KEYSTONE CHIROPRACTIC

## Confidential Patient Information

Name: _____ Today's date: _____

Nickname: _____ Date of birth: _____ Sex: □ Male □ Female

Occupation: _____
Please circle: □ Single □ Married □ Divorced □ Widowed

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Mobile phone: _____

Mobile phone carrier - used for appointment text reminders: □ Alltel □ AT&T

□ Boost Mobile □ Metro PCS □ Nextel □ Sprint PCS □ T-Mobile □ US Cellular

□ Verizon □ Virgin Mobile □ Other:_____

□ I prefer to NOT receive text or email reminders but I understand that I may be subject to a missed appointment fee of $25 for each cancelled or no-show massage appointment (within 24 hours of my appointment time) and after the 2nd occurrence for chiropractic appointments.

Initial if checked: _____

E-mail address: _____

Social Security #: _____ (only needed if we are billing an insurance company)

How did you hear about our office? □ Friend/Family □ Internet Search □ Facebook

□ Youtube □ Attorney Referral: _____ □ Doctor Referral: _____

Other: _____

Signature: _____

# Keystone Chiropractic - Medical History Information

**Medical Care Information**

Do You Have a Family Doctor? ☐ No ☐ Yes, Name of Doctor:

Date of last Visit: / / Date of last exam: / /

Have you been to a Chiropractor before? ☐ No ☐ Yes, Name of Chiropractor:

Reason: City: State:

Date of last Visit: / / Date of last exam: / /

Have you had any surgeries? ☐ Yes (please list all) ☐ No If yes, Last Surgery Date:

Reason for most recent Surgery:

Please list previous surgeries and dates:

_____

Please use back of page if needed

**Present illness /Conditions (Personal History):**

| | | | | | |
|---|---|---|---|---|---|
| ☐ AIDS | ☐ Cancer | ☐ Heart Problem | ☐ Multiple Sclerosis | ☐ Spinal Disc Disease | |
| ☐ Allergies | ☐ Cirrhosis/hepatitis | ☐ High blood pressure | ☐ Pacemaker | ☐ Thyroid trouble | ☐ Epilepsy |
| ☐ Anemia | ☐ Diabetes | ☐ HIV/ARC | ☐ Prostate trouble | ☐ Tuberculosis | ☐ Insomnia |
| ☐ Arthritis | ☐ Dislocated joints | ☐ Kidney trouble | ☐ Rheumatic fever | ☐ Ulcer | ☐ Ear infections |
| ☐ Asthma | ☐ Diverticulitis | ☐ Low Blood Pressure | ☐ Scoliosis | ☐ Polio | ☐ Heartburn |
| ☐ Bone fracture | ☐ Hay Fever | ☐ Mental/ Emotional Difficulty | ☐ Sinus trouble | ☐ STD'S | ☐ Irritable Bowel |
| ☐ Headaches | ☐ Dizziness | ☐ Constipation/Diarrhea | ☐ Menstrual cramps | ☐ Bed wetting | ☐ Hemorrhoids |

Other:

**Family History of illness (Parents, Grandparents):**

| | | | | | |
|---|---|---|---|---|---|
| ☐ AIDS | ☐ Cancer | ☐ Heart Problem | ☐ Multiple Sclerosis | ☐ Spinal Disc Disease | |
| ☐ Allergies | ☐ Cirrhosis/hepatitis | ☐ High blood pressure | ☐ Pacemaker | ☐ Thyroid trouble | ☐ Epilepsy |
| ☐ Anemia | ☐ Diabetes | ☐ HIV/ARC | ☐ Prostate trouble | ☐ Tuberculosis | ☐ Insomnia |
| ☐ Arthritis | ☐ Dislocated joints | ☐ Kidney trouble | ☐ Rheumatic fever | ☐ Ulcer | ☐ Ear infections |
| ☐ Asthma | ☐ Diverticulitis | ☐ Low Blood Pressure | ☐ Scoliosis | ☐ Polio | ☐ Heartburn |
| ☐ Bone fracture | ☐ Hay Fever | ☐ Mental/ Emotional Difficulty | ☐ Sinus trouble | ☐ STD'S | ☐ Irritable Bowel |
| ☐ Headaches | ☐ Dizziness | ☐ Constipation/Diarrhea | ☐ Menstrual cramps | ☐ Bed wetting | ☐ Hemorrhoids |

Other:

**Type of Cancer:** ☐ Breast ☐ Lung ☐ Prostate ☐ Other:

Misc. Other Health History:

Are you currently pregnant? ☐ YES ☐ NO (Dr. Neff will NOT take x-rays if you are pregnant)

Are you a smoker? ☐ Yes ☐ No ☐ Former How much? Alcoholic Drinks per day ____ per week _____

How many hours per week of exercise do you get? What type?

