ProCare
Oviedo
Chiropractors

Patient Information

This questionnaire was designed to provide important facts regarding the history of your pain or condition. The information you provide will assist in reaching a diagnosis and determining the source of your problem. Please take the time and answer each question as completely as possible. ***Please sign each page***.

TODAY'S DATE: _____/_____/_____ AGE: _____ GENDER: MALE / FEMALE

LAST NAME: _____ FIRST NAME: _____

DOB: ____/_____/_____ SOC.SEC#_____/_____/_____

MARITAL STATUS: Married / Single / Divorced / Widow

HOME ADDRESS: _____

CITY: _____ STATE: _____ZIP: _____

HOME PHONE#: (_____) _____ CELL#: (_____) _____

EMAIL: _____@_____.COM

EMPLOYER: _____

OCCUPATION: _____ PHONE #: (_____) _____

EMERGENCY CONTACT: _____ PHONE #: (_____) _____

RELATION: _____

FAMILY PHYSICIAN: _____

PHONE#: (_____) _____

How did you hear about our office? _____

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HEALTH INSURANCE INFORMATION

HEALTH INSURANCE COMPANY: _____

Name of the insured: _____ Insured's Date of Birth _____/_____/_____

Relationship to insured: self / spouse / child / other _____

Policy #: _____ Group #: _____

Insurance Phone #: (_____) _____

SECONDARY INSURANCE: _____

Name of the insured: _____ Subscriber ID: _____

Policy #: _____ Group #: _____

Insurance Phone #: (_____) _____

AUTO INSURANCE INFORMATION

NAME OF YOUR INSURANCE COMPANY: _____

DATE OF ACCIDENT: _____ Name on the Policy: _____

POLICY #: _____ CLAIM #: _____

ADJUSTER'S NAME: _____ PHONE #: (_____) _____

IF YOU DO NOT HAVE YOUR OWN INSURANCE, DO YOU LIVE WITH SOMEONE WHO DOES? **YES / NO**

NAME OF THE POLICY HOLDER: _____ RELATIONSHIP: _____

POLICY #: _____ CLAIM #: _____

ARE YOU BEING REPRESENTED BY AN ATTORNEY? Y / N

ATTORNEY'S NAME: _____ PHONE #: (____) _____

ADDRESS: _____CITY: _____STATE: ____ ZIP: _____

ASSIGNMENT OF BENEFITS

Health and accident policies are an arrangement between an insurance carrier and me. My insurance company states that policy information is not a guarantee for payment and that my benefits could change or be denied. My insurance company can take at least 60 days to respond to submitted claims and it is my responsibility to inform this clinic of any changes in my policy.

ProCare Chiropractic & Rehab will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to **ProCare Chiropractic & Rehab** will be credited to my account on receipt. However, I agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I agree to pay, in a current manner, any balance of said professional service charges over and above my insurance company's payments. If I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I hereby instruct and direct payment to be made by my insurance carrier to: **ProCare Chiropractic & Rehab.** A photocopy of this authorization shall be considered as effective and valid as the original.

I understand and agree to the aforementioned.

SIGNATURE: _____ DATE: _____

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HEALTH INFORMATION

WHAT ARE THE CHIEF COMPLAINTS FOR WHICH YOU ARE SEEKING TREATMENT?
(IN ORDER OF IMPORTANCE WITH 1 BEING MOST IMPORTANT)

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

How long have you had this condition (s)? _____ Have you had this condition in the past? Y / N

Is this condition getting progressively worse? YES [ ] NO [ ] CONSTANT [ ] COMES AND GOES [ ]

Is this condition interfering with your: WORK [ ] SLEEP [ ] DAILY ROUTINE [ ] OTHER: _____

Date of last physical examination _____

Have you had any surgical operations in the past? Y / N EXPLAIN _____

Are you allergic to any medications? Y / N List if any: _____

List any medication currently being taken: _____

Do you smoke cigarettes? Y / N If yes, please state frequency & quantity _____

Do you drink alcohol? Y / N If yes, please state frequency & quantity _____

Have you been in an auto accident in the past? YES / NO WHEN? _____

DESCRIBE: _____

Have you had any other personal injury or accident? YES / NO WHEN? _____

DESCRIBE: _____

Are you pregnant? YES / NO / POSSIBLY

***PLEASE INDICATE WHICH OF THE FOLLOWING CONDITIONS APPLY:**

YOU	FAMILY		YOU	FAMILY	
☐	☐	Allergies	☐	☐	Artificial Implants
☐	☐	Arthritis	☐	☐	Blood Disorders
☐	☐	Endocrine Disorders	☐	☐	Heart/Circulatory Disorders
☐	☐	Eye Disorders	☐	☐	HIV Disorders
☐	☐	Liver Disease	☐	☐	Kidney/Urinary Disorder
☐	☐	Lung/Respiratory Disorders	☐	☐	Muscle Disorders
☐	☐	Nerve Disorders	☐	☐	Stomach/Intestinal Disorders

