WELCOME

PATIENT INFORMATION

Name ____ **Date** ________________________

Address ____ **Apt #**_________

City ___________________________________ **State** __________ **Zip Code** ________________

Phone #: Home ______________________ **Cell** ______________________ **Work** ________________________

Referred By ____

Date of Birth _________________________ **Social Security #** ___________-_________-___________

Gender: Male _____ **Female** _____ **Marital Status (please circle): M S D W Sep**

Race (optional) Please check:

Hispanic/Latino _____ **African American**_____ **Asian** ______ **Caucasian** ______ **Other** _________________

Number of children _____ **Ages** __________________

Employer ____ **Occupation** _____________________________

Employer Address ____

Spouse's Name ___________________________________ **Spouse's DOB** _____________

Emergency Contact Name ______________________________________ **Phone #** ______________________

Party Responsible for Payment ____

If insurance, name of insurance company ____

HISTORY INFORMATION

Reason for visit ____

Related to Employment? YES NO Days lost from work _______________________

Related to Auto Accident? YES NO Date of accident ___________________________

Related to Other Accident? YES NO Date of accident ___________________________

Other doctors seen for these complaints? ____

Have you been treated at the hospital for these complaints? YES NO

What type of treatment did you receive? ____

Have you had similar symptoms before? YES NO When? ______________________________________

Have you ever seen a chiropractor before? YES NO When? ______________________________________

MEDICAL HISTORY (Check all that apply):

______Alcoholism	______Diabetes	______Irregular Heartbeat	______Rheumatic Fever
______Allergies	______Dizziness	______Jaundice	______Scarlett Fever
______Anemia	______Drug Addiction	______Known Deformity	______Shortness of Breath
______Arthritis	______Epilepsy	______Kidney Disease	______Stroke
______Asthma	______Fainting	______Liver Disease	______Suicide Attempt
______Birth Defects	______Frequent Headaches	______Low Back Pain	______Swelling of Feet
______Cancer	______Gallbladder Disease	______Multiple Sclerosis	______Thyroid Disease
______Chest Pain	______German Measles	______Nervousness	______Ulcers
______Chronic Cough	______Gout	______Neuritis	______Venereal Disease/STDs
______Chronic Diarrhea	______Hazardous Act.	______Numbness	Other ____________________
______Concussion	______Heart Disease	______Phlebitis	____________________
______Constipation	______High Blood Pressure	______Polio	____________________
______Convulsions	______HIV	______Psychological Illness	

List any previous surgeries____

Treated by a physician in the last 12 months? YES/NO Describe________________________________

FEMALES ONLY: Pregnant? YES/NO Date of last menstrual cycle ______________________________

MEDICATIONS

Medication names/strength	Reason Taken	How Often	Physician
____________________________	____________________	______________	______________
____________________________	____________________	______________	______________
____________________________	____________________	______________	______________

Vitamins/Other Supplements

____________________________	____________________	______________	______________
____________________________	____________________	______________	______________

Have you taken any antibiotics in the past year? YES NO

Allergies: Are you allergic to any medications? YES NO

Medications________________________________ **Reactions**__________________________

Medications________________________________ **Reactions**__________________________

Other allergies (food, animals, dust, etc.) ____

FAMILY HISTORY

	GENDER	AGE (current or at death)	Cause of Death	Illnesses	General Health
Father	M				
Mother	F				
Siblings	M/F				
	M/F				

PERSONAL HEALTH HABITS

Smoke? YES /NO How much? _______________ **How long?** _______________

Drink caffeine? YES/NO How much? _______________ **How long?** _______________

Drink alcoholic beverages? YES/NO How much? _______________ **How long?** _______________

<u>Financial Policy</u>

The Doctors and Staff at ***Riverview Family Chiropractic Center*** would like to welcome you to our practice!

We strive to provide you with excellent medical care.

BY SIGNING BELOW, YOU CONFIRM THAT YOU HAVE READ AND UNDERSTAND OUR OFFICE POLICY.

It is **<u>your</u>** responsibility to inform our office of any address and telephone number changes.

Your account is to be kept current accordingly; all self-pay or insurance co-pays and deductibles will be collected <u>at the time of service</u>, unless prior arrangements have been made. We take checks, MasterCard, Visa, American Express and Discover.

A returned check will result in a **$25.00 service charge** and all future payments must then be made with a credit card.

You will be sent a statement each month if your balance exceeds $10.00.