Signature: _____ Date: _____

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

KEYSTONE CHIROPRACTIC

Please update your current medications (prescribed and over the counter) and medication allergies. The office has to collect this information from every patient for a mandatory government update. Thank you, for your time and cooperation.

**Name:**_____ **Date:**_____

**Current Medications and Supplements:**

| Name or Reason for Taking: | Frequency: | Date Started: |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Current Medication Allergies:**

| Allergy: | Reaction: |
|---|---|
| | |
| | |
| | |
| | |
| | |

**Would you like the doctor to recommend any supplements for you specifically? □ Yes □ No □ ?**

KEYSTONE CHIROPRACTIC

# Treatment Authorization

Chiropractic healthcare is primarily concerned with the relationship between structure (primarily the spine) and function (primarily of the nervous system). Dr. Neff evaluates the patient using standard examination and testing procedures (orthopedic and neurologic evaluation, labs, x-rays) along with specialized chiropractic evaluation. The chiropractic evaluation focuses on structural and/or functional abnormalities which damage or irritate nearby nerves, joints and/or tissues. The primary goal of chiropractic treatment is to restore normal joint motion, decreasing the body's inflammatory response, resulting in improved function and/or decreased symptomology. This is accomplished by performing a procedure unique to the chiropractic profession called an "adjustment". A chiropractic adjustment involves the application of a quick, precise force, by hand, directed over a very short distance to a specific vertebra or bone. In addition to adjustments, other treatments used by Dr. Neff include physiotherapy modalities (e.g. ultrasound, ice, electric stimulation, soft-tissue manipulation), nutritional and supplemental recommendations and rehabilitative procedures.

Chiropractic treatments are one of the safest interventions available to the public as evidenced by malpractice statistics. While there are risks involved with treatment, these are seldom great enough to contraindicate care. Nonetheless, they must be considered when making the decision about whether or not to receive care. Local discomfort, headache, tiredness and radiating discomfort are all possible side effects of an adjustment, but most resolve in 24 to 48 hours. Rare complications include rib fracture, burns (with certain physiotherapies), disc herniation, Cauda Equina Syndrome (1 case per 100 million adjustments) and compromise of the vertebrobasilar artery (i.e. stroke) (1 case per 1-5 million adjustments).

**I understand that x-rays should NOT be taken on pregnant women. I have advised Dr. Neff if I am pregnant or if I may be pregnant.**

I am informed and understand that there are some very slight risks with chiropractic adjustments, including, but not limited to, muscle sprain, ligament strain, disc injury and stroke. I expect Dr. Neff to exercise judgment, based upon the known facts, and act in my best interest.

I have discussed with Dr. Neff the nature and purpose of chiropractic adjustments including any questions that I have.

I have been informed that it is not uncommon for patients to become tired or to be sore after an adjustment. I am aware that I should apply ice to the area and rest if I do experience discomfort. If I am concerned about any symptom, I understand that I may call Dr. Neff. If I am unable to contact Dr. Neff, I am aware that I can go to the emergency room.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including physical therapy and x-rays, by Dr. Neff or his authorized personnel.

Patient Printed Name_____ Date _____

Patient Signature_____

KEYSTONE CHIROPRACTIC

# Notice of Initiation of Treatment

**Insured Patient**_____

**Insurance Co.**_____

**Policy/Claim Number**_____

Pursuant to Florida Statute 627.736(5)(c)1., you are hereby notified that treatment on your insured, _____ , was initiated on _____ for injuries sustained in an automobile accident on _____.

This patient is now under my care for those injuries. We have enclosed with this notice a Standard Disclosure and Acknowledgement Form, Initial Exam notes and CMS 1500 relating to this first date of service.

This notice has been signed by Dr. John Neff along with the patient as an acknowledgement of services rendered and for future care to be rendered related to this case.

Insured Person (patient receiving treatment) or Guardian of Insured:

_____ _____ _____
(Please Print) (Signature) (Date)

Licensed Medical Professional Rendering Treatment:

Dr. John Neff _____ _____
(Please Print) (Signature) (Date)

KEYSTONE CHIROPRACTIC

## ASSIGNMENT OF BENEFITS

I, _____, assign all of the rights and benefits of any applicable personal injury protection, medical payments, or other coverage provided by any insurance policy issued pursuant to Florida Statutes §627.730 - §627.7405, to Dr. John Neff, for services and supplies provided to me related to my chiropractic treatment.

I agree to pay any co-payment or deductible not covered by the applicable personal injury protection, medical payments, or other insurance coverage.
This assignment includes, but is not limited to:
all rights to collect benefits directly from any insurance carrier obligated to provide benefits for services and supplies I have received;
all rights to take legal or other action against any insurance carrier obligated to provide benefits if for any reason the insurance carrier fails to pay any benefits due; and
all rights to recover attorney fees, legal assistant fees, costs, and any interest on fees and costs, for any legal or other action taken by Dr. John Neff as my assignee.

