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______________

Patient Health Questionnaire

Patient Name ______________________________ Date ____________________

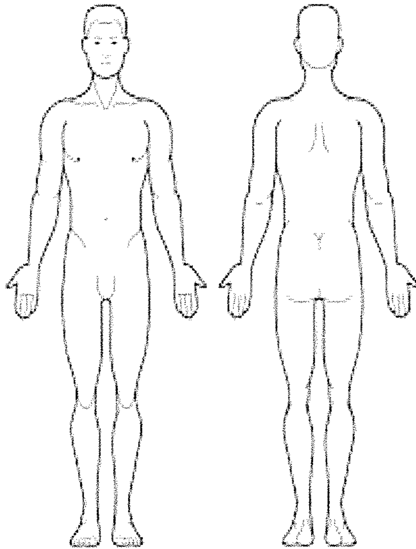
1. Describe your symptoms: ____

____

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 ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Unbearable

b. How much has pain interefered 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 heatlh right now is:

① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

8. 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______________

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? O This Office O Medical Doctor O Chiropractor O Physical Therapist O Other

10. What is your occupation? O Professional/Executive O Tradesperson O Laborer O Retired O White Collar/Secretarial O Homemaker O FT Student O Other

____

a. If you are not retired, a homemaker, or a student, what is your current work status? O Full-time O Self-Employed O Off work O Part-time O Unemployed O Other ______________________________

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.