Edgewater Chiropractic Clinic, P.A.
201 S. Ridgewood Ave, Suite 11
Edgewater, FL 32132
386-423-7575

Patient Name: _____ **Date**: _____

Address: _____

City_____ **State**_____ **Zip Code**_____

Phone: _____ ☐ H☐W ☐ C **2nd Phone**: _____☐ H☐W ☐ C

Gender: ☐M ☐ F Date of Birth: _____**Age**:_____**Marital Status**: MD S W

Race: ☐ Not Specified☐ White ☐ Am. Indian or Alaska Native ☐ Asian☐ Black/African American☐Hispanic

Occupation: _____**Social Security #:** _____

Email: _____

If you were referred by someone to our office please tell us who so we may thank them.

_____

Have you seen a Chiropractor in the past?☐Yes ☐ No

If yes, who _____**Year?**_____

Emergency Contact: _____ **Phone:** _____

Do you have health insurance? ☐Y ☐N **Please Present Card at Window**

Primary Care Physician: _____**Where?** _____

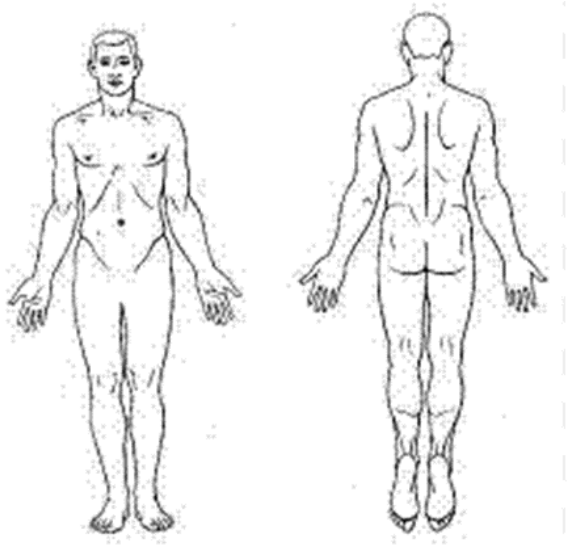
Last Physical Exam: _____

For sign-in purposes please select a 4-digit pin number _____ _____ _____ _____

Are you currently experiencing any of the following symptoms?

☐ Nausea or vomiting
☐ Numbness on one side of the face or body
☐ Fainting or lightheadedness
☐ Dizziness
☐ Difficulty walking
☐ Loss of bladder function
☐ Rapid eye movement
☐ Difficulty speaking
☐ Headache or neck pain
☐ Difficulty swallowing
☐ Double vision
☐ Loss of bowel function

Please circle area(s) where you are feeling symptoms...



What current problem(s) bring you to the clinic today? _____

_____

Date this condition began: _____

How did this happen:

- ☐ FALL
- ☐ LONG DRIVE
- ☐ LONG
- ☐ POOR NIGHT'S SLEEP
- ☐ SLIP
- ☐ LIFTING
- ☐ REACHING
- ☐ HOUSEHOLD CHORES
- ☐ YARD WORK
- ☐ CHRONIC ILLNESS
- ☐ OTHER

Has this pain ever happened before? ☐Y ☐N **When:** _____

How Long Did It Last? _____

Are you currently being treated for this condition? ☐Yes ☐ No

By Whom? _____

Have you had any of the following tests? ☐X-rays ☐EMG ☐ MRI ☐CT Scan

If yes, Year _____ **Where** _____ **Why** _____

Frequency of pain: (please check one)

- ☐ Constant (100% of the time)
- ☐ Frequent (< 75% but > 50% of the time)
- ☐ Occasional (< 50% but > 25% of the time)
- ☐ Intermittent (less than 25% of the time)

What type of pain are you experiencing? (please check all that apply)

- ☐ Aching
- ☐ Annoying
- ☐ Burning
- ☐ Deep
- ☐ Dull
- ☐ Heavy
- ☐ Intolerable
- ☐ Pulling
- ☐ Sharp"Shock Like"
- ☐ Stabbing
- ☐ Stiffness
- ☐ Throbbing
- ☐ "Tightness"
- ☐ Tingling

Is your pain Radiating? ☐Y ☐N **Please Describe** _____

_____

Since the pain began has it: (please circle)

- ☐Improved
- ☐ Stayed the same
- ☐ Worsened
- ☐ Relief which lasted for a while

Pain level: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Symptoms Relieved By: (please check all that apply)

- ☐ None
- ☐ Chiropractic Adjustment
- ☐ Cold Pack
- ☐ Heat Packs
- ☐ Exercise
- ☐ Massage
- ☐ OTC Medication
- ☐ Physical Therapy
- ☐ Prescription Medication
- ☐ Rest
- ☐ Stretching
- ☐ Work

Activity of Daily Living Most Effected? (Check All That Apply)

☐ **Employment**	☐ **Walking**	☐ **Traveling**	☐ **Golfing**
☐ **Homemaking**	☐ **Sitting**	☐ **Yard Work**	☐ **Exercise**
☐ **Lifting**	☐ **Sit to Stand**	☐ **Sitting at Computer**	
☐ **Personal Care**	☐ **Sleeping**		
☐ **Standing**	☐ **Social Life**	☐ **Caring for Family**	

What tasks do you find difficult due to the pain? (Check All That Apply)

☐ **bending over**	☐ **getting to sleep**	☐ **rising out of chair or bed**
☐ **caring for family**	☐ **grocery shopping**	☐ **showering or bathing**
☐ **climbing stairs**	☐ **performing household chores**	☐ **sitting**
☐ **concentrating**	☐ **lifting objects**	☐ **standing**
☐ **dressing self**	☐ **looking over shoulder**	☐ **staying asleep**
☐ **driving car**	☐ **making love**	☐ **using a computer**
☐ **exercising**	☐ **lying down**	☐ **walking**
☐ **getting in/out of car**	☐ **reaching overhead**	☐ **participating in yard work**

How long can you with stand activity before it begins to hurt?

☐1 ☐5 ☐10 ☐15 ☐20 ☐30 ☐45 ☐60 ☐ Seconds☐ Minutes☐ Hours

Is Your pain worse (please circle)? ☐Morning ☐Afternoon ☐Night

Are you currently under significant amount of stress? ☐ Yes ☐ No

Reason_____

Please select if YOU have ever been told you have, had or are currently experiencing any of the following:

☐ Arthritis	☐ Anxiety	☐Cancer
☐ Low Back Pain	☐ Depression	☐ HIV
☐ Mid Back Pain	☐ Dizziness	☐ Osteopenia
☐ Arm/Hand Pain	☐ Epilepsy or Seizures	☐ Osteomalacia
☐ Ankle Pain	☐ Headaches	☐ Sores That Won't Heal
☐ Foot Pain	☐ Numbness	☐ Heart Murmur
☐ Hip Pain	☐ Pins/Needles in Arms/Hands	☐ Rheumatoid Arthritis
☐ Implant or Plates	☐ Trouble Sleeping	☐ High Blood Pressure
☐ Knee Pain	☐ Stroke	☐ Low Blood Pressure
☐ Neck Pain	☐ Temp. loss of vision, smell or hearing	☐ Apnea
☐ Stiff Neck	☐ Loss of Grip/Strength	☐ Asthma
☐ Osteoporosis	☐ Loss of Hearing	☐ Emphysema
☐ Pins and Screws	☐ Blurred Vision	☐ Hay Fever
☐ Scoliosis	☐ Ringing in Ears	☐ Persistent Cough
☐ Shoulder Pain	☐ Head Feels Heavy	☐ Pneumonia
☐ TMJ	☐ Fatigue	☐ Shortness of Breath
☐Cramping	☐ Difficulty Swallowing	☐ Snoring Issues
☐Chest Pain	☐ Thyroid Disfunction	☐ Tuberculosis
☐ Muscle Spasm	☐ Abdominal Pain	☐ Wheezing
☐Any Bleeding/Discharge	☐ Light Headed	☐ Weight Loss/Gain

