CHIROPRACTICPLUS

Welcome! (Adult)

FULL NAME: AGE: DOB: REFERRED BY:

ADDRESS: CITY: STATE: ZIP:

PHONE: CELL: EMAIL:

OCCUPATION: WORK PHONE:

☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED CHILDREN (NAMES/AGES):

EMERGENCY CONTACT: RELATIONSHIP: PHONE:

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

Rate how you perceive your life experiences (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.	Your willingness to accept change is:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3.	Your willingness to learn is:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
4.	You like what you do for a living:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
5.	How connected do you feel to nature or a higher power?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6.	Do you enjoy a sense of purpose and peace in your life?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
7.	Are addictions a challenge for you?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
8.	Do you sleep well at night and wake up rested?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
9.	Do you have a sustained energy throughout the day?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

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

Describe Your Concerns:

	Main Concerns	Secondary Concerns
What?		
How did it start and when?		
What does it feel like?	☐ DEEP ☐ DULL ☐ ACHY ☐ SHARP	☐ DEEP ☐ DULL ☐ ACHY ☐ SHARP
What makes it worse?		
What makes it better?		
How often?	☐ DAILY ☐ WEEKLY ☐ MONTHLY	☐ DAILY ☐ WEEKLY ☐ MONTHLY
Is it constant?		
How severe? (1 = low, 10 = high)		
What all have you tried to do to resolve it?		

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.

I have read the above statements and understand Chiropractic Plus' objectives pertaining to my care in this office.

Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Witness Print: _____

CHIROPRACTICPLUS

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: _____

CHIROPRACTICPLUS

Office Policies

Patient-Doctor Agreements

The purpose of these agreements is to allow us to more completely serve you and to get the best result in the shortest amount of time. It is our experience that those who adhere to the following agreements get the best results.

Signing In

When you arrive, please sign in at the front desk. You will be called and assigned a treatment room in the order you signed in. Other patients may be called before you because of the particular services being received that day or their doctor may be available before yours. When you go to the assigned treatment room, rest, relax and the doctor will be in as soon as possible.

New Injuries

In the event you sustain a new injury. Please let the front desk know as soon as possible. There may be additional paper work to be filled out.

Appointments

After your treatment, please be sure to stop at the front desk to take care of any co-pays or balances, and be sure to make your next appointment.

Payment of Bills

We will expect that you honor all financial agreements made with our office. If you find that you cannot fulfill your financial obligation, notify our financial manager immediately so that new arrangements can be made. Our policy is that patients maintain a zero personal balance. Insurance companies are expected to pay their portion within 45 days of claim submission. If they do not, we expect the patient to call the insurance company on our behalf to help get the claim paid. If an insurance company sends a check to your home, it should be brought or sent to our office as soon as possible unless told specifically this is not the case. Please also bring in the attached explanation of benefits (EOB).

Rescheduling Appointments

We have set up a specific course of treatment for you. A certain number of treatments in a set amount of time are required for us to get the results we both desire. If you need to change this time. Please reschedule your appointment for another time on the same day if possible. If the same day is not possible, be sure to make up the missed appointment within one week. For our massage therapy and Pilates patients, a 24-hour advance notice phone call is required, so that we may fill that slot. If 24 hours notice if not given a no show/cancellation fee will be charged to your account.

Progress Evaluations and Re-Examinations

Progress evaluations and re-examinations will be performed periodically to determine your rate of progress and future course of treatment. A special time will be set up for your re-evaluation appointments.

Upsets

We are here to serve YOU. Please speak with the staff or doctor about anything that could be upsetting you (i.e. long waits, staff insensitivity, treatment confusion etc.). We see your comments as helping us to help you and others.

