PATIENT INFORMATION SHEET

PATIENT:

Last Name:_____ First Name: _____ Middle Initial:_____

Gender: ☐ M ☐F Date of Birth:_____/_____/_____ Age:_____ SS#: _____

Home Address:_____ Apt #_____Marital Status: _____

City:_____ State: _____Zip:_____Email:_____

Home Phone: _____ Work Phone: _____ Cell Phone:_____

Employer Name:_____ Occupation: _____

Employer Address:_____

City: _____ State _____ ZIP: _____

SPOUSE or GUARDIAN:

Last Name: _____ First Name: _____ Initial:_____

Employer Name: _____ Work Phone: _____

Date of Birth: _____/_____/_____ Social Security: _____

EMERGENCY Name and address of nearest relative or friend:

Last Name: _____ First Name: _____ Initial: _____

Home Phone #_____ Work Phone #:_____

Relation to Patient:_____

SIGNATURE: (Patient, Parent, Legal, Guardian, or Responsible Party)

I request services X_____ Date_____

The following Medicare requested information is OPTIONAL to give. You are <u>not required</u> to answer:

PREFERRED LANGUAGE:

☐English ☐Spanish ☐French ☐German ☐Cantonese ☐Hindi ☐ Arabic ☐Other:_____

ETHNICITY: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Decline to Answer

RACE:

☐American Indian or Alaska Native

☐Asian

☐Black or African American

☐Native Hawaiian or Other Pacific Islander

☐White

☐Other: _____

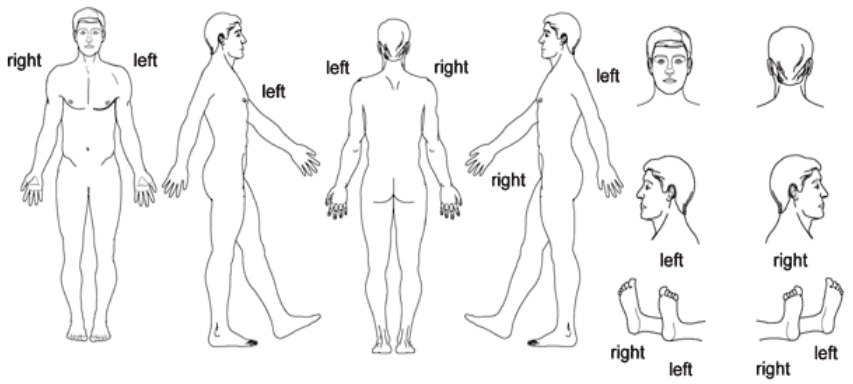
☐Decline to Answer

What brought you here today? _____

When/How did it start? _____

What makes it better or worse? _____

(Place an "X" on the drawing below on areas causing pain)



What prior treatment or medications have you had for this condition?

_____

How did you learn of our practice? _____

Please check areas for which you have had treated, currently or in the past: ☐Hypertension ☐Heart ☐Lung

☐Kidney ☐Liver ☐Gall Bladder ☐Thyroid ☐Diabetes ☐Bladder ☐Uterine ☐Prostate ☐Neuro ☐Other:

_____

Smoke? ☐Y ☐N Amount: _____ Drink Alcohol? ☐Y ☐N Amount: _____

Please list previous traumas and accidents: _____

Surgical History: _____

Previous fractures? Y or N (list): _____

Please list allergies: _____

Present Medications: _____

Physicians who have treated you in last five years: _____

FEMALE ONLY: Pregnant? ☐Yes ☐ No

FAMILY HISTORY:

RELATIVE	AGE	HEALTH CONDITION(S)	AGE DECEASED	CAUSE OF DEATH
Mother				
Father				
Sister(s)				
Brother(s)				

FOR OFFICE USE: _____

_____

_____

_____

_____

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other treatment options which could be considered may include the following:

- *Over-the-counter analgesics*. The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.

- *Medical care*, typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.

- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.

- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual risks: I have had the following unusual risks of my case explained to me.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment and herby give my full consent to treatment.

PRINT PATIENT NAME _____

PATIENT SIGNATURE _____ DATE _____

INSURANCE ASSIGNMENT AND RELEASE

FOR INSURANCE OTHER THAN MEDICARE:

I, the undersigned, have insurance coverage with _____
(Name Of Insurance Company)

and assign directly to Dr. Maria V. Meesit, D. C. all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

_____ Date _____
(Signature of Insured / Guardian)

MEDICARE AUTHORIZATION:

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Maria V. Meesit, D.C. for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ Date _____
(Beneficiary Signature)

PAYMENT METHOD: ☐Cash ☐Check ☐Visa ☐MasterCard ☐Discover ☐American Express

INSURANCE:

Primary Insurance Company:_____

Insured's Name:_____ I.D. Policy # _____

Secondary Insurance Company:_____

Insured's Name:_____ I.D. Policy # _____

Workers Compensation:_____

Insured's Name:_____I.D. Policy # _____

RESPONSIBLE PARTY: Complete this section if you are the responsible party for the bill.

