

WELCOME

PATIENT INFORMATION

Name _____ Date _____
Address _____ Apt. # _____
City _____ State _____ Zip Code _____
Phone #: Home _____ Cell _____ Work _____
Referred by: _____

Date of Birth: _____
Gender: Male _____ Female _____ Marital Status (please circle): M S D W Sep
Race (optional) Please check:
Hispanic/Latino _____ African American _____ Asian _____ Caucasian _____ Other _____
Number of Children _____ Ages _____
Employer _____ Occupation _____
Employer Address _____
Spouse's Name _____ Spouse's DOB _____
Emergency Contact Name _____ Phone # _____
Party Responsible for Payment _____
If insurance, Name of Insurance Company _____
If Auto Accident, Name of Your Auto Ins. Company _____
Claim # _____ Were you cited as the at-fault driver? YES NO

HISTORY INFORMATION

Reason for visit _____
Related to Employment? YES NO Days lost from work _____
Related to Auto Accident? YES NO Date of accident _____
Related to Other Accident YES NO Date of accident _____
Other doctors seen for these complaints _____
Have you been treated at the hospital for these complaints? YES NO
What type of treatment did you receive? _____

Have you had similar symptoms before? YES NO When? _____
Have you ever seen a Chiropractor before? YES NO When? _____

MEDICAL HISTORY (Indicate Y or N for each)

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Known Deformity | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Birth Defect | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Swelling of Feet |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Gallbladder Disease | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> German Measles | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Gout | <input type="checkbox"/> Neuritis | <input type="checkbox"/> Venereal Diseases/STDs |
| <input type="checkbox"/> Chronic Diarrhea | <input type="checkbox"/> Hazardous Act. | <input type="checkbox"/> Numbness | Other _____ |
| <input type="checkbox"/> Concussion | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Phlebitis | _____ |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Polio | _____ |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> HIV | <input type="checkbox"/> Psychological Illness | _____ |

List any previous surgeries _____

Treated by a physician in last 12 months? YES NO Describe _____

FEMALES ONLY: Pregnant? YES NO Date of last menstrual cycle _____

If pregnant, Due Date: _____

MEDICATIONS (if none-please write None Taken)

Medication Name/Strength	Reason Taken	How Often	Prescribing Physician
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Vitamins / Other Supplements (over-the-counter medications)

_____	_____	_____	_____
_____	_____	_____	_____

Have you taken antibiotics in the past year? YES NO

Allergies: Are you allergic to any medication? YES NO

Medication _____ Reaction _____

Medication _____ Reaction _____

Other allergies (food, animals, dust, etc.) _____

FAMILY HISTORY

	GENDER	AGE (current or at death)	Cause of Death	Illness	General Health
Father	M	_____	_____	_____	_____
Mother	F	_____	_____	_____	_____
Siblings	M/F	_____	_____	_____	_____
	M/F	_____	_____	_____	_____

PERSONAL HEALTH HABITS

Smoke? YES NO How much? _____ How long? _____ If quit, how long ago? _____

Drink Caffeine? YES NO How much? _____ How long? _____

Drink alcoholic beverages? YES NO How much? _____ How long? _____

Initials _____

Patient Health Questionnaire

Patient Name _____

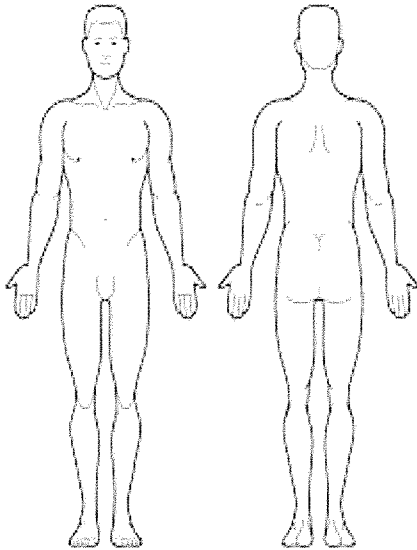
Date _____

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?

- Constantly (76-100% of the day)
- Frequently (51-75% of the day)
- Occasionally (26-50% of the day)
- Intermittently (0-25% of the day)

3. What describes the nature of your symptoms?

- Sharp Dull Ache Numb
- Shooting Burning Tingling
- Other: _____

4. How are your symptoms changing?

- Getting Better
- Not changing
- Getting Worse

5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms

None Unbearable
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. During the past 4 weeks, how much of the time has your condition interfered with your social activities?

