Anders Chiropractic & Sports Performance
11873 High Tech Ave. Ste A
Orlando, Fl 32817
(407)249-3300 fax (407)249-3322

Date: ___/_____/_____
Patient's Full Name _____
Home Phone: _____ Cell Phone: _____ E-Mail: _____
□ Male □ Female Age: _____
Date of Birth: ____/____/_____ Social Security # _____ - _____ - _____
Mailing Address: _____ City: _____
State: _____ Zip: _____
□ Married □ Single Number of Children/Ages_____
Occupation: _____ Employer: _____ Business Phone: _____
Spouse's Name: _____Employer:_____ Business Phone: _____
Emergency Contact: _____ Relationship: _____ Phone: _____
Address: _____ City: _____
State: _____ Zip: _____
Family Physician: _____City: _____ State: _____ Phone_____
May our office inform your family physician of presenting condition/s, exam findings, diagnosis, and treatment plan? □ Yes □ No
Do You Have Health Insurance? _____ If yes, please present insurance card to Front Desk Staff.
Previous Chiropractic Care: □ Yes □ No If Yes, for what Problem:
_____
Doctor's Name _____City: _____ State: _____
Where did you hear about us? Or Referred By (Friend, Relative, or Physician):_____
Is Today's Visit Due To A Work Related Injury: □ Yes □ No
Is Today's Visit Due To An Auto Accident: □ Yes □ No
(If yes to either questions above, please check with receptionist, additional information is needed)

Pain Chart

Please Mark Areas of Pain using these Codes!

+++ Burning **### Dull/Ache** ***** Numbness/Tingling** **=== Throbbing** **000 Stabbing/Sharp**

SEVERITY OF PAIN:

List the region of pain and circle the number which represents the intensity of your pain

1. Complaint: _____

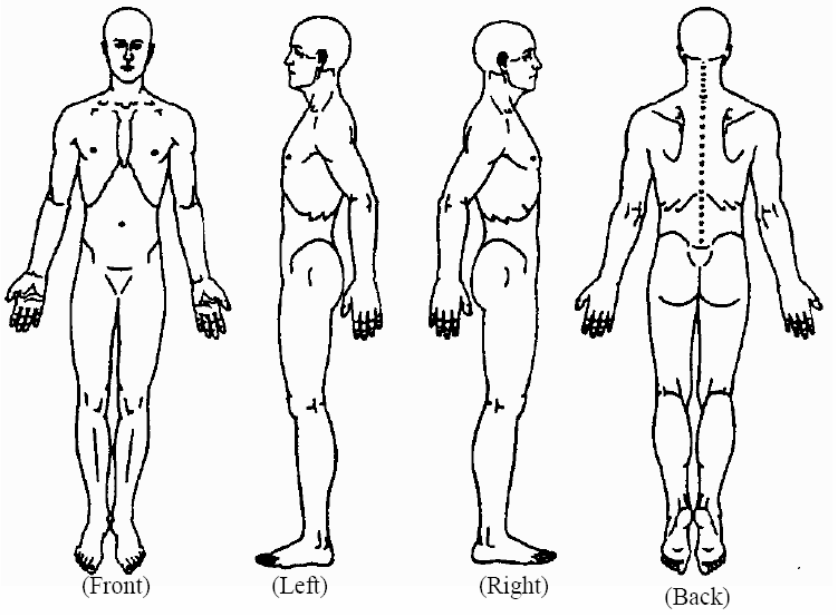
0 1 2 3 4 5 6 7 8 9 10
no pain unbearable

2. Complaint: _____

0 1 2 3 4 5 6 7 8 9 10
no pain unbearable

3. Complaint:_____

0 1 2 3 4 5 6 7 8 9 10
no pain unbearable



Dear Patient: Please complete this form and questionnaire. If you need assistance, please ask. Your answers will help us determine if chiropractic care can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU.

