BAILEY SPINE & WELLNESS

224 Southpark Circle East
St. Augustine, FL 32086
904-342-4941

Name:	☐ Male ☐ Female	Today's Date:
Address:	City/State/Zip:	
Home Phone: ( )	Cell Phone: ( )	Work Phone: ( )
Age: Social Security#:	Date of Birth:	Marital: ☐ M ☐ S ☐ Other
Occupation:	Employer:	Name of Spouse:
Number of Children:	Ages of Children:	Email:
Insurance type: ☐ Health ☐ Medicare ☐ Medicaid ☐ Car accident ☐ Workers' Compensation ☐ Other		

Welcome to our office! Please complete all questions.

ARE YOU HERE FOR WELLNESS CARE OR FOR A SYMPTOM? ☐ Wellness ☐ Symptom

If you have a specific symptom(s), fill out this box and briefly describe each one in order of severity:

1. (Main complaint)_____
2. _____
3. _____
4. _____
5. _____

How long have you had your main complaint?_____

Have you ever had this before? ☐ Yes ☐ No When?_____

Was this related to: ☐ Auto Accident Date of Accident? _____

Have you lost work days? ☐ Yes ☐ No If so, how many?_____

HOW DO YOU WANT TO HANDLE THIS PROBLEM?

☐ Temporary relief (Help the symptom but don't fix the cause of the problem)
☐ Maximum correction (Correct the cause of the problem for maximum stability in the future)

List drugs you are currently taking(prescription and non-prescription)_____

What surgeries have you had?_____

Is there any chance you are pregnant? ☐ Yes ☐ No

Have you ever been diagnosed with cancer? ☐ Yes ☐ No If so, what kind?_____

When did you last see a chiropractor?_____ Dr._____

What spinal maintenance programs were you given to maximize the future stability of your spine?_____

_____

Who is your primary care physician? _____ Phys. city:_____

May we send progress note regarding your case to your physician? ☐ Yes ☐ No

PLEASE CHECK ANY OF THE FOLLOWING THAT GIVE YOU DIFFICULTY:

☐ Headaches	☐ Depression	☐ Mid-back pain	☐ Kidney trouble
☐ Shooting head pains	☐ Dizziness	☐ Heart attacks	☐ Menstrual cramps and pain
☐ Sinus Troubles	☐ Fainting	☐ High blood pressure	☐ Menstrual irregularity
☐ Loss of smell	☐ Loss of Balance	☐ Low blood pressure	☐ Diabetes
☐ Allergies	☐ Ringing in ears	☐ Anemia	☐ Cancer
☐ Hay fever	☐ Blurred vision	☐ Stomach trouble	☐ Sleeping problems
☐ Ear Infections	☐ Light bothers eyes	☐ Nervousness	☐ Painful joints
☐ Asthma	☐ Neck Pain	☐ Inner tension	☐ Swollen joints
☐ Loss of taste	☐ Muscle spasms in neck	☐ Irritability	☐ Pinched nerves in back
☐ Tightness of throat	☐ Tightness of shoulder muscles	☐ Cold Sweats	☐ Pins and needles in legs
☐ Inflammation of throat	☐ Pain in shoulders and arms	☐ Gall bladder trouble	☐ Swollen ankles
☐ Thyroid trouble	☐ Pins and needles arms/hands	☐ Indigestion	☐ Cold feet
☐ Twitching of face	☐ Cold hands	☐ Intestinal gas	☐ Pains in legs and feet
☐ Loss of memory	☐ Chest pains	☐ Low back pain	☐ Constipation
☐ Fatigue	☐ Pain when coughing	☐ Numbness in the low back	☐ Difficulty breathing
☐ Lung problems	☐ Frequent urination	☐ Mental Disorders	☐ Excess sweating
☐ Stroke	☐ Prostate problems	☐ Dyslexia	☐ Liver problems

PATIENT SOCIAL:

Alcohol:	☐Daily	☐Weekly	☐Occasionally	☐Never	**Drugs:**	☐Daily	☐Weekly	☐Occasionally	☐Never
OTCStimulants:	☐Daily	☐Weekly	☐Occasionally	☐Never	**Exercise:**	☐Daily	☐Weekly	☐Occasionally	☐Never
Homemade Food:	☐Daily	☐Weekly	☐Occasionally	☐Never	**Processed Food:**	☐Daily	☐Weekly	☐Occasionally	☐Never
Soft Drinks:	☐Daily	☐Weekly	☐Occasionally	☐Never	**Tobacco:**	☐Daily	☐Weekly	☐Occasionally	☐Never
Water:	☐Daily	☐Weekly	☐Occasionally	☐Never					
Caffeine:	☐Daily	☐Weekly	☐Occasionally	☐Never					

FAMILY HEALTH HISTORY: Please list diagnosed conditions and untimely deaths of family members (Family members include: Parents and siblings and paternal and maternal grandparents/uncles/aunts)

I certify that I'm the patient of legal guardian listed on this entrance form. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge.

Signature:_____ Date:_____

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. .Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____(Full Name) hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Signature _____ Date _____

Informed Consent

Chiropractic healthcare is an art and a science that is primarily concerned with the relationship between structure (primarily of the spine) and function (primarily of the nervous system). The doctor of chiropractic evaluates the patient using standard examination and testing procedures (such as orthopedic and neurological evaluation, labs, x-rays) along with specialized chiropractic evaluation. The chiropractic evaluation focuses on structural and/or functional abnormalities called "subluxation". Subluxation exists when one or more vertebrae in the spine or bones in the extremity are misaligned sufficiently enough to result in damage or irritation to either the nearby nerves, joints, and/or tissues. The primary goal of chiropractic treatment is the removal of subluxation(s). This is accomplished by performing a procedure unique to the chiropractic profession called an "adjustment". A chiropractic adjustment involves the application of a quick, precise force directed over a very short distance to a specific vertebra or bone. There are a number of different techniques that may be used to deliver the adjustment, some of which utilize specially designed equipment. Adjustments are usually performed by hand but may also be performed by hand-guided instruments. In addition to adjustments, other treatments used by chiropractors include physiotherapy modalities (e.g. heat, ice, ultrasound, soft-tissue manipulation), nutritional recommendations, and rehabilitative procedures.

As is the case with all health care interventions, the benefits of care must be weighed against the inherent risks and limitations of receiving treatment. Chiropractic treatments are one of the safest interventions available to the public as evidenced by malpractice statistics. While there are risks involved with treatment, these are seldom great enough to contraindicate care. Nonetheless, they must be considered when making the decision on whether or not to receive chiropractic care. Listed below are summaries of some key research articles that have addressed both common and rare side-effects/complications associated with chiropractic care.

One research study indicated that within the first 2 months of care, approximately half of patients report some "reaction" to chiropractic treatment. Of those who reported a reaction, the following were the most commonly reported reactions to initial chiropractic care (1):

- Local discomfort (53%)
- Headache (12%)
- Radiating discomfort (10%)

Initial here _____

Most appeared within 4 hours of treatment and resolved within 24 hours.

Rare, Yet Possible Side-Effect/Complications:

- Rib fracture
- Burns (if certain types of physiotherapy are used in your treatment)
- Disc herniation
- Cauda Equina Syndrome (2) (1 case per 100 million adjustments)
- Compromise of vertebrobasilar artery (i.e. stroke) (1 case per 3,000,000 adjustments) (3)

In addition to national guidelines (4), our clinic has set criteria for how we manage our patients. Through questioning and examination, we will do our best to determine what risk, if any, chiropractic care may pose to you and advise you of those risks as well as the possible need for medical referral. We may also suggest alternate chiropractic or medical approaches if we detect absolute or relative contraindications to the standard chiropractic treatment.

1. Senstad O, et al. . Frequency and characteristics of side effects of spinal manipulative therapy. Spine 1997;22:435-41
2. Shekelle PG, et al. Spinal manipulation for low-back pain. Ann Intern Med 1992;117(7):590-8.
3. A report on the occurrence of cervical cerebral vascular accidents in chiropractic practice." *Journal of the Canadian Chiropractic Association*, 1993; 37 (2): 104-6.
after cervical trauma and spinal manipulation. Spine 1999;(24):785-94.
4. Haldeman S, et al. Guidelines for chiropractic quality assurance and practice parameters. Aspen Publishers, 1997.