Had any surgeries?☐Y☐N

Describe_____Year?_____

Describe_____Year?_____

Describe_____Year?_____

Describe_____Year?_____

Have you had a knee replacement? ☐Yes ☐No ☐Right ☐ Left Year_____

Have you had a hip replacement? ☐Yes ☐No ☐Right☐ Left Year_____

Current medication, including frequency and dosage if known. If there are no current medications check here: ❑

1) _____ **5)** _____

2) _____ **6)** _____

3) _____ **7)** _____

4) _____ **8)** _____

List any known allergies you have had to any <u>MEDICATIONS</u>.
If no allergies are known, check here: ❑

1) _____ **3)** _____

2) _____ **4)** _____

Do you have a pacemaker? ☐Yes ☐No
Are you or could you be pregnant? ☐Yes ☐No

Briefly list additional health conditions: _____

_____

Has any doctor diagnosed you with Hypertension presently?❑ Yes ❑No

If yes, describe: _____

Has any doctor diagnosed you with Diabetes presently?❑ Yes❑No If yes, what kind? ❑ Type I ❑ Type II
If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%?❑ Yes❑ No❑ Not Sure
If yes, other comments regarding Diabetes: _____

Do you have any family history in your mother, father, sibling or grandparents of BACK PAIN, HEADACHES, CANCER, DIABETES, STROKE, ARTHRITIS OR HEART DISEASE? ☐Y ☐N

If yes: Who?_____

What conditions?_____Age deceased_____

If yes:Who?_____

What conditions?_____Age deceased_____

If yes: Who?_____

What conditions?_____Age deceased_____

Had any broken bones? ☐Y ☐ N

Describe_____Year?_____

Describe_____Year?_____

Due to Insurance guidelines, we must have 3 measurable goals when it comes to your treatment process. Please provide us with your goals.

1. _____
2. _____
3. _____

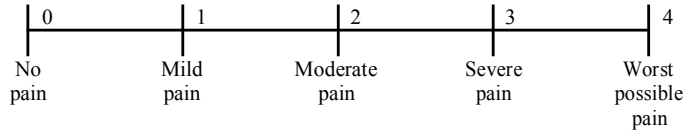
_____
(Patient or Legal Guardian Signature) (Date)

Functional Rating Index

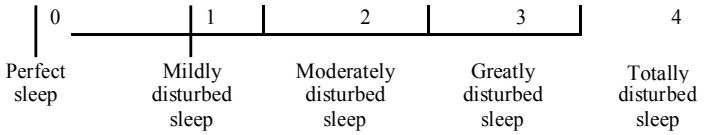
For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** has affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now**.

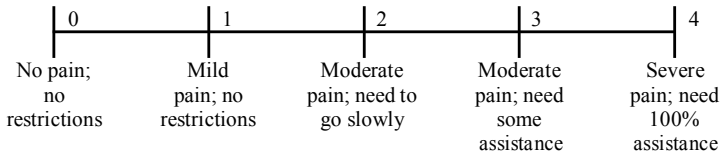
1. Pain Intensity



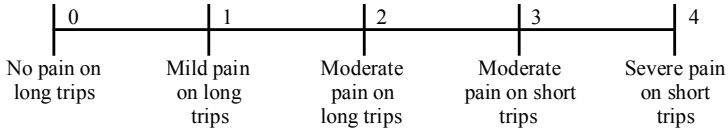
2. Sleeping



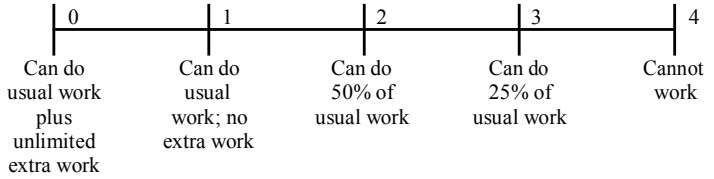
3. Personal Care (washing, dressing, etc.)