(like visiting with friends, relatives, etc) 1 All of the time 2 Most of the time 3 Some of the time 4 Quite a bit 5 None

7. In general, would you say your overall health right now is:

① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

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

a. What treatment did you receive and when? _____

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

9. 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?
 This Office Medical Doctor Chiropractor
 Physical Therapist Other

10. What is your occupation?

Professional/Executive Tradesperson Laborer Retired
 White Collar/Secretarial Homemaker FT Student Other

a. If you are not retired, a homemaker, or a student, what is your current work status?

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

Patient Signature _____

Date _____

Personal Injury Application

Name _____ Date of Birth _____ Phone _____

Address _____ Work Phone _____

Social Security # _____ Years lived in Florida _____

Date of Accident _____ Time of Accident _____ Were you injured? _____

Make / Model of Your Vehicle _____

Describe other vehicle(s) in accident _____

Place of Accident _____

Were you the () Driver () Passenger () Front Seat () Back Seat # of People in car _____

Were you wearing a seatbelt? () Yes () No

What direction were you headed? () North () South () East () West

Street name other vehicle was on _____

You were struck from () Behind () Front () Left Side () Right Side

Were you knocked unconscious? () Yes () No If YES, for how long? _____

Were the Police notified? () Yes () No Name of witness(s) _____

Have you retained an attorney? () Yes () No Attorney Name _____

Where were you taken after the accident? _____

Have you been treated by another doctor for this accident? () Yes () No If YES, who? _____

What type of treatment did you receive for these injuries? _____

Since the injury occurred, are your symptoms () Improving () Getting Worse () Same

Please describe your accident _____

Please describe your injuries/complaints _____

Please describe how you felt **during** the accident _____

Immediately **after** the accident _____

Later that day _____

The next day _____

Did you have any physical complaints **before** the accident? () Yes () No

If yes, please explain _____

Were you treated for any previous accidents? () Yes () No

If yes, please explain _____

Doctor's you have consulted _____

Address _____

Name/Address of hospital where you were treated _____

Treated as () In-patient () Out-patient Were X-rays taken? () Yes () No

At time of accident, was this during the performance of your employment? () Yes () No

Did you lose wages or salary as a result of the accident? () Yes () No

Amount to-date _____

Average weekly salary _____ Date disability began _____

Date returned to work _____ Eligible for Workman's Compensation Benefits? () Yes () No

If yes, amount per week _____ Employer _____

Employer address _____

Your occupation _____ From _____ To _____

As a result of injuries, have you had other expenses? () Yes () No

Please explain _____

Pursuant to Florida Statute 817.231, any person **knowingly** and with intent to injure, defraud or deceive any insurance company by filing a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree. I hereby authorize the release of medical information including, but not limited to, medical bills and reports to such persons as the company may deem necessary to perfect its rights of recovery under the "No-Fault" Auto Insurance Law.

Signature _____ Date _____

Guardian _____ Date _____

Authorization for Medical Information

This authorization or photocopy hereof, will authorize you to furnish all information you may have regarding any condition while under your observation or treatment, including the history obtained, x-rays and physical findings, diagnosis, and prognosis. You have been authorized to provide this information in accordance with the Florida "No-Fault" Auto Insurance Law (Chapter 71-25f.S)

Signature _____ Date _____

Guardian _____ Date _____

PATIENT AUTHORIZATION FORM

Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, significant other, parents or children to call and request the result of tests, procedures and financial information. Under the requirements for H.I.P.A.A. we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, any diagnostic test results and/or financial information released to any family members you must sign this form.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize **Riverview Family Chiropractic Center** to release my records and any information requested to the following individuals.

