Bartram Family Chiropractic

☐Check in box indicates no changes below

Today's Date: ____/____/____

Patient Name: _____ □Male □Female

Date of Birth: _____/_____/_____ Age: _____

Social Security Number: _____-_____-_____

Marital Status: □Single □Married □Divorced □Widowed □Separated □Other

Home Address: _____

City:_____ State:_____ Zip:_____

PLEASE CHECK BEST CONTACT NUMBER

□Home Phone: (_____)_____ □Work Phone: (_____)_____

□Mobile Phone: (_____)_____ *Cell Phone Carrier: _____

Preference for Appointment Reminders: □Phone □Email □Text *must supply cell carrier for texting

Email: _____@_____._____ (Please print clearly and accurately)

Occupation: _____

Emergency Contact: _____ Phone: (_____)_____

Spouse's Name: _____ Spouse's Date of Birth (if the insured) _____

INSURANCE INFORMATION

Insurance Carrier:_____ Member ID/Claim #:_____

Policy Holder:_____ Policy Holder's DOB:_____

*****Insurance information: Please present insurance card to Receptionist with Driver's License**

I understand that I am financially responsible for all the charges whether or not paid by my insurance. I authorize the use of my signature on all insurance submission and authorize payment of medical benefits to the undersigned or Bartram Family Chiropractic for the services described on any bill. Dr. Thompson may use my health care information and disclose such information to the insurance company and other agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. Should the insurance company perform an audit of records and determine that your treatment was not medically necessary or excessive, they may request monies back directly from Bartram Family Chiropractic. At that time, you can request an appeal but must understand that you, the patient, will be responsible for any monies owed to Bartram Family Chiropractic for services rendered. This consent will end when my current treatment plan is completed or one year from the date signed below. I authorize the release of any medical or other information necessary to process any claim by Bartram Family Chiropractic. I also request payment of government benefits either to myself or the party who accepts assignment.

Signature of Patient or Guardian _____ Date_____

PATIENT HISTORY

NAME: _____ DOB: _____ Date: _____

Major Complaint: _____

How long have you had this condition? _____

Date of onset _____

Have you lost work days? _____yes _____no If yes, how many? _____

Have you had this similar condition before? _____yes _____no If yes, when? _____

Was the injury accident related? _____auto _____work If yes, date occurred? _____

When was your last auto accident? _____

Previous Chiropractic Care _____yes _____no Chiropractor's Name: _____

What was the reason for your initial visit? _____

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

_____

Did you follow it? _____yes _____no If not, why? _____

Why are you changing chiropractors? _____

Please check if you have had any of these symptoms in the past 12 months:

- ___ Fractured bones
- ___ Auto accidents
  - ___ 0-1 years ago
  - ___ 1-5 years ago
  - ___ 5 years or more
- ___ Other accidents, falls etc.
- ___ Arthritis
- ___ Diabetes
- ___ Convulsions, epilepsy
- ___ Skin problems
- ___ Cancer
- ___ Frequent colds
- ___ Depression
- ___ Irritability
- ___ Anemia
- ___ Allergy, sinus
- ___ Stress
- ___ Eating disorders
- ___ Trouble sleeping
- ___ Trouble concentrating
- ___ Neck pain or stiffness __R or __L
- ___ Numbness, tingling, pain in arms, hands, or fingers __R or __L
- ___ Jaw pain or click (TMJ) __R or __L
- ___ Difficulty in excessive standing, sitting, riding, bending, lifting, or twisting
- ___ Shoulder pain __R or __L
- ___ Dizziness
- ___ Ringing in ears __R or __L
- ___ Hearing loss
- ___ Blurred or double vision
- ___ Upper back pain, stiffness
- ___ Mid back pain, stiffness
- ___ Lower back pain, stiffness
- ___ Pain with cough, sneeze
- ___ Hip pain __R or __L
- ___ Headaches
- ___ Learning Disability
- ___ Mood changes
- ___ Numbness, tingling, pain, in buttocks, legs, feet, toes __R or __L
- ___ Foot trouble __R or __L
- ___ Chest pain
- ___ Heart problems
- ___ Stroke
- ___ High/low blood pressure
- ___ Varicose veins
- ___ Liver trouble
- ___ Gall bladder trouble
- ___ Digestive problems
- ___ Ulcers
- ___ Hemorrhoids
- ___ Prostate problems
- ___ Impotence
- ___ Kidney trouble
- ___ Menstrual problems, PMS
- ___ Pregnant (now)
- ___ Bedwetting
- ___ Ear infections

NAME: _____ DOB: _____ DATE: _____

HEIGHT:_____ **WEIGHT:_____**

PAST MEDICAL HISTORY: Please select if condition applies to your medical history:

□ AIDS/HIV	□ Coronary artery disease	□ Hypertension	□ Peptic ulcers
□ Alcoholism	□ Crohn's disease	□ Inflammatory bowel disease	□ Psoriasis
□ Alzheimer's	□ Degenerative joint disease	□ Juvenile Rheumatoid Arthritis	□ PVD (vascular disease)
□ Anemia	□ Depression	□ Kidney disease	□ Renal disease
□ Angina	□ Diabetes	□ Liver disease	□ Rheumatoid arthritis
□ Arthritis	□ Drug Abuse	□ Lyme disease	□ Scoliosis
□ Asthma	□ DVT (blood clot)	□ Migraine headaches	□ Seizure disorder
□ Atrial fibrillation	□ Fibromyalgia	□ Multiple Sclerosis	□ Sleep apnea
□ Enlarged prostate	□ Gallbladder disease	□ Myocardial Infarction	□ SLE (Lupus)
□ Cancer _____	□ GERD (acid reflux)	□ Obesity	□ Spinal stenosis
□ CVA (Stroke)	□ Gout	□ Osteoarthritis	□ Spondyloarthropathy
□ Congestive heart failure	□ Hepatitis	□ Osteoporosis	□ Thyroid disease
□ COPD	□ High Cholesterol	□ Parkinson's disease	□ Valvular disease

Other: _____

PAST SURGICAL HISTORY: Please list all previous surgeries that required anesthesia.

_____ _____

_____ _____

_____ _____

_____ _____

SOCIAL HISTORY:

Tobacco Use: □Yes □No □Former Type: _____ Packs/Day: _____ Years: _____ Year Quit: _____

Alcohol Use: □Yes □No □Former Type: _____ Frequency:_____ Amount/Day:_____ Last Drink: _____

Caffeine Use: □Yes □No Type: _____ Amount/Day: _____

Activity: □Moderate □Sedentary □Vigorous Type(s) of exercise: _____ Frequency: _____

Hand Dominance: □Right □Left □Ambidextrous

NAME: _____ DOB: _____ DATE: _____

MEDICATIONS AND ALLERGIES: Please attach medication list if available.

Medication or Vitamin Name:	Dosage:	Reason for Taking:
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		
17.		
18.		
19.		
20.		

Drug Allergies:	Reaction:
1.	
2.	
3.	
4.	
5.	

NOTICE OF PRIVACY PRACTICES

Bartram Family Chiropractic
13720 Old St. Augustine Rd., #4
Jacksonville, FL 32258
904-268-9100

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice takes effect on your first date of treatment and remains in effect until we replace it.

1. **OUR PLEDGE REGARDING MEDICAL INFORMATION**

   The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe the rights and certain duties we have regarding the use and disclosure of medical information.

2. **OUR LEGAL DUTY**

   Law Requires Us To:

   1. Keep your medical information private.
   2. Giving you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
   3. Follow the terms of the current notice.

   We Have The Right To:

1. Change our privacy practice and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including the information previously created or received before the changes.

Notice of Change to Privacy Practices:

1. Before we make any important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. **USE AND DISCLOSE YOUR MEDICAL INFORMATION**

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below without your specific written authorization. Any specific written authorization you provide may be revoked any time by writing to us at the address provided at the end of this notice.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to other healthcare providers to assist them in treating you.

FOR PAYMENT: We may disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

I have received these notices of privacy practices and I have been provided an opportunity to read it.

Signature _____Date _____

INFORMED CONSENT TO CHIROPRACTIC CARE

Bartram Family Chiropractic
13720 Old St. Augustine Rd., #4
Jacksonville, FL 32258
904-268-9100

Patient Name: _____ Date of Birth: _____

Thereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays by any doctor of chiropractic employed by Bartram Family Chiropractic.

I have had the opportunity to discuss with the doctor and/or with other office or clinic personnel the purpose and benefits of the chiropractic adjustments and other treatments outlined below.

Alternatives to treatment have been reviewed.

Though chiropractic adjustments and treatments are usually beneficial and seldom cause any problem, I understand and am informed that there are some risks to treatment. Risks include, but are not limited to fractures, disc injuries, strokes, dislocations, and sprains.

I understand that I will be receiving the following treatment:

- Chiropractic Adjustments/Manipulation
- Electric Muscle Stimulation
- Heat/Cold Packs
- Ultrasound
- Traction
- Massage/Therapeutic Exercises and Stretches
- Decompression Therapy

I understand the chiropractic is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the chiropractic treatment that I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

CONSENT TO EVALUATE AND TREAT

_____ _____

Signature of Patient or Parent/Guardian Date

PREGANCY RELEASE STATEMENT

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

_____ _____

Patient/Parent Signature Date

ASSIGNMENT OF BENEFITS, AUTHORIZATION TO SETTLE CLAIM AND DIRECTION TO PAY MEDICAL PROVIDER DIRECTLY

By my signature below, for good and valuable consideration (including but not limited to the extension of credit to me), I hereby assign, transfer and convey to **BARTRAM FAMILY CHIROPRACTIC** (hereinafter "the Provider") all of my rights, title, and interest in and to medical expense reimbursement in whatever form, including but not limited to any automobile liability medical expense payments or other health benefits indemnification and/or agreement otherwise payable to me. This payment shall not exceed my indebtedness to the above named assignee that is not otherwise satisfied by the above-mentioned assigned proceeds. I also acknowledge that any medical expense not covered under my insurance policy will be my responsibility.

I further authorize the provider to negotiate, collect, and settle any claim with any insurance carrier or other third party payer with regard to these services, which authorization shall include authority to:
(1) request and receive from any insurer or any other third party any and all documentation and records that I am empowered to request regarding this claim, including, without limitation, a statement of coverage, policy declarations page and insurance policy pursuant to section 627.4137. In addition, the provider has the authority to request and receive any Independent Medical Examination Reports, notices sent to me regarding appointments for Independent Medical Examinations and Examinations Under Oath (including proof of mail), Records Review Reports, coverage denial letters, Explanations of Benefits, and Benefit Payment Sheets or Logs (P.I.P. Payout Sheets), without regard as to whether such documentation has already been provided to me and,
(2) to endorse in my name any check issued for payment where benefits were assigned. By way of this assignment and notice, I further instruct you, the insurer, to finish to Provider copies of all furniture notices affecting Provider's interest in this claim, including, without limitation, any notices of requested medical examinations of statements.

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 of payment in full.

I further direct my insurer to direct all payments for services rendered by the Provider directly to the Provider at the billing address contained on Provider's medical bills.

THIS IS A DIRECT AND IRREVOCABLE ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER MY POLICY OF INSURANCE.

A photocopy of this form shall be considered as effective and valid as the original.

I have read the foregoing and understand and agree to each other of the above provisions:

Patient's Signature _____ Date _____