Chiropractic Center of Lakeland

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name:_____ **Last Name:**_____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Smoking Start Date (Optional):_____

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) / Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank because of the nature and frequency of chiropractic care.)*

Patient Signature: _____ Date: _____

For office use only

Height: _____ Weight:_____ Blood Pressure:_____/_____

CHIROPRACTIC CENTER OF LAKELAND

New Patient Intake

Name: _____ **Date:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell Ph:** _____ **Wk Ph:** _____

Birthdate: _____ **SSN:** _____ **Email:** _____

Status: Single Married Divorced Widowed **Children:** Yes No **How Many:** _____

Are you considered a minor? Yes No **If Yes, who is the responsible payer?** _____

Occupation: _____ **Employer:** _____

Family Doctor: Yes No **Name of Doctor:** _____ **Phone:** _____

Emergency Contact: _____ **Phone:** _____

Do you have insurance we will be using? Yes No **Insurance Company:** _____

Past Medical History

For the conditions below, place a check in the "past" column if you have had the condition in the past. If you presently have any condition listed below, please place a check in the present column.

Condition	Past	Present
Headaches	☐	☐
Neck Pain	☐	☐
Upper Back Pain	☐	☐
Mid Back Pain	☐	☐
Low Back Pain	☐	☐
Shoulder Pain	☐	☐
Elbow/Arm Pain	☐	☐
Wrist Pain	☐	☐
Hand Pain	☐	☐
Hip Pain	☐	☐
Upper Leg Pain	☐	☐
Knee Pain	☐	☐
Ankle/Foot Pain	☐	☐
Jaw Pain	☐	☐
Joint Pain/ Stiffness	☐	☐
Arthritis	☐	☐
Rheumatoid Arthritis	☐	☐
Cancer	☐	☐
Tumor	☐	☐

Condition	Past	Present
Asthma	☐	☐
Sinus Problems	☐	☐
High Blood Pressure	☐	☐
Heart Attack	☐	☐
Stroke	☐	☐
Angina	☐	☐
Kidney Stones	☐	☐
Kidney Disorders	☐	☐
Bladder Infection	☐	☐
High Cholesterol	☐	☐
Loss of Bladder Ctrl	☐	☐
Prostate Problems	☐	☐
Abnormal Wt Loss/Gain	☐	☐
Loss of Appetite	☐	☐
Abdominal Pain	☐	☐
Ulcer	☐	☐
Hepatitis	☐	☐
Liver Disorder	☐	☐
Gall Bladder Disorder	☐	☐

Condition	Past	Present
General Fatigue	☐	☐
Thyroid Disorder	☐	☐
Muscular Incoordination	☐	☐
Visual Disturbances	☐	☐
Dizziness	☐	☐
Diabetes	☐	☐
Excessive Thirst	☐	☐
Frequent Urination	☐	☐
Addiction Drug/Alcohol	☐	☐
Allergies	☐	☐
Depression	☐	☐
Systemic Lupus	☐	☐
Fibromyalgia	☐	☐
Epilepsy	☐	☐
Skin Conditions	☐	☐
HIV/AIDS	☐	☐
For Women:	☐	☐
Birth Control	☐	☐
Hormone Replacement	☐	☐

List Treatments for <u>Past</u> Conditions: _____

List ALL Medications you are <u>Currently</u> Taking: _____

_____

List any Allergies: (including food) _____

List any Surgeries: _____

Family Medical History

Please indicate if you have any immediate family members with the following conditions:

☐ Rheumatoid Arthritis ☐ Diabetes ☐ Lupus/Fibromyalgia
☐ Heart Problems ☐ Cancer ☐ Mulitple Sclerosis

Other Family Medical history: _____

Social History

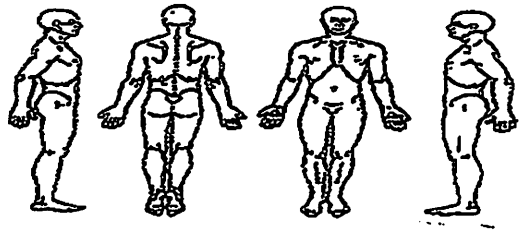
Do you smoke: Yes No **How Much:** _____ **Drink Alcohol:** Yes No **How Much:** _____

For Women Only: Pregnant? Yes No **How Long:** _____ **Nursing?:** Yes No

CHIROPRACTIC CENTER OF LAKELAND

New Patient Intake

Please indicate on the drawing below where you are experiencing your symptoms



1) Where does it hurt: _____ **When Did It Start:** _____

Pain Level (0= No Pain/10=Highest Pain) 0 1 2 3 4 5 6 7 8 9 10

How often does it occur: Occasionally (0-25% of the time) Intermittently (26-50% of the time) Frequently (51-75% of the time) Constantly (76-100% of the time)