Chief complaint: _____

Date of Onset: _____ Was the Onset: □ Gradual □ Sudden Since onset has it gotten: □ Worse □ Better

Describe what caused the pain: _____

Secondary or related complaint(s) if any: _____

PLEASE ANSWER THE FOLLOWING QUESTIONS TO HELP EXPLAIN YOUR **CHIEF COMPLAINT:**

Describe the quality of the complaint/pain:

□ sharp
□ dull/ache
□ throbbing
□ tingling/numbness/burning
□ other: _____

Does any of the following make the pain worse:

□ lifting/bending/pushing/pulling
□ cough/sneeze/bowel movement
□ driving/riding/sitting
□ walking/running/standing
□ other: _____

Describe if pain is in a single spot or does is spread out:

□ Single Spot
□ Radiates (ex. Down leg/ arm)
□ other: _____

Does any of the following make it better:

□ rest/laying down
□ sitting
□ walking/exercise
□ other: _____

How often are you aware of the pain: Does it interfere with your daily activities?

□ intermittent (less than 25% of time when awake)
□ occasional (25-50% of time when awake)
□ frequent (50-75% of time when awake)
□ constant (75-100% of time when awake)

□ minimal (annoyance, no impairment)
□ slight (tolerated, some impairment)
□ moderate (marked impairment)
□ marked (preclude any activity)

Have you detected any possible relationship of your current complaint with any of the following:
□ Muscle Weakness □ Bowel/Bladder problems □ Digestion □ Cardiac/Respiratory □ Other: _____

Have you tried any self-treatment or taken any medication (over the counter or prescription): □ Yes □ No

If yes, explain: _____Results:_____

What type of care are you interested in: □ Pain relief only □ Healing of current condition □ Performance Enhancement □ All Three

What is your long-term goal from treatment (e.g. play a round of golf without pain)? _____

In general, would you say your health is (check one): □ Excellent □ Very good □ Good □ Fair □ Poor

PAST HEALTH HISTORY:

1. Have you ever experienced your present problem before for which you are consulting us: □ Yes □ No If yes, when:

_____

Was treatment provided: □ Yes □ No If yes, By whom: _____ Outcome:

_____

2. Have you **ever** had a **stroke** or issues with **blood clotting**? □ Yes □ No If yes, when:

_____

3. Have you recently experienced **dizziness**, unexplained **fatigue**, **weight loss**, or **blood loss**? □ Yes □ No If yes, explain:_____

4. Have you **ever** had any **major illnesses, injuries, broken bones, hospitalizations, accidents, or surgeries?** □ Yes □ No

If yes, please explain:

Please read and sign:

I hereby state that all information that I have provided to Anders University Chiropractic is complete and truthful and that I fully disclosed my health history.

SIGNED: _____ Date_____

Witnessed: _____ Date_____

INFORMED CONSENT

Medical doctors, chiropractic doctors, osteopaths, and physical therapists that perform manipulation are required by law to obtain your informed consent before starting treatment.

I_____, Do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Physical therapy and exercises may also be used. Although spinal and extremity manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:

Soreness/Bruising: I am aware that like exercise it is common to experience muscle soreness and occasionally bruising in the first few treatments.

Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare.

Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disc, or other abnormality is detected, this office will proceed with extra caution.

Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in a million to once in ten million treatments. Once in a million is about the same chance as getting hit by lightning. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol® causing death.

Physical Therapy Burns: Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase in pain and possible blistering. This should be reported to the doctor. Tests have been or will be performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

TREATMENT RESULTS

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits. I realize that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures. I agree to the performance of these procedures by my doctor and such other persons of the doctor's choosing.

ALTERNATIVE TREATMENTS AVAILABLE

Reasonable alternatives to these procedures have been explained to me including, rest, home applications of therapy, prescription or over-the counter medications, exercises and possible surgery.

Medications: Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.

Rest/Exercise: It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of limited value but are not corrective of injured nerve and joint tissues.

Surgery: Surgery may be necessary for joint instability or serious disc rupture. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery.

Non-treatment: I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

I have read or had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.

