

KEYSTONE CHIROPRACTIC

Confidential Patient Information

Last Name: _____ First Name: _____ Nickname: _____

Today's date: _____ Date of birth: _____ Sex: Male Female

Occupation: _____ Single Married Divorced Widowed

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Mobile phone: _____

Please check your 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 understand that I may be subject to a missed appointment fee of \$25 for each cancelled or no-show appointment (within 24 hours of my appointment time) after the 2nd occurrence for chiropractic appointments.

Initial and check if you prefer to NOT receive text or email appointment reminders. ____

E-mail address: (for receipts) _____

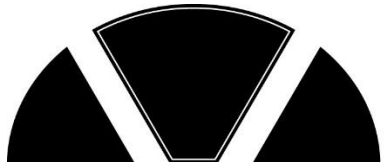
Social Security #: (only if billing an insurance company) _____

How did you hear about our office? Friend / Family BNI Chamber of Commerce
 Internet Search Facebook Youtube Gonstead Directory Dr. or Mrs. Neff

Attorney Referral: _____ Doctor Referral: _____

Other: _____

Signature: _____



KEYSTONE CHIROPRACTIC

Medical History Information

Do you have a family doctor ? <input type="checkbox"/> No <input type="checkbox"/> Yes		Name of doctor:	
Date of last visit: / /	Date of last exam: / /		
Have you been to a chiropractor before? <input type="checkbox"/> No <input type="checkbox"/> Yes Where?			
Reason for visit(s):			
Date of last visit: / /	Date of last exam and/or x-rays: / /		
Please list surgeries and dates – use back of page if needed.			
Date:	Type of surgery:	Date:	Type of surgery:

Personal History: Current and previous conditions – please check all that apply

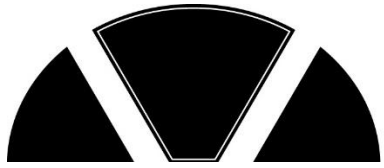
<input type="checkbox"/> AIDS	<input type="checkbox"/> Cirrhosis/Hepatitis	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Irritable Bowel	<input type="checkbox"/> Prostate Trouble
<input type="checkbox"/> Allergies	<input type="checkbox"/> Constipation/Diarrhea	<input type="checkbox"/> Headaches	<input type="checkbox"/> Kidney Trouble	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart Condition	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Scoliosis
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Dislocated Joints	<input type="checkbox"/> Heartburn/Acid Reflux	<input type="checkbox"/> Mental/Emotional Difficulty	<input type="checkbox"/> Seizures
<input type="checkbox"/> Asthma	<input type="checkbox"/> Diverticulitis	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Menstrual Cramps	<input type="checkbox"/> Sinus Trouble
<input type="checkbox"/> Bedwetting	<input type="checkbox"/> Dizziness	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> STDs
<input type="checkbox"/> Bone Fracture	<input type="checkbox"/> Ear Infections	<input type="checkbox"/> HIV/ARC	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Thyroid Trouble
<input type="checkbox"/> Cancer	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Polio	<input type="checkbox"/> Ulcers
Type of cancer:			Other:	

Family History (Parents, Grandparents): Current and previous conditions – please check all that apply

<input type="checkbox"/> AIDS	<input type="checkbox"/> Cirrhosis/Hepatitis	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Irritable Bowel	<input type="checkbox"/> Prostate Trouble
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Type of cancer:			Other:	
Are you currently pregnant? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Trying		(We will not take any x-rays if you are pregnant)		
Are you a smoker? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Former		Average alcoholic drinks per day ____ Per week ____		
Do you consume any: <input type="checkbox"/> sugar free drinks <input type="checkbox"/> diet soda <input type="checkbox"/> chewing gum <input type="checkbox"/> coffee/tea sweeteners <input type="checkbox"/> protein shakes <input type="checkbox"/> calorie-free foods <input type="checkbox"/> sugar-free food or drink <input type="checkbox"/> water flavoring mixes				
How many hours of exercise do you get per week?		What type?		

Signature: _____

Date: _____



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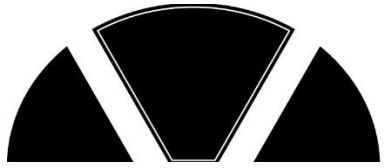
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How many hours of exercise do you get per week?		What type?		

Signature: _____

Date: _____



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 mandatory government updates. Thank you for your cooperation.

Name: _____ Date: _____

Current Medications and Supplements: (Please use the back or attach a list if more room is needed)

Name or Reason for Taking:	Frequency:	Date Started:

Current Medication Allergies:

Medication:	Reaction:

Would you like the doctor to recommend any supplements for you specifically?

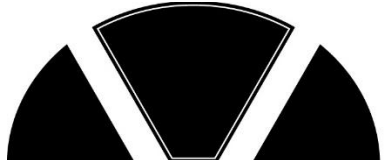
- Yes No Not sure

We offer clinical nutrition with a functional medicine approach using a system call *Science Based Nutrition (SBN)*. A complete analysis of body function is done through an extremely thorough testing process using common (although under-utilized) blood, urine, stool, and hair tests. Based on the results, a specific dietary and vitamin protocol is recommended. After a few weeks to a few months, re-testing is done to track progress and make necessary adjustments to the protocols.

This type of functional testing is ideal for people who wish to reduce their need for prescription drugs, or assess their risk for conditions like diabetes, heart disease, auto-immune disorders, and cancer.

Would you like any information on SBN?

- Yes No Not sure



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 that may be 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 temporary 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). The Gonstead system of chiropractic greatly limits the risk of these complications.

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.

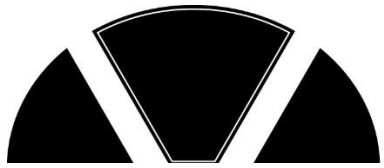
I am informed and understand that there are some very slight risks with chiropractic adjustments, including, but not limited to, muscle sprain, ligament strain, disc injury and stroke. I expect Dr. Neff to exercise judgment, based upon the known facts, and act in my best interest.

I understand that I am able to discuss with Dr. Neff the nature and purpose of chiropractic adjustments including any questions that I have. If, at any time, I am uncomfortable with any recommended treatments, I may decline treatment. 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

Financial Policy

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

For self-pay patients:

- We are able to offer our time-of-service (TOS) discounted rates (which are 15-20% less than our standard rates) to patients paying in-full for treatments at the time that service was provided. [For example, a standard fee of \$68 for an ankle x-ray is reduced to \$55 for self-pay patients paying at the time of the service.]
- **All fees are due at the time of the service. If payment is unable to be made at the time of service, future treatments will not be provided until the balance has been paid.**
- Financial hardship options are available if needed. Please discuss this with Dr. Neff if you are interested.

For patients going through their automobile PIP insurance:

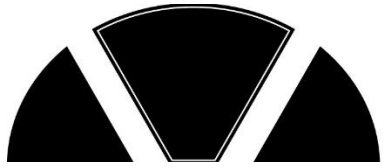
- By Law, all Copays are due and payable on the same day that services are rendered. Prompt payment allows us to control costs. Outstanding accounts cost both of us time and money therefore, all patients will be required to establish financial arrangements for payment of their account.
- All new patients 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 (EOB) 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 over payment for professional services. If you have any questions concerning our policy or need assistance, please contact us immediately.

Dr. John Neff

Signature

Date



**KEYSTONE
CHIROPRACTIC**

Acknowledgement of Receipt of Notice of Privacy Practices

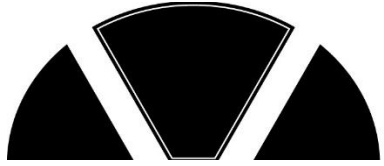
I acknowledge that I was provided a copy of the **Notice of Privacy Practices** (red folder in the lobby) and that I have read them or declined the opportunity to read them, and that I understand the **Notice of Privacy Practices** explaining my privacy rights as a patient. I understand that this form 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

XXX-XX-_____
Social Security Number