pain ____Pain Between Shoulders ____Neck Pain
____Joint Pain/Stiffness ____Walking Problems ____Arm Pain
____General Stiffness ____Difficult Chewing/Clicking Jaw

GENITO-URINARY

____Painful/Excessive Urination ____Discolored Urine ____Bladder Trouble

CARDIO-VASCULAR-RESPIRATORY

____Chest Pain ____Short Breath ____Blood Pressure Problems
____Irregular Heartbeat ____Heart Problems ____Lung Problems/Congestion
____Varicose Veins ____Ankle Swelling ____Stroke

NERVOUS SYSTEM

____Nervous ____Numbness ____Paralysis ____Dizziness
____Forgetfulness ____Confusion/Depression ____Fainting ____Convulsions
____Cold/Tingling Extremities ____Stress ____Hearing Difficulty

EYES, EARS, NOSE, THROAT

____Vision Problems ____Dental Problems ____Sore Throat
____Ear Aches ____Stuffed Nose

GENERAL

____Fatigues ____Allergies ____Headaches ____Fever

MALE/FEMALE

____Menstrual Irregularity ____Menstrual Cramps ____Vaginal Pain/Infection
____Breast Pain/Lumps ____Prostate/Sexual Dysfunction ____Other: ______________________________

GASTRO-INTESTINAL

____Poor/Excessive Appetite ____Excessive Thirst ____Frequent Nausea
____Vomiting ____Diarrhea ____Constipation
____Hemorrhoids ____Liver Problems ____Gall Bladder Problems
____Weight Trouble ____Abdominal Cramps ____Gas/Bloating after meals
____Heartburn ____Black/Bloody Stools ____Colitis

DESCRIBE ABOVE CHECKED ITEMS:

Symptom	**Date Last Experienced**	**Treatment Received**
________________	__________________________	_______________________________________
________________	__________________________	_______________________________________
________________	__________________________	_______________________________________
________________	__________________________	_______________________________________
________________	__________________________	_______________________________________

PATIENT NAME: ______________________________ Doctor Initials: ________
PATIENT SIGNATURE: ___________________________ Date: ________

Dr. Barry W. Levitt, D.C., P.A.
Dr. Erick A. Daes, D.C., P.A.
8955 S.W. 87th Court
Miami, Florida 33176
305-233-5700 305-279-2222

Automobile Accident History

Patient's Name ___________________________ **Today's Date**______________
Patient's Phone (____) _______________________
Date of Birth____________________ **Age** ____ **Height** _____ **Weight** _____**Sex**: M F
Where did the accident occur: City, State, Intersection _______________________________________
____
Date of Accident / Injury ______________________________
Number of people in your vehicle _____ **Number of people in other vehicle(s)** _______
1. Was the accident on the job? _____Yes _____ No
2. Where were you seated in the vehicle? ____Driver _____Front seat pass. _____Rea seat pass.
3. What direction were you headed? _____N _____S _____E _____W
What direction was the other car headed? _____N _____S _____E _____W
4. Your vehicle: Make__________________ Model___________________ Year__________
Estimated speed upon impact: _______ Stopped_______ Slowing______ Accelerating_______
If stopped, was your/driver's foot on the brake? _____ Yes ______No
5. Other vehicle: Make__________________ Model___________________ Year__________
Estimated speed upon impact: _______ Stopped_______ Slowing______ Accelerating_______
6. Road conditions at the time of the accident _______ Dry _______ Wet ______ Other
7. Time of day ___________ Daylight _____Dawn ______ Dusk ___________ Dark
8. Head restraints, seat backs
Was the headrest positioned properly _________Yes ________No
If adjustable, was the position of the headrest altered by the accident? _____ Yes ____No
Was the seatback adjustment altered by the accident? _____ Yes ______No
Was the seat broken? _____ Yes ______No
9. Seat belts and Air bags
Were you wearing a seat restraint? _____ Yes ______No _______ Don't know
What type? _____ Lap belt _____Shoulder seat belt _____Shoulder-lap seat belt
Did your airbag deploy? _____ Yes ______No
If yes, were you stuck? _____ Yes ______No Where? ______________________
10. Head and Body Position
Which way was your **body** pointed at the point of impact?
_____Straight ______ Right ______Left. Other (describe) ____________________________
Which way was your **head** pointed at the point of impact?
_____Straight ______ Right ______Left. Other (describe) ____________________________
11. During the Crash
Position of hands: _____ One on the wheel ______ Two on the wheel _______ N/A
Did you strike any part of the vehicle? _____ Yes ______No
If yes, please describe: ____
Did vehicle strike any objects after the crash? _____ Yes ______No
If yes, please describe: ____
Were you aware or surprised of the approaching collision? _______Aware _______Surprised
Did you lose consciousness (black out) upon impact? _____ No _____ Yes how long? ______
12. After the crash
Did you become _________confused ______disoriented _______light headed ______Dizzy
Are you suffering from ______restlessness ______irritable ______forgetful ______sleeplessness
Did the police come to the accident _____Yes _____No
Is there a report _____Yes _____No

Patient Name: ______________________________ **Date:** ______________

Dr. Barry W. Levitt, D.C., P.A.
Dr. Erick A. Daes, D.C., P.A.
8955 S.W. 87th Court
Miami, Florida 33176
305-233-5700 305-279-2222

13. Hospital
Did you go to the Hospital _______Yes _____No. How did you get there__________________
Name of Hospital____

14. Were you evaluated/x-rays/MRI/CAT scan, given medications, orthopedic supplies? Circle all that apply.
____

15. Are you? ______Right handed ______ Left handed

16. Since the accident, have your symptoms become _____Better_____Worse____Unchanged

17. Chief Complaints: ____

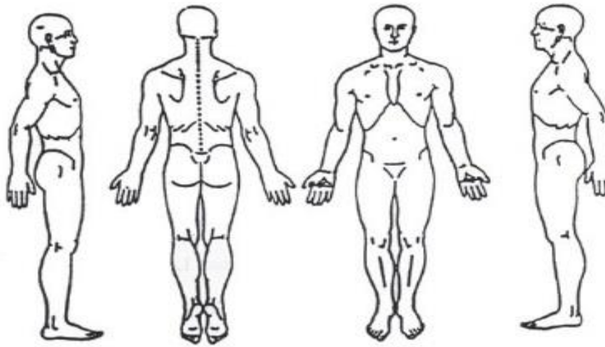
____

____

<u>Pain/Symptoms</u>:

Mark the areas of the body where you feel the described sensations. Use the appropriate symbols.

Aching	**Numbness**	**Needles**	**Burning**	**Stabbing**
*****	- - - - - -	//////	ooooo	xxxxx
*****	- - - - - -	//////	ooooo	xxxxx



Mark on the pain scales the degree of pain you feel from 0 to 10.

Neck-Shoulder-Arm Pain	**Mid Back Pain**	**Low Back and Leg Pain**
(______________________)	(______________________)	(______________________)
0 **10**	**0** **10**	**0** **10**
no pain severe pain	no pain severe pain	no pain severe pain

Patient Name: ______________________________ **Date:** ______________

Dr. Barry W. Levitt, D.C., P.A.
Dr. Erick A. Daes, D.C., P.A.
8955 S.W. 87th Court
Miami, Florida 33176
305-233-5700 305-279-2222

BOURNEMOUTH QUESTIONNAIRE FOR NECK PAIN:

The following scaled have been designed to find out about you Neck pain and how it is affecting you. Please answer ALL the scaled by **CIRCLING ONE** number on EACH scale that best described how you feel:

1. Over the past week, on average how would you rate your Neck pain?
No pain **0 1 2 3 4 5 6 7 8 9 10** Worst pain possible

2. Over the past week, how much has your Neck pain interfered with your daily activities (housework, washing, dressing, lifting, reading, driving)?
No interference **0 1 2 3 4 5 6 7 8 9 10** Unable to carry out activities
Please Describe: ____
____

