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

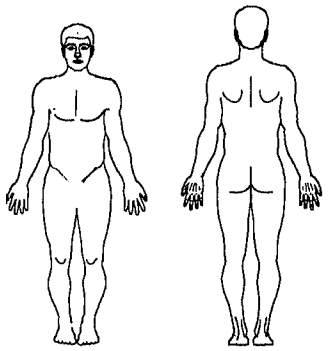
Reason for visit _____
_____
Related to Employment? YES NO Days lost from work _____
Related to Auto Accident? YES NO Date of accident _____
Related to Other Accident? YES NO Date of accident _____
Other doctors seen for these complaints _____
_____
Have you been treated at the hospital for these complaints?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

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_____ Gender: 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? ☐ 0 – 25% ☐ 26 – 50% ☐ 51 – 75% ☐ 76 – 100%

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**_____

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 _____

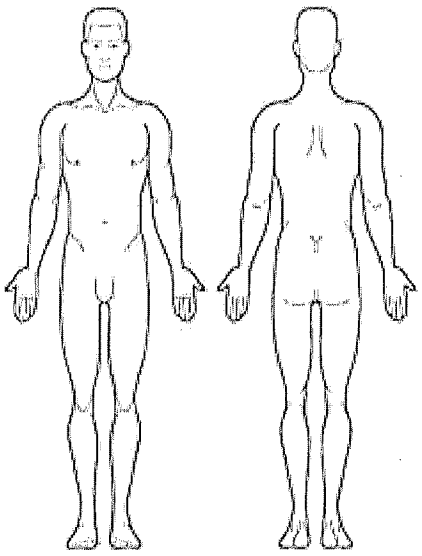
1. Describe your symptoms: _____

_____

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

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

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

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

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

5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms

None Unbearable

⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

b. How much has pain 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 ②Most of the time ③ Some of the time ④Little of the time 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, which is the balance turned over **PLUS 30-50%** of the balance at the time the account is turned over. This is including, but 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.

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: _____

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 _____

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

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:_____

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.

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:_____