ChiroStandard, PLLC
1962 Main Street Ste 100
Sarasota, FL 34236

Electronic Health Records Intake Form

This form complies with CMS EHR incentive program requirements

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): _____

Family Medical History ***(Record one diagnosis in your family history and the affected***				
Diagnosis (Write in below)	Father	Mother	Sibling: (_____)	Offspring: (_____)
Example: Heart Disease		*X*		

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? *(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 as a result of the nature and frequency of chiropractic care.)*

Patient Signature: _____ Date: _____

For office use only

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

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PATIENT INFORMATION FORM

First Name_____M.I.___ Last Name_____Phone#( )_____

Address_____

City_____State_____Zip_____

Age___ Sex_____Birth date_____Marital Status (S M W D) Soc Sec #_____

Email_____

Occupation_____Employer_____Work Phone( )_____

Person Responsible for this account_____

INSURANCE INFORMATION: Group____ Private_____Work/Comp_____Automobile_____
Name of insured_____Relationship to Patient_____Policy #_____
Insurance Co._____Group #_____
Street Address_____City_____State____Zip_____

ADDITIONAL INSURANCE: Group _____Private_____Work/Comp_____Auto_____
Name of insured_____Relationship to Patient_____Policy #_____
Employer_____Employee #_____Work Phone # ( )_____
Work Address_____City_____State_____Zip_____
Insurance Co._____Group #_____
Street Address_____City_____State____Zip_____

ATTORNEY INFORMATION:
Attorney Name_____Phone ( )_____
Street Address_____City_____State____Zip_____

I hereby assign any and all legal rights required with respect to the enforcement of medical benefit provisions of any insurance policy under which I qualify for benefits, including the right to proceed in AAA arbitration, necessary to collect monies due and owing to the ChiroStandard® for medical services which were provided to me.

I understood and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I authorize payment from my Insurance carrier directly to this office with the understanding that all monies will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature _____Date_____

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Patient History

Patient Name_____ Date_____

Reasons for seeking care:

Primary reason:

_____

Secondary reason:

_____

Have you ever received Chiropractic or Physical Therapy Care? Yes No
If yes, when?_____

History of Complaint:

Location of Complaint:

_____

Complaint Began when and how?

_____

Please circle the Quality of the complaint/pain: dull aching sharp shooting burning throbbing deep nagging other _____

Does this complaint/pain radiate or travel (shoot) to any areas of your body?
Where?_____

Do you have any numbness or tingling in your body? Where?

_____

Grade Intensity/Severity (No complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible pain/complaint imaginable)

How frequent is complaint present, how long does it last?

_____

Does anything aggravate the complaint?

_____

Does anything make the complaint better?

_____

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Patient Name_____

Previous interventions, treatments, medications, surgery, or care you've sought for your complaint:

_____

_____

Please List all Medical Doctors including Primary, Orthopedic, OBGYN, Podiatrist

_____

_____

Past Health History:

Previous illnesses you've had in your life:

_____

Previous injury or trauma:

_____

_____

Have you ever broken any bones?

_____

_____

Medications: Reason for taking

_____

_____

_____

Surgeries:
Date Type of Surgery

_____

_____

_____

_____

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Patient Name_____

Family Health History:

Health problems of relatives:

_____

_____

_____

Social and Occupational History:

Job description:

_____

Work schedule:

_____

Recreational activities:

_____

Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet):_____

Goals of Treatment:

(please circle all that apply)

Pain Relief Only

Pain Relief and Prevention

Return to Specific Activity or Sport _____

Performance Enhancement

Improvement in Overall Health

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office to provide me with care, in accordance with this state's statutes.

Patient or Guardian Signature _____ Date _____

Doctors Signature _____ Date _____

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INFORMED CONSENT TREATMENT & FINANCIAL AGREEMENT

Consent for Health Services & Treatment

I hereby request and consent to treatment, diagnostic and/or therapeutic services as ordered and/or provided by ChiroStandard®. I understand that there are certain complications, which may arise during treatment. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. I do not expect the doctor to be able to anticipate all risks and complications.