SIGNATURE: _____ DATE: _____

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CURRENT CONDITION

List treatments you have had for this problem and all health professionals that you are currently seeing:

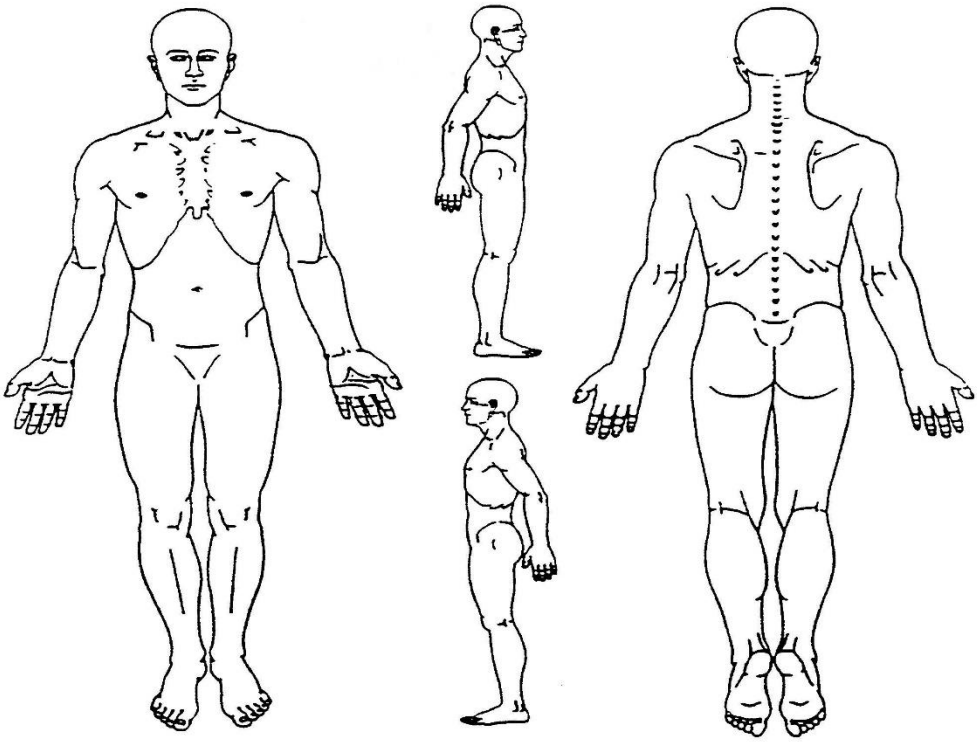
PHYSICIANS SPECIALTY TREATMENT & DURATION

1) _____
2) _____
3) _____
4) _____
5) _____

BREIFLY DESCRIBE YOUR INJURY:

_____
_____
_____

Please mark your areas of pain on the figures below:



SIGNATURE: _____ DATE: _____

PAIN DISABILITY QUESTIONNAIRE

Patient Name:_____ Date:_____

Instructions: These questions ask your views about how your pain now affects how you function in everyday activities. Please answer **EVERY** question and **CIRCLE** only **ONE** number on **EACH** scale that best describes how you feel today.

1. Does your pain interfere with your normal work inside and outside the home?

Work normally										Unable to work at all
0	1	2	3	4	5	6	7	8	9	10

2. Does your pain interfere with personal care (such as washing, dressing, etc.)?

Take care of myself completely										Need help with all my personal care
0	1	2	3	4	5	6	7	8	9	10

3. Does your pain interfere with your traveling?

Travel anywhere I like										Only travel to see doctors
0	1	2	3	4	5	6	7	8	9	10

4. Does your pain affect your ability to sit or stand?

No problems										Cannot sit/stand at all
0	1	2	3	4	5	6	7	8	9	10

5. Does your pain affect your ability to lift overhead, grasp objects, or reach for things?

No problems										Cannot do at all
0	1	2	3	4	5	6	7	8	9	10

6. Does your pain affect your ability to lift objects off the floor, bend, stoop, or squat?

No problems										Cannot do at all
0	1	2	3	4	5	6	7	8	9	10

7. Does your pain affect your ability to walk or run?

No problems										Cannot walk/run at all
0	1	2	3	4	5	6	7	8	9	10

8. Has your income declined since your pain began?

No decline										Lost all income
0	1	2	3	4	5	6	7	8	9	10

9. Do you have to take any pain medication every day to control your pain?

No medication needed										On pain medication throughout the day
0	1	2	3	4	5	6	7	8	9	10

10. Does your pain force you to see doctors much more often than before your pain began?

Never see doctors										See doctors weekly
0	1	2	3	4	5	6	7	8	9	10

11. Does your pain interfere with your ability to see the people who are important to you as much as you would like?

No problem										Never see them
0	1	2	3	4	5	6	7	8	9	10

12. Does your pain interfere with recreational activities and hobbies that are important to you?

No interference										Total interference
0	1	2	3	4	5	6	7	8	9	10

13. Do you need the help of your family and friends to complete everyday tasks (including both work outside the home and housework) because of your pain?

