

WELCOME TO OUR OFFICE!

Name _____ Date: ____/____/____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ E-Mail _____

Birthdate _____ Age _____ SS# _____ Race: _____ Marital Status: M W D S

Employer _____ Work Phone _____ Occupation _____

Name & Birthdate of Primary Insured _____ Spouse Name _____

Primary Care Medical Doctor — Name & Location _____

Most patients are referred to our office by a caring family member or friend. What brought you in contact with our office?

Friend/Family Member/Doctor — Name _____ Postcard

Sign Internet Billboard Newspaper — Name _____ Event Seminar

Please describe the primary health complaint you are experiencing. _____

How long have you had this condition? _____

Doctor treating condition: _____ Treatment Received: _____

Other Doctor: _____ Other Treatment: _____

Please list all surgeries _____

What medications are you currently taking and for what conditions? _____

Is this condition related to an automobile accident or injury suffered at your job? Yes No

Are you or could you be pregnant? Yes No Tobacco Use? Yes No

Please put an "X" next to any current conditions and a "P" next to any past conditions:

- | | | | | |
|--|--|--|-------------------------------------|-------------------------------------|
| <input type="checkbox"/> Hip Pain – R / L | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Headaches | <input type="checkbox"/> Cancer | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Foot Trouble – R / L | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Ear Infection | <input type="checkbox"/> Tremors | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Shoulder Pain – R / L | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Allergies | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Irritable |
| <input type="checkbox"/> Convulsions/Epilepsy | <input type="checkbox"/> Trouble Sleeping | <input type="checkbox"/> Fractured Bones | <input type="checkbox"/> Fainting | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Trouble Concentrating | <input type="checkbox"/> Accidents/Falls | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Anemia | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Jaw Pain/TMJ – R / L | <input type="checkbox"/> Pain w/ Cough/Sneeze | <input type="checkbox"/> Skin Problems | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Ringing in Ears – R / L | <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Diabetes |

Help our Therapists help you! Circle your preference below.



Light amount of pressure



Moderate amount of pressure



Heavy amount of pressure



The above information is true and accurate to the best of my knowledge.

Patient Signature _____

Date _____

To Our Patients Regarding Cancellations and No-Shows

The following are our policies regarding cancellations and no-shows. We take this subject seriously because it can make a difference between responding to treatment or not. Usually your referring doctor and/or therapist have prescribed a set frequency of treatment. If you show up for treatment, it will enable you to get better. Other than that all you need to do is follow your doctor's instructions, and you should achieve your treatment goals.

We require 24 hours notice in the event of a cancellation. It is your responsibility, when you call in, to have an alternative time in mind that will ensure you get the full number of prescribed treatments that week whenever possible.

There is a **\$20 charge for a cancellation or no-show without proper notice.** This charge will not be covered by your insurance, but will have to be paid by you personally.

For **Workmen's Compensation and Personal Injury patients**, documentation of any missed appointments is forwarded to your case manager and primary physician. This could jeopardize your claim.

You may occasionally need to see another physician other than the one who normally sees you if you do need to re-arrange your appointment. All of our physicians are experienced professionals and they will study your chart. You may return to your original physician at the next appointment.

Please understand that your pain will probably increase and decrease as your course of treatment progresses and before it is finally eliminated. Either condition should not be a reason not to come in: 1) Your pain is gone or 2) Your pain is worse. If the pain is gone, now is the time to really begin rehabilitating the injured area to prevent recurrence. If your pain is worse, we can do something to help.

When you don't show as scheduled, three people are hurt. 1) You, because you didn't get the treatment you need as prescribed by your doctor; 2) The doctor who now has a hole in their schedule; 3) The person that couldn't get in when you had your appointment scheduled.

Thank you for cooperating with us on this matter. We are looking forward to working with you.

Patient Signature

Date

ABBREVIATED NOTICE OF PRIVACY POLICY FOR JACKSONVILLE SPORT & SPINE

Effective October 1, 2005

We collect your personal health information from you through treatment, payment or other means as applicable. Your personal health information is protected by federal law. Generally we do not use or disclose your information without your permission. Once permission has been obtained, we must disclose your personal health information in accordance with the specific terms of permission. The following is an outline of the circumstances under which we are permitted by law to use or disclose your personal health information. You may request a copy of the detailed privacy policy with a written request sent to: JACKSONVILLE SPORT & SPINE – 2233 PARK AVE. STE. 200B • ORANGE PARK, FL 32073

1. Without your consent we may use or disclose your personal health information in order to provide you with services and treatments you may require or request, or to collect payment for services and/or to conduct other operations otherwise permitted or required by law. We can also disclose your personal health information within and among our workforce to accomplish the same purposes.
2. As required by law we may use or disclose your personal health information to the extent that such use or disclosure as required by law and the use or disclosure complies with and is limited to the relevant requirements of such law.
3. All other situations with your specific authorization. Except as otherwise permitted or required, as outlined above, we may not use or disclose your personal health information without your written permission. You may revoke your authorization at any time except in some circumstances.
4. Miscellaneous activities NOTICE: We may contact you to provide appointment reminders or information about treatments or other health-related benefits and services that may be of interest to you.

