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: _____ Date of Birth: _____/_____/_____

EMERGENCY Name and address of nearest relative or friend:

Last Name: _____ First Name: _____ Initial: _____

Home Phone #_____ Work Phone #:_____

Relation to Patient:_____

HIPAA/Disclosure/Authorization

The Health Insurance Portability and Accountability Act (HIPAA) is a U.S. law designed to protect your private health information. Please provide the following information to assist Maria V. Meesit, D.C. in ensuring your personal health details are shared only with those you authorize.

I give permission for Maria V. Meesit, D.C. to share information with the following person(s) listed below:				Check all that apply:		
Name	Contact Number	Relationship		Appointment	Billing	Medical

_____ (initial) **I understand that it is my responsibility to notify Dr. Meesit of any changes to my information.**

The following Medicare requested information in THIS box 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 ☐White

☐Native Hawaiian or Other Pacific Islander ☐Other: _____ ☐Decline to Answer

Reason for visit today? _____

When/How did it start? _____

What makes it better? _____ Worse? _____

*Type of pain-check all that apply: ☐Sharp ☐Dull

☐Throbbing ☐Burning ☐Numbness

☐Tingling ☐Aching ☐Shooting

☐Cramps ☐Stiffness ☐Swelling ☐Other

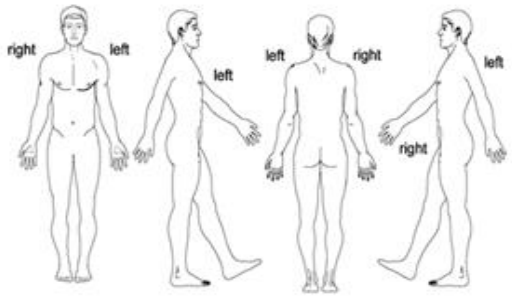
*Is it ☐constant or does it ☐come and go?

*Rate the severity of your pain on a scale of 1 (least pain) to 10 (severe pain): _____

*Date of Last: Chiropractic Adjustment: _____

Spine x-ray_____ MRI/CT scan: _____

Place an "X" on the drawing below on areas causing pain, numbness, tingling, etc.



What treatment have you already received for this condition? ☐None ☐Medications ☐Surgery ☐Physical Therapy ☐Chiropractic Services ☐Other: _____

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: _____

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

Traumas, falls, accidents you have had: _____

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 primary treatment used by doctors of chiropractic is spinal manipulative therapy. I will use my hands or a mechanical device upon your body in such a way as to move your joints. That may cause an audible "click" or "pop", much as you might have experienced when you “crack” your knuckles. You may feel a sense of movement.

Analysis/Examination/Treatment: As a part of the analysis, examination and treatment, you are consenting to the following procedures: spinal manipulative therapy, palpation, vital signs, range of motion testing, orthopedic testing, basic neurological testing, muscle strength testing, postural analysis testing, foot scanning, ultrasound hot/cold therapy, EMS, radiographic studies.

Possible Risks: As with any health care procedure, there are certain complications which may arise during chiropractic manipulation and therapy. Complications could include but are not limited to: fractures, muscle strain, ligamentous sprain, dislocations, cervical myelopathy, costovertebral strains and separation, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. The Doctor will make every reasonable effort during the examination to screen for contraindications to care; however if you have a condition that would otherwise not come to the Doctor’s attention, it is your responsibility to inform the Doctor.

Probability of risks occurring: Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and x-ray. Stroke and/or arterial dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most current research on the topic is inconclusive as to a specific incident of this complication occurring. If there is a causal relationship at all, it is extremely rare and remote. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of arterial stroke. The probability of adverse reaction due to ancillary procedures is also considered "rare".

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

- Self-administered, over-the-counter analgesics and rest.
- Medical care and prescription drugs, such as anti-inflammatory drugs, muscle relaxants and pain-killers.
- Hospitalization
- Surgery

If you chose to use one of the above noted “other treatment” options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

Risks of remaining untreated: Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time, this process may complicate treatment, making it more difficult and less effective the longer it is postponed.

CONSENT TO TREATMENT (MINOR): I hereby request and authorize Maria Meesit D.C. to perform diagnostic tests and render chiropractic adjustments and other treatment to my minor son/daughter: _____. This authorization also extends to all other doctors and office staff members and is intended to include radiographic examination at the doctor’s discretion.

As of this date, I have the legal right to select and authorize health care services for the minor child named above. (If applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW.

I have read☐ or have had read to me☐ the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Maria Meesit D.C. and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated: _____ Dated: _____

_____ **Maria Meesit DC** _____

Patient’s Name Maria Meesit DC

_____ _____

Signature Signature

_____

Signature of Parent or Guardian (if a minor)

INSURANCE ASSIGNMENT AND RELEASE

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

and assign directly to Dr. Maria V. Meesit, D. C. all medical insurance 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)

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 # _____

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 by (check all that apply):

☐Mail ☐Email – please list email address:_____
☐Telephone numbers- please list phone numbers:

Work: _____ Home: _____ Cellular:_____

☐By voice mail ☐By text message ☐By FaceBook (name): _____

_____ _____
Patient Name (please print) Date

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

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

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