Ph 727.216.6929
Fx 727.216.6930

countryside chiropractic

28467 US Highway 19N
STE 302
Clearwater, FL 33761

Full Name:_____Today's Date:_____

Address:_____City:_____State:_____Zip_____

Your date of Birth:_____SSN:_____

Primary Doctor & Ph #:_____

Current Occupation:_____Email:_____

Work Phone:_____Can we leave messages for you? (circle one) Y N

Cell Phone*:_____Can we leave messages for you? (circle one) Y N

*Cell phone service provider for text reminders?(circle) Verizon AT&T Tmobile Other:_____

Emergency Contact:_____Ph#:_____Relationship:_____

Relationship Status: Single Married Divorced Widowed Dom.Partnership #of Children:___

Who may we thank for referring you? _____

Insurance Information:* Are you the subscriber or dependent? □ **Subscriber** □ **Dependent**

If Dependent, who is the subscriber? Name: _____ Date of Birth: _____

***Please see Assignment of Benefits page for further detail

<u>If your injuries are the result of an accident, please complete the section below:</u>

What type of accident? (circle one) Motor Vehicle Workers' Comp Other _____

What was the date of the accident? _____ Do you have an attorney? (circle one) Y N

If yes, who is the attorney? _____ Phone #: _____

YOUR auto insurance company name: _____

Accident Claim #: _____

Adjuster name: _____ Phone #: _____

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Please describe the type of problem / pain you are having**:** _____

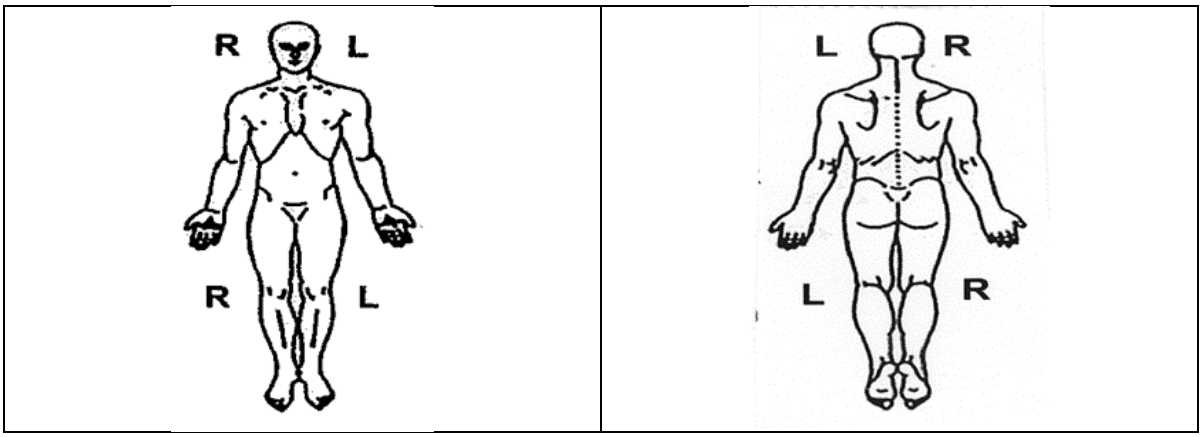
_____

Have you had this pain before? Y N How many episodes of this pain have you had? _____

Have you had any recent (within 12 months) imaging (XRAY, MRI, etc) for this condition? Y N

If yes, what did you have done?_____

Circle your PAIN and/or NUMBNESS on the following diagram:



Medical History- Please circle any that apply:

Diabetes	High blood pressure	Liver Disorder	Gout
Cancer	Bleeding Disorders	Seizures	Autoimmune disease
Stroke / TIA	Heart Disease	Lung Disorders	Kidney disease
Fibromyalgia	Osteoporosis/penia	Arthritis	Ulcers

Additional medical disorders?_____

Are you taking any medications?_____

Previous surgeries / hospitalizations?_____

Concerns regarding treatment? Y N If yes,_____

Do you smoke? Y N Do you drink alcohol daily or excessively? Y N

Height:_____ Weight:_____

INFORMED CONSENT

In consideration of the undertaking of treatment, I,_____ agree to the following:

