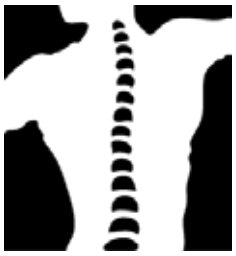
DeLand Chiropractic & Spinal Decompression

New Patient Application



The information that you will provide on this form will play a key role in determining your ability to be accepted as a patient in this office. Your qualification as a patient is determined by the nature of your injury, the doctor's ability to treat your condition, your commitment to getting well, your family and/or spousal support, your ability to pay for recommended care, and your willingness to make sacrifices to ensure your proper healing. Please be sure that you answer all questions. Thank you – Dr. Gordon's Staff.

Name: _____ Sex: Marital Status:
Address: _____ City:_____
State: _____ Zip Code: _____ Date of Birth: _____ SSN: _____
Home Phone: _____ Work Phone: _____ Cell Phone:_____
Employer: _____ Occupation: _____
Age:_____ Email:_____ Hobbies:_____
Name Of Your Medical Doctor And May We Contact Them?:_____
Race: _____ Ethnicity: _____ Are You Pregnant?
How Did You Hear About Our Clinic: _____ Preferred Language:_____
Emergency Contact Name & Phone #: _____ Relation:_____

What Is Your Chief Complaint?

_____
Date Of Your Injury? _____ Work Related? Auto Accident Related?
Have Had Chiropractic Care Before? How About Acupuncture?

Do You Smoke Cigarettes? Currently: Formerly: Never___
Do You Drink Alcohol? If Yes, How Often?_____ How Much? _____
Do You Use Recreational Drugs? What Type?_____

Do You Have A <u>Family History</u> Of: (check all that apply)

Heart Disease Arthritis Hypothyroid Diabetes (Type I Type II) Seizures
Stroke Osteoporosis Rare Genetic Disease (type) _____
Cancer (type) _____

Do <u>You</u> Have A Past Medical History Of: (check all that apply)

Lower Back Pain	**Stroke**	**Thyroid Disease**	**Diabetes (Type I II)**
Sciatic Pain	**Birth Control Pills**	**Auto Accidents**	**Hormone Replacement**
Hypertension	**Head Trauma**	**Heart Attack**	**Osteoporosis**
Neck / Back Trauma	**Blood Clots**	**Balance Problems**	**Dizziness**
Cancer (type)_____		**Numbness On ½ Of Your Face or Body**	

Will you be filing through insurance? If yes, please provide insurance company name and member ID number. If not, please move on to the next page.

Insurance Co. _____ Member ID _____

Please List Any Allergies, Surgeries, Accidents, Falls, Pregnancies, Or Hospitalizations:

List All Medications & Dietary Supplements That You Are Taking (List Dosage & Frequency):

When discussing possible treatment options, do you prefer: _____

Our team has four goals that drive our practice and quality of care. All are important to us, but out of these values, which would be your priority for today's visit? _____

Are you willing to do your part to help us achieve your goal? _____

Looking at this list, would any of these be a possible barrier to you when considering treatment?
___Fear ___Time ___Budget ___Trust

IF YOU HAVE ANY QUESTIONS OR CONCERNS WITH THE INFORMATION BELOW, IT IS YOUR RESPONSIBILITY TO ADDRESS THOSE CONCERNS WITH THE DOCTOR.

Informed Consent, Financial Responsibility, and Assignment of Benefits:

As with all medical or chiropractic treatments, I acknowledge and understand that there are inherent risks to receiving care including but not limited to sprains, strains, fractures, dislocations, muscle pain, bruising, and stroke. Statistically, these risks are extremely rare and uncommon (1 in 1 – 5 million in the case of strokes), especially when compared to those risks related with alternative treatment options for my condition including the use of over the counter analgesics, prescription drugs, and surgery. Due to that fact, I will not hold the physician or staff responsible for those risks listed above. In addition, I understand that the risk and danger of allowing my condition to go untreated may lead to further deterioration of my condition with possible serious and/or permanent consequences to my health. I acknowledge and understand that the use of certain prescription medications (i.e. birth control pills, hormone replacement, aspirin, Coumadin), illicit drug or alcohol use, and cigarette smoking may increase these risks and inhibit proper healing. I also understand that if I am accepted as a patient, and if I receive care, that I am the ultimate responsible party on my account regardless of the actions of any 3rd party carrier (insurance company). I agree that should my account become delinquent, I will be responsible for all collection costs, including but not limited to the outstanding balance, attorney fees, court costs, collection agency fees, and interest at the rate of 18% per annum(1.5% per month). By signing below, I also agree to allow the doctor to share any and all medial reports and findings with my primary care physician, and I allow the doctor to use my name and case history in monthly newsletters and/or patient testimonial booklets. Lastly I understand that any physician at DeLand Chiropractic & Spinal Decompression cannot evaluate, examine, x-ray, diagnose, or treat me for my presenting condition without my signature below. By signing below I acknowledge that I have weighed the risks versus benefits of treatment, and I give the doctor consent to treat me for my condition.

Print Name:_____ Date:_____

Signature: _____

PAIN DISABILITY QUESTIONNAIRE

Patient Name _____Date_____

Instructions: These questions ask your views about how your pain now affects how you function in every day activities. Please answer every question and mark the ONE number on EACH scale that best describes how you feel.

1. Does your pain interfere with your normal work inside and outside the home?

Work Normally — Unable to work at all

0 1 2 3 4 5 6 7 8 9 10

2. Does your pain interfere with personal care (such as washing, dressing, etc.)?

Take care of myself completely — Need help with all my personal care

0 1 2 3 4 5 6 7 8 9 10

3. Does your pain interfere with your traveling?

Travel anywhere I like — Only travel to see doctors

0 1 2 3 4 5 6 7 8 9 10

4. Does your pain affect your ability to sit or stand?

No problems — Can not sit/stand at all

0 1 2 3 4 5 6 7 8 9 10

5. Does your pain affect your ability to lift overhead, grasp objects or reach for things?

No problems — Can not do at all

0 1 2 3 4 5 6 7 8 9 10

6. Does your pain affect your ability to lift objects off the floor, bend, stoop or squat?

No problems — Can not do at all

0 1 2 3 4 5 6 7 8 9 10

7. Does your pain affect your ability to walk or run?

No problems — Can not walk/run at all

0 1 2 3 4 5 6 7 8 9 10

8. Has your income declined since your pain began?

No decline — Lost all income

0 1 2 3 4 5 6 7 8 9 10

9. Do you have to take pain medication every day to control your pain?

No medication needed — Need medication throughout the day

0 1 2 3 4 5 6 7 8 9 10

10. Does your pain force you to see doctors much more often than before your pain began?

Never see doctors — See doctors weekly

0 1 2 3 4 5 6 7 8 9 10

11. Does your pain interfere with your ability to see the people who are important to you?

No problem — Never see them

0 1 2 3 4 5 6 7 8 9 10

12. Does your pain interfere with recreational activities and hobbies?

No interference — Total interference

0 1 2 3 4 5 6 7 8 9 10

13. Do you need the help of your family and friends to complete everyday tasks?

Never need help — Need help all the time

0 1 2 3 4 5 6 7 8 9 10

14. Do you now feel more depressed, tense, or anxious than before your pain began?

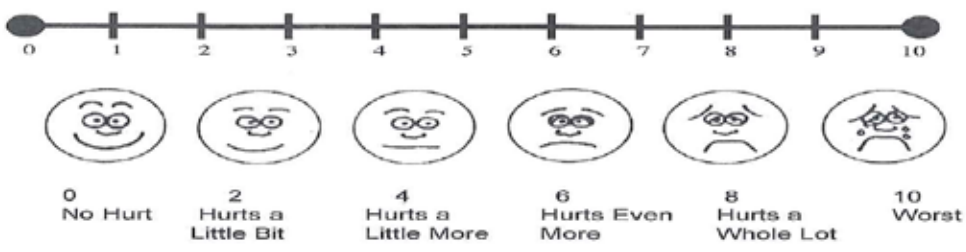
No depression/tension — Severe depression/tension

0 1 2 3 4 5 6 7 8 9 10

15. Are there emotional problems caused by your pain that interfere with your family, social and or work activities?

No problems — Severe problems

0 1 2 3 4 5 6 7 8 9 10



ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
DELAND CHIROPRACTIC & SPINAL DECOMPRESSION

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.

