PATIENT INTRODUCTION

Please answer the following questions completely

Name: _____ SS #: _____

Address: _____ Apt#: _____ City: _____ St: ___ Zip: _____

Home Phone#: (____) _____ Work Phone #: (___) _____

Employer: _____ Occupation: _____

Duties/ Daily Activities @ Work: _____

Sex: M F Marital Status: S M D W Age: _____ Date of Birth: ___ / ___ / _____

How did you hear about our clinic? _____

Describe Problem: _____

Have You had Chiropractic Care before? _____ Yes _____ No If so, Who was the chiropractor? _____

When was your last visit? _____ Where? _____ How were the results? _____

Is it possible you are Pregnant? _____ Yes _____ No Do you have health insurance? _____ Yes _____ No

Are you here because of : _____ An Auto Accident Date injured: ____ / ____ / _____

_____ An on the job injury Do you have an attorney? _____ Yes _____ No

Date of last physical exam: _____ / ____ / _____ Reason: _____

Please list all accidents, falls, injuries, surgeries, major illnesses, or traumas no matter how long ago they occurred.

TYPE	DATE	DESCRIBE/COMMENTS

ARE YOU PRESENTLY TAKING ANY MEDICATIONS?

NAME OF DRUG	AMOUNT	DESCRIBE/COMMENTS

PLEASE CHECK ANY OF THE FOLLOWING THAT GIVE YOU DIFFICULTY

___Headaches	___Head feels heavy	___Heart Pain	___Indigestion
___Shooting head pains	___Dizziness	___Heart Palpitation	___Intestinal Gas
___Sinus Pain	___Fainting	___Mid-Back Pain	___Low back pain
___Loss of smell	___Loss of balance	___Heart Attacks	___Constipation
___Hay fever	___Stress	___High Blood Pressure	___Menstrual Cramps
___Loss of taste	___Muscle spasm in neck	___Anemia	___Menstrual Irregularity
___Tightness in throat	___Grating in neck	___Nervous Stomach	___Diabetes
___Inflammation in throat	___Tight shoulder muscles	___Stomach trouble	___Swelling
___Thyroid Trouble	___Neuritis-arms/shoulders	___Ulcers	___Arthritis
___Face flushed	___Pins and Needles	___Nerves & nervousness	___Ruptured Disc
___Twitching of face	___Arms/hands pain	___Irritability	___Pinched Nerve
___Loss of memory	___Cold hands	___Cold sweats	___Night sweats
___Irregular sleep	___Fatigue	___Chest pains	___Liver trouble
___Leg/Feet pain	___Depression	___Shortness of breath	___Gallbladder trouble
___Neck pain	___Ringing in ear(s)	___Cold/Heat intolerability	___Allergies

___Other: (please explain:) _____

Are any of your family members experiencing any of the above difficulties?

Family members: _____ Difficulties: _____

_____ _____

_____ _____

Do you have any family history of diseases? If so, please explain: _____

_____

Amount of sleep you get per night (hours): _____ Position you sleep in at night: _____

Is your sleep: Great Good Fair Poor

PRESENTLY: Quality of Life Value (1-100): _____

Performance Level of Daily Functions (1-100): _____

PAYMENT/INSURANCE INFORMATION

Please complete all applicable information

OUR OFFICE POLICY STATES THAT PAYMENT IS DUE WHEN SERVICES ARE RENDERED.
S A COURTESY TO YOU, WE WILL FILE YOUR INSURANCE CLAIMS FOR YOU

( ) **CASH/CHECK:** Payment is due in full when services are rendered.

( ) **INSURANCE:** We will file your medical insurance for you. Deductible amounts and co-payment amounts are due in full as services are rendered. Any charges not covered by the insurance company will be billed directly to you for payment.

( ) **AUTOMOBILE INSURANCE:** We must have verification of insurance, a copy of your insurance card, and the accident report. Any charges not covered by the insurance company will be billed directly to you for payment.

( ) **WORKER'S COMPENSATION:** Authorization for treatment must be in writing from your employer. If this is not possible on the first visit, we will accept verbal authorization until authorization can be obtained in writing.

( ) **MEDICARE:** We must have a copy of your Medicare card or verification of coverage.

