Name: Preferred: Referred by:

Address: City/Zip: Date of Birth:

Marital Status: # of children: Occupation: Employer:

Cell Home Email:

Chief complaint or reason for today’s visit Date this first started

Have you had this condition before? Y / N If yes, when?

Is condition related to:  Auto  Work Date of Loss Have you missed work? Y /N

What other doctors have you seen for this condition?

What did they do?

When was your last visit to a chiropractor? Were you helped? Y / N

What Spinal Correction programs were you given?

Did you follow doctor recommendations? Y / N If no, why not?

How did the post x-rays look? What surgeries have you had?

What drugs are currently being used? (List prescription and OTC)

\*\*(Females Only) Are you pregnant or is there a possibility that you are pregnant? Y / N

Are you currently wearing . . . .?  Heel Lifts  Arch Supports  Back Brace

 Fractured bones  Sinus problems  Diarrhea/Constipation  Headaches

 Auto accidents  Allergies/Asthma  Colon trouble  Neck pain

 0-1 yrs ago  Trouble sleeping  Hemorrhoids  Shoulder pain R / L

 1-5 yrs ago  Heartburn  Prostate problems  Arm pain R / L

 5+ yrs ago  Learning disability  Impotence  Jaw pain/TMJ

 Other accidents/falls  Mood changes  Kidney trouble  Upper back pain/stiff

 Back curvature  Chest Pain  Menstrual problems/PMS  Mid back pain/stiff

 Arthritis  Lung problems  Menopausal problems  Low back pain/stiff

 Diabetes  Difficulty breathing  Bed wetting  Hip/Knee pain R / L

 Swollen/Painful joints  Heart condition  Ear infections  Ankle/Foot pain R / L

 Convulsions/Epilepsy  Stroke  Immune problems  Numbness/tingling

 Skin Problems  High/Low blood pressure  Visual disturbances  Arm R / L

 Cancer  Pain with cough/sneeze  Dizziness  Hand R / L

 Frequent Colds/Flu  Varicose veins  Ringing in ears  Buttocks R / L

 Depression/Anxiety  Liver trouble  Hearing loss  Thigh R / L

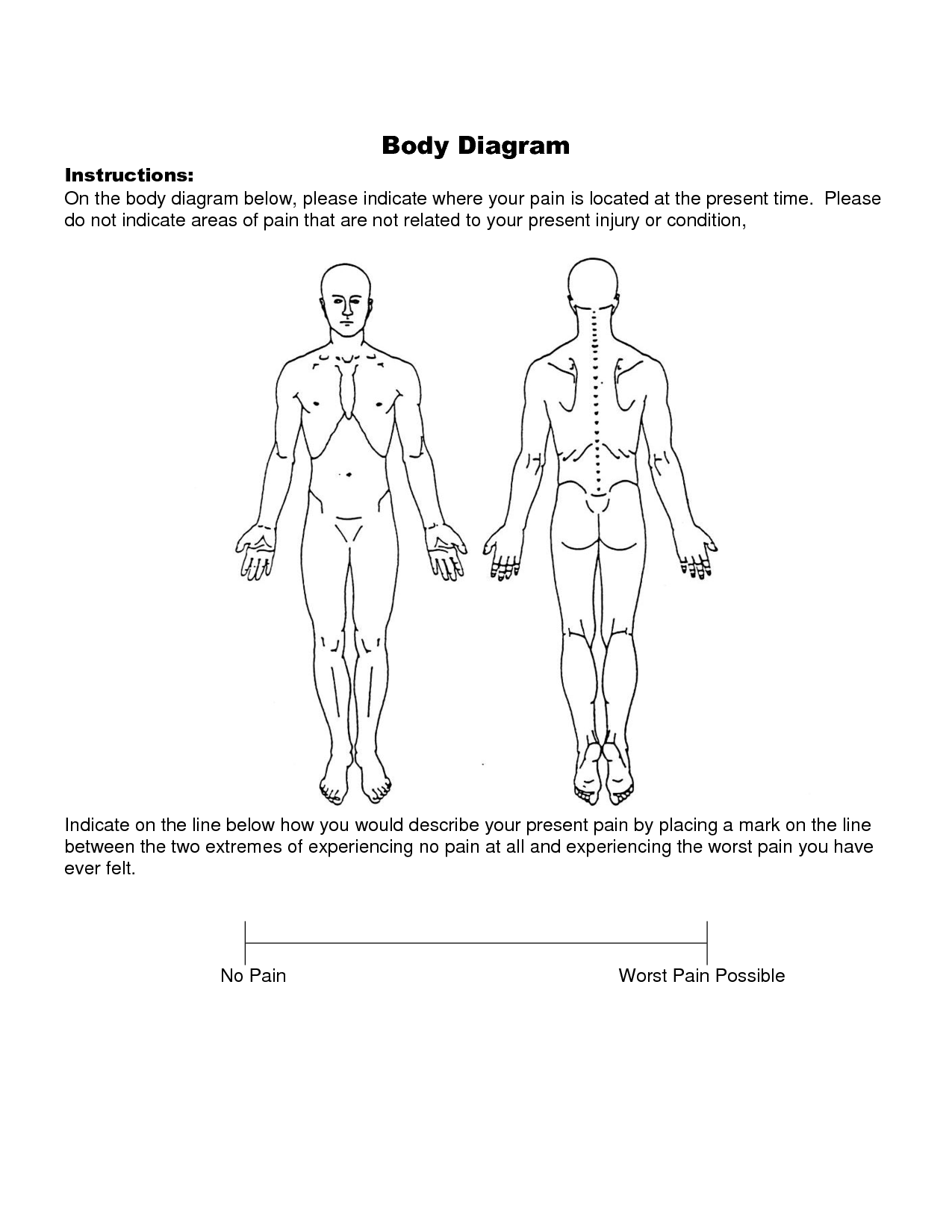
 Anemia  Gall bladder trouble  Fainting  Leg R / L