Patient Signature: _____ Date: _____

CHIROPRACTIC PLUS

Release Of Records / Payment Agreement And Assignment Of Benefits

Patient to sign prior to any medical treatment to be performed

Patient: _____ DOA: _____

Insurance Company: _____ 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 PLUS

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 PLUS

CONSENT FOR RELEASE OF MEDICAL RECORDS

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 +
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+/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

A. Scott Thorpe, DC, DACBR, Rudy N. Heiser, DC, MS, DACBR,
Terry Sandman, DC, MPH, DACBR

CHIROPRACTIC PLUS
11512 LAKE MEAD AVE. STE. 203 JACKSONVILLE, FL 32256
PH: (904) 565-1116 FAX: (904) 565-1118

REFERRING DR.:_____
(DR NAME FOR REPORT)

Films/Date Exposed _____ ***Medical History*** _____

****Please print and complete form with patient's signature****

Patient Name _____ Date of Birth _____ Sex ___M___F
Address _____ City/State/Zip _____
Phone _____ SS# _____ Case/Acct# _____

BILL: ____ PIP ____ Health/Other Ins. ____DR. ____Atty. ____Patient

Primary Insurance: _____ Phone _____
Adjuster_____ ID/Claim#_____
Address_____ Insured _____
City/State/Zip_____ Date of Injury____/____/____

Attorney: _____ Phone_____
Address_____City/State/Zip_____

****

ASSIGNMENT, LIEN AND AUTHORIZATION/INSURANCE BENEFITS

For and in consideration of receiving services by "Assignee" and for other good and valuable consideration, I hereby agree to the following: I authorize assignee to release any information pertinent to my case to any insurance company, adjuster, or attorney to facilitate collection under this Assignment, Lien, Reservation of Benefits and Authorization.

ASSIGNMENT OF BENEFITS, RESERVATION AND REQUEST TO ESCROW ANY DISPUTED BENEFITS:

I HEREBY ASSIGN MY insurance benefits and any and all causes of action available under my policy of automobile insurance to, DIAGNOSTIC IMAGING CONSULTANTS OF ST. PETERSBURG, PA d/b/a DIAGNOSTIC IMAGING CONSULTANTS hereinafter, collectively referred to as the Assignee. Additionally, both the assignee and the undersigned patient acknowledge they are foregoing or assuming certain rights under this agreement that they would not otherwise have under normal circumstances, and as such, agree the same serves as additional consideration for this assignment of benefits to the provider/assignees. In the event my insurance company, obligated to make payments to me upon charges made by assignee for services, refuses to make or reduces such payments and in order to maximize the benefits available under my policy coverage, I hereby request the insurance company (assuming there is coverage remaining at the time the company receives the Assignees' bill and if the company fails to pay Assignee the full amount of the bill(s) submitted), to avoid exhaustion of coverage while Assignee pursues its rights under this Agreement, both parties to this agreement (the Assignee and I) further authorize, direct, notice and request the Insurance Company to set aside and place in escrow an amount equal to the full amount of any such denial or reduction, and to hold that amount in escrow until the dispute is resolved in the appropriate forum.

IN THE EVENT MY insurance company obligated to make payments to me upon the charges made by Assignee for their services refused to make such payments, upon demand by me or Assignee, I hereby assign and transfer to Assignee any and all causes of action that I might have or that might exist in my favor against such company and authorize Assignee to prosecute said cause of action either in my name or in Assignee name and further I authorize Assignee to compromise, settle or otherwise resolve said claim or cause of action as they see fit.

I AUTHORIZE ASSIGNEE to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under this Assignment, Lien and Authorization. I agree that the above mentioned Assignee be given Special Power of Attorney to endorse/sign my name on any and all checks and claim forms for payment of my bill.

I UNDERSTAND THAT I remain personally responsible for the total amounts due the Assignee for their services as insurance coverage may only pay a certain percentage of the bill; as, I may have an insurance deductible or my insurance benefits may exhaust or otherwise be limited. I further understand and agree that this Assignment, Lien and Authorization does not require Assignee to await payments and they may demand payments from me immediately upon rendering services at their option, although the Assignee agrees to first demand immediate payment from the insurance company as their first means of pursuing payment for services rendered. Also, I understand that if this account is assigned to an attorney for collection and/or suit, the assignee shall be entitled to reasonable attorney fees and costs of collection. I also understand that, if any bad check is written, I agree to pay for those added costs.

Dated this _____ day of _____, 20 ___.

Patient Signature_____**Printed Name**_____**Witness**_____

5136 Central Ave., St. Petersburg, FL 33707
Phone: 727-579-2500 Toll Free: 877-579-8800 Fax 727-579-1060