Adult Self Pay Patient Intake

You are completing the following intake forms designed for wellness adult patients.
Please take a moment to fill out our Online intake form before your visit.
All information is kept completely confidential.

First Name

Last Name

Preferred Name (if different)

Prefix / Title Ms.

Email Address

Mobile Phone Home Phone

**Your mobile number can be used to look up your Account and receive text message appointment reminders

Street Address
Suite Number
City
State
Postal / Zip

Date of Birth
Gender (Refers to current gender which may be different than what is indicated on your insurance policies).
Sex (Field may be used for submitting claims to insurance provider. Please ensure the sex you provide here matches what your insurance provider has on file).

Emergency Contact Emergency Contact Phone
Emergency Contact Relationship

Family Doctor Family Doctor Phone (if known)
Family Doctor Email (if known)

Occupation
How did you hear about us? Name of referring person?

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT AND SHARING OF INFORMATION

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.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

Protected health information includes demographic and medical information that concerns the past, present, or future physical or mental health of an individual. Demographic information could include your name, address, telephone number, social security number and any other means of identifying you as a specific person. Protected health information contains specific information that identifies a person or can be used to identify a person.

Protected health information is health information created or received by a health care provider, health plan, employer, or health care clearinghouse. The Department of Health can act as each of the above business types. This medical information is used by the Department of Health in many ways while performing normal business activities.

Your protected health information may be used or disclosed by the Department of Health for purposes of treatment, payment, and health care operations. Health care professionals use medical information in the clinics or hospital to take care of you. Your protected health information may be shared, with or without your consent, with another health care provider for purposes of your treatment. The Department of Health may use or disclose your health information for case management and services. The Department of Health clinic or hospital may send the medical information to insurance companies, Medicaid, or community agencies to pay for the services provided you.

Your information may be used by certain department personnel to improve the department's health care operations. The department also may send you appointment reminders, information about treatment options or other health-related benefits and services.

Some protected health information can be disclosed without your written authorization as allowed by law. Those circumstances include:

- Reporting abuse of children, adults, or disabled persons.
- Investigations related to a missing child.
- Internal investigations and audits by the department's divisions, bureaus, and offices.
- Investigations and audits by the state's Inspector General and Auditor General, and the legislature's Office of Program Policy Analysis and Government Accountability.
- Public health purposes, including vital statistics, disease reporting, public health surveillance, investigations, interventions, and regulation of health professionals.
- District medical examiner investigations;

- Research approved by the department.
- Court orders, warrants, or subpoenas;
- Law enforcement purposes, administrative investigations, and judicial and administrative proceedings.

Other uses and disclosures of your protected health information by the department will require your written authorization. These uses and disclosures may be for marketing and for research purposes, certain uses and disclosure of psychotherapist notes, and the sale of protected health information resulting in remuneration to the Department of Health.
This authorization will have an expiration date that can be revoked by you in writing.

INDIVIDUAL RIGHTS

You have the right to request the Department of Health to restrict the use and disclosure of your protected health information to carry out treatment, payment, or health care operations. You may also limit disclosures to individuals involved with your care. The department is not required to agree to any restriction.

You have the right to be assured that your information will be kept confidential. The Department of Health will make contact with you in the manner and at the address or phone number you select. You may be asked to put your request in writing. If you are responsible to pay for services, you may provide an address other than your residence where you can receive mail and where we may contact you.

You have the right to inspect and receive a copy of your protected health information that is maintained by the Department of Health within 30 days of the Department's receipt of your request to obtain a copy of your protected health information. You must complete the Department's Authorization to Disclosure Confidential Information form and submit the request to the county health department or Children's Medical Services office. If there are delays in getting you the information, you will be told the reason for the delay and the anticipated date when you will receive your information.

Your inspection of information will be supervised at an appointed time and place. You may be denied access as specified by law.

If you choose to receive a copy of your protected health information, you have the right to receive the information in the form or format you request. If the Department cannot produce it in that form or format, it will give you the information in a readable hard copy form or another form or format that you and the Department agree to.

The Department cannot give you access to psychotherapy notes or certain information being used in a legal proceeding. Records are maintained for specified periods of time in accordance with the law. If your request covers information beyond that time the Department is required to keep the record, the information may no longer be available.

If access is denied, you have the right to request a review by a licensed health care professional who was not involved in the decision to deny access. This licensed health care professional will be designated by the department.

You have the right to correct your protected health information. Your request to correct your protected health information must be in writing and provide a reason to support your requested correction. The Department of Health may deny your request, in whole or part, if it finds the protected health information:

- Was not created by the department.
- Is not protected health information.
- Is by law not available for your inspection.
- Is accurate and complete.

If your correction is accepted, the department will make the correction and tell you and others who need to know about the correction. If your request is denied, you may send a letter detailing the reason you disagree with the decision. The department may respond to your letter in writing. You also may file a complaint, as described below in the section titled Complaints.

You have the right to receive a summary of certain disclosures the Department of Health may have made of your protected health information. This summary does not include:

- Disclosures made to you.
- Disclosures to individuals involved with your care.
- Disclosures authorized by you.
- Disclosures made to carry out treatment, payment, and health care operations.
- Disclosures for public health.
- Disclosures to health professional regulatory purposes.
- Disclosures to report abuse of children, adults, or disabled.
- Disclosures prior to April 14, 2003.

This summary does include disclosures made for:

- Purposes of research, other than those you authorized in writing.
- Responses to court orders, subpoenas, or warrants.

You may request a summary for not more than a 6 year period from the date of your request.

If you received this Notice of Privacy Practices electronically, you have the right to a paper copy upon request.

The Department of Health may mail or call you with health care appointment reminders.
You may request a summary for not more than a 6 year period from the date of your request.
If you received this Notice of Privacy Practices electronically, you have the right to a paper copy upon request.

DEPARTMENT OF HEALTH DUTIES

DH8006-SSG-09/2017

The Department of Health is required by law to maintain the privacy of your protected health information. This Notice of Privacy Practices tells you how your protected health information may be used and how the department keeps your information private and confidential. This notice explains the legal duties and practices relating to your protected health information. The department has the responsibility to notify you following a breach of your unsecured protected health information.

As part of the department's legal duties this Notice of Privacy Practices must be given to you. The department is required to follow the terms of the Notice of Privacy Practices currently in effect.

The Department of Health may change the terms of its notice. The change, if made, will be effective for all protected health information that it maintains. New or revised notices of privacy practices will be posted on the Department of Health website at http://www.floridahealth.gov/about-the-department-of-health/about-us/patient-rights-and-safety/hipaa/index.html and will be available by email and at all Department of Health buildings. Also available are additional documents that further explain your rights to inspect and copy and amend your protected health information.

COMPLAINTS

If you believe your privacy health rights have been violated, you may file a complaint with the: Department of Health's Inspector General at 4052 Bald Cypress Way, BIN A03/ Tallahassee, FL 32399-1704/ telephone 850-245-4141 and with the Secretary of the U.S. Department of Health and Human Services at 200 Independence Avenue, S.W./ Washington, D.C. 20201/ telephone 202-619-0257 or toll free 877-696-6775.

The complaint must be in writing, describe the acts or omissions that you believe violate your privacy rights, and be filed within 180 days of when you knew or should have known that the act or omission occurred. The Department of Health will not retaliate against you for filing a complaint.

FOR FURTHER INFORMATION

Requests for further information about the matters covered by this notice may be directed to the person who gave you the notice, to the director or administrator of the Department of Health facility where you received the notice, or to the Department of Health's Inspector General at 4052 Bald Cypress Way, BIN A03/ Tallahassee, FL 32399-1704/ telephone 850-245-4141.

EFFECTIVE DATE

This Notice of Privacy Practices is effective beginning July 1, 2013, and shall be in effect until a new Notice of Privacy Practices is approved and posted.

REFERENCES

"Standards for the Privacy of Individually Identifiable Health Information; Final Rule." 45 CFR Parts 160 through 164. Federal Register 65, no. 250 (December 28, 2000).

"Standards for the Privacy of Individually Identifiable Health Information; Final Rule" 45 CFR Part 160 through 164. Federal Register, Volume 67 (August 14, 2002).

DH8006-SSG-09/2017

HHS, Modifications to the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules under the Health Information Technology for Economic and Clinical Health Act and the Genetic Information and Nondiscrimination Act; Other Modifications to the HIPAA Rules, 78 Fed. Reg. 5566 (Jan. 25, 2013).