3. Over the past week, how much has your Neck pain interfered with your ability to take part in recreational, social, and family activities?
No interference **0 1 2 3 4 5 6 7 8 9 10** Unable to carry out activities
Please Describe: ____
____

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/ relaxing) have you been feeling?
Not at all anxious **0 1 2 3 4 5 6 7 8 9 10** Extremely anxious

5. Over the past week, how depressed (down-in-the-dumps, sad, low in spirits, pessimistic, unhappy) have you been feeling?
Not at all depressed **0 1 2 3 4 5 6 7 8 9 10** Extremely depressed

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your Neck?
Made it no worse **0 1 2 3 4 5 6 7 8 9 10** Made it much worse
If worse, which activities? ____
____

7. Over the past week, how much have you been able to control (reduce/help) your Neck pain on your own?
Completely control it **0 1 2 3 4 5 6 7 8 9 10** No control whatsoever
What have you done? ____
____

Patient Name: ______________________________ **Date:** ______________

Dr. Barry W. Levitt, D.C., P.A.
Dr. Erick A. Daes, D.C., P.A.
8955 S.W. 87th Court
Miami, Florida 33176
305-233-5700 305-279-2222

BOURNEMOUTH QUESTIONNAIRE FOR LOW BACK PAIN:

The following scaled have been designed to find out about you Low Back pain and how it is affecting you. Please answer ALL the scaled by **CIRCLING ONE** number on EACH scale that best described how you feel:

1. Over the past week, on average how would you rate your Low Back pain?
No pain **0 1 2 3 4 5 6 7 8 9 10** Worst pain possible

2. Over the past week, how much has your Low Back pain interfered with your daily activities (housework, washing, dressing, lifting, reading, driving)?
No interference **0 1 2 3 4 5 6 7 8 9 10** Unable to carry out activities
Please Describe: ____
____

3. Over the past week, how much has your Low Back pain interfered with your ability to take part in recreational, social, and family activities?
No interference **0 1 2 3 4 5 6 7 8 9 10** Unable to carry out activities
Please Describe: ____
____

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/ relaxing) have you been feeling?
Not at all anxious **0 1 2 3 4 5 6 7 8 9 10** Extremely anxious

5. Over the past week, how depressed (down-in-the-dumps, sad, low in spirits, pessimistic, unhappy) have you been feeling?
Not at all depressed **0 1 2 3 4 5 6 7 8 9 10** Extremely depressed

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your Low Back?
Made it no worse **0 1 2 3 4 5 6 7 8 9 10** Made it much worse
If worse, which activities? ____
____

7. Over the past week, how much have you been able to control (reduce/help) your Low Back pain on your own?
Completely control it **0 1 2 3 4 5 6 7 8 9 10** No control whatsoever
What have you done? ____
____

Patient Name: ______________________________ **Date:** ______________

Dr. Barry W. Levitt, D.C., P.A.
Dr. Erick A. Daes, D.C., P.A.
8955 S.W. 87th Court
Miami, Florida 33176
305-233-5700 305-279-2222

The therapist in our office is performing the techniques described below to perform manual therapy, not traditional massage. Manual therapy is accomplished by hand or with use of instrument(s).

Manual Therapy (CPT 97140) describes multiple manually applied services, including manual traction, myofascial release, joint mobilization, soft tissue mobilization, connective tissue massage, manual lymphatic drainage, and manipulation (non-chiropractic). For myofascial release work, the targeted region(s) is targeted to a specific muscle or other soft tissue. Findings generally involve an adhesion or area of fibrosis exhibited by a painful band or "knot" within the muscle and subsequent limited range of motion. This code describes manually applied techniques that increase active pain-free range of motion and increase extensibility of myofascial tissue, with the goal of restoring function of the muscle or soft tissue. The specific technique is general described as active, passive, or both. Active or passive indicates the methods of stretching or elongation of the soft tissue. I acknowledge this has been explained to me and the therapist is performing the procedure stated above.