1. **Personal Responsibility for Charges:** I understand that I am personally responsible for charges and/or balances not covered by insurance payments or settlements.
2. **Senior Adults:** Chiropractic spinal manipulation is typically covered by Medicare for active injury management. Many of the ancillary services provided (therapies, extremity manipulation, etc) are not reimbursable in this office. If these services are recommended, I agree that I will be responsible for associated costs.
3. **Release of Information:** I authorize Active Chiropractic, LLC DBA Countryside Chiropractic (Countryside Chiropractic) to discuss and release my medical records, imaging and lab results, and financial records to insurance companies, adjusters, other medical providers, attorneys' names as being involved with my case, and those named below for the purpose of administration and reimbursement of treatment rendered
4. **Access to Protected Health Information:** I understand that I have a right to access my medical information and obtain copies of medical records for a reasonable fee in accordance with Florida Law.
5. **Consent for Treatment:** I am seeking medical treatment from Countryside Chiropractic, and I voluntarily consent to receiving health care services for my minor child or myself provided by my doctor(s) or a designee. I understand that such services my include, but are not limited to: diagnostic tests, examinations, manual therapies (manipulation, soft-tissue mobilization, etc), passive modalities (electrotherapy, ultrasound, laser, etc), exercises, and self-care recommendations necessary to treat my health issue. I also understand that I may be released before all my medical problems are known and it is my responsibility to make arrangements for follow-up care.
6. **Chance of Injury and Other Risks:** I understand that there is some risk with any medical procedure. I understand that, despite my efforts and the efforts of health providers at Countryside Chiropractic, my condition may not improve and in some cases, may worsen. Although there is some chance of soreness or stiffness following chiropractic manipulation and manual therapies, the chance of serious injury is very small. However, in very rare cases, I understand that a person can experience vascular, musculoskeletal, or other types of injury as a result of medical treatment administered by a licensed professional, including injury to a disc, ribs, or the spine.
7. **Alternative Treatments:** I understand that while not available in this office, alternative treatments may be available for my health concern. These may include, but are not limited to : self-care, over-the-counter medications, physical measures and rest, medical care with prescription medications, physical therapy, bracing, injections, and surgery. I am free to discuss these options with my provider at Countryside Chiropractic, but they are prohibited from providing any treatment that falls outside the scope of their license.
8. **Attention to Female Patients:** In the event that x-rays are required, please advise the doctor if you are or have any reason to believe you may be pregnant.
9. **Cancellation / Change Policy:** To ensure appointment availability to all patients requesting care, all cancellations/changes to appointments made within 24 hrs of the scheduled time are subject to a **$30 fee.**

PATIENT INITIALS: ____

ASSIGNMENT OF BENEFITS

PRIMARY insurer:_____	**SECONDARY insurer:_____**
Policy #:_____	**Policy #:_____**

I authorize the aforementioned insurer(s) to make medical benefit payments otherwise payable to me for services rendered by Active Chiropractic, LLC DBA Countryside Chiropractic, but not to exceed the charges for those services, payable and mailed (or electronically delivered, if applicable) directly to:

Active Chiropractic d/b/a Countryside Chiropractic
28467 U.S. Highway 19N STE 302
Clearwater, FL 33761

I hereby instruct the insurance carrier that in the event that the subject medical benefits are disputed, and/or reduced for any reason, including medical reasonableness and/or necessity, that the amount of the unpaid benefits claimed by Active Chiropractic, LLC DBA Countryside Chiropractic is to be set aside and not disbursed until the dispute is settled.

Furthermore, I hereby irrevocably assign to Active Chiropractic, LLC DBA Countryside Chiropractic the right and benefits to any and all causes of action resulting from any reduction and/or nonpayment under any policy of insurance, indemnity agreement or any other collateral source as defined by Florida Statues for any service and/or charges provided by Active Chiropractic, LLC DBA Countryside Chiropractic.

TECHNOLOGY DISCLAIMER

At Countryside Chiropractic, we pride ourselves on maintaining evidence-based, patient-centered care recognizing the importance of blending current scientific research with practitioner experience and patient values. We strive to regularly further the education of our providers to bring you the latest advances in healthcare technology.

These advances include Class IV laser, Radial Shockwave Therapy, and proprietary evaluation and soft tissue techniques; to name a few. We have made substantial investments in software to allow us to manage your care with thorough documentation; and we have installed software that allow us to immediately access and analyze imaging results from some providers, substantially increasing our ability to provide convenient and patient-centered care.

