Email Communication Informed Consent

Information contained in email messages may be privileged and confidential. There is some risk that any protected health information that may be contained in such email may be disclosed to, or intercepted by, unauthorized third parties. Please be aware that email communication can be intercepted in transmission or misdirected. Your use of email to communicate protected health information to us indicates that you acknowledge and accept the possible risks associated with such communication.

We will respond to your email query, but to do so via email, you must provide your consent, recognizing that email is not considered a secure form of communication. If you do not wish to have your information sent by email, please call 239-495-1166 to make an appointment for an office visit.

If you wish to conduct discussions regarding your medical issues via email, please indicate your acceptance of this risk by signing below.

Patient Signature:_____Date:_____

chirocareandrehab@gmail.com

CHIROPRACTIC REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex M F Age _____

Birthdate _____

Married Widowed Single Minor

Separated Divorced Partnered for _____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

2 INSURANCE INFORMATION

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? Yes No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

3 PHONE NUMBERS

Cell Phone (_____) _____ Home Phone (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

4 ACCIDENT INFORMATION

Is condition due to an accident? Yes No Date _____

Type of accident Auto Work Home Other

To whom have you made a report of your accident?
Auto Insurance Employer Worker Comp. Other

Attorney Name (if applicable) _____

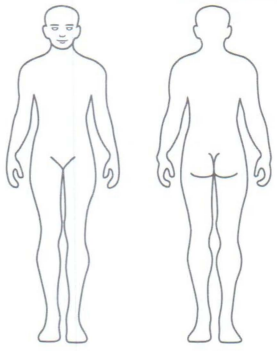
5 PATIENT CONDITION

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? Yes No Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: Sharp Dull Throbbing Numbness Aching Shooting
Burning Tingling Cramps Stiffness Swelling Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your Work Sleep Daily Routine Recreation

Activities or movements that are painful to perform Sitting Standing Walking Bending Lying Down

6 HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Alcoholism	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Measles	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Allergy Shots	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Migraine Headaches	☐ Yes ☐ No	Sexually Transmitted Disease	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Fractures	☐ Yes ☐ No	Miscarriage	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Anorexia	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Mononucleosis	☐ Yes ☐ No	Suicide Attempt	☐ Yes ☐ No
Appendicitis	☐ Yes ☐ No	Goiter	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Gonorrhea	☐ Yes ☐ No	Mumps	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Bleeding Disorders	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Tumors, Growths	☐ Yes ☐ No
Breast Lump	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Parkinson's Disease	☐ Yes ☐ No	Typhoid Fever	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	Hernia	☐ Yes ☐ No	Pinched Nerve	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Bulimia	☐ Yes ☐ No	Herniated Disk	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No	Vaginal Infections	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Polio	☐ Yes ☐ No	Whooping Cough	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Prostate Problem	☐ Yes ☐ No	Other _____	
Chemical Dependency	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Prosthesis	☐ Yes ☐ No		
Chicken Pox	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No		
				Rheumatoid Arthritis	☐ Yes ☐ No		

EXERCISE

☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY

☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

HABITS

☐ Smoking Packs/Day _____
☐ Alcohol Drinks/Week _____
☐ Coffee/Caffeine Drinks Cups/Day _____
☐ High Stress Level Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date _____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

7 MEDICATIONS

_____
_____
_____

Pharmacy Name _____

Pharmacy Phone (____) _____

ALLERGIES

_____
_____
_____
_____
_____

VITAMINS/HERBS/MINERALS

_____
_____
_____
_____
_____

Chiropractic Care and Rehab Center

Estero Park Commons
9250 Corkscrew Road, Suite 4
Estero, Florida 33928
Office: 239.495.1166
Fax: 239.495.0116

Christopher M. Green, D.C.
Michelle M. Giroux, D.C.

Acknowledgement of Receipt of Privacy Notice

I understand that as part of my health care, Chiropractic Care and Rehab Center, originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment, as well as plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment;
- A means to facilitate communication among the many healthcare professionals who contribute to my care;
- A source of information for applying my diagnosis and surgical information to my bill;
- A means by which a third-party payer can verify that services billed were actually provided;
- A tool for healthcare operations of Chiropractic Care and Rehab Center such as assessing quality of care and reviewing the competence of healthcare professionals.