By checking the lines below I authorize being contacted for practice reminders, birthday greetings or promotions by: Mail ☐ Email ☐ Telephone ☐ Text Message ☐

By checking the box below I authorize the doctor to personally discuss with me products and services that may benefit my health or condition. ☐

_____ _____

Patient Name (please print) Date

_____

Name of Parent, Guardian or Patient's legal representative

_____

Signature of Patient, Parent, Guardian or Patient's legal representative

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

List below the names and relationship of people to whom you authorize the Practice to Release PHI.

DELAND CHIROPRACTIC & SPINAL DECOMPRESSION

HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

Patient Name: _____ DOB: _____

Address: _____ City: _____ State: _____ ZIP: _____

AUTHORIZATION

I authorize **DELAND CHIROPRACTIC & SPINAL DECOMPRESSION** to request and/or release the disclosure for the protected health information described below to and/or from the following individual/organizations:

Name of Practice/Organization: _____

Address: _____ City: _____ State: _____ ZIP: _____

Phone: _____ Fax: _____

EFFECTIVE PERIOD

This authorization for release of information covers the period of healthcare from this date forward unless I revoke the authorization in writing. I understand that this for will be placed in my patient chart and maintained for six years.

ACKNOWLEDGEMENT

I acknowledge that Deland Chiropractic & Spinal Decompression has issued or offered to issue me a copy of the Notice of Privacy Practices. This notice describes how medical information about me may be used and disclosed and how I may obtain access to this information.

_____ _____

Signature of Patient/Guardian **Date**

_____

Print Name of Patient/Guardian

DeLand Chiropractic & Spinal Decompression
Dr. Jeremy M. Gordon & Dr. Michael Munson

905 North Stone Street
DeLand, FL 32720

Phone (386)734-9995
Fax (386)734-9949

Nutritional Counseling *DRX Spinal Decompression* *Chiropractic* *Acupuncture* *Comprehensive Blood Analysis*

ASSIGNMENT, LIEN AND AUTHORIZATION OF BENEFITS

I,_____, hereby authorize and direct you, my insurance company, and/or attorney, to pay directly to DeLand Chiropractic and Spinal Decompression such sums as may be due and owing this office for services rendered me, both by reason of accident or illness, and by reason of any other bills that are due this office, to withhold such sums from any disability benefits, medical payments benefits, "no-fault benefits", health and accidental benefits, workmen's compensation benefits, or any other insurance benefits obligated to reimburse me or from my settlement, judgment or verdict on my behalf as may be necessary to adequately project this office. I hereby further give a lien to said office against any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness from which I have been treated by this office. Signature of this document authorizes the release of any medical or other information necessary to process this claim, and I request payment of government benefits and authorize payment of medical benefits to the undersigned physician or durable medical goods supplier for goods or services provided. This is to act as an assignment of my rights and benefits to the extent of the office's services provided.

In the event my insurance company which is obligated to make payments to me for the charges incurred at this office refuses to make such payments, upon demand of 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 in the office's name and further I authorize this office to compensate settle or otherwise resolve said claim or cause of action as they see fit.

DeLand Chiropractic and Spinal Decompression accepts the aforesaid assignment and hereby notifies any insurer issuing payment that DeLand Chiropractic and Spinal Decompression objects to any repricing or reduction of billed amounts unilaterally made by any insurer. Any such reduced payments issued by any insurer are accepted under protest and without waving any right of the provider to pursue all legal remedies against the insurer.

I, _____, understand that I remain personally responsible for the total amounts due the office for their services that are not paid by the insurance company.

I, _____, authorize the 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 on any and all checks for payment of my doctor (medical) bill.

Please read this document completely before signing. If you do not understand this document or have any questions about this document, please ask us to explain it to you. If there is any portion of this document that you do not wish to authorize, we will remove that portion from this document. Your signature below is your agreement you fully understand this document and you fully agree to the terms of this document.

_____ _____
Patient or guardian's signature ***Date***

_____ _____
Witness to patient or guardian's signature ***Date***

ELECTRONIC SIGNATURE: