St. Lucie Chiropractic Clinic

787 E Prima Vista Blvd
Port Saint Lucie, Florida 34953
772-878-3773
Fax 772-878-5783

Patient Information Sheet

Date: _____/_____/_____

Last _____ First _____ Middle ____

Language _____ Birth Date _____/_____/_____ Age _____ Male ○ Female ○

Address _____ City _____ State _____ Zip _____

Race _____ Phone _____ Married ○ Single ○ Divorced ○ Widowed ○

Email Address_____ Emergency Contact _____ Emergency Contact Phone Number_____

Your Occupation _____

Drug Allergies _____ _____ _____ _____ _____

Current Medications _____ _____ _____ _____ _____

List Medical Conditions / Surgical Operations _____

What is your major complaint? _____

Have you had similar conditions in Past? Yes ○ No ○ How long have you had this condition: _____?

What activities aggravate your condition: _____

Is this condition getting progressively worse? Yes ○ No ○ Have you had previous chiropractic care? Yes ○ No ○

List below all conditions for which you have been treated in the past 10 years:

Have You Ever:	**Yes**	**No**	**Describe:**
Been knocked unconscious	○	○	_____
Used a cane, crutch or other support	○	○	_____
Been treated for a spine or nerve disorder	○	○	_____
Had a fractured bone	○	○	_____
Been Hospitalized other than surgery	○	○	_____

Family Health History

Many health problems are the result of hereditary spinal weakness; information about your family members will give us a better picture of your health

Have any family members had spinal disorders? Yes ○ No ○ Describe: _____

Name	Relation	Past and Present Health Problems

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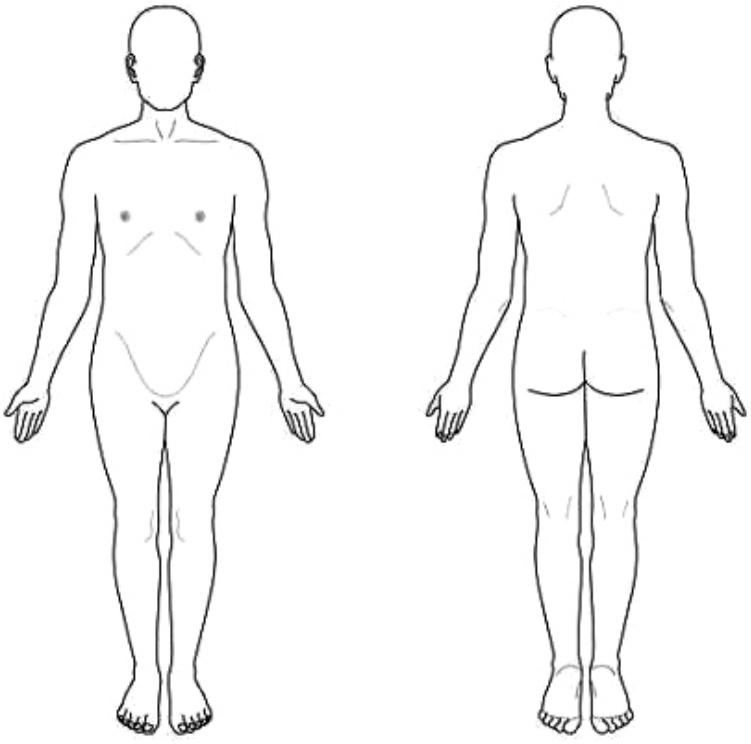
Date Of Last:	Less than 6 months	6-18 months	Over 18 months	Never
Last Immunization	○	○	○	○
Physical Exam	○	○	○	○
Blood Test	○	○	○	○
Chest X-Ray	○	○	○	○
Spinal X-Ray	○	○	○	○
Habits	**Heavy**	**Moderate**	**Light**	**None**
Alcohol	○	○	○	○
Tobacco	○	○	○	○
Drugs	○	○	○	○
Exercise	○	○	○	○
Sleep	○	○	○	○

Please Circle the of your current pain/problem (circle all that apply):

- Electric
- Sharp
- Stabbing
- Knife-Like
- Piercing
- Shooting
- Achy
- Griping
- Heavy
- Cramp-Like
- Burning
- Deep
- Superficial
- Stiffness
- Spasm
- Tearing
- Other _____

- ON THE BODIES, DRAW CIRCLES AROUND AREAS WHERE YOU HAVE PAIN.



