Application for Patient Care

First Name:_____________________M.I______Last Name:_____________Date:____________

Address:_________________________City______________State______Zip Code____________

Phone: (_____)________-_________ SS#________–_______–_________ DOB: ___________ M / F

E-mail Address__________________________Primary Care Physician_______________________

Do we have permission to contact your doctor regarding care in our office?____Yes__No

Occupation: __________________________ Employer: ____________________________________

Types of Tasks Performed/Common Movements: _____________________________________

Marital Status: Single Married Divorced Widowed Separated Minor

Spouse's Name:___________________#of Children?____________Children's Ages___________

Emergency Contact:_________________Relation: _____________ Phone: ____________________

Auto accident history: ____

Have you ever had a fall or other accident? ____

Past chiropractic care? ___yes ___no Name of doctor and last visit: ____________________________

Past physical therapy? ___yes ___no Name of therapist and last visit: ___________________________

How did you hear about our office? ____

Do you have health insurance? ___yes ___no Name of carrier: ________________________________

Do you have secondary insurance? ___yes ___no Name of carrier: ____________________________

Please provide this office with a copy of your insurance card(s)

Assignment and release (insured patients)

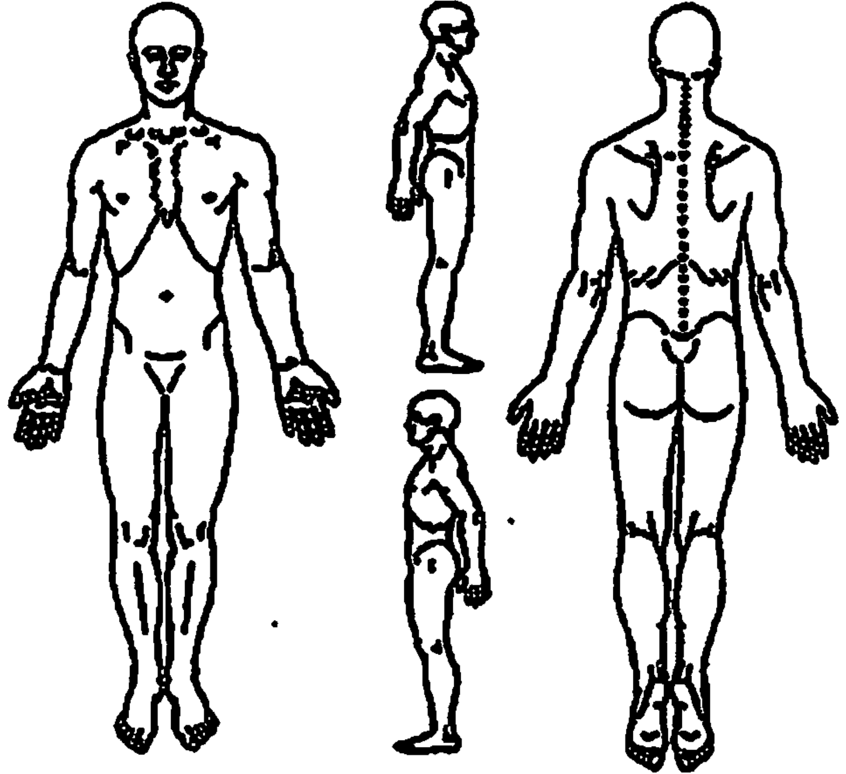
I certify that I (or my dependent) have insurance coverage with __________________________ and I authorize, request and assign my insurance company to pay directly to the physician practice, Elite Health and Wellness insurance benefits otherwise payable to me. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

SIGNATURE (X)____DATE____________________________

PATIENT HEALTH HISTORY

Please check to indicate if you are currently experiencing any of the following conditions and then circle problematic areas on body to right:

- ☐ Neck Pain/Stiffness
- ☐ Back Pain/Stiffness
- ☐ Arm/Hand Pain
- ☐ Leg/Knee Pain
- ☐ Headaches
- ☐ Night Pain
- ☐ Depression
- ☐ Cold Extremities
- ☐ Nervousness
- ☐ Sleeping Difficulties
- ☐ Jaw Problems
- ☐ Loss of Smell
- ☐ Fainting
- ☐ Dizziness
- ☐ Stomach Problems
- ☐ Asthma
- ☐ Swollen Joints
- ☐ Mood Changes
- ☐ Foot Trouble
- ☐ Pins/Needles in Arms
- ☐ Pins/Needles in Legs
- ☐ Light Bothers Eyes
- ☐ Recent Weight Change
- ☐ Loss of Memory
- ☐ Nausea
- ☐ Loss of Taste
- ☐ Fatigue
- ☐ Chest Pain
- ☐ Tension
- ☐ Fever
- ☐ Cold Sweats
- ☐ Constipation/Diarrhea
- ☐ Allergies
- ☐ Shortness of Breath
- ☐ Blurred/Double Vision
- ☐ Bowel/Bladder
- ☐ Changes
- ☐ Trouble Concentrating
- ☐ Loss of Balance



Please check if you have ever had the following:

- ☐ Add/ADHD
- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Allergy Shots
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Wheezing
- ☐ Bad Breathe
- ☐ Bleeding Disorders
- ☐ Blood Pressure high or Low (Circle)
- ☐ Breast Lump
- ☐ Broken Bones
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical
- ☐ Dependenc
- ☐ Chicken Pox
- ☐ Colon Trouble
- ☐ Contacts/Glasses
- ☐ Diabetes
- ☐ Dry Skin
- ☐ Ear Infections
- ☐ Epilepsy
- ☐ Fractures
- ☐ Gail Bladder
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heartburn
- ☐ Heart Attack
- ☐ Heart Problems
- ☐ Hemorrhoids
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herniated Disc
- ☐ Herpes
- ☐ High Cholesterol
- ☐ Hormone/Gland Problems
- ☐ Insomnia
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Measles
- ☐ Menopausal Prob.
- ☐ Migraines
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Mouth Sores or Bleeding Gums
- ☐ Multiple Sweats
- ☐ Mumps
- ☐ Nosebleeds
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Parkinson's Disease
- ☐ Pinched Nerve
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problems
- ☐ Prosthesis
- ☐ Psychiatric Care
- ☐ Rheumatoid Arthritis
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Sexual Difficulty
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ TMJ Pain
- ☐ Tonsillitis
- ☐ Tremors
- ☐ Tuberculosis
- ☐ Tumors/Growths
- ☐ Thyroids Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease
- ☐ Whooping Cough
- ☐ Other: ____________________

ALLERGIES: Please place a checkmark next to any known allergy that you have.

_Milk _Eggs _Peanuts _Almonds _Cashews _Walnuts _Fish _Shellfish _Soy _Wheat
_Gluten __Penicillin _Sulfa Drugs _Tetracycline _Codeine _NSAIDS _Phenytoin _Carbamazepine
_Mildew _Mold _Dust _Fungus _Mites _Tree Pollen _Grass Pollen _Weed Pollen _Insects
_Dog Dander __ Cat Dander _Latex _Other Animal Dander _OTHER:________________________________

Please list any supplements you are currently taking (vitamins/herbs/minerals): ___________________________
____
____

Do you exercise: ☐ Frequently ☐ Moderately ☐ Occasionally ☐ Never

Do your work activities mostly involve (check all that apply): ☐ Sitting ☐ Standing ☐ Light labor ☐ Heavy labor

Do you sleep on your: ☐ Back ☐ Side ☐ Stomach

Are you currently taking any medications? ☐ Yes ☐ No
If yes please list: ____
____
____

Are you currently under medical or physical therapy? ☐ Yes ☐ No
If yes please explain:____
____
____

Have you been hospitalized or have you had surgery in the past? ☐ Yes ☐ No
If yes please explain:____
____
____

I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health, will give complete and accurate information during my exam.

SIGNATURE____DATE_________/________/________

X-ray Questionnaire: For Women ONLY

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time:

☐ There is a possibility that I may be pregnant at this time
☐ Yes, I am definitely pregnant
☐ No, I am definitely not pregnant at this time
☐ I request that x-ray film not be taken because: ____
Date of last menstrual cycle: ______/_____/______

Patient Signature: ____________________________________ Date: _____/_____/_______

HIPAA Practice Requirements

The Practice:

a) Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.

b) Under the Privacy Rule, may be required by State Law to grant greater access or maintain greater restrictions on the use or release of your PHI than that which is provided for under federal law.

c) Is required to abide by the term of this privacy notice

d) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice Provisions effective for your entire PHI that it maintain s.

e) Will distribute a revised Privacy Notice to you prior to implementation

f) Will not retaliate against you filing a complaint

Effective Date

This notice is in effect as of 04/ 15/2003

State Law

A copy of the state HIPAA laws will be available to me at any time for my review, and a copy will be given to me upon my request

Patient Acknowledgement

By signing my name below, I acknowledge receipt of this notice, and my understanding and my agreement to its terms.

Patient Signature___________________________________Date:_____/_____/_____

Patient Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name____DOB:________/_________/_________

I acknowledge that I have reviewed the Notice of Privacy Practices of Elite Health and Wellness.
(Please initial one of the following options and sign below.)

___________ I wish to receive a paper copy of Privacy Notice.

___________ I wish to receive an electronic copy of Privacy Notice.

My e-mail address is:_____________________________________@_________________

___________ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office.

Please initial below:

___________ I acknowledge that it is the policy of Elite Health and Wellness to leave reminder messages on my answering machine or with another person in my home. I may make a request of an alternative means of communication (within reason) in writing.

___________ I acknowledge that if I should have a problem or question in regard to my rights, I may speak with the Privacy Officer, Dr. Chet Barton, about my concerns.

________________________________ ___________________________
Signature of Patient/Guardian Date

________________________________ ___________________________
Witness (Office Staff) Date

RECORDS RELEASE AUTHORIZATION

DATE: ______/______/_______

To Doctor or Hospital

Name: _________________________________ Phone: _______-_______-________

Address: _______________________________ Fax: _______-________-_________

____

I hereby authorize and request release to: Elite Health and Wellness

The complete history records in your possession, concerning my illness and/or treatment during the period:

From: _______/_______/________ To: _______/_______/________

Patient: ___________________________________

SSN: _______________________________________ DOB: _______/_______/________

Patient's Signature: ______________________________ Date: _______/_______/________

Witness: _______________________________________ Date: _______/_______/________

THIS FAX IS INTENDED ONLY FOR THE USE OF THE PERSON OR OFFICE TO WHOM IT IS ADDRESSED, AND CONTAINS PRIVILEGED OR CONFIDENTIAL INFORMATION PROTECTED BY LAW. ALL RECIPIENTS ARE HEREBY NOTIFIED THAT INADVERTENT OR UNAUTHORIZED RECEIPT DOES NOT WAIVE SUCH PRIVILEGE, AND THAT UNAUTHORIZED DISSEMINATION, DISTRIBUTION, OR COPYING OF THIS COMMUNICATION IS PROHIBITED. IF YOU HAVE RECEIVED THIS FAX IN ERROR, PLEASE DESTROY THE ATTACHED DOCUMENT(S) AND NOTIFY THE SENDER OF THE ERROR BY CALLING 407-808-6899. IF YOU DO NOT RECEIVE ALL OF THE PAGES, OR IF YOU HAVE ANY PROBLEMS WITH THIS TRANSMISSION, PLEASE CALL 407-808-6899.

"Informed Consent to Chiropractic and Physical Therapy"

Please initial each box below

____

Patient Name (Please Print)

Patient Initials

☐ I hereby request and consent to the performance of chiropractic adjustments, physical therapy and other procedures, including various modes of physical therapy and diagnostic x-rays on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic, and therapy assistants in this office and/or anyone working in this clinic authorized by the doctor.

☐ I further understand and am informed that, as in all healthcare, in the practice of medicine/chiropractic there are some very slight risks to treatment, including but not limited to, muscle strains and sprains, disc injuries, stroke, and fracture. I do not expect the doctor to be able to anticipate and explain all the risks and complications and I wish to rely on the doctors to exercise judgment during the course of the procedure that the doctor feels at the time, based on the facts then known, and is in my best interest.

