

CONFIDENTIAL HEALTH INFORMATION QUESTIONNAIRE

This information is needed so we can better serve you. Please fill in ALL portions of the form. If you need assistance, please ask our receptionist, and we will be happy to have our Patient Services Representative help you.

Your Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone#: _____ Pager: _____ Cell Ph: _____

Age: ____ Date of Birth: _____ SS#: _____ E-mail: _____

Marital Status: M S D W Drivers License#: _____

Your Occupation: _____ Employed by: _____

Phone #: _____ Address: _____

Is your visit due to an accident? Yes / No

Are you are Medicare Patient? Yes / No **Medicare #:** _____

Your Spouse's name: _____

Spouse's Employer: _____ Spouse's work ph#: _____

Name of person to contact in case of emergency: _____

Their home and work phone number: _____

Name of nearest relative not living with you: _____

Their phone number: _____

Who referred you to this office so we may thank them? _____

Referring Physician: _____

In order to determine if care can be of benefit to you, this office will extend the courtesy of an initial consultation without charge. If the doctor might be able to help you with your condition, are you interested in seeking care?

Yes Unsure

THERE WILL BE NO CHARGED SERVICES WITHOUT YOUR INFORMED CONSENT.

I attest that the above information is true and correct to the best of my knowledge. I further understand that any charges incurred by me in this office are my sole responsibility, despite any insurance plan, legal involvement, or settlement.

Patient's Signature: _____ Date: _____

Parent or Guardian: _____

Signature: _____ Date: _____

Please complete the information on the opposite side. Thank you!

Medical Insurance:

Insurance Carrier: _____ Phone: _____

Policy Holder name: _____ Policy Number: _____

Group Number: _____

Workers Compensation Injury:

Employer: _____ Work Number: _____

Address: _____ Supervisor: _____

Was injury/accident reported to supervisor? Y/N Date: _____ Time: _____

Workers Comp Carrier: _____ Policy #: _____

Carriers Phone: _____ Adjuster: _____

Claim Number: _____

Auto / Personal Injury:

Do you have "Med Pay" on your Auto Policy: Yes / No Amount: \$ _____

Insurance Carrier Name: _____ Phone: _____

Adjuster: _____ Claim Number: _____

Third Party Payer (other involved vehicle insurance)

Third Party (Person at Fault's) Name: _____ Ph: _____

THEIR Insurance Carrier: _____ Ph: _____

Address: _____

Adjuster: _____ Claim Number: _____

Patient Name: _____ **Date:** _____

List any operations that you've had and approximate dates:

- 1. _____ Date: _____ Dr: _____
- 2. _____ Date: _____ Dr: _____
- 3. _____ Date: _____ Dr: _____
- 4. _____ Date: _____ Dr: _____
- 5. _____ Date: _____ Dr: _____

Are you allergic to any medication? Please list: _____

Are you taking any medications? Please list: _____

Do you wear Orthotics (shoe inserts)? Yes / No

If yes, what type? _____

Are you Pregnant? Yes / No Due date: _____

Do you: Smoke: Yes / No Amount per day:

 Drink: Yes / No Light Medium Heavy

 Exercise: Never Sometimes Frequently Regularly

Does anyone in your family have a similar health related problems? Yes / No

Who: _____ What condition: _____

Care they are receiving: _____

Is it helping? Yes / No

May we contact them regarding their condition? Yes / No

Patient Name: _____ **Date:** _____

PATIENT CONSENT

CONSENT FOR TREATMENT:

I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I hereby request and consent to the performance of medical care, chiropractic adjustments and other physical therapy procedures including various therapeutic procedures and diagnostic x-rays on me (or on the patient named below, for whom I am legally responsible) by the physicians at **Florida Health and Chiropractic Medicine/ Central Boca Medical Center/ Seals Chiropractic, PA./ Lauderdale Chiropractic**, or any associate or covering physician. I understand and am informed that, as in the practices of Medicine, Chiropractic and Physical Therapy there are some risks to treatment, including, but not limited to, infection, allergic reactions, fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the physician(s) to exercise judgment during the course of the procedures that the physician(s) feels at the time, based on the acts known, are in my best interest. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician(s).

RELEASE OF INFORMATION:

By signing this form, you are granting consent to **/Florida Health and Chiropractic Medicine/ Central Boca Medical Center/ Seals Chiropractic, PA./ Lauderdale Chiropractic**, to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full. It is posted in our office and by signing below you acknowledge that you will or have read it. Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by telephoning our office. You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement. You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

MEDICARE AND MEDICAID CONSENT TO RELEASE INFORMATION:

I certify that the information given by me in applying for payment under Title XVIII and /or Title XI of the Social Security Act is correct. I authorize any holder of medical or other information about me, to release to the Social Security Administration or its intermediary carriers, any information needed for this or related Medicare or Medicaid claim.

VERIFICATION OF NON-PREGNANCY (Female Patients Only):

By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time. Date of last menstrual period _____.

X _____ Printed Patient's Name

X _____ Patient's Signature

X _____ Other - Print Name & Relationship

X _____ Witness

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

Patient Name: _____ **Insured Name:** _____
Insurance Company: _____
Employer: _____
Claim/Group#: _____
SSN/ID#: _____

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to **Florida Health And Chiropractic Medicine/Central Boca Medical Center /Seals Chiropractic, PA / Lauderdale Chiropractic Center** all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

Print Name

Signature of Insured / Guardian

Date

FINANCIAL POLICY

Our policy is to extend to you the courtesy of allowing you to assign your insurance benefits directly to us. This policy reduces your out-of-pocket expense and allows you to place your family under care.

1. If You Do Not Have Insurance: All payments are made at the time of service or by an authorized payment plan. Your personal balance may not exceed \$100 at any time or care may be terminated. Our payment plans make care an affordable part of your family budget.

2. If You Have Insurance: All deductibles and co-payments are expected at the time of service or by an authorized payment plan. **Your co-insurance balance may not exceed \$100** or care may be terminated. Our payment plans make care an affordable part of your family budget. You are considered a cash patient until you bring in your completed insurance forms, and we qualify and accept your insurance coverage. We do not accept assignment for secondary insurance carriers, but will be happy to provide you with a claim form for your secondary carrier. Our fees are considered usual, customary and reasonable by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard and of care in this area. If your carrier has not paid a claim within sixty (60) days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid within ninety (90) days of submission, you accept responsibility for payment in full of any outstanding balance and authorize us to use your credit card to collect full payment. When your schedule of visits is once per month or longer, you will not be eligible for insurance assignment. Charges for services rendered will be due as they are rendered or by an authorized payment plan. We will continue to provide you with an insurance claim form. If you discontinue care for any reason other than discharge by the doctor, all balances will become immediately due and payable in full by you, regardless of any claim submitted.

3. Missed Appointments and or Transportation: For your convenience, our office makes every attempt to stay on schedule. Therefore it is imperative that all patients be punctual and present for all of their scheduled appointments and or pre arranged transportation. **Twenty-four (24) hours notice is required to cancel** any appointment for pre-arranged transportation. Failure to provide notice will result in a **\$40** missed appointment fee if being transported, missed transportation fee, made payable by the patient (not the insurance company) on the following visit. Failure to pay may result in termination of your care.

By signing below I have read and agree to adhere to the above policies.

Patient's Printed Name: _____

Signature: _____ Date: _____

Witness: _____ Date: _____

For your convenience you may retain your credit card number on file with us.

Card #: _____ Expiration Date: _____

Name as appears on card: _____