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The center of my pain is easily identified? Yes ○ No ○

The boundaries of my pain are easily identified? Yes ○ No ○

I feel more pain in my leg(s) than in my lower back? Yes ○ No ○

I feel the Pain more in my arm(s) and or hand(s) than in my neck? Yes ○ No ○

How Did Your Symptoms Start: _____?

Average Pain Intensity Last 24hours (circle): 1 2 3 4 5 6 7 8 9 10

Average Pain Intensity Last Week (circle): 1 2 3 4 5 6 7 8 9 10

Average Pain Intensity At Its Best (circle): 1 2 3 4 5 6 7 8 9 10

How often do you experience your symptoms? Constantly ○ Frequently ○ Occasionally ○ Intermittently ○

How much have your symptoms interfered with your usual daily activities? (Including both work outside the home and housework)

Not At All ○ A Little Bit ○ Moderately ○ Quite A Bit ○ Extremely ○

How is Condition changing since care began at this facility?

N/A Initial Visit ○ Much Worse ○ Worse ○ A Little Worse ○ No Change ○ A Little Better ○ Better ○ Much Better ○

In general, would you say your overall health right now is? Excellent ○ Very Good ○ Good ○ Fair ○ Poor ○

Has your pain spread down your leg(s) at some time in the last 2 weeks? Yes ○ No ○

Have you had pain in the shoulder or neck at some time in the last 2 weeks? Yes ○ No ○

In the last 2 weeks, I have only walked short distances because of my pain? Yes ○ No ○

In the last 2 weeks, I have dressed more slowly than usual because of my pain? Yes ○ No ○

It's really not safe for a person with a condition like mine to be physically active? Yes ○ No ○

Worrying thoughts have been going through my mind a lot of the time in the last 2 week? Yes ○ No ○

I feel that my pain is terrible and that it is never going to get any better? Yes ○ No ○

In general in the last 2 weeks, I have not enjoyed all things I used to enjoy? Yes ○ No ○

Overall, how bothersome has your pain been in the last 2 weeks? Not at all ○ Slightly ○ Moderately ○ Very Much ○ Extremely ○

I authorize Dr. Danielle Cossin, D.C. and Health And Abundance Inc. to give me reasonable and proper Chiropractic Care by today's standards.

Patient Signature_____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received the Notice of Privacy Practices (NOPP), which outlines the information practices of this chiropractic practice in accordance with the Health Insurance Portability and Accountability Act (HIPAA). The NOPP provides a comprehensive overview of how my health information may be used and disclosed. I understand that I possess the following rights and privileges:

1. The Right to Review: I have the right to review the NOPP before consenting to its terms.
2. The Right to Object: I have the right to object to the use of my health information for directory purposes.
3. The Right to Request Restrictions: I have the right to request restrictions on how my health information is used or disclosed for treatment, payment, or healthcare operations.

Patient's Signature: _____ Date: _____

EXPLANATION OF NON-COVERED CHIROPRACTIC SERVICES

The following section pertains specifically to Medicare and Medicare Plans. Patients with private insurance coverage must refer to their plan provisions for information regarding covered services.

DEDUCTIBLE:
Medicare requires you to pay a yearly deductible towards your medical expenses. If you have already been treated by other doctors this year, you may apply those bills to your deductible.

WHAT MEDICARE WILL PAY FOR:
After you have met your deductible, Medicare will reimburse you for 80% of your "allowable treatment charges". The only "allowance treatment charge" for chiropractic is "manual manipulation of the spine".

X-RAYS:
Medicare requires you to have current x-rays. "Current" means x-rays that are less than one year old. Medicare WILL NOT REIMBURSE you for x-rays, and payments must be made by you.

EXAMINATIONS:
In order to determine the extent of your condition, as well as the type of treatment you need, the doctor will examine you prior to the initiation of treatment. Medicare WILL NOT REIMBURSE for this examination and payment must be made by you.

PHYSICAL THERAPY, SUPPLEMENTS & SUPPORTS: During the course of your treatment in this office, the doctor may determine that certain physical therapy, vitamin supplements and/or orthopedic supports are necessary to assist in the treatment of your condition. Medicare WILL NOT REIMBURSE you for any of these services and payments must be made by you.

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The following section pertains specifically to Medicare and Medicare Plans. Patients with private insurance coverage may skip this form.