YOUR RIGHTS WITH RESPECT TO YOUR PERSONAL HEALTH INFORMATION

1. Right to request restrictions on use or disclosure
2. Right to receive confidential information
3. Right to receive confidential communications
4. Right to inspect and copy your personal health information
5. Right to amend your personal health information
6. Right to receive accounting of disclosures of your personal health information
7. Right to file a complaint with us and the Secretary of the DHHS if you believe your privacy rights have been violated. You may submit your complaint in writing by mail to our privacy officer, JACKSONVILLE SPORT & SPINE, within 180 days of when you knew or should have known the act of omission complained of occurred. You will not be retaliated against for filing any complaint.

We reserve the right to amend this privacy policy at any time for which we will provide you with notice within 60 days of the effective date of such revision, amendment or change.

PRIVACY PRACTICES ACKNOWLEDGMENT

I. ACKNOWLEDGMENT OF PRIVACY PRACTICE NOTICE

I have received/reviewed a copy of JACKSONVILLE SPORT & SPINE'S Notice of Privacy Practices:

Patient's Name _____ **Date of Birth** _____ **Signature of Patient/Parent** _____ **Date** _____

II. **Open Adjusting Rooms:** Due to the open office floor plan, sensitive matters should be discussed in private. Please make the doctor aware of any such issues so appropriate arrangements can be made for privacy.

III. DESIGNATION OF RELATIVES, FRIENDS AND OTHER CAREGIVERS FOR HEALTHCARE DISCLOSURE

I agree that JACKSONVILLE SPORT & SPINE may disclose certain healthcare information to persons involved with my healthcare decisions or payment. I designate the following person(s) listed below as being involved with my healthcare for the purpose of JACKSONVILLE SPORT & SPINE making limited information disclosure for the above purpose. I UNDERSTAND I AM NOT REQUIRED TO LIST ANYONE. I also understand I may change the designees in writing at any time.

Print Name _____ **Relationship** _____ **Contact Phone #** _____

INFORMED CONSENT

I hereby request and consent to the performance of: physical examination and any other diagnostic tests such as x-rays to diagnose my condition(s), and of spinal adjustments, extremity adjustments, physical therapy, and axial decompression. If during the course of care the doctors encounter non-chiropractic or unusual findings, they may recommend I consult a specialist for the area in question. I have had the opportunity to discuss with the doctor or office personnel that results are not guaranteed and the rare risks of treatment. I do not expect the doctors to be able to anticipate and explain all risks and complications, and wish to rely upon the doctor's judgment during the course of treatment, based upon the facts then known, that is in my best interest. This consent will cover the entire course of my treatment for present conditions or any future conditions for which I seek treatment.

I have read and understand the terms above and grant permission for care:

Patient's Signature _____ **Date** _____

In case of emergency, contact _____ Phone # _____

Complete if patient under 18 years of age:

Child Name: _____

As parent/legal guardian of above child, I understand the terms above and grant permission for treatment.

Parent/Guardian Signature _____ **Date** _____

ASSIGNMENT OF BENEFITS

Patient Name _____

Address _____ City _____ State _____ Zip _____

Insurance Company _____

Name of Policyholder _____ Policy Number _____

1. I, the undersigned, hereafter referred to as "the patient" do hereby assign all of my rights and interests to JACKSONVILLE SPORT & SPINE, hereafter referred to as "the medical provider" to pursue and obtain payment from the above mentioned insurance carrier.
2. I, irrevocably assign, to the medical provider, all my rights and benefits under the insurance contract for payment for services rendered to me.
3. I, the patient, do hereby understand and acknowledge that if I willfully refuse to comply with reasonable requests of the insurance carrier, payment of my medical bills may be denied and I will be held responsible for same.
4. I, the patient, do hereby direct my health insurance carrier and/or other insurance carrier to issue payment on my behalf directly to the medical provider. The check should be made payable to the medical provider. Further, in the event that the health carrier and/or other insurance carrier fails to forward the check to the medical provider, I will endorse and sign the check to the medical provider within (5) days of receipt of same.
5. For any/all balances over 120 days, a collection fee of \$20.00 will be added to your balance.

Signed _____

Patient's Name _____ **Dated** _____

Witness _____