

**Olde Naples Chiropractic
Health Center**

**689 Tamiami Trail N., Suite D
Naples, FL, 34102
239-262-0606**

Patient Full Name: _____ E-Mail Address: _____
Mailing Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Emergency Contact Name/number: _____

Occupation: _____ Employer: _____
Status: Employed Full Time Student Part Time Student Retired Unemployed

Who may we thank for referring you? Friend Relative Physician Website Race Other _____

Date of Birth: ____/____/____ Male Female Number of Children/Ages: _____
 Married (Spouse's Name: _____) Single Widowed Divorced Separated

Family Physician: _____ City/State: _____ Phone: _____
May we share your information in our patient records with your above listed physician for integrated care? YES NO

Previous Acupuncture or Chiropractic Care?: Yes No *If yes, for what problem?* _____

Doctor's Name: _____ City/State: _____

We offer many types of care in our office. What type of care are you interested in?

- Spinal Pain Relief Non-Spinal Pain Relief (i.e. knee, shoulder) Acupuncture
 Chiropractic Physical Therapy Weight Loss Other:

Is today's visit due to a work related injury? Yes No Date of Injury: _____

Is today's visit due to an auto accident? Yes No Date of Injury: _____

(If yes to either question above, please check with receptionist, additional information may be needed)

INSURANCE INFORMATION:

Patient Social Security #: _____ - _____ - _____ Social Security # of Primary Insured: _____ - _____ - _____

Primary Insurance Company: _____ ID #: _____

Group #: _____ Insured Name: _____ DOB: ____/____/____

Employer: _____ Relation to Insured: _____

Secondary Insurance Company: _____ ID #: _____

Group #: _____ Insured Name: _____ DOB: ____/____/____

Employer: _____ Relation to Insured: _____

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Dear Patient: Please complete this form and questionnaire. If you need assistance, please ask. Your answers will help us determine if acupuncture or chiropractic care can help you, and where to focus your examination. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU!

In general, would you say your health is (check one): Excellent Very Good Good Fair Poor

PAST HEALTH HISTORY:

1. Have you ever experienced your present problem you are consulting us for previously? Yes No
If yes, when? _____
Was treatment provided? Yes No If yes, by whom: _____ Outcome: _____
2. Have you ever had a **stroke** or issues with **blood clotting**? Yes No If yes, when? _____
3. Have you recently experienced **dizziness**, unexplained **fatigue**, **weight loss**, or **blood loss**? Yes No
If yes, when? _____
4. Have you ever had any major illnesses, injuries, broken bones, hospitalizations, car accidents, or surgeries?

Date	Injury/Fracture/Illness/Accident/Surgery	Treatment	Results

SYSTEMS REVIEW QUESTIONS:

Do you, or have you ever, had any problems with the following areas? (Please mark Y for yes or N for no:)

- | | | |
|---------------------------------|--------------------------------|-----------------------------------|
| 1. ___Eyes | 8. ___Nerves | 15. ___Eating Disorder |
| 2. ___Ears, Nose, Mouth, Throat | 9. ___Joints/Bones | <i>For Females Only:</i> |
| 3. ___Heart | 10. ___Skin | 16. ___Gynecological/Menstrual |
| 4. ___Lungs/Breathing | 11. ___Internal Organs | 17. ___Breast |
| 5. ___Intestines/Bowels | 12. ___Blood | <i>For Males Only:</i> |
| 6. ___Urinary | 13. ___Allergies | 18. ___Prostate/Testicular/Penile |
| 7. ___Muscles | 14. ___Psychological/Emotional | |

Please explain any of the above YES answers:

Social History:

Recreational Activities/Hobbies: _____

Have these activities been limited by your pain? If yes, describe: _____

- | | | |
|--------------------------|--------------------------|--|
| Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you exercise? _____ times/week |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you smoke? _____ Packs/day (If you have quit smoking, when did you quit? _____) |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you use other forms of tobacco? What/How much per day? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you consume alcohol? How many drinks per week? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you eat a balanced diet? If no, explain: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you get adequate sleep? How many hours per night? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Is work stressful to you? If yes, explain: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Is family life stressful to you? If yes, explain: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you use recreational drugs? If yes, explain: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you drink enough water daily? How much water do you drink per day? _____ oz/day |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you consume caffeine? How much? _____ oz./day |

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What problem brings you to us today? _____

When did your symptoms begin? _____

Have you had this problem before? Yes No

Was the onset: Gradual Sudden Since its onset, symptom has gotten: Better Worse No Change

