Chiropractic

Welcome! (Children)

MINOR'S NAME:	AGE: DOB:	SS#:	
ADDRESS:	CITY:	STATE:	ZIP:
HOME PHONE:	CELL:	PARENTS EMAIL:	
REFERRED BY:	STUDENT STATUS: ☐ FULL TIME ☐ PART TIME ☐ HOME SCHOOL ☐ OTHER		
MOTHER'S NAME:	CELL:	FATHER'S NAME:	CELL:
LEGAL GUARDIAN:	CELL:		

Primary Insurance

PRIMARY INSURANCE COMPANY:

PHONE:

ADDRESS:

CITY/STATE/ZIP:

INSURED NAME:

RELATIONSHIP TO PATIENT:

INSURED DOB:

INSURED ID/CLAIM #:

GROUP #:

Secondary Insurance

PRIMARY INSURANCE COMPANY:

PHONE:

ADDRESS:

CITY/STATE/ZIP:

INSURED NAME:

RELATIONSHIP TO PATIENT:

INSURED DOB:

INSURED ID/CLAIM #:

GROUP #:

Lifestyle Questions?

1. Main purpose for consulting for care? _____
2. Is your symptom(s) related to an accident? ☐ WORK INJURY ☐ MOTOR VEHICLE ACCIDENT ☐ OTHER INJURY
3. Is there currently a claim or lawsuit open or pending regarding this injury? _____
   If yes, please provide the name and phone number to your attorney: _____
4. Have you had chiropractic care before? ☐ YES ☐ NO If yes, rate your experience: ☐ POSITIVE ☐ NEGATIVE ☐ NEUTRAL
5. Are you taking any medications? ☐ YES ☐ NO If yes, please list the name and purpose of each: _____
   _____
6. What percent of your diet consists of: Fruits & vegetables _____% Grains (ex. pasta/bread/rice) _____%
7. How many glasses of water do you consume on average, daily? _____

	NONE	ONCE IN A WHILE	WEEKLY	DAILY	MULTIPLE TIMES PER DAY
8. How much protein do you consume?	☐	☐	☐	☐	☐
9. How much dairy do you consume?	☐	☐	☐	☐	☐
10. How much alcohol do you consume?	☐	☐	☐	☐	☐
11. Do you smoke?	☐	☐	☐	☐	☐
12. Do you exercise?	☐	☐	☐	☐	☐

13. Are you healthier now than you were 5 years ago? ☐ YES ☐ NO
14. What do you prefer for your symptom(s)? ☐ ICE ☐ HEAT
15. When do you generally feel your best? ☐ MORNING ☐ AFTERNOON ☐ NIGHT
16. When do you generally feel your worst? ☐ MORNING ☐ AFTERNOON ☐ NIGHT
17. Do you take supplements? ☐ YES ☐ NO If yes, please list: _____
18. How committed to your health are you? (Circle one) NOT 1 2 3 4 5 6 7 8 9 10 EXTREMELY

Please answer ALL that apply (1 = poor, 10 = very good)

		1	2	3	4	5	6	7	8	9	10
1.	Do you have a confident and a compassionate view of yourself?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
2.	Are you open to new ideas?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3.	Would others say you're a happy person?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
4.	Are addictions a challenge for you?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
5.	Are you teachable? How are your grades? _____	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6.	Do you sleep well at night and wake up rested?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
7.	Do you have a sustained energy throughout the day?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

8. Do you awake frequently at night to urinate? ☐ YES ☐ NO If yes, how many times on average: _____

9. What emotion(s) best describes you? _____

10. Are you involved in sports? ☐ YES ☐ NO Which ones? _____

11. How many hours per day (combined) do you spend with: TV, computer, video games, cell phone? _____

Describe Your Main Concerns:

What? _____

How did it start and when? _____

What does it feel like? ☐ DEEP ☐ DULL ☐ ACHY ☐ SHARP

What makes it worse? _____

What makes it better? _____

How often? ☐ DAILY ☐ WEEKLY ☐ MONTHLY

Is it constant? _____

How severe? (1 = low, 10 = high) _____

What all have you tried to do to resolve it? _____

General, Developmental, Prenatal, Feeding:

How many times were you prescribed antibiotics?
Past 6 months: _____ Lifetime Total: _____

Were you vaccinated? ☐ YES ☐ NO Any reaction? ☐ YES ☐ NO
Please Explain: _____

Any developmental challenges? ☐ YES ☐ NO
If yes, please Explain: _____

What type of birth? ☐ OBSTETRICIAN ☐ MIDWIFE
Any complications? _____

Birth intervention? ☐ FORCEPS ☐ VACUUM ☐ C-SECTION

Breast Fed? ☐ YES ☐ NO How Long? _____

Formula Fed? ☐ YES ☐ NO How Long? _____

Rate how you perceive your life experiences (P = Previously, C = Currently)

P	C		P	C		P	C	
☐	☐	Headaches, Migraines	☐	☐	Kidney Challenges, Stones	☐	☐	Frequent Flu, Cough, Colds
☐	☐	Insomnia	☐	☐	Constipation	☐	☐	Warts
☐	☐	Dizziness, Light Headedness	☐	☐	Bladder Challenges	☐	☐	Jaundice
☐	☐	Sinus Trouble	☐	☐	Impotency	☐	☐	Fevers
☐	☐	Ear Aches	☐	☐	Menstrual Cramps	☐	☐	Blood Pressure Challenges: High or Low?
☐	☐	Stiff Neck	☐	☐	Knee Pain	☐	☐	Diabetes, Type I, Type II: Insulin?_____
☐	☐	Thyroid Condition, Throat Condition	☐	☐	Leg Cramps: Nightly, Daily, Weekly, Monthly	☐	☐	Cancer
☐	☐	Excessive Sweatiness	☐	☐	Hemorrhoids	☐	☐	Indigestion
☐	☐	ADD, ADHD, OCD	☐	☐	Grinding Teeth at Night	☐	☐	Ulcers
☐	☐	Difficulty Breathing, Lung Condition	☐	☐	Nervousness	☐	☐	Gas Challenges
☐	☐	Nausea, Vomiting	☐	☐	Chronic Tiredness	☐	☐	Diarrhea
☐	☐	STD's	☐	☐	Amnesia	☐	☐	PMS, Emotional, Mood Swings
☐	☐	Immune System Challenges	☐	☐	Allergies. If so, where?	☐	☐	Irregular Menstrual
☐	☐	Gallbladder. If removed, when?_____	☐	☐	Vision/Ear Problems	☐	☐	Sciatica
☐	☐	Liver Condition	☐	☐	Acne, Pimples, Eczema, Psoriasis	☐	☐	Swollen Ankles
☐	☐	Poor Circulation: Arms, Hands, Legs, Feet?	☐	☐	Adrenal Condition	☐	☐	Weak Ankles
☐	☐	Slow to Heal from Cuts	☐	☐	Excessive Dryness	☐	☐	TMJ
☐	☐	Arthritis	☐	☐	Asthma	☐	☐	Shoulder Pain: Left or Right?
☐	☐	Heartburn	☐	☐	Heart Condition, Palpitations, Surgeries	☐	☐	Other: _____

Surgeries, Injuries, Accidents?

Please list all surgeries, injuries or accidents you have experienced in your life (include dates).

SURGERY, INJURY, ACCIDENT	DATE

Comments?

Is there anything else you would like us to comment on today?

_____

_____

Almost done! Lastly, we want to be absolute certain that agreements are in place in order to avoid any disagreements.

PHILOSOPHICAL AGREEMENT

I hereby agree and understand that health is a state of optimal physical, mental and social well being, not merely the absence of disease. I understand that all doctors of Chiropractic Plus do not offer diagnosis or treatment for specific diseases. Our only practice objective is to eliminate interference to the expression of the body's innate wisdom and to create an alkaline or anti-inflammatory environment that supports your body to integrate, update and hold your treatments (adjustments).

ASSIGNMENT, AUTHORIZATION AND FINANCIAL AGREEMENT

I hereby consent to a chiropractic evaluation and examination, sEMG, Thermography, PWP (Heart Rate Variability) scan, x-ray(s), chiropractic treatment(s), supplements, healthy lifestyle information (books, CD's, DVD's etc), activities of daily living information or laboratory procedures rendered to the client which Dr. Huber and her associate doctor(s) may consider or advise in the treatment of my case and guarantee payments of the charges incurred. I hereby assign and authorize payment of insurance benefits directly to Chiropractic Plus. I hereby authorize the above named doctor(s) to release information requested on this form and I further authorize release of any and all medical records or other pertinent information necessary to obtain payment. I understand that payment is due at the time service is rendered, and the above named doctor(s) / Chiropractic Plus will not accept the responsibility for filing collection of my insurance claim of benefits or negotiation of a settlement with my insurance company. I know I am responsible for payment of my account and I understand and agree that I am ultimately responsible to ensure that all services needing pre-authorization by my insurance company are pre-authorized and that any balances for denied services, deductibles, coinsurances and co-pays are my responsibility to pay.