I, the undersigned, do hereby acknowledge that I have received a copy of this office's Notice of Privacy Practices Pursuant to HIPAA and have been advised that a full copy of this office's HIPAA Compliance Manual is available upon request. I authorize the clinic and its associated health professionals to collect my personal and medical information as documented above. In addition, I authorize the clinic and its associated health professionals to communicate with my family doctor and/ or referring doctor as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission. I agree to the above.

CONSENT TO TREAT ACKNOWLEDGEMENT

I hereby request and consent to the performance of chiropractic adjustments and other associated procedures on myself or the patient named below for who I am legally responsible.

I understand, as with any health care procedures, that there are certain complications, which may arise during chiropractic treatments. Those complications include but are not limited to: headaches, dizziness, nausea, muscle spasms, disc injuries, dislocations, and fractures.

If there is any dispute about my care, I agree to a resolution by binding arbitration according to the American Arbitration Association guidelines. I have read (or have had read to me) the above explanation of the chiropractic treatments. I state that I have been informed and weighed the risks involved in chiropractic treatment at this health care office. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

I have read (or have had read to me) the above explanation of the chiropractic treatments. I state that I have been informed and weighed the risks involved in chiropractic treatment at this health care office. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

MEDICAL HISTORY QUESTIONNAIRE

What is the primary reason for seeking care at our office?

Rate your primary pain or discomfort on a scale from 0 to 10 0

0 - Being in no pain or discomfort
1, 2 - Mild pain or discomfort
3, 4, 5 - Moderate pain or discomfort
6, 7, 8 - Severe pain or discomfort
9, 10 - Highest level of pain or discomfort experienced

Pain or discomfort description (check all that apply)

Aching ☐
Burning ☐
Dull ☐
Sharp ☐
Stabbing ☐
Throbbing ☐
Weakness ☐
Numbness/tingling ☐
Tension ☐
Stiffness ☐
Radiating Pain ☐

Secondary or other areas of complaint (please provide a brief description, if applicable)

Range / Scale 0

Were you injured at work or in a car accident? (If so, please describe the incident)

How long have you had pain?

What aggravates your complaints?

What relieves your complaints?

HEALTH HISTORY QUESTIONNAIRE - (please check all that may apply)

☐ General Symptoms
☐ History of Migraines
☐ Night Sweats
☐ Nervousness
☐ Allergies
☐ Dizziness
☐ Blurred Vision
☐ Radiating pain

☐ Loss of consciousness
☐ Fever
☐ Night Pain
☐ Convulsions
☐ Loss of Bowel or Bladder Control
☐ Fainting
☐ Nausea
☐ Eyes/Ears/Nose/Throat Symptoms

History of Headaches ☐
Excess Sweating ☐
Generalized Pain ☐
Loss of Sleep ☐
Neurological Symptoms ☐
Problem Speaking ☐
Numbness or tingling ☐
Failing Vision ☐

HEALTH HISTORY QUESTIONNAIRE - (please check all that may apply) (Continued)

Vision Problems ☐
Eye Pain ☐
Ringing / Buzzing in ears ☐
Hearing Loss ☐
Other Hearing problems not otherwise listed Respiratory Symptoms ☐
Asthma ☐
Chronic Cough ☐
Difficulty Breathing ☐
Shortness of breath ☐
Bronchitis ☐
Emphysema ☐
Cardiovascular Symptoms ☐
Bleeding Disorder ☐
High Blood Pressure ☐
Low Blood Pressure ☐
Previous Stroke ☐
Cerebral Vascular Aneurysm ☐
Hardening of Arteries ☐
Swelling of Ankles ☐
Poor Circulation ☐
Angina ☐
Chronic Congestive Heart Failure ☐
Previous Heart Attacks ☐
Phlebitis / Varicose veins ☐
Pacemaker or similar device ☐
Other Heart / Blood Disease not discussed Gastrointestinal Symptoms ☐
Jaundice ☐
Irregular or absent bowel movement ☐
Ulcer ☐
Diabetes ☐
Indigestion ☐
Genitourinary Symptoms ☐
Trouble Urinating ☐
Kidney Infection ☐
Prostate Trouble ☐
Genitourinary Symptoms (Female only) ☐
Hot Flashes ☐
Irregular / Absent Cycle ☐
Cramping / Backache ☐

Are you currently pregnant ?