Please describe what causes the symptom: _____

What aggravates this condition? _____

What decreases the symptoms/pain? _____

Does this interfere with your sleep? Yes No

Is your condition worse in the: AM PM Constant

Have you detected any possible relationship of your current complaint with any of the following:

Muscle Weakness Bowel/Bladder problems Digestion Cardiac/Respiratory Other: _____

Are you currently pregnant? Yes No

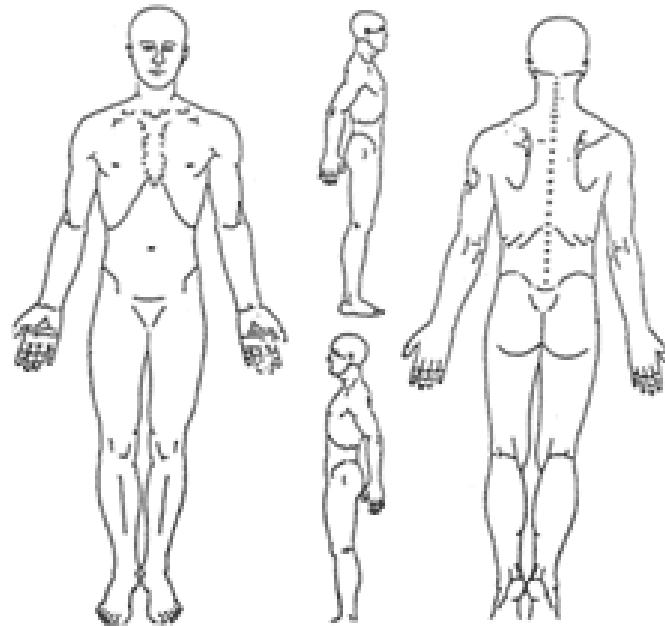
Are you currently taking any natural vitamins or supplements? Yes No

What medications and supplements are you currently taking?

Please mark areas of pain using these codes:

+++ Burning
Dull/Ache
*** Numbness/Tingling
=== Throbbing
ooo Sharp/Stabbing

PAIN CHART: (If applicable)



SEVERITY OF PAIN: (If applicable)

Please list area of pain & write a number 1-10 which represents the intensity of your pain (1= minor pain, 10=unbearable):

- Complaint: _____ At worst: ____/10 At best: ____/10 Typical: ____/10
- Complaint: _____ At worst: ____/10 At best: ____/10 Typical: ____/10
- Complaint: _____ At worst: ____/10 At best: ____/10 Typical: ____/10

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OUR MISSION STATEMENT

Our MISSION is to provide the best care possible to every patient which is accomplished by supporting our staff and providers in every way possible to allow them to practice efficiently and dedicate their time to the individual needs of the patient.

INFORMED CONSENT

I understand this Facility, its doctors & staff are accepting my case based on examination findings and believe the outlined treatment should produce change and/or improvement. However as with any diagnostic test, procedure, examination or doctor's care, a guarantee of improvement or complete recovery cannot be made and it is even possible that no change occur.

I further understand that in the practice of medicine, acupuncture, chiropractic, massage therapy, weight loss counseling and physical therapy there are some risks including but not limited to fractures, disc injuries, strokes, dislocations, sprain-strains, drug interactions & reactions and/or other injuries or side effects which cannot be predetermined.

I do not expect the doctor/provider to be able to anticipate and explain all risks and/or other complications, and I wish to rely on the doctor/provider to exercise judgment during the course of the procedure(s) which the doctor/provider feels at the time is in my best interest.

In addition, because psycho-social, spiritual, and cultural values affect a patient's response to care, patients are allowed to express and follow spiritual beliefs and cultural practices that do not harm others or interfere with the planned course of treatment.

Patients have the right to refuse treatment, but must be aware of the probably consequences of refusing treatment and/or failing to cooperate with the prescribed treatment. Should you refuse and/or fail to comply with prescribed treatment your provider will discuss specific consequences with you.

Therefore I give my full consent to the doctor/provider to render treatment on me or the minor whom I am legally responsible by a health care provider of this Facility.

ASSIGNMENT OF BENEFITS- AUTHORIZATION AND LEIN

I, the assignee, being the patient or legal guardian for the said minor listed below, do hereby irrevocable authorize, direct, assign and give full lien to the office named above and listed below, hereinafter referred to as the "Facility" against any and all insurance benefits, proceeds of any settlement, judgment or verdict which may be paid to the undersigned as a result of the injuries or illness for which I have been treated by the Facility.