While most of the services provided in our office are covered by most medical plans, some services may become patient responsibility. *If you have concerns related to your deductibles, health savings accounts (HSA's) or health reimbursement accounts (HRA's) we encourage you to discuss these concerns with your healthcare provider.*

PATIENT INITIALS: ____

PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES

Section 381.026, Florida Statues, addresses the Patient's Bill of Rights and Responsibilities. The purpose of this section is to promote the interests and well-being of patients and to promote better communication between the patient and the health care provider. Florida Law requires that your health care provider or health care facility recognize your rights while you are receiving medical care and that you respect the health care provider's or health care facility's right to expect certain behavior on the part of patients. A summary of your rights and responsibilities follows:

A patient has the right to:

- Be treated with courtesy and respect, with appreciation of his/her dignitiy and protection of privacy.
- Receive a prompt and reasonable response to questions and requests.
- Know who is providing medical services and who is responsible for his or her care.
- Know that patient support services are available, including in an interpreter is available if the patient does not speak English.
- Know what rules and regulations apply to his or her conduct.
- Be given by the health care provider information such as diagnosis, planned course of treatment, alternatives, risks, and prognosis.
- Refuse any treatment, except as otherwise provided by law.
- Be given full information and necessary counselling on availability of known financial resources for care.
- Know whether the health care provider or facility accepts the Medicare assignment rate, if the patient is covered by Medicare.
- Receive, prior to treatment, a reasonable estimate of charges for medical care.
- Receive a copy of understandable itemized bill and, if requested, to have the charges explained.
- Receive medical treatment or accommodations regardless of race, national origin, religion, handicap, or source of payment.
- Receive treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- Know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such research.
- Express complaints regarding any violation of his or her rights.

A patient is responsible for:

- Giving the healthcare provider accurate information about present complaints, past illnesses, hospitalizations, medications, and any other information about his or her health.
- Reporting unexpected changes in his or her conditions to the health care provider.
- Reporting to the health care provider whether he or she understands a planned course of action and what is expected of him or her.
- Following the treatment plan recommended by the health care provider.
- Keeping appointments, and when unable to do so, notifying the health care provider or facility.
- His or Her actions if he/she refuses treatment or does not follow the health care provider's instructions.
- Making sure financial responsibilities are carried out.
- Following the health care facility conduct rules and regulations.

You may request a copy of the full text of this law from your health care provider or health care facility. It is also available online at: http://www.floridahealthcarefinder.gov/reports-guides/patient-bill-rights.aspx

PATIENT INITIALS: ____

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I was provided a copy of the Notice of Privacy Practices 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)	Patient's DATE OF BIRTH
Signature	Date Signed
Patient's Authorized Representative's Name (Please print)	Relationship to Patient

Please list below the names and relationship of people to whom you authorize Active Chiropractic d/b/a Countryside Chiropractic to release Protected Health Information

Name:_____	Relationship:_____
Name:_____	Relationship:_____
Name:_____	Relationship:_____

PATIENT INITIALS: ____

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Prior Practice Name(s) and Location (s): _____

_____

I authorize my health information to be disclosed to and used by:

Active Chiropractic d/b/a Countryside Chiropractic
28467 U.S. Highway 19N STE 302
Clearwater, FL 33761

I may refuse to sign this authorization and I understand that it is strictly voluntary. My treatment, payment, enrollment, or eligibility for benefits may not be contingent upon signing this authorization.

This authorization will expire without my express revocation, 180 days from the date hereof, unless otherwise specified. If I am a minor, this authorization will expire on the date I become an adult according to state law. I may revoke this authorization at any time in writing, but if I do, it will not have any effect upon actions taken prior to receiving the revocation. A copy of this authorization or my signature thereon, may be utilized with the same effectiveness as an original.

The medical information released by this authorization may include information concerning treatment of physical and mental illness, alcohol/drug abuse, and past medical history. The type and amount of information to be disclosed is as follows (as applicable):

☐ Last TWO progress notes ☐ Last Complete Physical

☐ All Laboratory Results ☐ All Imaging Results and Copies of Images

☐ Complete list of Current Medications ☐ Other: _____

_____

I do hereby consent and acknowledge my agreement to the terms set forth in the INFORMED CONSENT, ASSIGNMENT OF BENEFITS, TECHNOLOGY DISCLAIMER, PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES, and AUTHORIZATION TO DISCLOSE HEALTH INFORMATION; and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

_____ _____

PRINT Patient's name Patient's Date of Birth

_____ _____ _____

Signature of Patient / Authorized Representative Relationship to Patient Date Signed