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

Dear Patient,

Thank you for choosing our office for your care! We are EXCITED about helping you enjoy life again, without the painful symptoms of peripheral neuropathy! We currently have you scheduled to see our doctor on:

Day_____ **Date** _____ **at** _____**.**

PLEASE NOTE: We do our very best to keep the doctor on schedule, and we do not "overbook" for that very reason. The doctor, the exam room, and approximately 45 minutes of time is reserved just for you. To keep all of us and other patients on schedule, we recommend that you arrive at least 10 minutes before your scheduled appointment. We promise to do our very best to have you back with the doctor within 10 minutes of your scheduled appointment time.

Please come dressed in loose pants or shorts with a short sleeved shirt. That way the doctor can easily examine and treat your areas of concern.

Enclosed with this letter is a copy of our new patient paperwork. Please fill in as much information as possible before you arrive for your appointment. If you have any questions about any of your paperwork, please call our staff at **941- 629-6700**. They will be happy to assist you.

If necessary, the staff will go over any questions with you upon your arrival, but we would prefer you have all your questions answered prior to coming, in order for us to keep each other on time! If you come in with partially incomplete paperwork, please allow an *additional* 20 minutes in your early arrival time as our staff is very busy helping many patients in the building, and we need to allow extra time for them in addition to address your questions and paperwork.

If you need to reschedule or cancel your scheduled appointment, we ask that you please call us at least 24 hours before your scheduled appointment, if at all possible, or at least at your very earliest convenience. That would not only help us, but also other patients needing to be seen.

Thank you, again, for choosing Korman Relief and Wellness Center, and we look forward to meeting you soon!

Yours in health,

Dr. Laura Korman

PS: Please bring any of the following items to your appointment, if you have them:

- ☐ MRI Written Reports or Copies of MRI (CD version preferred)
- ☐ Radiology Reports & Copies of X-rays (CD version preferred)
- ☐ Blood Chemistry Results (performed within this past year)
- ☐ List of Current Medications
- ☐ Driver's License
- ☐ Your Spouse or Partner (if applicable)

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NEUROPATHY TREATMENT INTAKE FORM

Name _____ Date _____/_____/_____

Street Address _____

City _____ State _____ Zip _____

Main Phone _____ Alternate Phone _____

Date of Birth _____/_____/_____ Age _____ Gender M / F

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

Spouse / Partner Name _____

Your Race - Check any that apply ____White ____ American Indian or Alaskan Native ____ Asian ____Black or African American ___ Hispanic or Latino ___Native Hawaiian or Other Pacific Islander

Your Primary Language _____

Retired? **Yes / No** Current / Previous Occupation _____

Referred to our office by _____

REVIEW OF SYSTEMS (Check all that Apply)

- ☐ Foot Pain
- ☐ Pinched Nerve
- ☐ Chemotherapy
- ☐ Vascular Problems
- ☐ Leg Pain
- ☐ Foot Numbness
- ☐ Hand Numbness
- ☐ Implanted Cord / Bladder Stimulator
- ☐ Diabetes
- ☐ Hand Pain
- ☐ Poor Circulation
- ☐ Arthritis in Hands
- ☐ Arthritis in Feet
- ☐ Herniated Disc
- ☐ Bulging Disc
- ☐ Degenerative Discs
- ☐ Spinal Stenosis
- ☐ High Cholesterol
- ☐ Low Back Pain
- ☐ Joint Replacements
- ☐ Foot Surgery
- ☐ Plantar Fasciitis
- ☐ Morton's Neuroma
- ☐ Excessive Thirst / Excessive Urination
- ☐ Cancer
- ☐ High Blood Pressure
- ☐ Neck Pain
- ☐ Pacemaker /Defibrillator
- ☐ Poor Wound Healing
- ☐ Sciatica

PRESENT HEALTH CONDITION

In order of importance, list the health problems you are most interested in getting corrected and how long you have noticed these problems.

1) _____ How Long? _____

2) _____ How Long? _____

3) _____ How Long? _____

4) _____ How Long? _____

5) _____ How Long? _____

Is there a certain time of day any of these problems are better or worse? _____

_____

_____

Is your balance / walking ability affected? **Yes / No** If yes, please describe _____

_____

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NEUROPATHY TREATMENT INTAKE FORM

Check or list any over-the-counter medications or other treatments you've used to treat your problems.