Please describe your pain: Aching Burning Dull Pulling Sharp Shooting Stabbing Stinging Throbbing

What aggravates your symptoms: _____

Doctor's Notes: _____

_____

_____

2) Where does it hurt: _____ **When Did It Start:** _____

Pain Level (0= No Pain/10=Highest Pain) 0 1 2 3 4 5 6 7 8 9 10

How often does it occur: Occasionally (0-25% of the time) Intermittently (26-50% of the time) Frequently (51-75% of the time) Constantly (76-100% of the time)

Please describe your pain: Aching Burning Dull Pulling Sharp Shooting Stabbing Stinging Throbbing

What aggravates your symptoms: _____

Doctor's Notes: _____

_____

_____

3) Where does it hurt: _____ **When Did It Start:** _____

Pain Level (0= No Pain/10=Highest Pain) 0 1 2 3 4 5 6 7 8 9 10

How often does it occur: Occasionally (0-25% of the time) Intermittently (26-50% of the time) Frequently (51-75% of the time) Constantly (76-100% of the time)

Please describe your pain: Aching Burning Dull Pulling Sharp Shooting Stabbing Stinging Throbbing

What aggravates your symptoms: _____

Doctor's Notes: _____

_____

_____

Current Treatment of Symptoms

Have you seen anyone else for these symptoms: *Yes* *No* Who: _____

List any treatment given for these symptoms: _____

List any medications given for these symptoms: _____

Patient Signature: _____ **Date:** _____

CHIROPRACTIC CENTER OF LAKELAND

Auto Accident Questionnaire

Patient Name: _____ **Today's Date:** _____ **Accident Date:** _____

Please give a brief description of your accident: (Where, What, When & How)

Where did it happen? _____

What happened? _____

_____

_____

_____

Where were you in the vehicle? Driver Passenger Rear Right Passenger Rear Left Passenger

What type of vehicle were YOU in? Compact Car Midsize Car Full Size Car Small Truck Full Size Truck

Small SUV Midsize SUV Large SUV Mini Van Full Size Van Motorcycle

What type of vehicle collided with you? Compact Car Midsize Car Full Size Car Small Truck Full Size Truck

Small SUV Midsize SUV Large SUV Mini Van Full Size Van Motorcycle

Where was the impact on your vehicle? Front Rear Driver Side Passenger Side

Front Driver Side Rear Driver Side Front Passenger Side Rear Passenger Side

Were you wearing your seatbelt? Yes No **Did the Airbag deploy?** Yes No

Estimate the damage to your vehicle: Minimal Moderate Extensive Totaled Unsure

Were you anticipating the accident? Expecting the collision Completely Unexpected

What position were you sitting? Straight ahead Rotated Right Rotated Left Unsure

What position was your head? Straight ahead Rotated Right Rotated Left Unsure

Was your body thrown? Yes No **In what direction?** Backwards Forwards Left Right Outside the vehicle

How did your head move during the collision? Forwards then backwards Backward then Forwards

Right to Left Left to Right Unsure of motion

Did any part of your body strike anything in the vehicle? Yes No **If Yes, please circle all body part involved:**

Head Upper Back Mid Back Lower Back Chest Left Shoulder Right Shoulder Left Arm Right Arm

Left Elbow Right Elbow Left Leg Right Leg Left Knee Right Knee Left Shin Right Shin

How did you feel immediately following the accident? Dazed Disoriented Headache Pain Unconscious None

CHIROPRACTIC CENTER OF LAKELAND

Auto Accident Questionnaire

Where did you feel pain immediately following the accident? None Head Neck Upper Back Mid Back Lower Back Chest Left Shoulder Right Shoulder Left Arm Right Arm Left Elbow Right Elbow Left Leg Right Leg Left Knee Right Knee Left Shin Right Shin Other: _____

Did you go to the hospital immediately following the accident? Yes No **Where?** _____

How were transported to the hospital? Ambulance Drove self Driven there by friend/family member

Were you admitted to the hospital? Yes No **How many days in the hospital?** _____

What was done at hospital? **Xrays?** Yes No **Xrays of what?** Neck Mid back Low back Other: _____

MRI? Yes No **MRI of what?** Neck Mid back Low back Other: _____

CT scan? Yes No **CT of what?** Neck Mid back Low back Other: _____

Given Medication? Yes No **What Medication?** _____

Later after the accident, where did you feel pain? None Head Neck Upper Back Mid Back Lower Back Chest Left Shoulder Right Shoulder Left Arm Right Arm Left Elbow Right Elbow Left Leg Right Leg Left Knee Right Knee Left Shin Right Shin Other: _____

Are you feeling numbness or tingling anywhere? Yes No **Where?** _____

_____

Has the accident affected your sleep? Yes No **How much sleep do you lose a night?** _____hours of sleep.