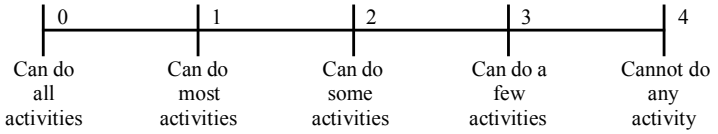
4. Travelling (driving, etc.)



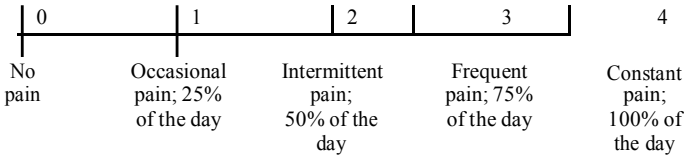
5. Work



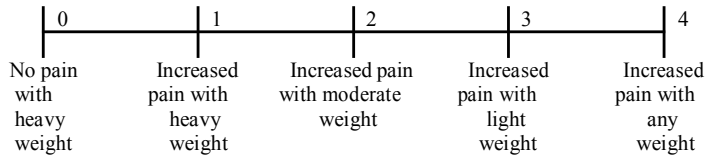
6. Recreation



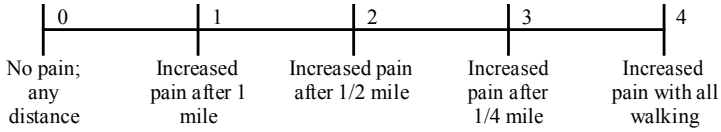
7. Frequency of Pain



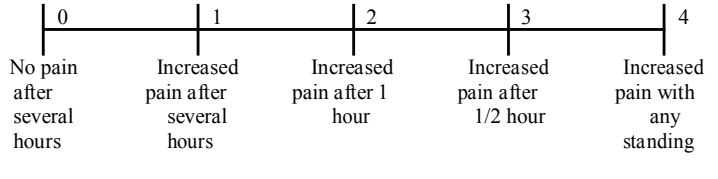
8. Lifting



9. Walking



10. Standing



Patient's Signature _____ **Date** _____

For Office Use Only:

Practitioner ID#: _____

Total Score _____ **/ 40**

Clinical Diagnosis Codes:

Patient ID#: _____

Informed Consent for Chiropractic Treatment

TO THE PATIENT: *You have a right to be informed about your condition, the recommended chiropractic treatment, and the potential risks involved with the recommended treatment. This information will assist you in making an informed decision whether or not to have the treatment. This information is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or refuse to give your consent to treatment.*

I request and consent to chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays. The chiropractic treatment may be performed by the Doctor of Chiropractic named below and/or other licensed Doctors of Chiropractic working at this clinic or office. Chiropractic treatment may also be performed by a Doctor of Chiropractic who is serving as a backup for the Doctor of Chiropractic named below

I have had the opportunity to discuss with the Doctor of Chiropractic named below, my diagnosis, the nature and purpose of my chiropractic treatment, the risks and benefits of my chiropractic treatment, alternatives to my chiropractic treatment, and the risks and benefits of alternative treatment, including no treatment at all.

I understand that, there are some risks to chiropractic treatment including, but not limited to:

- ☐ Broken bones
- ☐ Dislocations
- ☐ Sprains/strains
- ☐ Burns or frostbite (physical therapy)
- ☐ Worsening/aggravation of spinal conditions
- ☐ increased symptoms and pain
- ☐ No improvement of symptoms or pain
- ☐ Infection (acupuncture)
- ☐ Punctured lung (acupuncture)
- ☐ Other _____

In rare cases there have been reported complications of arterial dissections n (stroke) when a patient receives a cervical adjustment. The complications reported can include temporary minor dizziness, nausea, paralysis, vision loss, locked in syndrome (complete paralysis of voluntary muscles in all parts of the body except for those that control eye movement), and death.

