# New Patient Forms

## ◆Confidential Patient Information◆

*PLEASE PRINT:*

Name_____ Social Security Number _____

Address_____City_____State _____Zip_____

Age____ Date of Birth____/____/____ Sex M○F○ Status ○Single ○Married ○Divorced ○Widowed Number of Children_____

Home Phone_____Bus.Phone _____Cell Phone_____

Email_____ Instagram_____Twitter _____

Occupation_____Employer_____

Busines Address_____ City_____State____Zip_____

Spouse/Parent Name_____ Date of Birth _____Ph#_____

Emergency Contact _____Phone_____

Address_____City_____State _____Zip_____

What Hobbies/Sports Are You Active In ?_____

Purpose of Today's Visit:_____

Briefly State Your Main Complaint _____

_____

Briefly Describe What Caused Your Symptoms _____

_____

Briefly Describe How Your Symptoms Affect Your Daily Job, Household and/or Recreational Activities_____

_____

Name of Insurance Co _____ Effective Date_____

Insurance Policy Number_____ Group Number_____

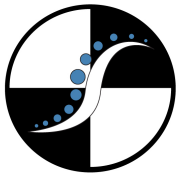
Are You The Primary Insured On This Insurance Policy? ○ Yes ○ No If NO, Who Is The Primary Insured?

○ Parent ○ Spouse ○ Someone Else (how are they related to you?_____

Primary Insured's Name _____ Date of Birth_____

Primary Insured's Address_____

City_____ State _____ Zip _____



## Insurance Authorizations & Releases

**Office Policy Regarding Payment For Services & Insurance Reimbursement:**

I understand and agree that health insurance policies are an arrangement between an insurance company and myself. Furthermore, I understand that the Evolve Family Chiropractic Center will prepare any necessary reports and forms to assist me in collecting from my insurance company, and that any amount authorized to be paid to Evolve Family Chiropractic Center, will be credited towards my account upon receipt. However, I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment, including payment of any applicable insurance deductible and/or insurance co-payments. I also understand that if I suspend or terminate my care and treatment prior to the doctor releasing or discharging me from care, any fees for professional services rendered to me will be immediately due and payable.

**Consent For Physician To Proceed With Examination & Treatment:**

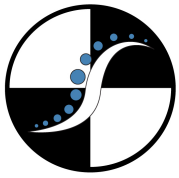
Although extremely rare, there are risks of being treated with physical therapy, massage therapy, rehabilitation and chiropractic, including sprains, strains, fractures, herniation, burns, bruises, strokes and even death (1 in 5.85 million manipulations). I understand that if I am accepted as a patient by Evolve Family Chiropractic Center, I am authorizing them to proceed with any examination & treatment that may be necessary. Any risks regarding examination & treatment have been discussed and explained to my satisfaction and I understand the doctor feels the benefits outweigh the risks. I voluntarily consent to the rendering of care, including examinations, treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carryout the instructions of such physician(s).

**Authorization To Release Medical Information:**

I authorize the release of any medical information necessary to process my insurance claim(s). I also certify that all insurance information given to this healthcare provider is correct and complete.

**Authorization To Release Medical Records:**

I authorize any person to whom this authorization is presented, either in person, by mail, by fax, or otherwise; to furnish the Evolve Family Chiropractic Center; any and all medical records, medical reports, x-rays, or other diagnostic tests, reports, & films concerning my present or past health condition/injury or general health status.



**Limited Power Of Attorney To Endorse Checks:**

I agree that this office and any of its duly authorized agents and employees be given power of attorney to endorse/sign my name on any and all checks, drafts, money orders, unpaid insurance claims or affidavits, which are payable to me for professional services rendered to me by Evolve Family Chiropractic Center. The undersigned by these presents does thus give and grant this limited power of attorney to the above named office the full power and authority to do and perform the intents and purposes as the undersigned might or could do if personally present insofar as the endorsing and cashing of said checks are concerned. The undersigned does hereby ratify and confirm any and all actions taken by said attorney in accordance with this special power of attorney and which the said attorney shall do or cause to be done by virtue of these presents.

**Acknowledgement Of Receipt Of Notice Of Privacy Practices:**

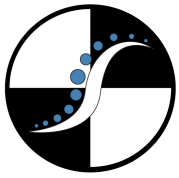
I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them, and understand the Notice of Privacy Practices in the state of Florida. I understand that a copy of this form will be placed in my patient chart.

Patient/Minor's Printed Name: _____

Patient Signature: _____ Date: _____

Legal Guardian Printed Name: _____

Legal Guardian Signature: _____ Date: _____



## Informed Consent To Chiropractic Care Agreement

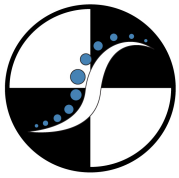
You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, dislocations, strains, and sprains. In addition, the literature recognizes an association between strokes and chiropractic manipulation of the cervical spine. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Carotid and vertebral artery dissections are rare, with an annual incidence of 2.5 – 4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke. The reported association between visits to a chiropractor or a primary care physician and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million visits.