 Tremors  Digestive problems/ulcers  Loss of balance  Foot R / L

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

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

**Please use the following letters to show areas of concern on the diagram.**



**P** Pain

**S** Stiffness

**B** Burning

**T** Tingling

**N** Numbness

**Assignment of Benefits**

I, , hereby authorize

* Medicare
* Medicaid
* My Group Insurance:
* My No-Fault Insurance:
* My BCBS:
* Medigap
* Other:

to make payment of all benefits for chiropractic services rendered to me at this clinic for all dates and covered services directly to:

Hands On Family Chiropractic

2876 S Alafaya Trail Ste 100

Orlando, FL 32828

(407) 203-2883

fax (877) 703-2883

I also authorize any holder of medical and chiropractic information about me to release the health care financing administrators or insurance adjuster agents any information needed to determine these benefits for related services.

I do agree to pay directly to this clinic in a current manner and any and all balances for professional services rendered over and above any insurance payment. This agreement is valid for all services from this date forward, unless other written arrangements are made.

If my current policy prohibits direct payment to doctor, then I hereby authorize you to make the check to me and mail it as follows:

Hands On Family Chiropractic

2876 S Alafaya Trail Ste 100 Orlando, FL 32828

***This is a direct assignment of my rights and benefits under this policy.***

A photocopy of this Assignment of Benefits shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

Signature Date

THIS DOCUMENT CONSTITUTES INFORMED CONSENT FOR CHIROPRACTIC CARE.

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

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

Adjustment: An adjustment is the specific application for forces to facilitate the body’s correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustment 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 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 the 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 the specific chiropractic adjustment of vertebral subluxation. However, we may use other procedures to help your body hold the adjustments.

**POLICIES**

1. All first visit charges are payable when services are rendered since it is impossible to determine what insurance covers with a diagnosis of severity.
2. The fee paid for x-rays is for the analysis only of those x-rays. The film itself is the property of this office. X-rays may be released to the patient; however, they must be returned to the office once you have finished with them.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Hands On Chiropractic will prepare any necessary reports and forms to assist in making collections from the insurance company and that any amount authorized to be paid directly to Hands On Chiropractic will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

In case of emergency, please notify at phone #

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 that basis.

**Signature Date**

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

**\*\*COMPLETE ONLY IF THE PATIENT IS A MINOR: Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

\*\*I, being the parent or legal guardian of the aforementioned child, have \*\*read and fully understand the above terms of acceptance and hereby grant permission for my child to receive \*\*chiropractic care.

\*\*Signature Date

HIPAA Practice Requirements

**The Practice:**

1. Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice’s legal duties and privacy practices with respect to you PHI.

1. Under the Privacy Rule, may be required by State Law to grant greater access or maintain greater restrictions on the use or release of your PHI than that which is provided for under federal law.

1. Is required to abide by the terms of this Privacy Notice.

1. Reserves the right to change the terms of this Privacy Notice to you prior to implementation.

1. Will distribute a revised Privacy Notice to you prior to implementation.

1. Will not retaliate against you for filing a complaint.

# EFFECTIVE DATE

This Notice is in effect as of 04/15/2003

# STATE LAW

A copy of the state HIPAA laws will be available to me at any time for my review, and a copy will be given to me upon my request.

# PATIENT ACKNOWLEDGEMENT

By signing below, I acknowledge receipt of a copy of this notice, and my understanding and my agreement to its terms.

**Patient Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date:** \_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_