13315 Cortez Blvd
Brooksville, FL. 34613

Phone: 352-596-1900
Fax: 352-596-9888

Patient Application Form

Welcome to our clinic. We specialize in assisting our patients in achieving their highest level of health through our spinal and postural correction programs. Our approach is very different and more complete than other rehabilitative programs, which allows us to achieve superior correction as compared to other systems.

Please fill out the following information completely so the Doctor can let you if we can accept your case. Please feel free to ask any questions if you need assistance. We look forward to serving you.

_____

Patient Name

_____

Patient Signature

_____

Date

Electronic Health Records Intake Form

In compliance with Medicare requirements for the Government EHR incentive program

First Name: _____ Last Name: _____

Email address: _____

Preferred method of communication: ☐ Email ☐ Phone ☐ Text ☐ Mail

DOB: ____/____/_____ Gender: ☐ Male ☐ Female Preferred Language: _____
(MM) (DD) (YYYY)

CMS requires providers to report both Race and Ethnicity

Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ White or Caucasian
☐ Native Hawaiian or Pacific Islander ☐ Other: _____ ☐ I decline to answer

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ I decline to answer

Are you currently taking any medications? ☐ Yes ☐ No (Please include regularly used over-the-counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg 2x daily)

Do you have any medication allergies? ☐ Yes ☐ No

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: _____

Please list all past surgeries and associated dates:

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____
5. _____ _____
6. _____ _____

Please list any previous accidents and injuries, with associated dates:

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____
5. _____ _____
6. _____ _____

Please list any health health conditions not mentioned:

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____
5. _____ _____

Health Lifestyle

Do you exercise? ☐ Yes ☐ No How often? ☐ 1x ☐ 2x ☐ 3x ☐ 4x ☐ 5x Per: ☐ Week ☐ Month

Smoker status? ☐ Every day smoker ☐ Occasional smoker ☐ Former Smoker ☐ Never smoked
If a smoker, what is your daily usage? ☐ <5 daily ☐ 5-10 daily ☐ 11-15 daily ☐ 15-20 daily ☐ >1 pack daily

Do you drink alcohol? ☐ Yes ☐ No What and how much?: _____

Do you drink coffee? ☐ Yes ☐ No How many cups per day? _____

Do you drink soda? ☐ Yes ☐ No How many 12oz servings per day? _____

Do you drink water? ☐ Yes ☐ No How much per day? _____

Do you eat fruits and vegetables? ☐ Yes ☐ No How many servings per day? _____

Do you take any supplements? (ie: vitamines, minerals, herbs) ☐ Yes ☐ No

Please list: _____
_____

Patient Signature: _____ Date: _____

Date: _____

Last Name: _____ First Name: _____ MI: ___ Nickname: _____

Address:_____ City:_____ State:_____ Zip:_____

Mobile Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____ Social Security Number: _____

Date of Birth (mm/dd/yyyy):_____ Age:_____ Gender:_____ Marital Status:_____

Employer Name: _____ Occupation: _____

In case of emergency contact: _____ Phone: _____

Relationship to Patient: _____

Are You Pregnant? ☐ Yes ☐ No If yes, how many weeks: _____

Primary Care Physician: _____ Phone: _____

Purpose of This Visit

Reason for this visit – **Main Complaint**: _____

When did this condition begin (date): _____ Did it begin: ☐ Gradually ☐ Suddenly

Is this related to a motor vehicle accident or injury at work? ☐ Yes ☐ No If yes, Date of accident: _____

What activities aggravate your symptoms? :_____

Has anything relieved your symptoms? ☐ Yes ☐ No Please explain: _____

Type of pain: ☐ Sharp ☐ Dull ☐ Ache ☐ Burning ☐ Throbbing ☐ Spasm ☐ Numbness ☐ Tingling ☐ Shooting

Does the pain radiate into your: ☐ Arms ☐ Hands ☐ Legs ☐ Feet Is the condition getting worse? ☐ Yes ☐ No

How often do you experience these symptoms throughout the day: ☐ 0%-25% ☐ 26%-50% ☐ 51%-75% ☐ 76%-100%

Does your complaint interfere with: ☐ Work ☐ Sleep ☐ Hobbies ☐ Daily Routine ☐ Other

Please explain: _____

Have you experienced this condition before? ☐ Yes ☐ No

If yes, please explain: _____

Who have you seen for this: _____

What did they do: _____

How did you respond: _____

Second Complaint (if applicable): _____

When did this condition begin (date): _____ Did it begin: ☐ Gradually ☐ Suddenly

Is this related to a motor vehicle accident or injury at work? ☐ Yes ☐ No If yes, Date of accident: _____

What activities aggravate your symptoms? :_____

Has anything relieved your symptoms? ☐ Yes ☐ No Please explain: _____

Type of pain: ☐ Sharp ☐ Dull ☐ Ache ☐ Burning ☐ Throbbing ☐ Spasm ☐ Numbness ☐ Tingling ☐ Shooting