____

Signature

______________________________ ______________________________

Printed Name **Date**

Dr. Barry W. Levitt, D.C., P.A.
Dr. Erick A. Daes, D.C., P.A.
8955 S.W. 87th Court
Miami, Florida 33176
305-233-5700 305-279-2222

Patient Consent for Use of Disclosure of Protected Health Information

I give my consent for the above Doctors to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations. (TPO)

Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. The above stated Doctors reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Private Practices may be obtained by forwarding a written request to the above stated Doctors.

With this consent, the above stated Doctors may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, the above Doctors may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards, and patient statements as they are marked Personal and Confidential.

With this consent, the above stated Doctors may email to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and PHI to carry out TPO. However, the practice is not required to agree to my request restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to the above stated Doctors' use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, the above stated Doctors may decline to provide treatment to me.

____

Signature of Patient or Legal Guardian

___________________________ ___________________________

Print name of Patient or Legal Guardian **Date**

Dr. Barry W. Levitt, D.C., P.A.
Dr. Erick A. Daes, D.C., P.A.
8955 S.W. 87th Court
Miami, Florida 33176
305-233-5700 305-279-2222

NOTICE OF EMERGENCY MEDICAL CONDITION

The undersigned **licensed medical provider**, hereby asserts:

1. The below patient, has in the opinion of this medical provider, suffered an **Emergency Medical Condition**, as a result of the patient's injuries sustained in an automobile accident that occurred on _______________ (fill in date of accident).
2. The basis of the opinion for finding an **Emergency Medical Condition** is that the patient has sustained acute symptoms of sufficient severity, which may include severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following: a) serious jeopardy to patient health b) serious impairment to bodily functions or c) serious dysfunction of a bodily organ or part.

I hereby attest that I am a physician licensed under Chapter 458 or Chapter 459, a dentist licensed under Chapter 466, a physician assistant licensed under Chapter 458 or Chapter 459, or an advanced registered nurse practitioner licensed under Chapter 464, and that the above facts are true and correct.

___________________________ ___________________________ ___________________________

NAME (PRINT OR TYPE) Signature of **Medical Provider** **DATE**

The undersigned **injured person** or legal guardian of such person asserts:

1. The symptoms I reported to the medical provider are true and accurate.
2. I understand the medical provider has determined I sustained an Emergency Medical Condition as a result of the injuries I suffered in the car accident.
3. The medical provider has explained to my satisfaction the need for future medical attention and the harmful consequences to my health which may occur if I do not receive future treatment.

Injured patient receive this diagnosis or legal guardian of said injured patient:

___________________________ ___________________________ ___________________________

NAME (PRINT OR TYPE) Signature of Injured **Patient/Guardian** **DATE**

Dr. Barry W. Levitt, D.C., P.A.
Dr. Erick A. Daes, D.C., P.A.
8955 S.W. 87th Court
Miami, Florida 33176
305-233-5700 305-279-2222