Refunds will be issued at the end of each month if there are not insurance claims pending.

There is a $20.00 NO SHOW fee for anyone not giving the office 24 HOUR NOTICE for appointments (doctor, massage or laser).

If your account is turned over to a collection agency, you will be responsible for any cost incurred in collection of said balance and must work with the collection agency to the pay the balance, not our office.

<u>We submit your claims, however we must emphasize that as a medical provider, our relationship is with you and not your insurance company.</u>

It is your responsibility to inform us of any changes in your insurance coverage.

It is your responsibility for non-covered charges not payable by your insurance company. Although filing your insurance claim is a courtesy extended to you, all charges are always **<u>your</u>** responsibility.

We realize that temporary financial problems may affect payment of your account. If such problems do arise, we urge you to contact our billing department at **(813) 741-0655** for assistance in management of your account. If you have any questions, please do not hesitate to ask us.

Print Name: ____

Signature: ____

Date: ______________________

Payment Authorization

I hereby authorize and direct you, my insurance company, and/or my attorney, to pay directly to "**Riverview Family Chiropractic Center, PA**" such sums as may be due and owing this office for services rendered me, both by reason of accident or illness, and any disability benefits, medical payment benefits, and to withhold such funds from any disability benefits, medical payment benefits, no fault benefits, health and accident benefits, workman's compensation benefits, or any other payments which may be necessary to adequately protect said office. I hereby further give a lien to said office against any and all insurance benefits named herein, and any and all proceeds of any settlement, judgment or verdict which may be unpaid to me as a result of the injuries or illness for which I have been treated by said office. This is to act as an assignment of benefits and an assignment of direct payment to the extent of the office's services provided.

In the event my insurance company is obligated to make payments to me upon the charges made by this office for services rendered, refuses to make such payments, upon demand by me or this office, I hereby assign and transfer to this office, any and all causes of action that I might have or that might exist in my favor against such company and authorize this office to prosecute said cause of action either in my name or the office's name and further I authorize this office to compromise, settle and otherwise resolve said claim or cause of action as they see fit.

I authorize this office 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 office be given power of attorney to endorse/sign my name in any and all checks for payment of my doctor bill. I understand that health and accident insurance policies are arrangement between an insurance carrier and myself.

I further understand and agree that if this office must take any action to collect an outstanding balance on my account, I will be responsible for payment of and will reimburse this office for all costs of such collection efforts, including but not limited to all court costs, interest incurred, collection fees and all attorney fees.

FOR OFFICE USE ONLY

Co-Pay is $_________ per visit while under active care toward services rendered. Balance will be billed at the end of care.

Patient Signature: ____

Spouse/Guardian Signature: ____

Date: _________________

RIVERVIEW FAMILY CHIROPRACTIC CENTER, P.A.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, *Riverview Family Chiropractic Center, P.A*. may use my disclosed protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Riverview Family Chiropractic, P.A.'s Notice of Privacy Practices for a more complete description.

I have the right to review the Notice of Practices prior to signing this consent. I am acknowledging that I have been provided a copy of the Notice of Privacy Practices and that I have, will or decline 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. *Riverview Family Chiropractic Center, P.A.* reserves the right to revise its Notice of Privacy Practice at any time. A revised Notice of Privacy Practice may be obtained by forwarding a written request to ***Riverview Family Chiropractic Center, P.A., Privacy Office at 10833 Boyette Rd. Riverview, FL 33569.***

With my consent, *Riverview Family Chiropractic Center, P.A.* my mail to my home or other designated location any item that assist the practice in carrying out TPO; such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent, *Riverview Family Chiropractic Center, P.A.* may email to my home or other designated location any item that assists the practice in carrying out TPO; such as appointment reminder cards and patient statements. I have the right to request that Riverview Family Chiropractic Center, P.A. restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested patient statements as long as they are marked Personal and Confidential.

By signing this form, I am consenting to *Riverview Family Chiropractic Center, P.A.'s* use of my disclosed PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, *Riverview Family Chiropractic Center, P.A*. may decline to provide treatment to me.

_________________________________	_________________________________
Print Name of Patient	Print Name of Legal Guardian
_________________________________	_________________________________
Signature of Patient of Legal Guardian	Date

___By initialing here, I am stating that I was provided with a copy of the Notice of Privacy Practices and have chosen not to keep the copy. I have been made aware of an office-copy that is available for review.