

# WELCOME

## PATIENT INFORMATION

Name \_\_\_\_\_ Preferred Name: \_\_\_\_\_ Date \_\_\_\_\_  
Address \_\_\_\_\_ Apt. # \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Phone #: Home \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_  
Email address: \_\_\_\_\_ 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 \_\_\_\_\_ Job Title \_\_\_\_\_  
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? \_\_\_\_\_  
\_\_\_\_\_

## MEDICAL HISTORY (Indicate Y or N for each)

|                        |                           |                             |                              |
|------------------------|---------------------------|-----------------------------|------------------------------|
| _____ Alcoholism       | _____ Diabetes            | _____ Irregular Heartbeat   | _____ Rheumatic Fever        |
| _____ Allergies        | _____ Dizziness           | _____ Jaundice              | _____ Scarlet 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    | _____                     | _____          | _____   | _____          |

## 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 \_\_\_\_\_

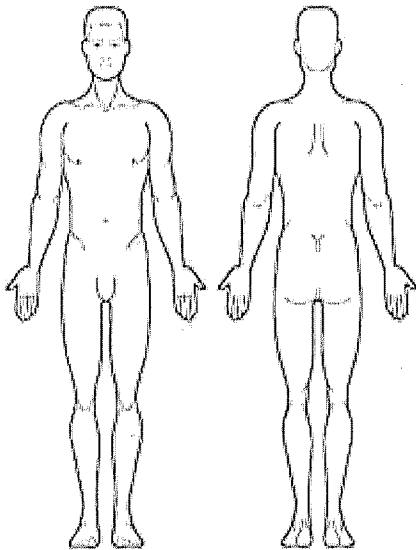
Date \_\_\_\_\_

**1. Describe your symptoms:**

a. When did your symptoms start?

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

**Mark/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 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 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?

O X-rays date

O CT Scan date

O 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(es) \_\_\_\_\_

Have you retained an attorney? ( ) Yes ( ) No

Attorney Name / Ph# \_\_\_\_\_

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

Eligible for Workman's Compensation Benefits? ( ) Yes ( ) No

Employer \_\_\_\_\_

Employer address \_\_\_\_\_

Your occupation \_\_\_\_\_

Employer Contact / Phone # for Workman's Compensation \_\_\_\_\_

Pursuant to Florida Statute 817.231, any person **knowingly** and with intent to harm, 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

## 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 **AND FUTURE SESSIONS**.

Client/Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Therapist Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## **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 cash, checks, MasterCard, Visa, American Express and Discover credit cards and Apple pay.

If paying by credit card, there is a **4%** or less convenience fee added to the charge by our card processing company. A returned check will result in a **\$30.00 service charge**, and all future payments must then be made by cash or credit card.

**There is a \$30.00 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 the balance turned over, **PLUS 30% to 50%**, depending on the balance at the time it is sent to the collection agency, and you 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’s 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, which is the balance turned over **PLUS 30% to 50%**, depending on the balance at the time it is sent to the collection agency. This includes, but is not limited to all 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.

**USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION  
ACKNOWLEDGEMENT AND CONSENT**

The federal laws that protect your protected health information ("HIPAA") do not provide you with complete privacy. HIPAA allows your health care provider to use or disclose your protected health care information without further authorization or consent from you in a number of circumstances, such as:

- In the course of providing you treatment;
- In the event a referral to another health care provider if/as necessary for the diagnosis, assessment, or treatment of your health condition;
- For insurance and billing purposes;
- For internal clinic purposes (related to quality control or operations); and
- In limited and unusual circumstances related to public health matters and research.

**Our privacy policy.** We are very concerned with protecting your privacy, and always will respect the privacy of your health information. Along with this consent form, you will be given a copy of our privacy policy, in detail. You have the right to review our privacy policy before you sign this consent form. We reserve the right to change our privacy policy. If we make a change, we will notify you in writing when you come in for treatment or by mail.

**Your right to limit uses or disclosures.** You have the right to restrict our ability to use or disclose your protected health information with specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, you must inform us in writing.

**Your right to authorize us to disclose your protected health information.** You have the right to authorize us to disclose your protected health information to specific individuals, companies, or organizations. If you would like to make an authorization, we will ask you to complete an authorization form.

**Your right to revoke any limitation, authorization, or consent.** You have the right to revoke any limitation or authorization to use or disclose your protected health information at any time. Your revocation must be in writing. If you refuse to give us an authorization or consent or revoke any authorization or consent in the future, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

**I ACKNOWLEDGE receipt of the PRIVACY POLICY and CONSENT to my personal health information being used in the manner described above. I am also acknowledging that I have been offered a copy of this consent.**

Patient Name Printed \_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient (or Personal Representative) Signature

\_\_\_\_\_  
Authorized Provider Representative

\_\_\_\_\_  
Personal Representative's Name Printed

\_\_\_\_\_  
Personal Representative's Authority

**I am acknowledging that I have been offered a copy of the PRIVACY POLICY and this consent, but I DECLINE to give my chiropractor and members of the practice staff consent to use my protected health information for any purpose other than treatment and those required by federal law.**

\_\_\_\_\_  
Patient Name Printed

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient (or Personal Representative) Signature

\_\_\_\_\_  
Personal Representative's Authority

## 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 provided to me by Riverview Family Chiropractic Center, PA. This authorization to file a 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 is 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 medical records in possession of such insurer to Riverview Family Chiropractic Center, PA upon their request. This authorization includes the authorization to release to Riverview Family Chiropractic Center, PA a copy of any medical examination or evaluation requested by any insurance company.

**DIRECTIONS TO INSURER TO FURNISH PROVIDER ADVANCED 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 advanced notice to Riverview Family Chiropractic Center, PA of any physical 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



**Riverview Family Chiropractic Center**

*Quality Care for the Entire Family*

**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

Patient: \_\_\_\_\_

Dated of Injury: \_\_\_\_\_

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 regarding 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 to this 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 this office 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](mailto:chirorfcc@gmail.com).

Thank you.

## Informed Consent Document

PATIENT NAME: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**To the Patient:** Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

### **The nature of chiropractic adjustment.**

The primary treatment used by Dr. Todd Jarvis and Dr. Preston Rogers is spinal manipulative therapy. We will use that procedure to treat you. We may use our hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

### **The risks inherent in chiropractic adjustment.**

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. The Doctor will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to the Doctor's attention **it is your responsibility to inform the Doctor.**

### **The probability of those risks occurring.**

Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and X-ray. Stroke and /or arterial dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most current research on the topic is inconclusive as to a specific incident of this complication occurring. If there is a causal relationship at all it is extremely rare and remote. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of arterial stroke.

### **The availability and nature of other treatment options.**

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and painkillers
- Hospitalization
- Surgery

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

### **The risks and dangers attendant to remaining untreated.**

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction, further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

**DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW**

I have read the above explanation of the chiropractic adjustment and related treatment. I have discussed it with my doctor and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated: \_\_\_\_\_

Dated: \_\_\_\_\_

\_\_\_\_\_  
Patient's Name (printed)

\_\_\_\_\_  
Witness Name (printed)

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Doctor's initials

## Medical Records Release Form

By signing this form, I authorize \_\_\_\_\_ to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/person/facility listed below:

**Patient name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

The information you may release subject to this signed release form is as follows:

\_\_\_\_\_ Complete Records    \_\_\_\_\_ Progress Notes    \_\_\_\_\_ Initial and/or Final Report  
\_\_\_\_\_ Radiology Reports    \_\_\_\_\_ Other (please specify): \_\_\_\_\_ **x-rays** \_\_\_\_\_  
\_\_\_\_\_ EMC (Emergency Medical Condition)

**Release my protected health information to the following physician/person/facility/entity and/or those directly associated in my medical care:**

Facility: **Riverview Family Chiropractic Center**  
**10833 Boyette Road**  
**Riverview, Fl. 33569**  
**(T) 813-741-0655 (F) 813-741-0945 email: chirorfcc@gmail.com**

Thank you.

**Signature:**

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Patient's Date of Birth

\_\_\_\_\_  
Witness Signature



**Riverview Family Chiropractic Center**

*Quality Care for the Entire Family*

**Todd Jarvis, D.C.**

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

### **Text Messaging Consent Form**

Patients in our practice may be contacted via text messaging to remind you of an appointment and general information.

**Please check either OPT-IN or OPT-OUT.**

    **OPT-IN** I consent to receiving appointment reminders and general information via text from Riverview Family Chiropractic Center. The cell phone number that I authorize to receive text messages for appointment reminders is:  
(         ) \_\_\_\_\_

You can cancel the SMS service at any time. Just text **"STOP"** to the number from which you have received a message. After you send the SMS message **"STOP"** to us, we will send you an SMS message to confirm that you have been unsubscribed. After this, you will no longer receive SMS messages from us. If you want to join again, just sign up as you did the first time and we will start sending SMS messages to you again. You may also text **"START"** to the number to resume receiving SMS communications.

If you are experiencing issues with the messaging program you can reply with the keyword **"HELP"** for more assistance, or you can get help by calling us at **(813) 741-0655**.

Carriers are not liable for delayed or undelivered messages.

As always, message and data rates may apply for any messages sent to you from us and to us from you. You will receive text reminders for each appointment and may receive occasional general messages. If you have any questions about your text plan or data plan, it is best to contact your wireless provider.

    **OPT-OUT I DO NOT** consent to receive text messages from the practice at my cell phone.

I understand that this request to text messages will apply to all future appointment reminders, unless I request a change in writing.

### **SMS Privacy Policy**

We value your privacy and the information you consent to share in relation to our SMS (text messaging) service. We use this information to send you text notifications/reminders concerning the status of your scheduled appointment. Opt-in data and consent for text messaging will not be shared with any third parties except for messaging partners, for the purpose of enabling and operating our text messaging program.

Patient's Printed Name: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_