Insurance Information:

Insured's Full Name: _____ Insured's Date of Birth:__/__/___
Relationship to the Insured: _____ Home Phone: (__)_____
Insured's SS #: _____
Insurance Company Name: _____
Insurance Company Phone Number: (__)_____ Group #: _____
Insured's Employer: _____ Phone #: (__)_____

I _____, have read the above and checked one method of payment. I have agreed that the balance is my responsibility and will pay any balance that has gone unpaid over 60 days. If balance owed after stated period has not been met, I understand that I will be responsible for ALL fees incurred(attorney fees, collection agency fees, court costs, interest and any other fees needed to collect the balance) such that the balance owed to this office is paid in full.

Patient Signature:_____ Witness: _____
Date: _____

FLORIDA CHIROPRACTIC CLINICS, INC.
5290 Seminole Blvd. Ste. A & B
St. Petersburg, Fl. 33708
Ph: (727) 398 - 2988 / Fax: (727) 398 - 5025

POWER OF ATTORNEY AND MEDICAL RELEASE

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.

Know by all these present that: The undersigned has made, constituted and appointed, and by these presents does hereby make, constitute and appoint **FLORIDA CHIROPRACTIC CLINICS, INC** and any of it's duly authorized agents and employees as and to be the undersigned's true and lawful attorney for and in the undersigned's name, place and stead to endorse any and all checks, drafts, money orders which are made payable to the undersigned alone or to the undersigned and the said **FLORIDA CHIROPRACTIC CLINICS, INC.** which checks, drafts or money orders are made payable for services which have been made by **FLORIDA CHIROPRACTIC CLINICS, INC.** at the request or with the knowledge and approval of the undersigned and /or the maker of the check, draft, or money order.

Furthermore, the undersigned allows **FLORIDA CHIROPRACTIC CLINICS, INC.** or any of it's agents to sign any paper that will be necessary to enhance, expedite, and /or allow payment to said provider. This may include affidavits of non-ownership of vehicles, insurance forms and other statements.

The undersigned by these presents does give and grant the said **FLORIDA CHIROPRACTIC CLINICS, INC.** as attorney the full power and authority to do and perform all and every act whatsoever requisite and necessary to be done in and about the premises as fully to all intents and purposes as the undersigned might or could do to personally present insofar as the endorsing and cashing of said checks are concerned as well as any other document.

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 **FLORIDA CHIROPRACTIC CLINICS, INC.** 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.

The undersigned does hereby ratify and confirm any and all actions taken by the said attorney in accordance with this special power and which the said attorney shall do or cause to be done by virtue of these presents.

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 **FLORIDA CHIROPRACTIC CLINICS, INC.** but not to exceed the charges of those services, payable to mailed directly to:

FLORIDA CHIROPRACTIC CLINICS, INC.
5290 Seminole Blvd. Ste. A & B
Seminole, Fl. 33708

Furthermore, I hereby **IRREVOCABLY ASSIGN** to **FLORIDA CHIROPRACTIC CLINICS, INC.** the rights and benefits under any policy of insurance, indemnity agreement, or any other collateral source as defined in Florida Statues for any service and or charges provided by **FLORIDA CHIROPRACTIC CLINICS, INC.**.

IN WITNESS WHEREOF the undersigned have hereunto set their hands, this _____ day of _____, 200___.

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

INSURANCE POLICIES AND GUIDELINES

The purpose of this letter is to let you know how our office works in the handling of your insurance claims. We do this to eliminate any questions, and to inform you of all of our policies in advance to better enable us to serve your health care needs effectively. In this way, policies can be followed as intended.

We itemize all of our procedures. The reason for this is to let the insurance company personnel know exactly what was done on each of your visits, what was not done, and why. In reporting to insurance companies, we are responsible to them on your behalf to accurately inform them as to your condition, status, complications, exacerbations, unusual circumstances, etc...., that would affect your recovery and journey to your optimal health. We are responsible for letting them know how long we anticipate your care will be , to what frequency. All of this involves a tremendous amount of staff and professional time and expense. However, we do this as a courtesy service to you: it lessens the burden of having to communicate with the insurance company, it lessens the responsibility and threat regarding when insurance will no longer cover your care, and it makes care a far easier process. All we ask is your cooperation. Our usual procedures and their costs are listed separately, and a copy can be provided when asked.