This is an assignment of rights only, and is not a delegation of any of my duties under the subject insurance policy. I understand that I remain fully responsible for payment for all expenses incurred for medical and diagnostic treatment, regardless of payment, partial payment or denial of payment by my insurance company.

I agree that Dr. John Neff may retain any attorney he chooses to bring legal action against any insurance carrier obligated to provide benefits for services and supplies I have received, and that the attorney chosen may be different than any attorney I may have handling any claim I may have for personal injuries.

I understand that I can request a copy of this assignment to retain for my records; I have read this assignment and I am satisfied that I fully understand the purpose and implications of executing this assignment and do so freely and voluntarily.

_____ _____
Patient Signature Date

The undersigned, as authorized representative of Dr. John Neff accepts the assignment of benefits as set forth above.

_____ _____
John Neff D.C. Date

Mailing address:
Keystone Chiropractic
244 E. Highland Ave.
Clermont, FL 34711

KEYSTONE CHIROPRACTIC

# Financial Policy

The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services.

- By Law, all Copays are due and payable on the same day that services are rendered. Prompt payment allows us to control costs. Outstanding accounts cost both of us time and money therefore, all patients will be required to establish financial arrangements for payment of their account.
- All new patients will be required to remit full payment to establish an account.
- Your insurance coverage is an agreement between you and your insurer. ***As a courtesy, our practice will provide an estimate of your insurance benefits. It is your responsibility to remit payment for charges not covered by your claim and insure that your insurance payments are made to our office.*** If a problem occurs with your claim, you will be required to establish a separate written arrangement with our practice until your insurance claim is resolved.
- In some cases, your insurance company may send a check directly to you as payment for service rendered. ***It is imperative that this check and the Explanation of Benefits be brought to our office as payment for services rendered. Without the Explanation of Benefits, you are liable for the full amount of services rendered.***
- You will receive a statement for services if you have an outstanding balance. This will be due and payable within 30 days. If your payment is late, or if you have not previously made financial arrangements, we will then mail one reminder notice indicating there is a problem with your account. If you are experiencing a set of circumstances out of your control, please call our practice and we will be happy to make special arrangements.
- Please notify us immediately if a mistake appears on your statement.
- All patients refusing to remit payment after 61 days of notice without pending insurance or financial arrangements will force us to send your account to our Collection Agent. You will be responsible for your full account balance and any fees associated with the collection of your account.
- All patients will be required to sign a written legal agreement with our practice to alleviate any discrepancy.

Our practice firmly believes that a good doctor/patient relationship is based upon understanding and open communications. I have instructed our staff to make every effort available to you to clarify any misunderstanding you have concerning your balance. We hope to avoid any misunderstanding or over payment for professional services. If you have any questions concerning our policy or need assistance, please contact us immediately.

Dr. John Neff

_____ _____

Signature of Patient/Guardian/Legal Representative Date

KEYSTONE CHIROPRACTIC

**Acknowledgement of Receipt of Notice of Privacy Practices**

I acknowledge that I was provided a copy of the **Notice of Privacy Practices** (red folder in the lobby) and that I have read them or declined the opportunity to read them, and that I understand the **Notice of Privacy Practices.** I understand that this form will be placed in my patient chart and maintained for six years.

Patient Name (please print) Date

Parent, Guardian or Patient's Legal Representative (please print)

Signature

KEYSTONE CHIROPRACTIC

# HIPAA Authorization Form

For office use:

To: _____ Date: _____

_____

_____

Dear Sir/Madam:

I hereby specifically authorize use or disclosure of protected health information about me to be released to J T Neff, LLC, DBA, Keystone Chiropractic, 244 E. Highland Ave., Clermont FL, 34711.

Please be advised that there is no limitation with respect to this Authorization, and as such J T Neff, LLC, DBA, Keystone Chiropractic, should be provided any and all dental, medical, psychiatric, or other health related records of any kind from beginning of treatment to present date. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of person or facility receiving it, and would then no longer be protected by federal privacy regulations.

Furthermore, I understand that I may revoke this Authorization by notifying the above referenced addressee in writing of my desire to revoke this Release/Authorization, or otherwise automatically within seven (7) years from the date of this authorization. However, I understand that any action already taken in reliance on this Authorization cannot be reversed, and my revocation will not affect those actions. Last but not least, I understand that the medical provider to whom this authorization is furnished may not condition its treatment to me on whether or not I sign this Release/Authorization.

_____
Signature

_____
Printed Name

_____
Date of Birth

_____
Social Security Number