TERMS

Net 30 days from the date of the invoice unless otherwise indicated above. A finance charge of 1.5% per month (annual percent rate 18%) of the unpaid balance will be added monthly. Should collection become necessary, the responsible party agrees to pay an additional 40% collection fee and all legal fees of collection, with or without suit, including attorney fees and court costs.

CONSENT TO EVALUATE AND TREAT A MINOR

By signing below, I, _____ being the parent / legal guardian of _____ do hereby grant permission to the treating staff doctor, to perform chiropractic services to the minor listed above.

NOTICE OF PRIVACY PRACTICES

By signing below I acknowledge that I have received and reviewed the Privacy notice of: Chiropractic Plus and all my questions have been answered to my satisfaction in language that I can understand.

Signature: _____ Relationship: _____ Date: _____

Witness Signature: _____ Witness Print: _____

Chiropractic

Informed Disclosure and Consent:

Chiropractic Spinal Adjustment Procedures, Physical Modalities and Pilates Exercise

You have the right as a patient to be informed about your injuries and/or condition, as well as the doctor's recommended procedures and any necessary referrals to be utilized to evaluate and treat your complaints. There are potential risks and benefits in all forms of commonly used treatments, including deciding on non-treatment in the hope that the pain and/or lack of ability to perform normal activities will eventually go away. Evaluations at this office consist of a thorough regional examination of your complaints and any necessary diagnostic X-rays. If you are a female of child bearing age, you must inform the physician if there is even the slightest possibility that you may be pregnant (you must he sexually active and have missed a menstrual period), as X-rays can have harmful effects on a fetus. The physician will perform various Range of Motion and Orthopedic Stress Tests to determine the most likely cause of your pain and most appropriate course of treatment for each of your complaints. Your non-surgical spinal-related complaints will be treated with specific chiropractic spinal adjustment procedures using the hands or a mechanical instrument. You may feel joint movement and hear joint noises during the procedure. Minor temporary soreness may occur, particularly early in the treatment, or during periods of flare-up with your return to normal activities; this is also true of massage therapy and physical therapy. More significant risks (for example, fractures, sprains/strains, strokes and disc injuries) are rare. Chiropractors, or D.C.'s, have the lowest medical malpractice insurance claims of all primary care physicians in the USA, including M.D., D.O., D.D.S., D.V.M. and D.P.M. Practitioners. The for-profit malpractice insurance industry has determined there is less risk involved in chiropractic spinal adjustment procedures and the adjunct therapies than in the prescribing of medication and surgery (both of which, however, may be necessary for a patients recovery).

I, _____, do not expect the doctor to be able to anticipate and explain all potential risks and complications, and I wish to rely on the doctor's education, training and experience to exercise judgment during the course of treatment, based on the facts then known, to do what is in my best interest. I further acknowledge that treatment may worsen or fail to relieve all of my spinal-related pain and that no guarantee of a "new spine" or complete cure have been given. I have had the opportunity to ask questions, and all my questions have been answered fully and satisfactorily. By signing below, I consent to the prescribed treatment plan and intend for this consent form to cover the entire course of treatment for my current complaints and for future conditions for which I seek treatment for my current complaints and/or therapists working at this office (or for the minor patient named below for whom I am the custodial parent or legal guardian). For Pilates exercise, I understand that participation in the program, like any physical conditioning activity or exercise program presents some unavoidable risks of injury. I understand the use of Pilates exercise equipment also carries with it a risk of injury.

