PATIENT BASIC INFORMATION

Group **Date: _____**

Last Name:	**First Name:**		**MI:**
Address:	**City:**	**State:**	**Zip:**
Home Phone:	**Cell Phone:**	**Social Security Number:**	
Date of Birth:	**Date of Injury/Onset:**		
Dominant Hand: **____ Right ____ Left ____ Both**			
Employer:	**Occupation:**	**E-mail:**	

How did you hear about our office:_____

Special Note: If your injury involved a motor vehicle, skip to page 2. Otherwise, use the spaces below to fully describe your accident, injury or onset, slip and fall, etc.

1. **Description of Accident / Injury / Onset**

   Enter a full description of the accident, injury or onset in the space below.

2. **Your condition during and immediately after injury / onset**

   Enter the details of your condition during and immediately after your injury / onset.

HISTORY

HAVE YOU EVER BEEN INVOLVED IN A WORK RELATED OR AUTO ACCIDENT?

_____

_____

PRIOR TO THIS, HAVE YOU EVER RECEIVED ANY INJURY TO THE AREA(s)NOW INJURED?

_____

HAVE YOU EVER HAD ANY BROKEN BONES? _____

HAVE YOU EVER HAD ANY SURGERIES: _____

DO YOU HAVE ANY PRESENT HEALTH CONDITION: ____Yes ____No IF YES, PLEASE EXPLAIN:

_____

DO YOU TAKE ANY MEDICATION AT THIS TIME: ____Yes ___No

IF YES, PLEASE LIST: _____

HAVE YOU EXPERIENCED ANY BOWEL OR URINARY CHANGES SINCE THIS CONDITION BEGAN? Explain

_____

DIDYOU ENJOY GOOD HEALTH PRIOR TO THIS INJURY / ONSET: ____Yes ____No

IF NO, PLEASE EXPLAIN: _____

FEMALE: Are you, or could you be pregnant? _____Yes _____No Date of Last Period _____

FAMILY DOCTOR NAME & ADDRESS	**WORK / AUTO ACCIDENT DOCTORS NAME & ADDRESS**

SOCIAL HISTORY

DO YOU USE: _____ Prescription drugs _____ Tobacco _____ Alcohol _____ Recreational drugs

IF YES, PLEASE LIST:_____

MARITAL STATUS _____M ____S ____W ____D HOW MANY CHILDREN IN HOME _____

OCCUPATIONAL HISTORY

WERE YOU EMPLOYED WHEN YOUR CONDITION OCCURRED: _____ Yes _____ No

DID YOU STOP WORKING DUE TO YOUR CONDITION: _____ Yes _____ No _____ Date

IF NO, DOES WORK MAKE YOUR CONDITION WORSE? _____ Yes _____ No

IF YES, PLEASE EXPLAIN: _____

_____

I hereby give authorization for my medical results/records to be disclosed to my other doctors that I have listed on this form. I hereby give consent for treatment to Brandon Chiropractic and Massage.

I hereby certify that the information I have given is true to the best of my knowledge.

SIGNATURE _____ DATE _____

Brandon Chiropractic and Massage

654 E. Bloomingdale Ave.
Brandon, FL 33511

ACKNOWLEDGEMENT 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 (please print)

_____

Signature

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

INSURANCE
ASSIGNMENT OF BENEFITS

I, _____ hereby authorize _____
(Name of Insured / Patient) (Name of Insurance Carrier)
to make medical benefits payments otherwise payable to me for services rendered by Brandon Chiropractic and Massage, but not to exceed the charges of those services, payable to and mailed directly to:

Brandon Chiropractic and Massage
654 E. Bloomingdale Ave.
Brandon, FL 33511

MEDICAL RELEASE

A photocopy of this document shall be sufficient to authorize any person having records of medical treatment, services, or supplies pertaining to me to release true copies of same to _____ or any insurer providing coverage to me in connection with the processing of any claim for benefits made by me or by the assignee herein. A photocopy of this document shall be as binding as an original signature page.

POWER OF ATTORNEY

POWER OF ATTORNEY TO ENDORSE CHECKS AND/OR TO SIGN ANY PIECE OF PAPER WHICH WILL ENHANCE OR EXPEDITE PAYMENT TO PROVIDER FOR SERVICES RENDERED, INCLUDING BUT NOT LIMITED TO A RELEASE OF MEDICAL RECORDS and ASSIGNMENT OF BENEFITS/AUTHORIZATION TO PAY.