I understand that as a part of Chiropractic Care and Rehab Center's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity for the purposes stated above.

I understand and have been provided with a notice of privacy practices that provides a more complete description of how Chiropractic Care and Rehab Center may use and disclose my protected healthcare information. I further understand that Chiropractic Care and Rehab Center reserves the right to change its notice of privacy practices. Should Chiropractic Care and Rehab change it notice of privacy practices, an amended copy will be posted in a prominent location at the practice site, or, upon my request, an amended copy will be sent to the address I have provided.

I agree that Chiropractic Care and Rehab Center may do the following unless I specifically give direction prohibiting such activity:

- Send visit reminders and test results to the address that I have provided.
- Send routine correspondence, such as billing statements, to the address that I have provided.
- Leave messages on an answering machine or voice mail associated with the telephone numbers I have provided to either confirm appointments or to request that I call the practice on medical or billing matters.
- This form will be placed in the patient's chart and maintained for six (6) years.

_____ _____

Patient's signature or signature of representative Date

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INFORMED CONSENT

I hereby consent to the performance of examination, chiropractic manipulation and other manual medical procedures, including various modes of physical therapy and diagnostic x-rays by Chiropractic Care and Rehab Center and it's employees, now and in the future.

I certify that I have had the opportunity to discuss, with the doctor of Chiropractic and/or other office personnel, the nature and purpose of the care that is being provided. I understand that the results are not guaranteed. Further, I have been informed and I understand that, as in the practice of any of the healing arts, in the practice of chiropractic or medicine, there are some risks to treatment including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I also understand that the doctor who has explained all of these things to me, is not expected to be able to anticipate and explain all risks and complications. I will rely on the doctor to exercise appropriate judgment during the course of care, based on the facts known at this time, and in my best interest.

My signature below certifies that I have read, or have had read to me the above consent. I also certify that I have had the opportunity to ask questions and the options of care have been explained to me. By signing this consent form, I agree to the care being provided to me for the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

_____ _____

Patient's name (please print) Witness' name

_____ _____

Patient's signature Witness' signature

_____ _____

Date Date

_____

Patient's representative (if patient is a minor or if physically or mentally impaired or if patient's primary language in not English)

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ASSIGNMENT OF BENEFITS / ERISA AUTHORIZED REPRESENTATIVE FORM

Financial Responsibility

I have requested professional services from Chiropractic Care & Rehab Center on behalf of myself and/or my dependents, and understand that by making this request, I am responsible for all charges incurred during the course of said services. I understand that all fees for said services are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement unless other arrangements have been made in advance.

Assignment of Insurance Benefits

I hereby assign all applicable health insurance benefits to which I and/or my dependents are entitled to Provider. I certify that the health insurance information that I provided to Provider is accurate as of the date set forth below and that I am responsible for keeping it updated.

I hereby authorize Provider to submit claims, on my, and/or my dependent's behalf, to the benefit plan (or its administrator) listed on the current insurance card I provided to Provider, in good faith. I also hereby instruct my benefit plan (or its administrator) to pay Provider directly for services rendered to me or my dependents. To the extent that my current policy prohibits direct payment to Provider, I hereby instruct and direct my benefit plan (or its administrator) to provide documentation stating such non-assignment to myself and Provider upon request. Upon proof of such non-assignment, I instruct my benefit plan (or its administrator) to make out the check to me and mail it directly to Provider.

I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from Provider are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductibles.

Authorization to Release Information

I hereby authorize Provider to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

ERISA Authorization

I hereby designate, authorize, and convey to Provider to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan, as my Authorized Representative: (1) the right and ability to act on my behalf in connection with any claim, right, or cause in action that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act on my behalf to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right to act on my behalf in respect to a benefit plan governed by the provisions of ERISA as provided in 29 *C.F.R.* §2560.5031(b)(4)) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines.

A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

_____ _____

Patient Date

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FINANCIAL POLICY

Cash patient: Payment is due at the time service is rendered.

Major Medical Insurance Coverage: Every insurance plan/coverage is different. In order to accept your insurance benefits, we must phone your carrier and verify your coverage. For this, we must have a copy of your insurance card. You will be considered a cash patient until your benefits are determined. Co payments are due at the time of service. Deductibles must be paid at the time of service until met. Many times coverage varies from what is printed on your insurance card. We will make every effort to determine your coverage prior to your first examination.

*Referrals from primary care physicians: Some HMO's and PPO's require a referral from PCPs for chiropractic benefits. We ask that the patient takes the responsibility of getting the referral slip. Dr. Green or Dr. Giroux will gladly phone your physician to help if necessary.

Worker Compensation: This office does accept most Work Comp cases. Communication with your employer is very important. Notify us immediately if you feel your case should be filed under Workers Compensation. BY LAW, YOUR EMPLOYER AND OUR OFFICE ARE BOUND TO CERTAIN TIME FRAMES FOR FILING CLAIMS UNDER WORKERS COMPENSATION.

Personal Injury/Auto accidents: This office does accept most Personal Injury cases. We must receive all insurance information prior to accepting your auto insurance as payment. We will phone your insurance carrier and verify your coverage. We will discuss your coverage with you in detail once verified.

Waiver of Right to Receipt: You are entitled to a receipt of all services rendered upon request. You are also entitled to a list for dates of service.

Your insurance policy is an agreement between you and your insurance company. Your help in obtaining your coverage will benefit both you and this office. In other words, you have more influence with your insurance company than we do. Ultimately, services rendered to you are your responsibility, regardless of your coverage.

Please sign and date below indicating you have read the above Financial Policy. If you have questions, please ask.

_____ _____

Signature Date

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Office Policies

We will gladly process and bill your insurance for you and await your carrier's portion of payment. However, unmet deductibles, co-insurances or co-payments and non-covered services are due at the time of your visit. We accept cash, personal checks and Visa/MasterCard/Discover/American Express. Payment plans and Care Credit are options pending approval.

Your insurance policy is a relationship between you and your insurance company therefore it is ultimately your responsibility to know your coverage.

It is the Patient's responsibility to know if a PCP referral is needed. Payment for services rendered could result.

Any **NEW INJURIES** or **ACCIDENTS** must be **IMMEDIATELY REPORTED** to the front desk prior to your visit.

PLEASE REPORT ANY CHANGES in insurance, address, or phone number upon arrival to the front desk.

All office notes or requests for information from attorneys or insurance carriers require 48 hours notice and must be requested in writing with a written release from the patient accompanying.

Copies of records and any other material will charged at $1.00 per copy with 48 hours advanced notice.

There is no charge for the first disability forms filled out, thereafter; there is a $3.00 charge per form.

Office phone is for EMERGENCY purposes only.

If you are fitted for Durable Medical Equipment, such as braces, orthotics, etc, you are financially responsible for HALF of the payment at the time of fitting. The remainder is to be paid in full when the actual Durable Medical Equipment arrive.

All Durable Medical Supplies, such as pillows, supports, etc, are to be paid for at the time of the visit.

NO UNAUTHORIZED PERSONS IN THE BACK RECEPTION OR TREATMENT AREAS.

Collection and Attorney's Fees. You agree that if your insurer fails to pay any portion of the billed services rendered or if you are not insured, you will be responsible for any cost of treatment. You understand that if your account balance becomes overdue that it may be referred to a collection agency, reasonable attorney's fees and collection costs may be added to the amount due and that you are financially responsible for the added collection fees. You are responsible for all attorneys fees and costs incurred to collect the fees and are also responsible for interest at the rate of eighteen percent per annum or the maximum rate allowed by law, whichever is greater, for any balance remaining unpaid for sixty days or more.

Please sign and date below acknowledging receipt of the policies outlined above

Name_____ Date_____

Signature_____