PATIENT INFORMATION

Name:______________________________ Date of Birth:______________ Social Security #:____-___-______

Address:____ Marital Status: S M W D Race: _____________

____ E-mail:_____________________________________

Home Phone:______________________ Cell Phone:______________________ Cell Carrier: ______________

Work Phone:______________________ Extension:___________

Occupation:________________________ Employer: ____

Spouse:________________________ How many children? _____ Names & Ages:_____________________

Name of nearest relative:_________________________________ ____________________________________

Address:____ Phone Number:_____________________________

____

Family medical doctor:___________________________________ Phone Number: _________________________

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office?______

How were you referred to our office?____

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INSURANCE

Please check any and all insurance coverage that may be applicable in this case:

( ) Major Medical ( ) Medicare ( ) Auto Accident ( ) Worker's Comp. ( ) Medical Savings/Flex Plan

Name of Primary Insurance Company:____

Name of Secondary Insurance Company (if any):____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and your rights concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you before signing this consent. The following person(s) have my permission to receive my personal health information:_________________________

____.

Patient/Guardian Signature:____________________________________ Date:_____________________

CURRENT CONDITION

Chief Complaint/Purpose of this appointment:____

Date Symptoms appeared or accident happened:____________________

Is this due to: ( ) Auto Accident ( ) Work ( ) Other:____

How did it originally occur?____

Has it become worse recently? ( ) yes ( ) no ( ) same ( ) better ( ) gradually worse

Describe the pain: ( ) sharp ( ) dull ( ) aching ( ) numbness ( ) tingling ( ) stabbing ( ) shooting

How long does the pain last? ( ) constant ( ) daily ( ) few hours ( ) minutes ( ) night only

Is there anything you can do to relieve the pain?____

If no, what have you tried that has not helped?____

What makes the pain worse? ( ) standing ( ) sitting ( ) bending ( ) lifting ( ) lying ( ) twisting

( ) other ____

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HEALTH HISTORY

Are there any other conditions or symptoms that may be related to your major symptom? ( ) yes ( ) no

If yes, please describe:____

____

Are there other unrelated health problems? ( ) yes ( ) no If yes, please describe:____________________

____

Do you have a history of stroke or hypertension? ( ) yes ( ) no

Have you had any major illnesses, injuries, falls, auto accidents, or surgeries? ( ) yes ( ) no

If yes, please describe (women, please include information about child birth, including dates):____

____

Have you been treated for any health condition by a physician in the past year? ( ) yes ( ) no

If yes, please describe:____

What medications or drugs are you currently taking?____

Women: Are you pregnant? ( ) yes ( ) no

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SOCIAL HISTORY

Please indicate beside each activity whether you engage in it:

OFTEN = "O" SOMETIMES = "S" NEVER = "N"

_____ Vigorous Exercise

_____ Moderate Exercise

_____ Caffeine

_____ High Stress Activity

_____ Family Pressures

_____ Financial Pressures

_____ Other; Specify____________________

____

SYMPTOMS AND CONDITIONS

Have you had or do you now have any of the following symptoms or conditions?

_____ Neck Pain
_____ Stiff Neck
_____ Back Pain
_____ Shoulder/Neck/Arm Pain
_____ Headaches; Frequency __________
_____ Muscle Spasms
_____ Sleeping Problems
_____ Weakness in Extremities
_____ Joint Pain/Swelling
_____ Broken Bones/Fractures ________________
_____ Disc Injuries/Degeneration
_____ Numbness in Fingers/Toes
_____ Dizziness
_____ Tension
_____ Ears Ring
_____ Loss of Smell
_____ Loss of Taste
_____ Loss of Memory
_____ Hands/Feet Cold
_____ Eating Disorder
_____ Drug Addiction
_____ Alcoholism
_____ Depression
_____ Circulation Problems
_____ Chest Pain/Tightness

_____ High/Low Blood Pressure
_____ Breathing Problems
_____ Osteoarthritis
_____ Pacemaker
_____ Stroke
_____ Heart Attack
_____ Heart Disease
_____ Arthritis
_____ Rheumatoid Arthritis
_____ Diabetes
_____ Seizures/Epilepsy
_____ Osteoporosis
_____ Cancer
_____ HIV Positive
_____ Ulcers
_____ Gall Bladder Problems
_____ Difficulty Urinating
_____ Unusual Bowel Pattern/Indigestion
_____ Fainting
_____ Fatigue
_____ Frequent Colds
_____ Sinus Problems
_____ Congenital Condition ___________________
_____ Allergies ________________________________
____

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FAMILY HISTORY

Please inform us of any diseases and/or conditions that are current health problems of the family member.