I authorize the above mentioned office to, and hereby give power of attorney to said office to endorse/sign my name on any and all checks for payment of medical services received from my insurance company and grant a lien to said medical services provider for any proceeds or insurance benefits payable under my policy. A photocopy of this instrument shall be considered as effective and valid as the original.

_____ _____ _____
PATIENT'S SIGNATURE DATE PATIENT'S NAME (PLEASE PRINT)

_____ _____ _____
WITNESS DATE WITNESS (PRINTED NAME)

Brandon Chiropractic and Massage

654 E. Bloomingdale Ave.

Brandon FL 33511

FINANCIAL POLICY

IT IS THE POLICY OF THIS OFFICE THAT ALL FEES FOR SERVICES ARE PAID WHEN SERVICES ARE RENDERED UNLESS INSURANCE BENEFITS HAVE BEEN VERIFIED

INSURANCE ASSIGNMENT

NO insurance will be accepted until all insurance information has been obtained and coverage has been verified.

The patient is responsible for the co-payment on a weekly basis once the deductible has been satisfied. In the event that the insurance carrier rejects your claim, or the amount paid is less than expected, the patient is responsible for the bill at that time.

This office **DOES NOT** promise that an insurance will pay, nor does this office promise that the insurance company will pay appropriately for the fee charges. Our office **WILL NOT** enter into a dispute with an insurance company over reimbursement or the amount of reimbursement. This is the patient's obligation.

CASH PATIENT

Payment is due when services are rendered. If payment cannot be made, other financial arrangements must be made **PRIOR TO THE START OF TREATMENT**.

I HEREBY AUTHENTICATE THAT I HAVE READ AND UNDERSTAND THE FOREGOING POLICY.

_____ _____

PATIENT SIGNATURE DATE

_____ _____

WITNESS DATE

Brandon Chiropractic and Massage

654 E. Bloomingdale Ave.
Brandon, FL 33511

AUTHORIZATION TO OBTAIN, RELEASE OR REVIEW PROTECTED HEALTH INFORMATION

Patient Name: _____ Social Security No.: _____

Address: _____

Date of Birth: _____ Date of Service: _____ Phone No.: _____

Identification Shown: _____ Mail _____ Pick Up _____

I hereby authorize Brandon Chiropractic and Massage to use and disclose to: _____ or obtain from: _____ or allow review: _____

_____ _____
Name of Facility or Person Phone Number

_____
Street Address City State Zip Code

the following information contained in my medical record regarding my hospitalization, care and treatment (please initial):

_____ Complete Record
_____ Abstract of Record
_____ Therapy Records
_____ Progress Note(s)
_____ All Diagnostic Test Results
_____ Consultation
_____ Radiology Only
_____ Operative Report
_____ Pathology Report(s)
_____ Lab Only
_____ Other (please specify)
_____

The purpose for the release of information at the request of the individual is:

____ Insurance ____ Legal Action ____ Continued Treatment ____ Personal Use
____ Patient Communication (Behavioral Health) ____ Other (please specify) _____

This authorization will expire on the following date, event or condition: _____
I understand that this authorization extends to all or any part of the records designated above, which may include psychiatric information, and/or genetic counseling/testing, and/or alcohol/drug abuse and/or AIDS (Acquired Immunodeficiency Syndrome), and/or may include the result of an HIV test or the fact that an HIV test was performed. I expressly consent to the release of information as designated above unless initialed below or otherwise required by law.

May NOT include information related to (please initial):
_____ HIV/AIDS _____ Mental Health _____ Drug and/or Alcohol Abuse _____ Genetic Counseling/Testing Information

If I fail to specify an expiration event or condition, the authorization will expire in one year. I understand that this authorization is revocable upon written notice to the office where the original authorization is retained, except to the extent that action has already been taken on this authorization. I understand that my protected health information that is used or disclosed under this authorization may be subject to re-disclosure by the recipient and the privacy of my protected health information may no longer be protected by law. I further understand that Brandon Chiropractic and Massage may not condition the provision of treatment, payment, enrollment in the health plan, or eligibility for benefits on the provision of this authorization. I understand that I will receive a signed copy of this form.

_____ _____
Patient/Legal Representative or Parent/Legal Guardian Signature Date

Translator or Interpreter's Name: _____