ADVANCED NOTICE OF NON-COVERED SERVICES

(Required Language)

PHYSICIAN NOTICE

In accordance with the Medicare Act, Section 1842 (i), this letter is to advise you that Medicare will only pay for services that it determines to be "reasonable and necessary" under Section 1842 (a)(i) of the Medicare Act. If Medicare determines that a particular service, although it would other otherwise be covered, is not "reasonable and necessary", under Medicare program standards, Medicare will deny payment for that service. I believe that in your case, Medicare is likely to deny payment for:

Treatment : Chiropractic Examinations, X-rays, Any Modalities including but not limited to E-stim, Traction, Ultrasound, Cryotherapy, Vaso compression Therapy, Laser Therapy, Diathermy, Ultrathermy, Massage and Maintenance Adjustments.

The reason(s) for this denial is: Medicare considers further treatment "not medically necessary".

BENEFICIARY AGREEMENT

I understand that although the chiropractic services listed above may be required for treatment of my condition, these charges are NOT covered by Medicare and I will be personally responsible for payment.

I have been notified by my physician that he/she believes that, in my case, Medicare is likely to deny payment for the services identified above for the reasons stated. If Medicare denies payment, I agree to be personally and fully responsible for payment.

Patient's Signature_____ Date ___/___/_____

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REQUEST FOR RECORDS

Date: _____ To: _____
(Doctor/Hospital/Attorney)

Address: _____

City:_____ State: _____ Zip: _____

Name of Patient _____

Date of Birth _____/_____/_____

I hereby authorize the release of my Records, X-Rays, MRI reports, any other Diagnostic Procedures or copies of such and request that they be transferred to:

Dr. Danielle M. Cossin
Health and Abundance Inc.
787 E. Prima vista Blvd
Port St. Lucie Fl, 34952
Tel: (772) 878-3773
Fax: (772) 878-5783

Patient Signature: _____

Pursuant to Florida law and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule, the record may be given only to the person designated, and it may be used only for the purpose listed on this form. Charges are in compliance with Florida law. I understand that once my information is disclosed to the recipient above, it may be re-disclosed to individuals not subject to HIPAA and may no longer be protected by HIPAA. I understand that signing this authorization is voluntary and will not affect my receipt of treatment. I understand that I may revoke this authorization at any time, in writing, to the address listed above provided that the information has not yet been released. This authorization expires in six (12) months unless another date is written here _____/___/_____

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Cancellation/ No Show Policy for Doctor Appointment

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.
If an appointment is not cancelled at least **24** hours in advance you will be charged a twenty-five-dollar **($25)** fee; this will not be covered by your insurance company. We understand that delays can happen, however we must try to keep the other patients and doctors on time. If a patient is **15** minutes past their scheduled time, we will have to reschedule the appointment.

Account Balances

We will require that patients with self-pay balances do pay their account balances to zero prior to receiving further services by our practice. Patients who have questions about their bills or who would like to discuss a payment plan option may call and ask to speak to a business office representative with whom they can review their account and concerns. Patients with balances over **$100** must make payment arrangements prior to future appointments being made.

Walk-In Patient Policy

Patients are encouraged to make appointments for chiropractic services. Having an appointment enables us to have your medical chart available at the time of your visit, allows the clinician to review your information prior to your visit, and gives the staff an opportunity to properly schedule your visit.

Walk-in patients will be seen, but they may experience longer waits since patients with appointments will be seen first.

Patient Form Completion Fees

• Permanent Disability Forms: **$ 50.00** • Short Term Disability Forms: **$ 25.00** (includes completion of FMLA, as well as any required records & follow up forms to this incident) • FMLA Paperwork: **$ 25.00**
• Handicap Parking Permit: **$ 10.00**• Other Forms: Call Office
*** Patient must have a recent office visit for forms to be completed. Please allow up to one week for pickup of completed forms.*

Medical Records Forms & Information

• Medical records will be sent to other physicians at no cost to patient after obtaining a valid medical record release from the patient.
• Patients requesting copies of medical records for personal use will be provided with one free copy of their records with any additional copies being charged a copying fee of **$1.00** per page for the first **25** pages, then **$0.25** for each additional page. **Payment is required prior to records being released** • Please allow up to 48 hours for copies of records.

_____	_____	___/___/_____
Print Name Patient	Signature Patient/Guardian	Date