Responsible Party:_____ Relationship to Patient:_____

Home Address:_____ APT #:_____

City:_____ State: _____ Zip: _____

Home Phone #:_____ Work Phone #:_____

ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

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

By checking the boxes below, I authorize being contacted for practice reminders by (check all that apply):

☐Mail
☐Email – please list at email address:_____
☐Telephone numbers- please list phone numbers:
work:_____
home: _____
cellular:_____
☐By voice mail
☐By text message
☐By FaceBook address _____.

By checking the boxes below, I authorize being contacted for birthday greetings or promotions about the practice by (check all that apply):

☐Mail
☐Email – please list at email address:_____
☐Telephone numbers- please list phone numbers:
work:_____
home: _____
cellular:_____
☐By voice mail
☐By text message
☐By FaceBook address _____.

☐By checking this box, I authorize the doctor to personally discuss with me products that may benefit my health or condition.

_____ _____
Patient Name (please print) Date

_____ _____
Name of Parent, Guardian or Patient's legal representative

Signature of Patient, Parent, Guardian or Patient's legal representative

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.
List below the names and relationship of people to whom you authorize the Practice to release PHI.

_____ _____

_____ _____

_____ _____

HIPAA Compliant Authorization for Release of Patient Information Pursuant to 45 CFR 164.508

Section I – Patient Information

Patient Name: _____

Parent/Guardian Name (if applicable):_____ Relationship to patient: _____

Address:_____

Telephone: _____ Email address: _____

Section II: Authorization for Release of Patient Information: I, or my authorized representative, hereby authorize _____(name of entity holding the requested records) and their respective employees, agents and subcontractors to disclose my Personal Health Information (PHI) and Insurance Record to: Meesit Chiropractic, 4801 Swift Road, Suite I, Sarasota, Florida 34231, Tel: 941-927-3770.

Section III – Specific Information to be Released:

☐ Please release my Medical Record from (insert date) _____ to (insert date) _____.

☐ Please release my entire Medical Record, including patient histories, office notes (excluding psychotherapy notes, test results, radiology studies, films, referrals, consults, billing records, insurance records sent to Freedom Health by health care providers.

☐ Other: (please explain) _____

Reason for release of information:

☐ Include: (Indicate by Initialing)

_____ Alcohol/Drug Treatment _____ Mental Health Information _____ HIV-Related Information

☐ At the request of the individual

☐ Other: _____

Section IV: I understand that Section 460.413 (1) (m), Florida Statutes, and Board of Chiropractic Medicine Rule 64B2-17.006 require chiropractic physicians to retain records and x-rays for at least four years. Therefore, a chiropractic physician receiving a request for a patient's x-ray within that four-year period must retain the x-ray and provide a copy of it in lieu of the original x-ray. I, further, understand that Section 456.057 (18), Florida Section 457.057 (16), Florida Statutes, authorizes a health care practitioner or patient records owner furnishing copies of reports or records or making the reports or records available for digital scanning pursuant to this section to charge no more than the actual cost of copying, including reasonable staff time, or the amount specified in administrative rule by the appropriate board, or the department when there is no board. The Board of Chiropractic Medicine Rule 64B-17.0055, Florida Administrative Code, authorizes chiropractic physicians to charge patients $1.00 per page for the first 25 pages, and 25 cents for each page in excess of 25 pages. The Board of Chiropractic Medicine Rule defines the reasonable costs of reproducing x-rays, and such other special kinds of records as the actual costs. The phrase "actual costs" means the cost of the material and supplies used to duplicate the record, as well as the labor costs and overhead costs associated with such duplication. The Board of Chiropractic Medicine Rule 64B-17.0055, Florida Administrative Code, authorizes chiropractic physicians to charge people who are not patients authorized to seek copies of my patient records $1.00 per page. I understand that the HIPAA regulations authorize the practice to charge the cost of labor and hardware onto which the records are electronically copied unless the Board of Chiropractic Medicine sets lower costs. I understand that there is no cost for transmitting the electronic records by email.

This authorization will be in effect for one year from the date signed, unless you indicate a shorter period below:
Date or event on which this authorization will expire: _____.
If an authorized representative is making this request, please provide your information below and attach certifying documentation of your status as the authorized representative, such as a Power of Attorney or Guardianship papers.

AUTHORIZED REPRESENTATIVE

By signing this form, I am confirming that it accurately reflects my wishes. In addition, I have kept a copy of this form for my records.

_____ _____

Signature of Member or Authorized Representative Date