WELCOME

PATIENT INFORMATION:

Name Date

Address

City State Zip

Home Phone Cell Work

Referred by Gender: Male Female

Marital Status: M S D W

Date of Birth

Employer Occupation

Employer Address

Emergency Contact Phone #

HISTORY:

Reason for visit

Have you ever had a massage prior to this visit? YES NO

PERSONAL HEALTH HABITS:

Do you smoke? YES NO How much? _____ How Long? _____

Do you drink caffeine? YES NO How much? _____ How Long? _____

Do you drink alcoholic beverages? YES NO How Often? _____

What kind? _____

For Females Only:

Are you pregnant? YES NO Date of last menstrual cycle? _____

BEFORE TREATMENT:

If you have any recent or chronic medical conditions, please check them below:

___Dislocations	___Back Injuries	___Neck Injuries	___Fractures
___Pulled Muscles	___Stiff Neck	___Broken Bones	___Headaches
___Muscle Cramps	___Back Pain	___Diabetes	___Arthritis
___Recent Surgery	___Skin Problems	___Sores	___Open Lesions
___Bruise Easy	___Fainting Spells	___Varicose Veins	___Numbness
___Cancer	___Hepatitis	___Car Accident	___Dizziness
___Nerve Problems	___High Blood Pressure	___Inflammations	

Other_____

MEDICATIONS:

Med. Names/Strength	Reason	How Often

Taken antibiotics in last year? YES NO

Are you allergic to any chemicals, scents, or ointments? YES NO

If so, please list: _____

I have read the above and have answered honestly to the above questions and will discuss it with the therapist. I understand that this bodywork does not constitute medical treatment, but rather is a form of health maintenance. I take responsibility for alerting my therapist to any physical conditions that would affect this work.

Please allow 24 hours' notice of appointment cancellations. We reserve the right to charge for any missed appointments not given sufficient notice of cancellation. Payment is due at the time services are rendered.

SIGNED **DATE**

Patient Health Questionnaire

Patient Name _____ Date _____

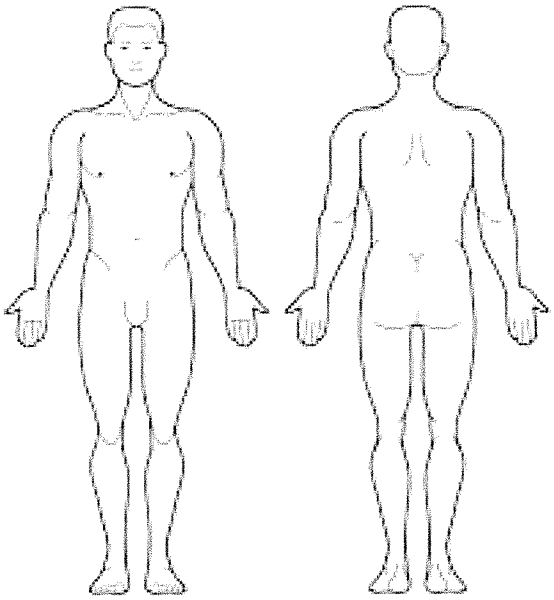
1. Describe your symptoms: _____

_____

a. **When did your symptoms start?** _____

b. **How did your symptoms begin?** _____

Indicate where you have pain or other symptoms TODAY



Please **FILL IN** bubble next to answer(s):

2. How often do you experience your symptoms?
- O Constantly (76-100% of the day)
- O Frequently (51-75% of the day)
- O Occasionally (26-50% of the day)
- O Intermittently (0-25% of the day)

3. What describes the nature of your symptoms?
- O Sharp O Dull Ache O Numb
- O Shooting O Burning O Tingling
- Other:_____

4. How are your symptoms changing?
- O Getting Better
- O Not changing
- O Getting Worse

5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms

None Unbearable

(0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)

b. How much has pain interfered with your normal work (including both work outside the home and housework)

(1) Not at all (2) A little bit (3) Moderately (4) Quite a bit (5) Extremely

6. Who have you seen for your symptoms? O No One O Medical Doctor O Chiropractor O Physical Therapist O Other

a. What treatment did you receive and when? _____

b. What test(s) have you had for your symptoms and when were they performed? O X-rays date_____ O CT Scan date_____ O MRI date_____ O Other date_____

7. Have you had similar symptoms in the past? ◯ **YES** ◯ **NO**

a. If you received treatment in the past for the same or similar symptoms, who did you see? O This Office O Medical Doctor O Chiropractor O Physical Therapist O Other

8. What is your occupation? _____

O Full-time O Self-Employed O Off work O Part-time O Unemployed O Other _____

Patient Signature _____ **Date** _____

RIVERVIEW FAMILY CHIROPRACTIC CENTER, P.A.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, *Riverview Family Chiropractic Center, P.A.*, may use my disclosed protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to Riverview Family Chiropractic Center, P.A.'s Notice of Privacy Practices for a more complete description.