Assignment of Insurance, Benefits, Power of Attorney and Release of Information

Insurer Please Read the Following, in its Entirety, upon Receipt

I, the undersigned patient/insured, ___________________________ (print name of patient/insured or parent/guardian if patient is a minor), knowingly, voluntarily and intentionally **assign the benefits** of insurance and any overdue interest payments under the No-Fault Policy of Automobile insurance, also known as Personal Injury Protection (P.I.P.), or Medical Payments policy of insurance from my automobile insurer or the responsible insurer to the above described medical provider or any and all services rendered to the undersigned patient/insured. It is the intent of this medical provider to accept this assignment-of benefits. The undersigned also assigns any and all claims for statutory bad faith to the above medical provider. The undersigned patient/insured directs the insurer to pay the medical provider directly. The insurer is further directed by the provider and the patient to not issue any checks or drafts in partial settlement of a claim that contain or are accompanied by language releasing the insurer tor it insured from liability unless there has been a prior written settlement agreed to by the medical provider and the insurer as to the amount payable under the insurance policy or contact. The provider hereby objects to any reductions or partial payments made at the discretion of the insurer. Any partial or reduced payment issued by the insurer and deposited by the provider shall be done so under protest and the deposit shall not be deemed a waiver, accord, satisfaction, discharge, settlement or agreement by the provider to accept a reduced amount as payment in full. The insurer is hereby placed on notice that this provider reserves the right to seek the full amount of the bills submitted. In the event the subject medical benefits are disputed for any reason, including but not limited to, medical reasonableness and /or necessity, the undersigned patient/insured hereby instructs the insurer to set aside any amount disputed (i.e. to escrow the money) and not pay the disputed amount to anyone, including myself, or any entity until the dispute is resolved. Any partial payment, regardless of the accompanying language, will be deemed a partial payment and the insured will be making the payment at its own risk unless there is a prior written settlement agreed to by this provider. I hereby instruct the insurer to notify the above provider immediately of any dispute. If the insurer schedules an IME or EUO the insurer is hereby requested and authorized to send a copy of said notification to this provider. The provider is not the agent of the insurer or the patient for any purpose. The undersigned patient/insured agrees to pay any applicable deductible, co-payments, for services rendered after the policy of insurance exhausts, and for any other services unrelated to the automobile accident. I understand this assignment will remain in full force and effect and will **NOT** by revoked unless the revocation is agreed to by both the medical provider **AND** the undersigned patient or the patient's attorney. This assignment applies to both past and future medical expenses and is valid even if undated or if not signed by provider, The patient understands it is the express intention of the provider to accept this assignment of benefit in lieu of demanding payment at the time services are rendered. A photocopy of this assignment is to be considered as valid as the original.

Power of Attorney I also agree the above provider is hereby given the power of attorney to sign my name on any checks for payment for services rendered by the above provider.

Release of Information I hereby authorize this medical provider to furnish my insurance company or companies and the patient's attorney with any and all information that may be contained in my medical records and to request a copy of my POP payout sheet from the insurer. I also hereby authorize this medical provider to obtain copies of my medical records, including but not limited to documents, reports, scans, notes, opinions, X-rays, and MRI's, from any other medical provider or any insurance company. The insurer is directed to keep the patient's medical records private and confidential. The insurer is NOT authorized to provide these medical records to anyone, including but not limited to third party vendors without the patient's and the provider's prior express written permission.

Caution! Please read before signing. If you do not completely understand this document please ask us to explain it to you. If you sign below we will assume you understand and agree to the terms.

Patient's Signature ____________________________ **Date ____________________**
(If patient is a minor, signature of parent/guardian)

Medical Provider's Signature _____________________________ **Date ____________________**

--Any person, who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete, or misleading information may be guilty of a felony of the third degree.

Dr. Barry W. Levitt, D.C., P.A.
Dr. Erick A. Daes, D.C., P.A.
8955 S.W. 87th Court
Miami, Florida 33176
305-233-5700 305-279-2222

I understand the information on all forms and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform the office of any changes in my medical status.

I authorize the staff to perform any necessary services during the diagnosis and treatment. I also authorize the provider and/or managed care organizer to release any information required to process insurance claims.

I authorize Dr. Barry W. Levitt or Dr. Erick A. Daes to provide medical services to me.

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees and any other expenses incurred in collection your account. I understand that I am financially responsible for all changes whether or not paid by the insurance companies.

I authorize the release of any medical information necessary to process this claim including but not limited to all of my insurance companies. I also request payment of government benefit either to myself or to the party who accepts assignments below.

Signature on File:

I authorize payment of medical benefits to the undersigned physician(s) or supplier of service. I authorize physician to act as my agent in helping me obtain payment from my insurance companies. I authorize payment directly to my physician. I permit a copy of this authorization to be used in place of my original signature. I authorize use of this form on all my insurance submissions.

____________________________________ _____________________

Patient's Signature **Date**

____________________________________ _____________________

Doctor's Signature **Date**

Dr. Barry W. Levitt, D.C., P.A.
Dr. Erick A. Daes, D.C., P.A.
8955 S.W. 87th Court
Miami, Florida 33176
305-233-5700 305-279-2222

Date _____________

To: Attorney
____
____
____

Re: _________________________ _____________________
Patient's Name **Date of Accident**

I hereby authorize the above doctor(s) to furnish you, my attorney, with a fully report of my (or that person for which I am the legal guardian) examination, diagnosis, treatment, prognosis, etc. of myself in regard to the accident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him for professional services rendered to me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment or verdict which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated or injured in connection therewith.