To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

_____ Signature of Patient Date_____

_____Signature of Witness Date_____

Financial/Privacy Policy and Disclaimer

Insurance Verification

- **Insurance verification is not a guarantee of payment.** Verification is only a quote of patient benefits. Insurance companies review charges individually and make payment accordingly. **Charges not covered by insurance are the patient's responsibility and due within 30 days of billing.**

Health Savings Accounts

- If all or a portion of your medical benefits are funded through a **Health Savings Account** and correspondence from the insurance company indicates the funds are exhausted, the account balance becomes patient responsibility.

Deductible Payments

- **It is our policy to collect at time of service.** Once we receive an "Explanation of Benefits" report form the patient's insurance company, we will bill or credit the account for the remaining balance. Reimbursement checks can be issued upon request.

Collection of Patient Balance

- Co-payments and Co-insurance is the patient's responsibility and will be collected at the time of service.
- If the "Explanation of Benefits" report shows the patient has an outstanding balance from services not covered by the individual insurance company, patients will receive a bill outlining these outstanding charges. **Upon receipt, payment is due within 30 days. After 30 day, it is the clinic's policy to turn unpaid accounts over to a collections agency.**

Returned Checks

- It is our policy to collect $25.00 for checks that are returned to us. This is to cover any fees that apply from the transaction

Appointments

- If unable to keep a doctor's appointment, as a courtesy to our staff and other patients please give 24-hour notice. If it is a continual problem, there will be a **$25 charge** added towards your account for each doctor's appointment that is missed. If you miss, cancel, or change your massage appointment with less than 24-hours notice, **you will be charged the full price of the massage, and if you miss an ART appointment you will be charged $50**. The patient will be responsible for payment. If you choose to schedule and there are less than 24 hours between when you scheduled and your appointment time we will ask for a credit card so that we may collect the appropriate fee in the event that you do not show up or cancel. If you show up and are late for your massage appointment we will give you the remaining time allowed, but you will be charged for the scheduled time.

Financial Policy Questions

- We are happy to address questions regarding you account at any time. Please direct accounting questions to our billing administrator.

HIPAA Privacy Policy

- Attached to the patient information packet at the back of these forms is the HIPAA Notice of Privacy Practices Policy for you**.**
- By signing below, the patient acknowledges that he/she has received the HIPAA Privacy Policy and that he/she understands and will comply with our financial policies.

Patient Signature_____ Date_____/_____/_____

AUTHORIZATION AND ASSIGNMENT OF BENEFITS

In consideration of your undertaking to care for me, I agree to the following:

1. You are authorized to release **any information** you deem appropriate concerning my physical or emotional condition and/or health history to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred.
2. I authorize the **direct payment to you** of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated make payment to me or you based in whole or in part upon the charges made for your services.
3. In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services **refuses to make such payment** upon demand by you , I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent data) and authorize you to prosecute said action either in my name as you see fit and further authorize you to compromise, settle, or otherwise resolve said claim as you see fit. However, it is understood that all reasonable efforts have been made to collect the sums due from the insurance company, or companies, contractually obligated; you will refrain from attempts and efforts to collect the amounts owed directly from me. I understand that whatever amounts you do not collect from insurance companies' proceeds, whether it is all or part of what was due, I personally owe you.
4. In addition to the above, I hereby waive the statute of limitations on collection and/or recovery in this state of Florida.
5. I further agree that this Authorization and Assignment is irrevocable until all moneys owed to Anders University Chiropractic are paid in full.

Patient Signature_____ Date_____/_____/_____

We are required by law to maintain the privacy of "protected health information." "Protected health information" includes any identifiable information that we obtain from you or others that relates to your physical or mental health, the health care you have received, or payment for your health care.
As required by law, this notice provides you with information about your rights and our legal duties and privacy practices with respect to the privacy of protected health information. This notice also discusses the uses and disclosures we will make of your protected health information. We must comply with the provisions of this notice, although we reserve the right to change the terms of this notice from time to time and to make the revised notice effective for all protected health information we maintain. You can always request a copy of our most current privacy notice from our office.