Does the pain radiate into your: ☐ Arms ☐ Hands ☐ Legs ☐ Feet Is the condition getting worse? ☐ Yes ☐ No

How often do you experience these symptoms throughout the day: ☐ 0%-25% ☐ 26%-50% ☐ 51%-75% ☐ 76%-100%

Does your complaint interfere with: ☐ Work ☐ Sleep ☐ Hobbies ☐ Daily Routine ☐ Other

Please explain: _____

Have you experienced this condition before? ☐ Yes ☐ No

If yes, please explain: _____

Who have you seen for this: _____

What did they do: _____

How did you respond: _____

Third Complaint (if applicable): _____

When did this condition begin (date): _____ Did it begin: ☐ Gradually ☐ Suddenly

Is this related to a motor vehicle accident or injury at work? ☐ Yes ☐ No If yes, Date of accident: _____

What activities aggravate your symptoms? :_____

Has anything relieved your symptoms? ☐ Yes ☐ No Please explain: _____

Type of pain: ☐ Sharp ☐ Dull ☐ Ache ☐ Burning ☐ Throbbing ☐ Spasm ☐ Numbness ☐ Tingling ☐ Shooting

Does the pain radiate into your: ☐ Arms ☐ Hands ☐ Legs ☐ Feet Is the condition getting worse? ☐ Yes ☐ No

How often do you experience these symptoms throughout the day: ☐ 0%-25% ☐ 26%-50% ☐ 51%-75% ☐ 76%-100%

Does your complaint interfere with: ☐ Work ☐ Sleep ☐ Hobbies ☐ Daily Routine ☐ Other

Please explain: _____

Have you experienced this condition before? ☐ Yes ☐ No

If yes, please explain: _____

Who have you seen for this: _____

What did they do: _____

How did you respond: _____

Notice of Privacy Practices

Authorization for Use or Disclosure of Protected Health Information

We keep a record of the health care services provided to you. You may ask to see a copy of that record. We will not disclose your records to others unless you direct us to, or unless the law compels or requires us to. You may see your record or get more information about it by contacting one of our offices. We may use your health information in the following ways:

- We may share your health information to run our office, collect payment, treat you, thank you for referring others, discuss your case with your family, include you in health care classes, help you collect from your insurance company, inform you about other services, or provide assistance with your diagnoses or treatment from another provider or radiologist.
- We may use your health information for health and safety reasons, court hearings and filings, reporting to law officials, and for reporting victims of abuse.
- We may call you by name in the reception area when the doctor is ready to see you.
- A postcard may be mailed to the address provided by you.
- When telephoning your home, we may leave a message on your answering machine or whomever answers when we call.
- We may include a photo of you on our referral wall.

You have the right to- request a copy of your records, ask to limit the information we share, amend your health information, or request a list of whom we share your records with. You have the right to revoke this authorization in writing at any time, except to the extent that the information has been released in reliance upon this authorization. Our office follows legal and ethical standards pursuant to HIPAA compliance at all times regarding your protected health information.
Please advise our management if you believe your privacy rights have been violated.

By signing below, you consent to our use and disclosure of your protected healthcare information as indicated above and as required by law, and you acknowledge that you have read, understand, and agree to our Notice of Privacy Practices.

_____ _____

Patient Name (Print) Patient Name (Sign)

_____

Date

Informed Consent

Signing below indicates a request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various methods of physiotherapy and, if necessary, diagnostic x-rays on me by the Doctor of Chiropractic and/ or by any other office or clinic personal.

Possible Risks

I understand and am informed that, as in all healthcare, in the practice of Chiropractic medicine there are some risks to treatment. These risks include but may not be limited to: stiffness, soreness, muscle strain, ligament sprain, fracture, disc injury, dislocation, paralysis, and stroke. The ancillary procedures could produce skin irritations, burns, or minor complications.

Probability of Risks Occurring

The risk of complications due to Chiropractic treatment have been described as rare, about as often as complications are seen from the taking of a single Aspirin tablet. The risk of cervicobrachial injury or stroke has been estimated at one in one million to one in twenty million, and can be reduced even further by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered rare.

Other Treatment Options that Could Be Considered

- Over-the-counter analgesics. The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- Medical care, typically anti-inflammatory drugs, tranquilizers, steroids, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- Hospitalization in conjunction with medical care adds risk of virulent communicable disease in a significant number of cases.
- Surgery in conjunction with medical care adds the risk of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Consent

I acknowledge I have discussed, or have had the opportunity to discuss, with my Chiropractor the nature and purpose of Chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of this Informed Consent waiver. I consent to the chiropractic treatments offered or recommended to me by my Chiropractor. I intend this consent to apply to all my present and future chiropractic care.

_____ _____

Print Patient Name Date

_____

Sign Patient Name

Terms of Acceptance
Procedures and Payment Policy

When a person seeks chiropractic care and rehabilitative health care, and is accepted for such care, it is essential for both parties to be working towards the same objective. It is important that each person understand both the objective and the method(s) that will be used to obtain this objective. By signing this form, you acknowledge that you have read, understand, and consent to the terms herein.

Procedures

- No Charge Consultation: This is a brief meeting between you and the Doctor to determining if you may benefit from the care we provide. There is no financial obligation in connection with this service.
- Clinical Exam: After your consultation, if the Doctor believes you will likely benefit from the care we provide, a thorough orthopedic, neurologic, and chiropractic clinical exam will be recommended.
- X-Rays: Based on the exam findings, the Doctor may recommend selected x-rays be taken to aid in comprehensive diagnosis of your condition(s).
- Included in the cost of the clinical exam is a report of findings. This is where the Doctor presents his findings regarding your diagnostic testing. The Doctor will also explain what he feels would be the best and fastest approach to improve your health, based on your condition.
- Treatments may include: Spinal and extraspinal adjustments, joint manipulation, intersegmental traction, electric muscle stimulation, curve restoration traction, core muscle training, posture correction exercises, scoliosis correction therapy, cold laser therapy, rehabilitation therapy, spinal decompression, massage/ manual therapy, ice (cryotherapy), neuromuscular re-education, custom orthotics, analgesic rubs/ creams/ sprays, and nutritional recommendations and supplements.

Payment Policy

- Payment is expected at the time of service, unless prior arrangement has been made between you and the office.
- Health/ Automobile Insurance
    - Your insurance coverage is a contract between you and your insurance company. We will gladly help you verify benefits of your particular coverage; however, we cannot take responsibility for what your insurance does or does not cover. Ultimately, all services rendered to you are charged directly to you, and you are responsible for any and all payment aside from benefit coverage approved by your insurance carrier.
    - We will file your insurance claim for you and do everything we can to ensure you receive proper reimbursement, if applicable.
    - If your policy has a deductible feature, it is due at the time of service.
    - We will do our very best to answer any questions you may have in regard to your insurance.
- There will be a $25 charge on all returned checks (plus the original amount of the check)

_____ _____

Patient Signature Date

No-call No-show Policy

I _____ am aware that Family Chiropractic Health Centers may charge a "no-call/ no-show" fee of $25 for any missed appointment that is not cancelled or rescheduled in advance. I understand and agree that this fee must be paid before my treatment can resume, and is not payable by insurance.
*To avoid this fee, please notify our office at least 24 hours in advance of any appointment you may not be able to keep. We understand that life happens, and will help you reschedule as needed.

_____ _____
Patient Signature Date

_____ _____
Office Staff Signature Date

X-ray/ Diagnostic Testing Consent

During the examination the Doctor may feel that additional scans and diagnostic tests will be needed in order to further assess and diagnose your condition. We would like to make you aware that, in those cases, additional x-rays and/ or diagnostic tests may be required in order to accurately diagnose your condition and administer treatment. In order to perform x-rays on any patient, our office requires consent for such tests to be performed.

Please choose one:

- ☐ I understand that my Doctor may need x-rays or diagnostic tests in order to diagnose my condition and I give my consent for all necessary scans and tests.

- ☐ I understand that my condition may require my Doctor to take x-rays to further diagnose my symptoms. I choose not to consent to additional scans or diagnostic tests at this time, and release the Doctor and Family Chiropractic Health Centers of all liabilities that may arise.

_____ _____
Patient Signature Date

_____ _____
Office Staff Signature Date

Pregnancy Release (Female Only)

This is to certify that to the best of my knowledge I am not pregnant, and Family Chiropractic Health Centers has my permission to perform an x-ray evaluation. I understand that receiving x-rays while pregnant may cause complications to an unborn child and agree to hold Family Chiropractic Health Centers free from liability of such complications.

_____ _____
Patient Signature Date

Estimated date of last menstrual cycle: _____ Initials: _____

Please help us out and tell us how you found us:

Drove by and saw sign? ☐ Yes ☐ No

Yellow pages listing ☐ Yes ☐ No
- ☐ Verizon Yellow Pages
- ☐ Yellow Book
- ☐ Other _____

Internet:
- ☐ Facebook Advertisement
- ☐ Google search
- ☐ Yahoo search
- ☐ Bing search
- ☐ YP.com
- ☐ Superpages.com
- ☐ Other _____

Were you referred? ☐ Yes ☐ No

If yes, who referred you?

- ☐ Friend _____
- ☐ Attorney _____
- ☐ Another Doctor _____
- ☐ Health Screening (where) _____
- ☐ Other (Please specify) _____

Did your referral include our phone number? ☐ Yes ☐ No

If No, where did you find our number?

- ☐ Called information
- ☐ Internet search
- ☐ Phone book
- ☐ Other _____