☐ I have been informed that it is not uncommon to experience some increased discomfort after physical therapy and chiropractic manipulation. If that happens, I will apply ice to the area and rest it. If I am concerned about this discomfort or develop any new symptoms, I can call the number below 24 hours a day for emergency attention. If I am out of town or unable to contact the doctor I can present myself to an emergency room.

☐ If any test were performed outside this office (laboratory or other diagnostic procedures), I understand that the doctor will notify me of the results at my next scheduled appointment or when the reports become available.

☐ I am aware that Elite Health and Wellness is not responsible for any damage or loss to my personal belonging. This includes but is not limited to clothing, jewelry, glasses, shoes, purses or wallets. We advise you to not wear or bring into the office any items that could easily be damaged during your treatments.

☐ I have had the opportunity to discuss the nature and purpose of the chiropractic treatment, physical therapy and other procedures with the doctor of chiropractic and/or with other office or clinical personnel. I understand that results are not guaranteed.

☐ I have read the above consent with the doctor as indicated by my initial. I have also had an opportunity to ask questions about its content; and by singing below, I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any injured condition for which I seek treatment at Elite Health and Wellness.

______________________________ ____/_____/______ ______________________________ _____/_____/______

Patient Date Parent or Guardian Date

______________________________ ______________________________ _____/_____/_____

Physician name Physician Signature Date

Patient Consent

I authorize Elite Health and Wellness to furnish chiropractic and physical therapy treatment as indicated by their evaluation. In addition I authorize Elite Health and Wellness to release any information including medical information that may be necessary to process medical claims on my behalf to related physicians, insurance carriers or attorneys.

ASSIGNMENT OF BENEFITS/FINANCIAL POLICY

PATIENT:

- I, the undersigned patient/insured, hereby assign the rights and benefits of the applicable medical payments and/or other insurance to Elite Health and Wellness, for the services and/or supplies rendered by the above named medical provider, to (patient Name) ___________________________________. I hereby request that my insurance carrier make payment directly to Elite Health and Wellness for all services rendered. I agree to pay any applicable deductible or co-payment not covered by my insurance coverage.
- I understand that verification of benefits is not a guarantee of payment and my financial responsibility is subject to change. If my insurance company fails to render payment for services rendered within 60 days, I agree to take an active role in petitioning my insurance carrier to make appropriate payments responsible for the full balance due and hereby guarantee payment for the services rendered.
- If my insurance carrier makes payments to me I agree to immediately endorse the payments and forward them to Elite Health and Wellness. I also authorize Elite Health and Wellness to deposit any checks received on my account when made out to me. I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all cost of collecting monies owed, including court cost, collection agency fees and attorney fees.
- The undersigned, on behalf of Elite Health and Wellness, hereby accepts assignment of the insurance rights and benefits for services rendered to (patient name) __________________________________. Payments from the undersigned insurance coverage is to be made directly to Elite Health and Wellness under (Insured's Name) _________________________________.
- I, _____________________________________, have read and fully understand the above statements. All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I, therefor, accept chiropractic care on that basis. Further, I have read the information herein and verify that it is true and correct to the best of my knowledge and belief.

Complete the following if the patient is a minor child

I, ___________________________________, being the parent of legal guardian of the aforementioned child have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care. I also understand being the parent or legal guardian of the aforementioned child being under 18 that I am responsible for the co-payment and deductible and final balances.

Signed____ **Date**_________/___________/__________

Waiver of Insurance Coverage

I, (patient name) ____________________________, acknowledge that I do not have active health insurance coverage that I wish to use at this time. I understand that I am responsible for charges incurred as a result of my treatment by Elite Health and Wellness and its employees. I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all cost of collecting monies owed, including court costs, collection agency fees and attorney fees. If I obtain active insurance coverage such as Medicare, Medicaid, or other health insurance plan, I will inform Elite Health and Wellness of the coverage. If I am involved in an automobile accident, work place injury, or experience a slip and fall accident, I will inform Elite Health and Wellness of any insurance coverage that may be applicable in such cases on my next visit.

Signed ____ Date ________/_________/___________

Witness Signed ____ Date ________/_________/___________

Witness Name (Print) __________________________________