If so, how many weeks into your pregnancy are you, and what is your estimated due date?

Number of Pregnancies 0

Number of Children 0

Have you ever had any fractures or surgeries ? If yes, please provide details.

Have you had any X-rays, CT scans, ultrasounds or MRIs in the past 5 years?

If so, please list what type of imaging and which clinic/hospital and the area examined:

Have you ever been diagnosed with cancer ?
If yes, please provide details

Please list your current Medications, Herbs, Supplements.

FAMILY MEDICAL HISTORY

(Please check if any immediate family members suffer from the following)

Headaches or Migraines ☐
Diabetes ☐
Fainting or Dizziness ☐
Circulatory Problems ☐
Neurological disorders ☐
Inflammatory Bowel Disease ☐
Respiratory disorders ☐
Osteoarthritis ☐
Fibromyalgia ☐
Multiple Sclerosis ☐

High or Low blood pressure ☐
Heart Disease ☐
Stroke ☐
Cancer ☐
Kidney disease ☐
Asthma ☐
Rheumatoid arthritis ☐
Osteoporosis ☐
Epilepsy ☐

Please add any additional information that you feel is pertinent:

EMAIL COMMUNICATION

Transactional Emails

You can opt to receive emails to keep you informed of new bookings, changes to your bookings, and reminders for upcoming appointments.

☐ I would like email notifications of new, canceled, and rescheduled appointments

☐ Text Message (SMS) 2 hours before appointment

☐ Email 24 hours before appointment

News and Special Promotions

☑ Yes, I would like to receive news and special promotions by email

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ACCURACY OF INFORMATION PROVIDED

I certify that the above medical information is correct to my knowledge. Required

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CANCELATION POLICY

Your appointment time is reserved just for you. A late cancellation or missed visit leaves a hole in the therapists' day that could have been filled by another patient. As such, we require 1 hour notice for any cancellations or changes to your appointment. Patients who provide less than 1 hour notice, or miss their appointment, will be charged a cancellation fee.

I am aware of the Cancellation Policy.

PHOTO CONSENT

We are PROUD of our patients and the progress they make while under our care! There's nothing we enjoy more than CELEBRATING our patients' successes along with them. And when something good is happening in our lives, we feel inclined to share it with others, right? If the moment arises, we would love to share your photo, story, or progress on our Social Media page(s) or website in the interest of showing others that "real people" visit our office and are smiling while they're here – and most importantly, getting results! Please check the box that applies to you:

☐ **Sure! You can use my picture on Premier Chiropractic & Wellness Website and its Social Media (i.e. Facebook, Instagram, etc.) pages, as long as you think I look good in it!**

☐ **No thanks! I'll pass for now.**

Covid-19 Visitor Screening Tool

At Premier Chiropractic & Wellness, we strive to provide the safest environment for our patients and staff. We have implemented a rigorous sanitary protocol and have installed a UV light system in the air filtration system in order to help prevent the propagation of germs, bacteria and viruses. This being said, as the recent pandemic has showed, nothing is unfortunately a 100% effective. We therefore ask our patients to help us keep our environment safe for everyone.

Please read below carefully. Thank you.

I, , undersigned patient of Premier Chiropractic & Wellness, acknowledge that I do not have any of the following at the time of my visit(s) and will advise Premier Chiropractic & Wellness should any changes in my health condition occur and cancel my appointment(s) should this change until my health situation has been cleared by a medical professional:
I have no Fever greater than 100F,

- I have no Cough/Shortness of Breath,
- I have do not have Pneumonia/flu,
- I have not traveled out of the country in the last 14 days to China, Japan, Italy, Iran or S. Korea,
- I have not had contact with anyone who has lab confirmed Coronavirus within 14 days of symptom onset

(Thank you for your understanding and cooperation in helping us keep our residents, staff and community safe)

I agree that if I have any of the above symptoms or exposures, I will not visit Premier Chiropractic & Wellness and will advise Premier Chiropractic & Wellness of the changes in my health status.

ALL DONE!

THANK YOU FOR YOUR TIME.

PLEASE RETURN iPAD TO THE FRONT DESK FOR OUR DOCTOR TO REVIEW :).