Patient Signature: _____ Date: _____

Printed Name: _____

If a minor (less than 18 years old), Parent or Guardian's Name: _____

Parent or Guardian's Signature: _____

Chiropractic

Release of Records/Payment Agreement & Assignment of Benefits:

Patient to sign prior to any medical treatment to be performed

Patient: _____ DOA: _____

Insurance Co.: _____ ID/Policy #: _____

I hereby authorize: Chiropractic Plus, my Health Care Provider/Facility, **to release any and all medical information** to the above named insurance carrier(s), or to my designated attorney, now or in the future, and/or to my physician(s), if necessary, for the purposes of payment of my medically related outstanding debts, administration and evaluation, utilization review and financial audit. This authorization remains valid and effective from the date of this signing until revoked in writing, to both my insurance carrier and to this provider of services. This authorization is given pursuant to Florida Statute 456.057 and HIPAA regulations. I understand that Florida Statute 456.057 (10) makes clear that any third party to whom records are disclosed is prohibited from further disclosing any information in the medical records are without the expressed written consent of the patient or the patient's legal representatives.

Payment Agreement: All charges are due at the time of service, unless other arrangements have been made in advance. All professional services rendered are charged to the patient and the patient is responsible for all fees, regardless of insurance coverage. I understand I am responsible to the above -mentioned facility/provider, for charges not covered by this assignment, including deductibles & co-payment requirements by my insurance policy or certificate. I further agree that in the event of non-payment, I will bear the expenses of collection and /or court costs, and reasonable legal fees, should this be required. I understand if my commercial insurance has not paid the bill within 60 days of my visit(s), for my services received by my provider /facility, I am responsible, and I will then make whatever arrangements are necessary & available to me to pay all unpaid charges.

Assignment of Benefits: I hereby assign to DR. KELLY J. HUBER, INC. dba Chiropractic Plus, all rights and benefits that I have under any group or individual health insurance plan or policy, any HMO plan and/or Automobile insurance policy, and any other health or medical plan or policy or reimbursement plan that may pay patient benefits for service and treatment that I have received or will receive from the above-named provider. This assignment includes, but is not limited to, all rights to collect benefits directly from these entities for those services and treatments that I have received, and all rights to proceed directly against the entity in any law suit or other legal proceeding. The benefit payment received shall not exceed my indebtedness, and any payment that the facility/health care provider receives from the insurance company beyond my indebtedness shall be refunded to me when my outstanding bill(s) are paid. This assignment also includes the right to recover any attorney fees and legal costs for such action.

I understand I may request a copy of any or all of my medical records for a reasonable fee or a fee allowed by State Statute or Workers' Compensation Statute. Any copy of this document shall be as valid as if it were the original. I have read the above authorization to release medical records, assignment of benefits, and payment agreement, and hereby acknowledge that I understand it. The payment agreement portion of this instrument may not be revoked in writing or otherwise.

Signed: _____ Date: _____

Witness: _____ Date: _____

Chiropractic

Acknowledgement of Receipt of Notice of Privacy Practices:

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)

DATE

PARENT, GUARDIAN OR PATIENT'S LEGAL REPRESENTATIVE

SIGNATURE

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

Chiropractic

Chiropractic x-ray Assignment Agreement and Consent

I understand that my doctor is submitting my x-rays to Radiology Professionals, Inc. for primary radiological interpretation and report by a specialist. I also understand that the fee for such services will be submitted to my insurance company, healthcare carrier, attorney or worker's compensation carrier for payment. If 1 am paid directly by an insurance carrier or through a legal settlement, I will be responsible for the amount paid. If Radiology Professionals, Inc. does not receive payment for services rendered, I understand that I am fully responsible for payment. If Radiology Professionals, Inc. does not receive a lien, or if Radiology Professionals, Inc. does not receive a reply to a case status information request from my attorney, I will be billed for the amount of services. Once Radiology Professionals, Inc. receives a reply from the attorney I will stop being billed.

I also give my consent to Radiology Professionals, Inc's use and disclosure of my Protected Health Information for the purpose of providing treatment to me, for purposes relating to the payment of services rendered to me, and for the Practice's general healthcare operations.

I understand that I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purpose of treatment, payment or healthcare operations of the Practice, but the Practice is not required to agree these restrictions. However, if the Practice agrees to a restriction that I request, the restriction is binding on the Practice.

I have the right to revoke this consent, in writing, at any time, except to the extent that the Practice has acted in reliance on this consent. I acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of Radiology Professionals, Inc, Which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received, or maintained by the Practice.

My signature authorizes the release of medical information to:

Radiology Professionals, Inc.
5 Norfolk Ave
P.O. Box 1240
South Easton, MA 02375

In the event my insurance company or attorney sends payment of services to me, I agree to promptly remit such payment to Radiology Professionals, Inc.