1. _____ Relation to Patient: _____ Ph _____
2. _____ Relation to Patient: _____ Ph _____
3. _____ Relation to Patient: _____ Ph _____
4. _____ Relation to Patient: _____ Ph _____

Authorization Regarding Messages (please check all that apply)

- I authorize you to leave a detailed message on my home or cell number regarding appointments
- I authorize you to leave a detailed message on my home or cell number regarding medical treatment, care, test results or financial information
- I authorize you to leave a message with anyone who answers the phone
- Messages may only be left with _____

Patient Name (PLEASE PRINT)

Date

Patient Signature

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: _____

PAYMENT AUTHORIZATION

I hereby authorize and direct you, my insurance company, and/or my attorney, to pay directly to “**Riverview Family Chiropractic Center, PA**” such sums as may be due and owing this office for services rendered to me, both by reason of accident or illness, and any disability benefits, medical payment benefits, no fault benefits, health and accident benefits, workman’s compensation benefits, or any other payments which may be necessary to adequately protect said office. I hereby further give a lien to said office against any and all insurance benefits named herein, and any and all proceeds if any settlement, judgement or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by said office. This is to act as a assignment of benefits and an assignment of direct payment to the extent of the office’s services provided.

In the event my insurance company is obligated to make payments to me upon the charges made by this office for services rendered, refuses to make such payments, upon demand by me or this office, I hereby assign and transfer to this office, any and all causes of action that I might have or that might exist in my favor against such company, and authorize this office to prosecute said cause of action either in my name or the office’s name. I further authorize this office to compromise, settle and otherwise resolve said claim or cause of action as they see fit.

I authorize this office to release any information pertinent to my case to any insurance company, adjuster, or attorney to facilitate collection under this assignment, lien, and authorization. I agree that the above-mentioned office be given authorization to endorse/sign my name in any and all checks for payment of my doctor bill. I understand that health and accident insurance policies are an arrangement between myself and the insurance company.

I further understand and agree that if this office must take any action to collect an outstanding balance on my account, I will be responsible for payment of, and will reimburse this office for all costs of such collection efforts. This is including, but not limited to al court costs, interest occurred, collection fees and all attorney fees.

Patient Signature: _____

Spouse / Guardian Signature: _____

Date: _____

FOR OFFICE USE ONLY

Co-Pay is \$_____ per visit, while under active care toward services rendered. Balance will be billed at the end of care.

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.

ASSIGNMENT AND AUTHORIZATION

For good and valuable consideration, including the agreement of Riverview Family Chiropractic Center, PA to accept this assignment in lieu of demanding full payment for services from the undersigned on the date each service is rendered, the undersigned patient executes this document hereby assigning to Riverview Family Chiropractic Center, PA, the right to receive insurance benefits directly from any insurance company that may be obligated to provide insurance benefits, to me or on my behalf, for services rendered by Riverview Family Chiropractic Center, PA for a motor vehicle accident that occurred on or about _____.

Any insurance company that may be obligated to pay any insurance benefits to me, or on my behalf, for the aforesaid accident, for services provided by Riverview Family Chiropractic Center, PA, is hereby directed to issue payment for those benefits directly to and payable to **Riverview Family Chiropractic Center, PA**.

I also authorize and assign to Riverview Family Chiropractic Center, PA, the right to file suit and pursue all legal remedies to obtain payment for services provide to me by Riverview Family Chiropractic Center, PA. This authorization to file suit is an assignment of my cause of action to obtain payment for services provided by Riverview Family Chiropractic Center, PA, and includes the assignment to pursue declaratory relief or any other legal remedies.

Riverview Family Chiropractic Center, PA accepts the aforementioned assignment and hereby notifies any insurer issuing payment that Riverview Family Chiropractic Center, PA objects to any "repricing" or reduction of billed amounts unilaterally made by any insurer. Any such reduced payment issued by any insurer are accepted under protest and without waiving any right of the provider to pursue all legal remedies against the insurer.

Please read this document completely before signing. If you do not completely understand this document or have any questions about this document, please ask us to explain it to you. If there is any portion of this document that you do not wish to authorize, we will remove that portion from this document. Your signature below is your agreement that you fully understand this document and you fully agree to the terms of this document.

Patient's signature (or guardian's signature)

Date

Witness to patient or guardian's signature

Date

Authorized signatory for medical provider

Date

ADDITIONAL AUTHORIZATIONS AND DIRECTIONS TO INSURER

AUTHORIZATION FOR DISCLOSURE OF INSURANCE DECLARATION PAGE:

I, the patient and insured, further authorize and direct any insurance company that may be obligated to pay any insurance benefits to me, or on my behalf, to provide to Riverview Family Chiropractic Center, PA, a copy of any declarations page of any insurance policy that may provide benefits to me for the aforesaid accident.