I have read the previous information regarding risks of chiropractic care and my clinician has explained my risks (if any) to me and suggested alternatives when those risks exist. I understand the purpose of my care and have been given an explanation of the treatment, the frequency of care, and alternatives to this care. All of my questions have been answered to my satisfaction. I agree to this plan of care understanding any perceived risk(s) and alternatives to this care.

PATIENT'S SIGNATURE _____ DATE _____

PARENT/GUARDIAN'S SIGNATURE _____ DATE _____

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Ph: (904) 342-4941

ASSIGNMENT OF INSURANCE BENEFITS, RELEASE, & DEMAND

Insurer and Patient Please Read the Following in its Entirety

I, the undersigned patient/insured knowingly, voluntarily and intentionally assign the rights and benefits of my automobile Insurance, also known as Personal Injury Protection (P.I.P.), and Medical Payments policy of insurance to the above health care provider, including the right to file a law suit to seek payment of any unpaid PIP benefits, penalty, postage and/or interest. It is the intention of the provider to accept this assignment in lieu of demanding payment at the time services are rendered and that this document will allow the provider to file suit against an insurance company for payment of the insurance benefits. This assignment of benefits includes over due interest payments and any potential claim for common law or statutory bad faith. The undersigned directs the insurer to pay the health care provider directly.

The insurer is directed by the provider and the undersigned to not issue any checks or drafts in partial settlement of a claim that contain or are accompanied by language releasing the insurer or its insured/patient from liability unless there has been a prior written settlement agreed to by the health provider and the insurer as to the amount payable under the insurance policy or contract. The provider hereby objects to any reductions or partial payments. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by the provider shall be done so under protest, at the risk of the insurer, and the deposit shall not be deemed a waiver, accord, satisfaction, discharge, settlement or agreement by the provider to accept a reduced amount as payment in full. The insurer is hereby placed on notice that this provider reserves the right to seek the full amount of the bills submitted. Please send a copy of any scheduled defense examinations or examination under oath to this provider.

Release of information: I hereby authorize this provider to furnish an insurer, an insurer's intermediary, and the patient's attorney via mail, fax, or email, with any and all information that may be contained in the medical records; to obtain insurance coverage information in writing (declaration sheet) and telephonically from the insurer; request from any insurer all explanation of benefits (EOBs) for all providers and non-redacted PIP payout sheets; obtain any statements the patient provided to the insurer; obtain copies of all medical records, X-rays, IMEs, and MRIs, from any other medical provider or any insurer. The provider may produce my medical records to its attorney in connection with any pending lawsuits. The insurer is directed to keep the patient's medical records private and confidential and is not authorized to provide these medical records to anyone without the patient's and the provider's prior express written permission.

Demand: Demand is hereby made for the insurer to pay all bills within 30 days without reductions and to mail the latest non-redacted PIP payout sheet and the insurance coverage declaration sheet to the above provider within 15 days. The insurer is directed to pay the bills in the order they are received. However, if a bill from this provider and a claim from anyone else is received by the insurer on the same day the insurer is directed to not apply this provider's bill to the deductible. If a bill from this provider and claim from anyone else is received by the insurer on the same day then the insurer is directed to pay this provider first before the policy is exhausted. In the event this provider's medical bills are disputed by the insurer for any reason the undersigned hereby instructs the insurer to set aside any amount disputed (i.e., to escrow the money) and not pay the disputed amount to anyone, including myself, or any entity until the dispute is resolved. The insurer is instructed to immediately explain in writing to the above provider of any dispute.

Certification: I certify that: I have read and agree to the above.

Caution: Please read before signing. **If you do not completely understand this document please ask us to explain it to you. If you sign below we will assume you understand and agree to the above.**

Patient's Name _____ Patient's Signature _____
(Please Print) (If patient is a minor, signature of parent/guardian)

Date_____