Never need help										Need help all the time
0	1	2	3	4	5	6	7	8	9	10

14. Do you now feel more depressed, tense, or anxious than before your pain began?

No depression/tension										Severe depression/tension
0	1	2	3	4	5	6	7	8	9	10

15. Are there emotional problems caused by your pain that interfere with your family, social and or work activities?

No problem										Severe problem
0	1	2	3	4	5	6	7	8	9	10

With permission from: Anagnostis C et al: The Pain Disability Questionnaire: A New Psychometrically Sound Measure for Chronic Musculoskeletal Disorders. *Spine* 2004; 29 (20): 2290-2302

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INFORMED CONSENT FOR TREATMENT

- All visit charges are payable when services are rendered. Any returned checks will incur a $25 fee.
- I authorize the taking of photographs and x-rays as well as performance of other diagnostic and therapeutic procedures to be used for treatment purposes.
- I hereby give consent to have chiropractic adjustments performed in a semi-open room setting. I understand that a semi-open room setting does not ensure complete privacy and will inform the staff if I need to discuss any confidential information in private.
- Chiropractic care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke.

  Prior to receiving chiropractic care this chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spine health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

I understand and accept that there are risks associated with chiropractic care and give my consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment.

_____ _____

Patient Name (printed) Date

_____ _____

Patient or legal Guardian Signature Relationship to patient

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that a copy of the Notice of Privacy Practices is available at my request 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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PATIENT'S REQUEST FOR COPIES OF RECORDS

I hereby request a copy of my patient records and x-rays from ProCare Chiropractic & Rehab. I request the copies on paper / in electronic format by email transmission to

_____@_____. _____.

I understand that Section 460.413 Florida Statutes, and Board of Chiropractic Medicine Rule 64B2-17-006 require chiropractic physicians to retain records and x-rays for at least 4 years. Therefore, a chiropractic physician receiving a request for a patient's x-ray within that four-year period must retain the x-ray and provide a copy of it in lieu of the original x-ray. I, further, understand that Section 456.057(18), Florida Section 457.057(16), Florida Statutes, authorizes a health care practitioner or patient records owner furnishing copies of reports or records or making the reports or records available for digital scanning pursuant to this section to charge no more than the actual cost of copying, including reasonable staff time, or the amount specified in administrative rule by the appropriate board, or the department where there is no board. The Board of Chiropractic Medicine Rule 64B-17.0055, Florida Administrative Code, authorizes chiropractic physicians to charge $1.00 per page for the first 25 pages, and 25 cents for each additional page. The Board of Chiropractic Medicine Rule defines the reasonable costs of reproducing x-rays, and such other special kinds of records as the actual costs. The phrase 'actual costs' means the cost of material and supplies used to duplicate the record, as well as the labor costs and overhead costs associated with such duplication. The Board of Chiropractic Medicine Rule 64-B17.0055, Florida Administrative Code, authorizes chiropractic physicians to charge people who are not patients authorized to seek copies of my patient records $1.00 per page. I understand that the HIPAA regulations authorize the practice to charge the cost of labor and hardware onto the records are electronically copied unless the Board of Chiropractic Medicine sets lower costs. I understand that there is no cost for transmitting the electronic records by email.

SIGNATURE: _____DATE: _____
(Patient's or Patient's Legal Representative's Signature)

*** YOU MAY REFUSE TO SIGN THIS REQUEST ***

For Use by Privacy Officer Only

DOCUMENTS FURNISHED TO PATIENT:

X-RAYS FURNISHED TO PATIENT:

Signature of staff member: _____

Date: _____

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APPOINTMENT CANCELLATION POLICY

We request that you please give our office a 24-hour notice in the event that you need to reschedule your appointment. This allows other patients to be scheduled into that appointment. It also makes it possible to reschedule your appointment more efficiently. If a patient misses an appointment without contacting our office, this is considered a missed appointment ("No-Show, No-Call."). **We reserve the right to charge a fee of $30.00 to any patient for either a missed appointment or an appointment cancelled without 24 hours' notice.** If a patient accumulates a total of three (3) missed appointments, the patient may not be rescheduled for future appointments.

