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)

_____Alcoholism	_____Diabetes	_____Irregular Heartbeat	_____Rheumatic Fever
_____Allergies	_____Dizziness	_____Jaundice	_____Scarlett Fever
_____Anemia	_____Drug Addiction	_____Known Deformity	_____Shortness of Breath
_____Arthritis	_____Epilepsy	_____Kidney Disease	_____Stroke
_____Asthma	_____Fainting	_____Liver Disease	_____Suicide Attempt
_____Birth Defect	_____Frequent Headaches	_____Low Back Pain	_____Swelling of Feet
_____Cancer	_____Gallbladder Disease	_____ Multiple Sclerosis	_____Thyroid Disease
_____Chest Pain	_____German Measles	_____Nervousness	_____Ulcers
_____Chronic Cough	_____Gout	_____Neuritis	_____Venereal Diseases/STDs
_____Chronic Diarrhea	_____Hazardous Act.	_____Numbness	Other _____
_____Concussion	_____Heart Disease	_____Phlebitis	_____
_____Constipation	_____High Blood Pressure	_____Polio	_____
_____Convulsions	_____HIV	_____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	_____

PERONAL 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? _____

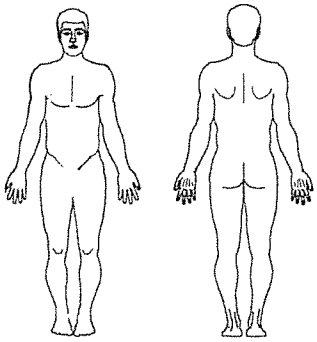
Initials_____

American Specialty Health (ASH)
P.O. Box 509001, San Diego, CA 92150-9001
California Only Fax: 877.427.4777 All Other States Fax: 877.304.2746

INITIAL HEALTH STATUS
Chiropractic

Patient Name_____ Birthdate_____ Sex: M / F
Address_____ City_____
State_____ Zip_____ Phone (____)_____ Patient Primary Language_____
Occupation_____ Employer_____ Work Phone_____
Address_____ City_____ State_____ Zip_____
Subscriber Name_____ Health Plan_____
Subscriber ID #_____ Group #_____ Spouse Name_____
Spouse Employer_____ City_____ State_____ Zip_____
Primary Care Physician Name_____ PCP Phone_____

MARK AN **X** ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.



DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

☐ Headache ☐ Neck Pain ☐ Mid-Back Pain ☐ Low Back Pain
☐ Other_____

Is this? ☐ Work Related ☐ Auto Related ☐ N/A

Date Problem Began_____

How Problem Began

Current complaint (how you feel today):

0 1 2 3 4 5 6 7 8 9 10
No Pain Unbearable Pain

How often are your symptoms present?
(Occasional) ☐ 0 – 25% ☐ 26 – 50% ☐ 51 – 75% ☐ 76 – 100% (Constant)

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores?

No interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities

In general would you say your overall health right now is:
☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN FOR YOUR AREA(S) OF COMPLAINT? ☐ No ☐ Yes

Date(s) taken_____ **What areas were taken?**_____

Please check all of the following that apply to you:

☐ Alcohol/Drug Dependence
☐ Recent Fever
☐ Diabetes
☐ High Blood Pressure
☐ Stroke (Date)_____
☐ Corticosteroid Use (Cortisone, Prednisone, etc.)
☐ Taking Birth Control Pills
☐ Dizziness/Fainting
☐ Numbness in Groin/Buttocks
☐ Cancer/Tumor (Explain)_____
_____
☐ Osteoporosis
☐ Epilepsy/Seizures
☐ Other Health Problems (Explain)_____

☐ Prostate Problems
☐ Menstrual Problems
☐ Urinary Problems
☐ Currently Pregnant, # Weeks_____
☐ Abnormal Weight ☐ Gain ☐ Loss
☐ Marked Morning Pain/Stiffness
☐ Pain Unrelieved by Position or Rest
☐ Pain at Night
☐ Visual Disturbances
☐ Surgeries_____
_____
☐ Tobacco Use - Type_____
Frequency_____/Day
☐ Medications_____

Family History: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure
☐ Heart Problems/Stroke ☐ Rheumatoid Arthritis

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this practitioner, I understand that I am liable for all charges for services rendered and I agree to notify this practitioner immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor may need to contact my physician if my condition needs to be co-managed. Therefore I give authorization to my chiropractor to contact my physician, if necessary.

Patient Signature_____ **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

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.

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: _____

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.