What other symptoms are you feeling now? Nervousness Irritability General Fatigue Depression Cramping Unintentional Twitching Difficult Urination

Have you experienced any weight changes? Yes No Gain of _____ pounds Loss of _____pounds

Has this affected your daily quality of life? Yes No **How much?** None Minimally Moderately Severely

Please write down any other information that you feel is important for us to know: _____

_____

_____

_____

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Patient Signature: _____ **Date:** _____

Chiropractic Center of Lakeland

Term of Acceptance

When a patient care at the Chiropractic Center of Lakeland and we accept a patient for such care, it is essential for both to be working toward a common goal.

Chiropractic has only one goal: to eliminate misalignments within the spinal column which interferes with the expression of the body's innate wisdom. It is important all patients understand both the objective and the method used to attain our goal. The following definitions will help to educate each patient.

Health: Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

Adjustment: A specific application of forces to facilitate the body's correction of the spinal Subluxation. Our method of correction is performed by mechanical device as well as by hand.

Spinal Subluxation: A misalignment of one or more of the 24 vertebrae in the Spinal Column which causes alteration and interference with the transmission of information from the brain to all systems of the body, thus having a positive effect on the body's organs and systems, even down to the cellular level.

We do not offer to diagnose or treat any disease or condition other than vertebral Subluxation. However if during the course of chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will recommend our patients seek care fro a health care provider who specializes in that area. Regardless of the specific condition we cannot provide care of give advice on the care provided by other practitioners.

Our Practice objective is to eliminate major interference to the expression of the body's innate wisdom.

All questions regarding the doctor's objectives pertaining to my care in this office have been fully answered.

_____

Print Name

_____ _____

Sign Name Date

OFFICE OF INSURANCE REGULATION
Bureau of Property & Casualty Forms and Rates

Standard Disclosure and Acknowledgement Form
Personal Injury Protection - Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

1. The services set forth below were **actually rendered.** This means that those services have **already been provided.**

   _____

   _____

2. I have the right and the **duty to confirm** that the services have already been provided.
3. I was **not solicited** by any person to seek any services from the medical provider of the services described above. This means that no person has initiated contact with me and/or persuaded me to use the doctor or licensed professional, clinic, or medical institution that provided the services.
4. The medical provider has **explained** the services to me for which payment is being claimed.
5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to $500.

The undersigned licensed medical professional affirms the statement numbered 1 above and also:

A. I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.

B. I have **explained** the services rendered to the insured person, or his or her guardian, **sufficiently** for that person to sign this form with informed consent.

C. The accompanying statement or bill is **properly completed** in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to **truthfully, accurately,** and in a **substantially complete** manner.

D. The coding of procedures on the accompanying statement or bill is proper. This means that **no service has been upcoded, unbundled,** or constitutes an invalid **or not medically necessary diagnostic test** as defined by Section 627.732 (15) and (16), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Insured Person (patient receiving treatment) or Guardian of Insured Person:

_____	_____	_____
Name *(PRINT or TYPE)*	Signature	Date

Licensed Medical Professional Rendering Treatment *(Signature by his or her own hand):*

_____	_____	_____
Name *(PRINT or TYPE)*	Signature	Date

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of Claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234(1)(b), Florida Statutes.

Note: The **original** of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may **not** be electronically furnished. Failure to furnish this form may result in non-payment of the claim.

ASSIGNMENT OF BENEFITS, LIENS, DIRECT PAYMENT AUTHORIZATION, AUTHORIZATION TO RELEASE INSURANCE INFORMATION, AND AUTHORIZATION TO ESCROW UNPAID MEDICAL & PIP BENEFITS

Chiropractic Center of Lakeland, Inc.

INSURANCE CARRIER: _____ POLICY NUMBER: _____ DATE OF LOSS: _____

For and in consideration of Chiropractic Center of Lakeland, Inc. agreeing to pursue the responsible automobile insurance carrier for payment of benefits due and not requiring prepayment for services, I hereby irrevocably assign all rights and benefits to Chiropractic Center of Lakeland, Inc. for Personal Injury Protection, extended Personal Injury Protection, Medical Payment Coverage, and other benefits which I may have in accordance with Florida Statute §627.736. This includes any benefits from my insurance company and any other entity which may be responsible for medical expenses incurred. I further authorize Chiropractic Center of Lakeland, Inc. to collect payments & prosecute any necessary actions to collect payment for services as they see fit and allowable by law and contract. THIS DOCUMENT CONSTITUTES AN ASSIGNMENT OF RIGHTS AND BENEFITS.