Financial Agreement

The undersigned individually obligates him/herself and guarantees prompt payment of all charges for services rendered to the patient when not covered by insurance carriers or others. A minimum fee of $35 will be charged for each returned check. The maximum charge permitted by law is the greater of $40 or 5% of the face amount of the check. The check writer is also responsible for all of the cost of collection. Payment of any unpaid balance is due within 30 days of final billing. If payment is not received within 30 days from the date of billing, finance charges may begin to accrue at the maximum rate allowable by law. In addition, such balance may be turned over for collection activity, at which time the undersigned shall be liable for attorney's fees and/or collection agency's fees and expenses. The undersigned understands that ChiroStandard® has the right to examine credit bureau files for financial information regarding collection of unpaid debt.

Assignment of Benefits

In the event that I am entitled to benefits of any and all types, I assign such benefits to ChiroStandard® for services rendered to me. I authorize payment directly to ChiroStandard® of all such insurance benefits payable to me. Such insurance includes, but is not limited to private commercial insurance, auto/liability insurance, or any governmental program such as Medicare, Medicaid, or Worker's compensation. I authorize ChiroStandard® to release medical information to such insurance providers as necessary to satisfy conditions for payment of the assigned benefits. I certify that the information given regarding my insurance is accurate and correct.

Release of Information

I authorize ChiroStandard® to release all or part of my medical record information when required or permitted by law or government regulation, including any physician(s) or healthcare provider responsible for continuing care.

Cancellation Policy

If you are unable to keep your appointment, please call us at least 24 hours in advance. Failure to do so will result in a cancellation fee of $20.

Please initial her acknowledging our policy: _____

Insurance Benefits

I have been verbally explained and/or read the benefit coverage that has been provided to ChiroStandard® by my insurance company. I understand that this is not a guarantee of benefits and that I am ultimately responsible for payment. I also understand that Medicare and/or my insurance company does not pay for maintenance care visits and only provides care for acute issues or exacerbations of such issues.

Please initial here verifying the above statement is true: _____

Chirostandard has been informed that I am not currently being treated by other chiropractic physicians at this time. I take full responsibility for any omission or intent to deceive insurance and/or medicare claims.

Please initial here verifying the above statement is true: _____

Medicare Recipient Notification

As of January 1 2010 Medicare has implemented a capitation for therapy services. Medicare recipients are limited to a total of $1840 towards physical therapy services. To help ChiroStandard® in obtaining the most accurate information as possible, it is my responsibility to inform ChiroStandard® of any therapy services I have received within the calendar year. I will be fully responsible for any charges exceeding the capitation amount.

During this calendar year, have you received prior Physical, Occupational or Speed Therapy? □ Yes □ No

If yes, approximate # of visits:_____

Please initial here verifying the above statement is true: _____

Insurance Precertification

I understand that before services are rendered, I personally am responsible for any required notification to my insurance company to obtain authorization for treatment. If this is not done, insurance benefits may be reduced and I am responsible for all charges not covered by my insurance.

Evaluation of Services and Follow-Up

I give permission for ChiroStandard® and/or its agent(s) to contact me for the purpose of evaluating the services rendered to me. □ Yes □ No

The undersigned certifies that he/she has been offered, read, and understands the above, fully accepts all specified terms, therein, and has **received a copy of the HIPPA Notice of Privacy Practices.**

_____ _____

Signature of Guarantor of Payment Print Name Date

(state relationship if other than patient)

ChiroStandard, PLLC
(941)487-8118

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Chirostandard, PLLC
1962 Main Street, Suite 100
Sarasota, FL 34236
Phone: 941-487-8118
Fax: 941-487-8121

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I, the above named patient, have had full opportunity to read and consider the contents of the Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment,

Signature: X _____ **Date:** _____

If a personal representative on behalf of the patient signs this Consent, complete the following:
Personal Representative's Name: _____
Relationship to Patient: _____

WE CANNOT SHARE YOUR INFORMATION WITH FRIENDS, FAMILY AND/OR SPOUSE WITHOUT YOUR CONSENT.
DO YOU HAVE ANYONE THAT YOU WOULD LIKE TO LIST AS A PERSON WHO CAN RECEIVE AND USE THE HEALTH INFORMATION

Person/Organization
Name _____ Phone (____)_____ Relationship_____

Name _____ Phone (____)_____ Relationship_____

Name _____ Phone (____)_____ Relationship_____

Name _____ Phone (____)_____ Relationship_____

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

___ All health information ___History/Physical Exam ___Past/Present Medications ___Lab Results
___ Physician's Orders ___ Progress Notes ___ Diagnostic Test Reports ___Billing Information
___Radiology Reports & Images __Other_____

******PATIENT REQUEST FOR RECORDS *******

If you would like us to review records from another provider, please inform the receptionist.