	Age (s)	Disease/Condition	Deceased?
Father			
Mother			
Spouse			
Brother (s)			
Sister (s)			
Children			

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ADDITIONAL INFORMATION

Additional information you would like the doctor to know:____

____

____

____

I certify that all of the information provided is accurate to the best of my knowledge:

Signature of patient/guardian:_____________________________________ Date:________________________

AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

Patient Name:__________________________________ Date of Birth:____________________________

I hereby request and authorize:

Hornback Chiropractic and Wellness, P.A.

11023 Gatewood Drive, Suite 101

Lakewood Ranch, FL 34211

_____ To Disclose Information To: _____ To Receive Information From:

Physician/Medical Facility/Hospital:____

Address: _______________________________________ Phone Number: ________________________

____ Fax Number:___________________________

Information to be disclosed includes copies of:

_____ Entire Record

_____ Progress Notes

_____ Physical Exam Forms

_____ Daily Chart Notes

_____ X-ray Reports

_____ X-ray Films

_____ Other, specify: ______________________

____

Purpose for Disclosure:

_____ Treatment, Payment OR _____ Other, specify:____

This authorization will be effective for six months after the date signed, unless cancelled in writing. I understand that the cancellation will have no effect on information released prior to receiving the cancellation. A copy of this authorization is as valid as the original.

Patient Signature:____________________________________ Date:___________________________

OR

Parent/Guardian/Legal Representative Signature:____

If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law.

Notice to recipient of information: This information has been disclosed to you from confidential records, which are protected by law. Unless you have further authorization, laws may prohibit you from making any further disclosures of this information without the specific written consent of the patient or legal representative.

PATIENT HEALTH INFORMATION CONSENT FORM

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions of the use of their PHI. Our office is obligated to agree to those restrictions only to the extent they coincide with state and federal law.
3. A patient's written consent need only be obtained one time for all subsequent care given to the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. Our office may contact you periodically regarding appointments, treatments, products, services, or charitable work performed by our office. You may choose to opt-out of any marketing or fundraising communications at any time.
6. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
7. Patients have the right to file a formal complaint with our privacy official and the Secretary of HHS about any possible violations of these policies and procedures without retaliation by this office.
8. Our office reserves the right to make changes to this notice and to make the new notice provisions effective for all protected health information that it maintains. You will be provided with a new notice at your next visit following any change.
9. This notice is effective on the date stated below.
10. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Name of Patient:____________________________________ Date:_____________________

Signature of Patient:____________________________________

For further information regarding this notice, please contact our Doctor at (941) 744-1585.

FINANCIAL POLICY

SCHEDULING

- While we do schedule appointments during regular hours (to reduce waiting time for you and others), patients are welcome to stop in at any time. Please be aware, however, that walk-in patients will be seen after all regularly scheduled patients have been treated.
- Although we do not charge for missed or cancelled chiropractic appointments, cancellations for massage appointments do require 24 hours notice. A $25 fee will be charged for missed massage appointments not cancelled within 24 hours prior. All patients are allowed one courtesy cancellation without charge. In consideration of our other patients, we will be unable to schedule further massages if three massage appointments are missed or cancelled without 24 hours notice.

PAYMENT

- Payment is expected in full at the time services are rendered. We do offer a credit guarantee option for patients who prefer to pay once a week, as opposed to each visit.
- For your convenience we accept cash, checks, Visa, MasterCard, and Discover.
- Should care be discontinued for any reason other than discharge by the doctor, any outstanding balance will become immediately due and payable in full.

INSURANCE

- Our office verifies insurance coverage in an effort to determine chiropractic coverage under your current policy. As benefits quoted are not a guarantee of coverage or benefits, it is the responsibility of the patient to contact their insurance if there is a discrepancy or error in benefits processing. Kindly keep in mind that you, as the patient, are responsible for any and all charges incurred in our office.
- Please provide us with your most current insurance card or information. If your insurance changes during the year, please let us know so that we may bill using the most current insurance information.
- Although we are not obligated to accept insurance payments on assignment from all carriers, we may do so as a courtesy to you, based on our experience with your insurance carrier.
- The patient/insured is responsible for any portion of the claim not covered by insurance.
- Please remember that insurance coverage is a contract between you and your insurance company.
- We do not bill any secondary insurance carriers.

REFUNDS

- If there is a credit due, the patient will have the option of using the credit towards future visits or calling the office and requesting a refund.

It is the goal of this office to provide you with the finest quality chiropractic care available. If you have any questions with regard to your health or any of our policies, please let us know. We welcome your referrals and look forward to a doctor-patient relationship that works for our mutual benefit.

I have read and agree to the guidelines of this financial/insurance policy.

I, the undersigned, have insurance coverage with ______________________________ Insurance Company and assign directly to Hornback Chiropractic and Wellness all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize HCW to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

Signature of Patient:____ Date:________________________