Because we itemize and document every procedure in accordance with the insurance protocol rather than just describe what is being done as an "office visit", the charges per visit may vary in costs, especially when multiple services are rendered. **For various reasons, we know that there are a lot of charges that will not be paid,** such as maximum dollar amount, limits per visits, procedures that the policy does not cover or deem as medically necessary, etc; We expect to receive denials on claims, as it is the nature of the insurance industry. However, we are still going to bill for everything we do, whether we get paid back or not, so that we can adequately document and communicate our visit procedures with these companies.

Different insurance companies cover different procedures and in different amounts. Some companies pay 100%, some pay 60%. Some patients under their policy will have $0 deductible and some will have a $1000 deductible. We only make you aware of this as you may see multiple patients paying different amounts for their care.

WE ACCEPT ALL PATIENTS REGARDLESS OF THEIR CONDITIONS OR FINANCIAL ABILITY TO PAY! This policy allows us to care for all people based on THEIR needs.
We do want you to know that you will be held responsible for your DEDUCTIBLE and a dollar amount toward your patient portion of the balance. If you have a special financial situation that makes it difficult or impossible for you to meet this requirement, simply speak with the Doctor or the FRONT DESK MANAGER and arrangements in some form will be made so you can receive the care you need at a fee you can afford.

_____ _____ _____

Printed Name Signature Date

FLORIDA CHIROPRACTIC CLINICS

PATIENT AND DOCTOR AGREEMENT

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both parties to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that we will be using to attain it. This will prevent any confusion or disappointment.

ADJUSTMENT: An adjustment is the specific application of forces to facilitate the body's correction of the vertebral subluxation. Our chiropractic method of correction is by specific adjustments to the spine.

HEALTH: A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

VERTEBRAL SUBLUXATION: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express it's maximum health potential.

We do not offer to diagnose or treat any disease or condition other than to correct vertebral subluxations. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advise regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method to achieve this is specific chiropractic adjustments to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.

ACKNOWLEDGEMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy, or had the opportunity to read, the NOTICE OF PRIVACY PRACTICES (located in the waiting room) 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

_____

Signature

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

FLORIDA CHIROPRACTIC CLINICS, INC.

OFFICE POLICIES AND GUIDELINES PERTAINING TO APPOINTMENTS

MISSED APPOINTMENTS and FINANCIAL AGREEMENTS

Our facility attempts to accommodate our patients by giving appointments that meet their schedules. We understand that things pop up prior to or at the last minute. As a courtesy we appreciate a phone call letting us know that you will be late or not be able to attend and thus, we can modify our schedule accordingly. Numerous times, other patients wish to obtain an office visit at the same time as what you wish to as well. We only have a certain number of time slots available to accompany our patients. If you can not make your scheduled appointment and you call in, we can fill your time slot with another patient who wishes to come in. Our office feels this is a common courtesy to us, you and other patients. However, others may not feel that way as we still encounter situations where patients do not notify us of not being able to meet their appointment. As a result, our office has a $30 fee for any patient that fails to notify the office of a cancellation, regardless if you are a cash, insurance, or automobile accident patient.

You have two options. Please provide your initials by your choice below.

____ Option A. I am providing a undated check made out to Florida Chiropractic in the amount of $30.00. This check is to be on file to cover any missed appointment that I fail to call and cancel. If I do not violate this policy, the **CHECK WILL NEVER BE CASHED.**

____ Option B, I am providing to Florida Chiropractic Clinics, Dr. Greg Yingling, my credit card information. The amount of $30.00 will ***ONLY BE CHARGED*** TO MY CREDIT CARD ***IF I FAIL*** to call and cancel a scheduled appointment. ***Shall I not violate this policy, UNDER NO*** circumstances will *MY CARD BE BILLED* or my information shared.

Card Holders Name (as on front of card) _____

Type of Card: *Visa* *MasterCard* *Card #* _____ Exp Date: ___/___

Three or four digit number on the back of the card on the signature line ____ ____ _____ _____

_____ _____

Patients Signature Date

Cc: patient