I have the right to review the Notice of Privacy Practices prior to signing this consent. I am acknowledging that I have been provided a copy of the Notice of Privacy Practices and that I have, will, or decline to read them, and understand the Notice of Privacy Practices. I understand this form will be placed in my patient chart and maintained for seven years. *Riverview Family Chiropractic Center, P. A.* reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practice may be obtained by forwarding a written request to ***Riverview Family Chiropractic Center, P. A., Privacy Office at 10833 Boyette Rd., Riverview, Fl. 33569.***

With my consent, *Riverview Family Chiropractic Center, P. A.* may mail to my home or other designated location, any item that assists the practice in carrying out TPO; such as appointment reminder cards and patient statements as long as they are marked *Personal and Confidential.*

I have the right to request that *Riverview Family Chiropractic Center, P. A.* restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested patient statements, as long as they are marked *Personal and Confidential.*

By signing this form, I am consenting to *Riverview Family Chiropractic Center, P. A.'s* use of my disclosed PHI to carry out TPO.

I may revoke my consent in writing, except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, *Riverview Family Chiropractic Center, P. A.* may decline to provide treatment to me.

_____ _____

Print Name of Patient Print Name of Legal Guardian

_____ _____

Signature of Patient or Legal Guardian Date

___ By initialing here, I am stating that I was provided with a copy of the Notice of Privacy Practices and have chosen not to keep the copy. I have been made aware of an office copy that is available for review.

FINANCIAL POLICY

The Doctors and Staff at ***Riverview Family Chiropractic Center*** would like to welcome you to our practice!

We strive to provide you with excellent medical care.

BY SIGNING BELOW, YOU CONFIRM THAT YOU HAVE READ AND UNDERSTAND OUR OFFICE POLICY.

It is **your** responsibility to inform our office of any address and telephone number changes.

Your account is to be kept current; accordingly, all self-pay or insurance co-payments and deductibles will be collected **at the time of service,** unless prior arrangements have been made. We take checks, MasterCard, Visa, American Express and Discover credit cards.

A returned check will result in a **$25.00 service charge** and all future payments must then be made by cash or credit card.

You will be sent a statement each month if your balance exceeds $10.00.

There is a $25.00 NO SHOW fee for anyone not giving the office a 24-HOUR CANCELLATION NOTICE for appointments (doctor, massage, or laser).

If your account is turned over to a collection agency, you will be responsible for any cost incurred in collection of said balance and must work with the collection agency to pay balance, not our office.

We submit your claims, however, we must emphasize that as a medical provider, our relationship is with you and not your insurance company.

It is your responsibility to inform us of any changes in your insurance coverage.

It is your responsibility for non-covered charges not payable by your insurance company. Although filing your insurance claim is a courtesy extended to you, all charges are always **your** responsibility.

We realize that temporary financial problems may affect payment of your account. If such problems do arise, we urge you to contact our billing department at **(813) 741-0655** for assistance in management of your account. If you have any questions, please do not hesitate to ask us.

Print Name: _____

Signature: _____

Date: _____

MASSAGE RELEASE FORM

PLEASE READ THE FOLLOWING INFORMATION AND SIGN WHERE INDICATED:

I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and the relief of muscular tension. If you have a serious medical or muscular problem, you may need to seek treatment from your physician before the massage can be given. If at any time, I experience any pain or discomfort during the session, I will **immediately** inform the therapist so that the pressure/strokes may be adjusted to my comfort level. I further understand that massage/bodywork should not be construed as a substitute for medical attention. I understand the therapist is not qualified to perform spinal or skeletal adjustment, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage/bodywork is contraindicated under certain medical conditions, I affirm that I have stated all of my known medical conditions and answered all questions honestly. I also understand that any illicit or sexually suggestive remarks or advances made by me will immediately terminate the session.

Client/Patient Signature:_____ Date:_____

Therapist Signature:_____ Date:_____