I do not expect the doctor to be able to anticipate and explain all risks and complications. I also understand that no guarantees or promises have been made to me concerning the results expected from the treatment.

TREATMENTPLAN:_____

_____

_____

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions. All of my questions have been answered to my satisfaction. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my current condition.

To be completed by the patient:

_____
print name

_____
signature of patient

_____
date signed

To be completed by the patient's representative:

_____
print name of patient

_____
print name of patient's representative

_____
signature of patient's representative as:

_____
relationship/authority of patient's representative

_____
date signed

To be completed by doctor or staff:

_____ _____
witness to patient's signature date

_____ _____
translated by date

Edgewater Chiropractic Clinic PA

Edgewater Chiropractic Clinic, P.A.
201 S Ridgewood Ave, Suite 11
Edgewater, Fl. 32132 Phone (386) 423-7575

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize _____to disclose my protected health information as described below. I understand that this authorization is voluntary. I understand that the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. I understand that I may see and copy the information described on this form if I ask for it, and that I will receive a copy of this form after I sign it. I understand that I may revoke this authorization at any time by giving notice in writing at the address found above, but if I do it will not affect any actions taken before receipt of my revocation.

I understand that my treatment will not be conditioned on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

Patient name:_____ Date of birth:_____
Persons/organizations to receive the information: _____

The specific information to be released/disclosed is specified below:

☐ **Complete Medical Record**
Or specify one or more of the following:

☐ Operative Reports	☐ X-rays
☐ Progress Notes	☐ Billing and Claim Records
☐ Laboratory	☐ (Other – specify) _____

This information is to be used/disclosed for the following purposes(s) only: _____
_____
(no purpose need be stated if the request is made by the patient and the patient does not wish to state the purpose).

This authorization will expire on _____ (state date or event).

SPECIFIC AUTHORIZATION

I understand that my health information to be released MAY INCLUDE information that is related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), behavioral or mental health services, and/or treatment for alcohol and/or drug abuse. My signature below authorizes release of all such information, unless I have crossed it out, and initialed it.

☐ **Yes** ☐ **No** _____**Initials**

_____ _____
Signature of patient or patient's representative **Date**
(Form MUST be completed before signing.)

Printed name of patient's representative (if applicable):_____
Relationship to the patient (if applicable):_____

*** YOU ARE ENTITLED TO A COPY OF THIS DOCUMENT**

Revised May 2015

Edgewater Chiropractic Clinic, PA.
201 S. Ridgewood Ave, Suite 11
Edgewater, FL. 32132
Phone: (386)423-7575

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your Personal Health Information. In addition, we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as dictated by our office policy, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled 'HIPAA' on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

PERMITTED DISCLOSURES:

1.Treatment purposes discussion with other health care providers involved in your care.
2.Inadvertent disclosures open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3.For payment purposes to obtain payment from your insurance company or any other collateral source.
4.For workers compensation purposes to process a claim or aid in investigation.
5.Emergencyin the event of a medical emergency we may notify a family member.
6.For public health and safety in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7.To Government agencies or Law enforcement to identify or locate a suspect, fugitive, material witness or missing person.
8.For military, national security, prisoner and government benefit purposes.
9.Deceased persons discussion with coroners and medical examiners in the event of a patient's death.
10.Telephone calls or emails and appointment reminders we may call your home and leave messages regarding a missed appointment or apprize you of changes in practice hours or upcoming events.
11.Change of ownership in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures.
2.To receive a paper copy of the comprehensive "Detail" Privacy Notice.
3.To request mailings to an address different than residence.
4.To request restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5.To inspect your records and receive one copy of your records at no charge, with notice in advance.
6.To request amendments to information. However, like restrictions, we are not required to agree to them.
7.To obtain one copy of your records at no charge, when timely notice is provided (72 hours). X-raysare original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call Dr. Carly Meckle (386) 423-7575.Ifshe is unavailable, you may make an appointment with our receptionist to see her within72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to: DHHS, Office of Civil Rights

200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201

Patient Financial Policy

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

- Thank you for choosing Edgewater Chiropractic Clinic, PA. For your chiropractic health care needs. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment process. The following is a statement of our financial policy, which we require that you read and sign prior to any treatment.