AUTHORIZATION FOR DISCLOSURE OF INSURANCE PAYMENT RECORD:

I further authorize and direct any insurance company that may be obligated to pay any insurance benefits to me, or on my behalf, to provide to Riverview Family Chiropractic Center, PA, a copy of any payment ledger or record of payments made under any insurance coverage available to me, without redacting the names of any other medical provider or entity to whom insurance benefits have been paid.

DIRECTION NOT TO EXHAUST BENEFITS BY PAYMENT OF OTHER CLAIMS:

I further authorize and direct any insurance company that may be obligated to pay any insurance benefits to me, or on my behalf, to not exhaust insurance benefits or coverage until all claims submitted by Riverview Family Chiropractic Center, PA have been paid in full, or at 80%, if the insurance policy is limited to 80% coverage of medical claims. If any insurance company obligated to pay any insurance benefits to me, or on my behalf, had denied payment of a claim submitted by Riverview Family Chiropractic Center, PA at an amount lesser than the amount billed, or lesser than 80% of the amount billed, if my coverage is limited to 80% for medical claims, I direct the aforesaid insurance company to hold in escrow the amount in dispute. If other claims would exhaust benefits, I direct the aforesaid insurance company to hold in escrow the disputed amount and to not exhaust benefits or coverage by payment of the amount I have hereby requested be held in escrow. I further authorize Riverview Family Chiropractic Center, PA to attempt to resolve the disputed claim in a manner acceptable to Riverview Family Chiropractic Center, PA.

DIRECTION TO INSURER TO MAINTAIN CONFIDENTIALITY:

I further direct any insurance company that may be obligated to pay any insurance benefits to me or on my behalf, to maintain the privacy and confidentiality of my medical records. I **do not** authorize any insurer to provide my medical records to anyone without first obtaining a written authorization from me to provide the medical records to any other entity.

AUTHORIZATION FOR RELEASE OF RECORDS TO PROVIDER:

I hereby authorize any insurance company that may be obligated to pay any insurance benefits to me, or on my behalf, to release a copy of my complete medical records in possession of such insurer to Riverview Family Chiropractic Center, PA upon the request of Riverview Family Chiropractic Center, PA. This authorization includes the authorization to release to Riverview Family Chiropractic Center, PA a copy of any medical examinations or evaluation of me requested by any insurance company.

DIRECTION TO INSURER TO FURNISH TO PROVIDER ADVANCE NOTICE OF IME OR EUO:

I further authorize and direct any insurance company that may be obligated to pay any insurance benefits to me, or on my behalf, to provide at least 15 (fifteen) days advance notice to Riverview Family Chiropractic Center, PA of any physical examination or examination under oath of myself that any insurance company may schedule.

Please read this document completely before signing. If you do not completely understand this document or have any questions about this document, please ask us to explain it to you. If there is any portion of this document that you do not wish to authorize, we will remove that portion from this document. Your signature below is your agreement that you fully understand this document and you fully agree to the terms of this document.

Patient's signature

Date

Guardian's signature / Relationship to patient

Date

Witness to patient or guardian's signature

Date



Todd Jarvis, D.C.
Preston Rogers, D.C.

10833 Boyette Road
Riverview, Fl. 33569
Office: 813-741-0655 Fax: 813-741-0945

To:

From: Todd Jarvis, DC
Preston Rogers, DC
Riverview Family Chiropractic Center

Re: Doctor's Report, Irrevocable Lien and Assignment on

Dated: _____

I hereby authorize the above doctor(s) to furnish you, my Attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was involved.

I hereby authorize and direct you, my Attorney, to pay directly to said Doctor(s) such sums as may be due and owing him for professional services rendered to me both by reason of this accident and by reason of any other bills that are due his office, and to withhold such sums from any settlement, judgement, or verdicts may be necessary to adequately protect said Doctor(s).

I fully understand that I am directly and fully responsible to said doctor for all professional bills submitted by him for services rendered to me. This agreement is made solely for said doctor's additional protection, and in consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, judgement, or verdict by which I may eventually recover said fee.

Patient's Signature (or Guardian's Signature)

Date

The undersigned, being the representing Attorney for the above, agrees to withhold such sums from any settlement, judgement, or verdict as may be necessary to adequately protect the said Doctor(s) named above.

Attorney Signature

Date

Attorney: Please sign, date and return to our office via fax (813)741-0945 or email: chirorfcc@gmail.com.

Thank you.