I hereby further give a lien to Chiropractic Center of Lakeland, Inc. against any and all insurance benefits named herein, and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by Chiropractic Center of Lakeland, Inc. as a result of the above stated loss date. This document acts as an irrevocable absolute assignment of my rights and benefits to the extent of the charges for services provided. I agree to cooperate with Chiropractic Center of Lakeland, Inc. and their attorney's (at their choosing), and to do all things reasonable to effect payment of the bills by the insurance company or other entity to Chiropractic Center of Lakeland, Inc. including, but not limited to, disclosing my medical condition, being available for factual discovery or other cooperation.

This assignment concerns only the bills for Chiropractic Center of Lakeland, Inc. and those costs including, but not limited to, attorney's fees, other costs, and interest necessary in procuring payment from the above-named insurance company and/or other entities. This assignment is not intended to assign any other causes of action that may belong to the undersigned patient. I agree to pay any applicable deductible or co-payment not covered by any policy of insurance cited above. I understand that as a benefit and convenience to me, Chiropractic Center of Lakeland, Inc. will bill and pursue collection against the insurance company or other responsible entity on my behalf. I hereby instruct and direct my insurance company to pay my benefits directly to Chiropractic Center of Lakeland, Inc. at the address provided on the bill. If my current policy prohibits direct payment to doctors, then I hereby instruct and direct my insurance company or other responsible entity to make the check payable to me and mail it to Chiropractic Center of Lakeland, Inc. at the address on the bill. Chiropractic Center of Lakeland, Inc.'s medical care is being provided for a reasonable fee for treatment causally related to the above loss date and is medically necessary. I instruct my insurance carrier or other responsible entity to pay these bills to the full extent of my available benefits under the insurance policy and Florida law. If any portion of the charge for these services is either reduced or denied in whole or in part, my insurance company or other entity is to place funds equal to the amount of the reduced or denied charges into escrow and hold the escrowed funds until agreement or resolution of legal action by Chiropractic Center of Lakeland, Inc.. I further instruct my insurance company to make payment for charges submitted by Chiropractic Center of Lakeland, Inc. in priority to any other requests to escrow benefits, including a request by myself to reserve benefits for pending disability claims. I hereby give Chiropractic Center of Lakeland, Inc. limited power of attorney to endorse and sign my name on any draft for payment to either Chiropractic Center of Lakeland, Inc. or myself if said draft represents payment for charges related to services rendered by Chiropractic Center of Lakeland, Inc..

I further direct my insurance carrier or responsible other entity to provide information to Chiropractic Center of Lakeland, Inc. which is otherwise available to me including but not limited to a copy of any applicable insurance policy, declaration page, all applicable endorsements, transcripts and/or copies of any recorded statements, examinations under oath and requests for same, independent medical evaluations and requests for same, peer review reports, and a listing of all PIP benefits paid to date which shall include when claims were made, when the claims were received, the payment or denial of each claim, the amount of the deductible and the claims applied thereto, and whether benefits have been exhausted and the amount of PIP benefits available, commonly known as a "PIP log". This request includes the name of other medical providers to whom payments have been under my policy of insurance. This agreement is intended to serve as an assignment of rights and benefits under my policy of insurance in favor of Chiropractic Center of Lakeland, Inc.. If any language within this agreement has the effect of invalidating this agreement, that language shall be deemed void and the remainder of the assignment shall maintain full force and effect. A photocopy of this assignment shall be considered as effective and valid as the original.

_____	_____	_____
Patient Signature	Date	Patient Name

If patient is incapacitated or under the age of 18, please indicate the patient name, guardian name and relation to patient, and obtain guardian signature.

Chiropractic Center of Lakeland

We want to thank you for choosing us as your chiropractic health provider. In order to provide you and our other patients with the best optimal spinal care, we request that you follow our guidelines regarding broken and/or canceled appointments. Please remember that we have reserved appointment times especially for you. Therefore, we request at least 24 hours notice in order to reschedule your appointment. This will enable us to offer your canceled time to other patients that desire to get their treatment completed. When you cancel your appointment at the last minute, everyone loses—you, the doctor and other patients that would like to have utilized your appointment time.

Since our office does not charge for broken or canceled appointments, please realize how important it is to keep your reserved time. However, if you are scheduled for a Massage, a $2□ cancellation fee is enforced for the inconvenience of others. Thank you for your consideration of our policies and the opportunity to be your chiropractic office of choice.

_____ _____

Signature Date

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Name_____ Date_____
Print Patient's Name

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

Dated this _____ day of _____, 20___

By_____
Patient's Signature

If patient is a minor or under a guardianship order as defined by State law:

By_____
Signature of Parent/Guardian (circle one)