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

__________________________ ______________ __________________________
Signature of Patient **Date** **Witness**

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

_______________________________ ______________
Attorney's Signature **Date**

Dr. Barry W. Levitt, D.C., P.A.
Dr. Erick A. Daes, D.C., P.A.
8955 S.W. 87th Court
Miami, Florida 33176
305-233-5700 305-279-2222

INFORMED CONSENT TO TREAT

(Patient: Please discuss any questions or concerns with the Doctor before signing this consent.)

I hereby request and consent to the performance of manipulation (adjustments) and other procedures including diagnostic x-rays and various modes of physical therapy on me (or on the patient named below, for whom I am legally responsible.)

I have had the opportunity to discuss with the doctor and/or with other office or clinical personnel the purpose and benefits of Manipulations (adjustments) and other treatments outlined below. Alternatives to treatments have been reviewed.

I understand that I will be receiving one or more of the following treatments: Manipulations (adjustments), Mobilization Therapy, Hot/Cold Packs, Electrical Stimulation, Inferential Current, Myofascial Release, Traction, Therapeutic Exercises, Massage, Spinal Decompression, Mechanical Traction, Passive Mobilization, Taping or Splinting.

I understand that Manipulation (adjustments) is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding treatment that I have requested or authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

______________________________ ______________________

Signature of Patient (or guardian) **Date**

______________________________ ______________________

Doctors Signature **Date**

Dr. Barry W. Levitt, D.C., P.A.
Dr. Erick A. Daes, D.C., P.A.
8955 S.W. 87th Court
Miami, Florida 33176
305-233-5700 305-279-2222

THERAPY NOTES

Myofascial trigger point (MFTP) release can be light and/or deep. It is accomplished by relaxing contracted muscles and fascia, and increasing circulation and lymphatic drainage. It is accomplished with the use of knuckles, elbows, or tools (instrument assisted, IAM) to slowly stretch the restricted myofascial structures and elongation of fascia and adhesive tissues. This causes an increase in range of motion and softening of the hypertonic tissues.

DATE	PERFORMED BY	AREAS/ MUSCLES TREATED	TIME (min.)
__________	__________	Group # 1 2 3 4 5 ____	__________
__________	__________	Group # 1 2 3 4 5 ____	__________
__________	__________	Group # 1 2 3 4 5 ____	__________
__________	__________	Group # 1 2 3 4 5 ____	__________
__________	__________	Group # 1 2 3 4 5 ____	__________
__________	__________	Group # 1 2 3 4 5 ____	__________
__________	__________	Group # 1 2 3 4 5 ____	__________
__________	__________	Group # 1 2 3 4 5 ____	__________
__________	__________	Group # 1 2 3 4 5 ____	__________
__________	__________	Group # 1 2 3 4 5 ____	__________
__________	__________	Group # 1 2 3 4 5 ____	__________
__________	__________	Group # 1 2 3 4 5 ____	__________
__________	__________	Group # 1 2 3 4 5 ____	__________

GROUP #

1. **Cervical group includes:** occipital fibers, scalenes, cervical paraspinals, trapezius, levator scapula rhomboid muscles.
2. **Shoulder group includes:** supra/infraspinatus, teres, rhomboids, deltoid, trapezius, levator scapula, pectoralis muscles.
3. **Dorsal group includes:** dorsal paraspinal muscles, trapezius, rhomboids, serratus, latissimus muscles.
4. **Lumbar group includes:** lumbar paraspinals/erector spinae, quadratus lumborum, lumbar fascia.
5. **Pelvic group includes:** piriformis, gluteals, TFL muscles, sacrotuberous ligament.

Patient Name__________________________ **Sign**______________________________ **Date**____________