- Regarding insurance: If you have an insurance plan that we participate in and the services which you are here for are expected to be covered expenses, we will gladly file your insurance claim for you. You will be billed for any amount that your insurance company leaves to your responsibility. We cannot bill your insurance unless you bring in your current insurance card. If your insurance company has not paid your account within 45 days, the balance will be transferred to your responsibility. Please be aware that some considered reasonable and necessary under the Medicare program and/or other medical insurance. If we do not participate with your insurance company, payment is due at the time of service.

- As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.

- Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept VISA, MasterCard, Discover, cash or check.

- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.

- We have made prior arrangements with certain insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible at the time of service.

- If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.

- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services or referrals; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.

- You must inform the office of all-insurance changes and authorization/referral requirements. In the event the office is not informed, you will be responsible for any charges denied.

- Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due this office.

- There is a service fee of $25.00 for all returned checks. Your insurance company does not cover this fee.

- Chiropractic appointments not canceled within 24 hours are subject to $25 fee.

- Massage appointments not canceled within 24 hours are subject to $35 fee.

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Service prices

- New patient Exam: $60
- Chiropractic adjustment $50
- Child under 13 years old$40
- 30-minute massage $60
- 1 hour massage $95
- 90-minute massage $150
- Ultrasound $40
- Class 4 laser 1 treatment$40
- Laser 6 pack $216
- Class 4 laser package 10 treatments $320
- Single Indiba pain treatment $80
- Indiba pain treatment package 4 treatments $240
- Indiba pain treatment package 6 treatments $360
- Single Indiba Esthetics treatment $325
- Indiba Esthetics treatment $1950

Signature of Patient/Responsible Party: _____

Printed Name of Patient/Responsible Party _____ Date: _____

Patient initials to indicate copy received. _____

Edgewater Chiropractic Clinic, PA.
201 S. Ridgewood Ave, Suite 11
Edgewater, FL. 32132
Phone: (386)423-7575

EDGEWATER CHIROPRACTIC CLINIC:

NOTICE REGARDING YOUR RIGHT TO PRIVACY

I have received a copy of the Patient Privacy Notice. I understand my rights as well as the practice's duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present. I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

_____
Printed Name

_____
DOB

_____
Signature

_____
Date

Edgewater Chiropractic Clinic, PA.
201 S. Ridgewood Ave, Suite 11
Edgewater, FL. 32132
Phone: (386)423-7575

Health Care Authorization:

The patient below authorizes Edgewater Chiropractic Clinic PA and its employees to use and/or disclose protected health information in accordance with the following:

Specific Authorizations: I give permission to Edgewater Chiropractic Clinic PA, and its employees to use my phone number, email address, home address and clinical records to contact me with appointments, reminders, missed appointments notification, birthday cards, holiday related cards, information about treatment alternatives, or other health related information.

If Edgewater Chiropractic Clinic PA, and its employees contact me by phone, I give them permission to leave a phone message on my answering machine/voice mail.

By signing this form, I am giving Edgewater Chiropractic Clinic PA, and its employees my permission to use and disclose my protected health information in accordance with the directives above.

Right to revoke authorization:

I have the right to revoke the above authorization by mailing or hand delivering a written notice to the privacy official of Edgewater Chiropractic Clinic PA. The written notice must contain the following information: My name, social security number, date of birth, a clear statement of my intent to revoke this authorization, the date and my signature. The revocation will not be effective until it is received by the privacy official. I have the right to refuse this authorization. If I refuse to sign it, Edgewater Chiropractic Clinic PA, will not refuse to provide treatment.

I have the right to inspect or copy the health information to be used/disclosed. I have a right to a copy of the signed authorization.

Patient's PRINTED Name: _____

Patient's Signature: _____Date:_____