I, the assignee, further authorize any and all insurance company, attorney and any & all third party payer to pay directly to the Facility all sums of money due them for any and all services rendered to me or minor by whom I am responsible for by reason of accident, illness and by any and all reason of any other bills that are due or may become due, and to withhold such sums from any health & accident, workers compensation and or including all insurance or third party benefits.

Assignee agrees that this Facility & staff may deliver medical records, consultations, depositions and/or court appearances which must be paid in full in advance and authorizes this Facility to release any information pertinent to said health care any insurance company, adjuster, attorney or legal service bureau to facilitate collections under the terms of this document. Assignee grants the Facility a full power of attorney to endorse and/or sign my name on any and all checks for payment of any indebtedness owed this office & assignee.

INSURANCE BENEFITS- CREDIT POLICIES- PAYMENT TERMS & CONDITONS

1. As a courtesy, the Facility will obtain a verification of applicable insurance benefits as they are quoted to us but some third party payers mis-quote benefits, coverage, and liability. Our Facility and staff are not responsible for what third party payer and/or representative may tell us. Any contractual, written, verbal or other obligations or arrangements between you and an attorney, insurance company, liable or third party payer are between you and said person.
2. Our Facility will file initial insurance claims for you. Secondary claim submission and/or additional reports or documents sent for your benefit may result in additional filing medical report charge which you are responsible to pay.
3. Co-pays, deductibles and all non-covered service charges are due the day the service is rendered.
4. Patients are responsible for charges on all service(s) and/or product(s) which may exceed the maximum allowable and/or when a third party and/or insurance carrier does not reimburse this Facility enough to meet our cost of service.
5. All account balances, including automobile and work injury claims must be paid in full within 90 days of treatment. Patients are fully responsible for all money owed this office and such payment is not contingent on any settlement, claim, judgment, or verdict by which they may eventually recover said fee and it is also regardless of any attorney liens or pending settlement(s). If a third party payer fails to pay said balance in full within the 90 day period, the patient must pay the balance in full. Assignee is fully responsible for all money owed this Facility for any and all treatment, products & services rendered to the patient or minor shown below.
6. A non-discriminatory "Time of Service Discount" is offered to anyone who pays for services the day they are rendered. The "TOS" is only offered on the day the service is rendered. This discount does not apply to orthopedic supports, orthotics, physical therapy equipment rentals or purchase, vitamins, supplements, ointments, acupuncture treatments, weight loss programs and massage therapy.
7. A service charge is computed by a "periodic rate" of 1 1/2% per month- 18% per annum and is added to all balances owed 60+ days. Any balance past due 90 days or more will be submitted to an attorney and/or agency for legal collection for which the undersigned agrees to be 100% responsible for all monthly service charges, costs related to but not limited to all collection related expenses, attorney fees, court & filing fee's.
8. Returned checks, debit & credit charges made payable to this Facility for insufficient funds, stop payments or other reasons of non-payment will be assessed a \$30.00 charge.

I understand & agree to the above statements. Any questions I have had regarding the above have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.

Signature

Date

HIPPA- NOTICE OF PRIVACY PRACTICE

I, _____ (name of individual) consent to Olde Naples Chiropractic Health Center (the practice)'s use and disclosure of my Protected Health Information for the purpose of providing treatment to me, for purposes relating to the payment of services rendered to me, and for the Practice's general healthcare operations services. Healthcare operations purposes shall include, but not be limited to, quality assessment activities, credentialing, business management and other general operation activities. I understand that the Practice's diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

For purposes of this Consent, "Protected Health Information" means any information, including my demographic information, created or received by the Practice, that relates to my past, present, or future physical or mental health or condition; the provision of healthcare to me; or the past present or future payment for the provision of healthcare services to me; and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me.

I understand that I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment, payment or healthcare operations of the Practice, but the Practice is not required to agree to these restrictions. However, if the Practice agrees to a restriction that I request, the restriction is binding on the Practice.

I understand I have the right to review the Practice's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes my rights and the Practice's duties regarding the types of uses and disclosures of my Protected Health Information.

I have the right to revoke this consent, in writing, at any time, except that Physician or the Practice has acted in reliance on this consent.

Signature of Patient or Personal Representative

Name of Patient or Personal Representative

Date

I furthermore hereby authorize Olde Naples Chiropractic to release my medical information to the following person(s)/entities:

Patient

ID

Date