Additionally, if a patient is more than 15 minutes late to his/her appointment, the appointment will be cancelled.

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you have.

We thank you for your patronage.

I have read and understand the Appointment Cancellation Policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

I, _____ (print name), have received a copy of ProCare Chiropractic & Rehab's Appointment Cancellation Policy.

_____ _____

Printed Name of the Patient Relationship to Patient (if patient is a minor)

SIGNATURE: _____ DATE: _____

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HIPPA EMAIL CONSENT

VERY IMPORTANT! PLEASE READ!

• HIPAA stands for the Health Insurance Portability and Accountability Act

• HIPAA was passed by the U.S. government in 1996 in order to establish privacy and security protections for health information

• Information stored on our computers is encrypted

• Most popular email services (ex. Hotmail®, Gmail®, Yahoo®) do not utilize encrypted email

• When we send you an email, or you send us an email, the information that is sent is not encrypted. This means a third party may be able to access the information and read it since it is transmitted over the Internet. In addition, once the email is received by you, someone may be able to access your email account and read it.

• Email is a very popular and convenient way to communicate for a lot of people, so in their latest modification to the HIPAA act, the federal government provided guidance on email and HIPAA

• The information is available in a pdf (page 5634) on the U.S. Department of Health and Human Services website - http://www.gpo.gov/fdsys/pkg/FR-2013-01-25/pdf/2013-01073.pdf

• The guidelines state that if a patient has been made aware of the risks of unencrypted email, and that same patient provides consent to receive health information via email, then a health entity may send that patient personal medical information via unencrypted email

☐ OPTION 1 – **ALLOW UNENCRYPTED EMAIL**. I understand the risks of unencrypted email and DO hereby give permission to allow ProCare Chiropractic & Rehab to send me and/or my attorney personal health information via unencrypted email.

☐ OPTION 2 – **DO NOT ALLOW UNENCRYPTED EMAIL**. I DO NOT give permission to ProCare Chiropractic & Rehab to send me and/or my attorney personal health information via unencrypted email.

_____ @ _____ . _____
Email address

_____
Printed Name
(parent or guardian if patient is a minor)

SIGNATURE: _____ DATE: _____

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MEDICAL RECORDS REQUEST FORM

Patient's Name: _____ DOB: _____

Social Security #: _____ D/A: _____

I request and authorize: _____

To release healthcare information of the patient named above to:

ProCare Chiropractic & Rehab
40 Alexandria Blvd. #1020 **Ph: (407) 359-0047**
Oviedo, FL 32765 **Fax: (407) 359-0071**

This request and authorization applies to:

- □ Full medical records held by this office
- □ A specific portion/section of the record as follows: _____
- □ Radiology reports
- □ Medical record for the period _____ through _____
- □ Other diagnostic studies: _____

Purpose of the requested disclosure: _____ At patient's request. ____ Continuing Care

I understand that I have the right to revoke this authorization at any time. My revocation must be in writing in a letter provided to the privacy officer. I am aware that my revocation is not effective to the extent that the person I have authorized to use and/or disclose my Protected Health Information have acted in reliance upon this authorization. I understand that I do not have to sign this authorization and that ProCare Chiropractic & Rehab may not condition treatment on whether I sign this authorization. I further understand that if the person(s) or organization(s) authorized to receive the information is not a health plan or health care provider, the release information may be re-disclosed and would no longer be protected by federal privacy regulations.

I agree that a copy of this release or fax of this release shall be as valid as the original release. If I authorize ProCare Chiropractic & Rehab to fax information, I realize there are inherent risks in faxing Protected Health Information; I understand a fee will be charged to cover the cost of copying, including the cost of supplies and labor of copying and mailing Protected Health Information released to anyone other than another health care provider. I understand I will get a copy of this form after I sign it.

_____ _____
Patient's or Representative's Signature Date Signed

THIS AUTHORIZATION EXPIRES 1 YEAR FROM THE DATE IT IS SIGNED

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PARENTAL CONSENT FOR TREATMENT AND CARE OF MINORS

I, _____, being the parent and/or legal Guardian of
print adult name

minor age child, _____, _____,
print child's name date of birth

hereby give consent for necessary or appropriate treatment and care by the health care providers affiliated with ProCare Oviedo Chiropractors, which may include, without limitation, arranging for and/or authorizing consultation, evaluation, referral, treatment, for the above-named minor.

This consent shall remain in effect unless it is revoked in writing.

Parent / Legal Guardian: _____
Print name

Parent / Legal Guardian: _____ Date: _____
Signature

Relationship to minor: _____

Address: _____

Phone: _____

*Please attach a copy of the parent/guardian valid ID or driver's license to this consent form.