Permitted Uses and Disclosures

We can use or disclose your protected health information for purposes of treatment, payment and health care operations.
♦ Treatment means the provision, coordination or management of your health care, including consultations between health care providers regarding your care and referrals for health care from one health care provider to another. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. Therefore, the doctor may review your medical records to assess whether you have potentially complicating conditions like diabetes.
♦ Payment means activities we undertake to obtain reimbursement for the health care provided to you, including determinations of eligibility and coverage and other utilization review activities. For example, prior to providing health care services, we may need to provide to your insurance carrier (or other third-party payor) information about your medical condition to determine whether the proposed course of treatment will be covered. When we subsequently bill the carrier or other third-party payor for the services rendered to you, we can provide the carrier or other third party payor with information regarding your care if necessary to obtain payment.
♦ Health Care Operations mean the support functions of our practice related to treatment and payment, such as quality assurance activities, case management, receiving and responding to patient complaints, physician reviews, compliance programs, audits, business planning, development, management and administrative activities. For example, we may use your medical information to evaluate the performance of our staff in caring for you. We may also combine medical information about many patients to decide what services are not needed, and whether certain new treatments are effective.

Disclosures Related To Communications With You Or Your Family

- We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you or relate specifically to your medical care through our office. For example, we may leave appointment reminders on your answering machine or with a family member or other person who may answer the telephone at the number that you have given us in order to contact you.
- We may disclose your protected health information to your family or friends or any other individual identified by you when they are involved in your care or the payment for your care. We will only disclose the protected health information directly relevant to their involvement in your care or payment. We may also use or disclose your protected health information to notify, or assist in the notification of, a family member, a personal representative, or another person responsible for your care of your location, general condition or death. If you are available, we will give you an opportunity to object to these disclosures, and we will not make these disclosures if you object. If you are not available, we will determine whether a disclosure to your family or friends is in your best interest, and we will disclose only the protected health information that is directly relevant to their involvement in your care.

Your Rights

1. You have the right to request restrictions on our uses and disclosures of protected health information for treatment, payment and health care operations. However, we are not required to agree to your request.
2. You have the right to reasonably request to receive communications of protected health information by alternative means or at alternative locations.

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Patient Waiver for Non-Covered Services

Your insurance does not always pay for all of your healthcare costs. The purpose of this notice is to help you make an informed choice about whether or not you want to receive these services.

Certain services are not considered medically necessary by your health plan. They may be helpful to you, but the terms of your plan do not pay for these services. These non-reimbursable services and/or supplies are typically the responsibility of the patient.

I acknowledge and agree that part of my care is not a covered benefit of my health plan. I acknowledge and understand that I will be financially responsible for this part of my treatment. I also understand and acknowledge and understand the information listed below:

Service	Fee
Active Release Treatment	$25 - 70
Massage Therapy	$50 - 75
_____	$_____
Total Due	$_____

- My provider and I have discussed the reasons for requesting non-covered services and what my alternatives are; my provider has allowed me to make the final decision regarding such services.
- I have been advised the recommended services will not be covered by my health plan and I will be responsible for payment of the recommended services.
- By signing this document, I am agreeing to pay for these services and charges at the time services are rendered.
- I understand this is not an ongoing authorization but is specific to the treatment plan discussed with me.

Print Patient Name:_____
Date

Patient Signature: _____
Date

Name of Parent or Legal Guardian (if applicable):_____
Date

Signature of Parent of Legal Guardian (If applicable):_____
Date

File: Non-covered services waiver

ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

_____ _____

Patient Name (please print) **Date**

_____

Parent, Guardian or Patient's legal representative

_____

Signature

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.

List below the names and relationship of people to whom you authorize the Practice to release PHI.

_____ _____

_____ _____

_____ _____

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In the event of a missed appointment, an effort to schedule you, or new information pertaining to your care, we may need to contact you. Please list below the phone number that you would prefer we reach you at, and also an email as an alternate point of contact. Thank you!

Phone: _____

E-mail: _____

_____
Date

_____
Signature