Date: _____

Patient Signature: _____

Print Patient Name: _____

Parent or Guardian Signature: _____

Chiropractic

Consent to Treatment (Minor)

I hereby request and authorize Dr. Kelly Huber to perform diagnostic tests and render chiropractic adjustments and other treatment to my son/daughter: _____ This authorization also extends to all other doctors and office staff members and is intended to include radiographic examination at the doctor's discretion.

As of this date, I have the legal right to select and authorize health care services for the minor child named above.

(If applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authorization to select and authorize this care should be revoked in or modified in any way, I will immediately notify this office.

Date: _____

Signature: _____

Print Name: _____

Relationship: _____

Chiropractic

Verification of Non-pregnancy

*****THE FOLLOWING IS TO BE READ AND SIGNED BY ALL FEMALE PATIENTS IN THE CHILD BEARING YEARS WHEN SCHEDULED FOR DIAGNOSTIC X-RAYS.*****

X-Rays taken during pregnancy may be extremely dangerous to the unborn child unless adequate safeguards are employed during the procedure. The most dangerous period for the unborn child is during the first three months of pregnancy. Therefore, you are asked to inform the doctor and/or x-ray technician if there is any possibility that you may be pregnant.

I certify to the best of my knowledge that **I AM NOT PREGNANT** and that the above doctor(s) or the facility have my permission to perform diagnostic x-ray examination.

_____

*****LO SIGUIENTE DEBE SER LEIDO Y FIRMADO POR TODAS LAS MUJERES EN EDAD FERTIL QUE SE LE INDIQUEN EXAMENES DE RAYOS-X.*****

Las radiografias durante el embarazo puden ser peligrosas para el feto. El periodo mas peligroso es durante los primeros tres meses del embarazo. Por favor, le pedimos que informe al doctor/a y/o a la tecnica de rayos-x si hay alguna posibilidad que Ud. este embarazada.

Yo certifico que **NO ESTOY EMBARAZADA** y autorizo que el doctor/a y/o la institucion me realizen los examenes de rayos-x.

Signature / Firma: _____

Date / Fecha: _____

Chiropractic

Consent for Release of Medical Records:

Patient to sign prior to any medical treatment to be performed

To (Doctor of hospital or other): _____

Phone: _____ Fax: _____

I hereby authorize request you to release the complete medical records in your possession concerning my illness and/or treatment to:

Chiropractic Plus
135 Professional Drive, Suite 105
Ponte Vedra Beach, FL 32082
Ph: 904-280-1101 Fax: 904-280-1102

This should include all insurance policies, ambulance and fire/rescue reports, police reports, complete hospital records and reports, medical reports, x-rays and x-rays reports, CT scans, and MRI results, photographs, videotapes, tests results or reports or records of any kind, including drug and/or alcohol abuse treatment, complete pharmacy and/or prescriptions records, made with respect to me. You are also authorized to confer with **Chiropractic Plus / Dr. Kelly Huber, D.C.** and, upon their request, to provide them reports concerning me. A photocopy of this authorization shall be acceptable for the release of the requested information.

Pursuant to Section 455.241. Florida Statutes, you shall not disclose any information to, nor discuss my medical condition with, any other person (including other health care providers) without written authorization to do so from me.

Print Name: _____

Date of Birth: _____ SS#: _____

Signature: _____ Date: _____

DIAGNOSTIC IMAGING CONSULTANTS

5136 Central Avenue, St. Petersburg, FL 33707
Phone (727) 579-2500 Fax (727) 579-1060
SCOTT THORPE, DC, DACBR
RUDY N. HEISER, DC, MS, DACBR
MUNYEONG CHOI, MS, DC, DACBR
Diplomates American Chiropractic Board of Radiology

REFERRING PHYSICIAN INFORMATION

CHIROPRACTIC PLUS (109221)
KELLY HUBER, D.C.
135 PROFESSIONAL DR. # 105 PONTE VEDRA, FL 32256
PH: (904)280-1101 FAX: (904)280-1102 EMAIL: frontdesk@chirojax.com

LIST FILMS & DATE EXPOSED: _____

MEDICAL HISTORY: _____

_____

PATIENT INFORMATION

Name: _____

Date of Birth: _____-_____-_____

Sex: ___M ___F

I, _____hereby authorize Chiropractic Plus to release my x-rays to Diagnostic Imaging Consultants for review and report of all medical diagnosis. I understand my information will not be shared with any other entity without my permission.

Patient signature: _____ **Date:** _____