- ☐ Gabapentin
- ☐ Neurontin
- ☐ Lyrica
- ☐ Cymbalta
- ☐ Aleve
- ☐ Tylenol
- ☐ Motrin
- ☐ Ibuprofen
- ☐ Pain Medication
- ☐ Chiropractic
- ☐ Physical Therapy
- ☐ Massage Therapy
- ☐ Creams on hands or feet
- ☐ Other _____

_____

Explain _____

_____

What do you think is causing your problem? _____

_____

_____

Name the doctors you have seen for these problems and treatments you've received.

Doctor _____ Treatment _____

Doctor _____ Treatment _____

Doctor _____ Treatment _____

Doctor _____ Treatment _____

Have your symptoms (Circle One) Improved / Worsened / Remained the Same

List anything that makes your condition worse. _____

_____

_____

List anything that makes your condition better. _____

_____

_____

Please describe your symptoms by checking all that apply.

- ☐ Aching Pain
- ☐ Throbbing Pain
- ☐ Burning
- ☐ Pins & Needles
- ☐ Numbness
- ☐ Tingling
- ☐ Tiredness
- ☐ Hot Sensation
- ☐ Swelling
- ☐ Heavy Feeling
- ☐ Cramping
- ☐ Sharp Pain
- ☐ Cold Hands / Feet
- ☐ Stabbing Pain
- ☐ Dead Feeling
- ☐ Electric Shocks

Is this condition interfering with Sleep / Work / Daily Activities / Housework / Recreational Activities Walking / Standing / Shopping

SOCIAL HISTORY

Do you smoke? **Yes / No** If yes, how many packs per day? _____

Do you drink? **Yes / No** If yes, how many drinks per day? _____ Per week? _____

Do you exercise regularly? **Yes / No** If Yes, what type? _____

How often? Daily / Weekly / Every other week / Monthly / Occasionally / Never

Patient Name _____ Date _____

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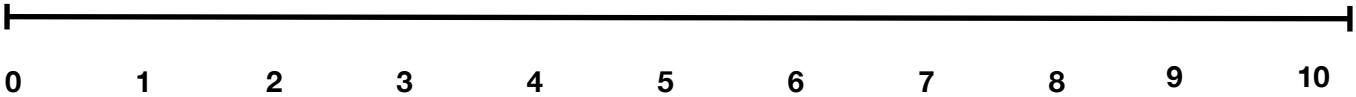
NEUROPATHY TREATMENT INTAKE FORM

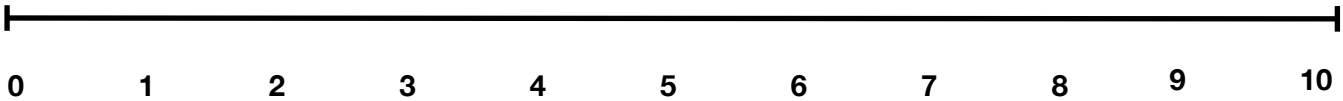
CURRENT PAIN LEVELS

How would you rate your pain in the last week?



No Pain — Worst Possible Pain

If you *had* to accept *some* level of pain after completion of treatment, what would be acceptable for you?



No Pain — Worst Possible Pain

PREVIOUS HEALTH HISTORY

This is a confidential record of your medical history and pertinent personal information. The doctor reserves the right to discuss this information with medical and allied health professionals, per the informed consent. Copies of this record can only be released by your written authorization, unless you sign here, indicating that we can release copies by your verbal request.

Printed Name _____ **Signature**_____ **Date** _____

Please give the name, address and office phone number of your primary care physician or family doctor.

Name of doctor _____ Office Phone _____

Address of doctor's office _____

Approximate date you were last seen by this doctor _____

May we send them updates on your treatment / condition? **Yes / No**

List ALL allergies or sensitivities to medicines, foods, and other items.

Item you react to	**Reaction that you have**
_____	_____
_____	_____
_____	_____
_____	_____

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NEUROPATHY TREATMENT INTAKE FORM

Please list or attach a list of the prescription drugs you are currently taking.

Name of drug	Dosage (Mg or IU)	Number of times per day

Please list or attach **nutritional supplements** you are currently taking (vitamins, herbs, homeopathies, etc.).

Please list surgeries, hospitalizations, and / or significant injuries you have had.

Surgeries	Dates

Hospitalizations	Dates

Injuries	Dates

Patient Name _____ **Date** _____

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INFORMED CONSENT FOR THERAPY TREATMENT

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

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

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

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

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

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

TREATMENT RESULTS

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

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

Signature_____ Date _____

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OFFICE & PAYMENT POLICY INFORMATION

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

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

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

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

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

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

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

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

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

PATIENT SIGNATURE: _____ **DATE:**_____