It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

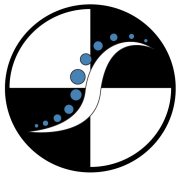
I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient/Minor's Printed Name: _____

Patient Signature: _____ Date: _____

Legal Guardian Printed Name: _____

Legal Guardian Signature: _____ Date: _____



## Use/Or Disclosure of Health Information Agreement

We're very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information. There are several circumstances in which we may have to use or disclose your health care information, however we will inform you separately to guarantee permission.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and financial records to another party if they are responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form. We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at anytime for a copy of our privacy notices.

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However if we agree with your restrictions, the restriction is binding on us.

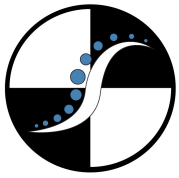
You may revoke your consent to us at anytime; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization.

Patient/Minor's Printed Name: _____

Patient Signature: _____ Date: _____

Legal Guardian Printed Name: _____

Legal Guardian Signature: _____ Date: _____

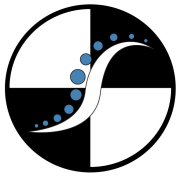


# Arbitration Agreement

Article 1: Agreement To Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process, except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. Further, the parties will not have the right to participate as a member of any class of claimants, and there shall be no authority for any dispute to be decided on a class action basis. An arbitration can only decide a dispute between the parties and may not consolidate or join the claims of other persons who have similar claims.

Article 2: All Claimants Must Be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, as to whether this agreement is unconscionable, and any procedural disputes, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider, including any heirs or past, present, or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is intended to bind any children of the patient whether born or unborn at the time of their current giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers, preceptors, or interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not. All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked.

Article 3: Procedures & Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days, and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator. The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have judgment for future damages conformed to periodic payments, shall apply to disputes within the Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this arbitration agreement.



Article 4: General Provision: All claims based upon the same incident, transaction, or related circumstances shall be arbitrated in one proceeding. A claim shall be waived an forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within thirty days of signature and, if not revoked, will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive effect: If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge this agreement.

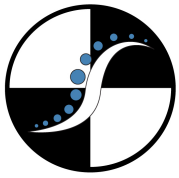
Notice: By signing this contract you are agreeing to have any issue of medical malpractice decided by neutral arbitration and you are giving up your right to a jury or court trial.

Patient/Minor's Printed Name: _____

Patient Signature: _____ Date: _____

Legal Guardian Printed Name: _____

Legal Guardian Signature: _____ Date: _____



## Appointment Reminder Agreement

Your chiropractor and members of the practice staff may need to use your personal information such as name, phone number, and other pertinent personal identifiers to contact you with appointment reminders and other health related information. By signing this form, you are giving us authorization to contact you with these reminders and other health related information.

You make revoke your authorization to us at anytime; however, your revocation must be submitted in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your information stated above before we receive your request to revoke your authorization.

This notice is effective upon submission of patient signature below and will remain in effect until a written request from patient is received.

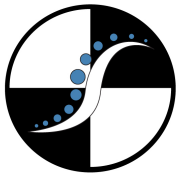
I authorize Evolve Family Chiropractic Center to use my information stated above for the purpose of appointment reminders and other health related information.

Patient/Minor's Printed Name: _____

Patient Signature: _____ Date: _____

Legal Guardian Printed Name: _____

Legal Guardian Signature: _____ Date: _____



## Photography/Videography Agreement

I, on behalf of myself, or acting legal guardian of the minor child, grant Evolve Family Chiropractic Center a perpetual, irrevocable and unrestricted basis the right to use, reuse, publish and re-publish pictures and/or video footage.

The right granted herein to use the patients pictures and/or video footage shall extend to any reproductions in color or otherwise, made through any medium and in any and all media now or hereafter known whether employed singularly or in conjunction with printed and/or other accompanying material and whether employed for any purpose whatsoever, and regardless of the manner in which said use is transmitted.

The patient waives any right to inspect or approve the finished product or products and/or the advertising copy or other matter containing the pictures and/or video footage. The Subject further waives any right to compensation received by Evolve Family Chiropractic Center in association with commercialization of the pictures and/or video footage.

The patient releases and agrees to hold harmless Evolve Family Chiropractic Center from any liability associated with this signed agreement, including without limitation any claims for libel or invasion of privacy.

For purposes of this agreement, the term "Evolve Family Chiropractic Center" shall include all business entities, which are now or in the future owned or controlled or managed by Evolve Family Chiropractic Center.

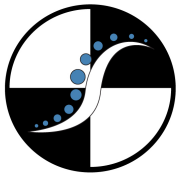
I warrant that I am over the age of 18 and have the right to contract in my name, or acting legal guardian of the minor child. I have read and understand the content of this document prior to signing it. This release shall be binding upon the patient or the legal guardian of minor, and his heirs, legal representatives and assigns.

Patient/Minor's Printed Name: _____

Patient Signature: _____ Date: _____

Legal Guardian Printed Name: _____

Legal Guardian Signature: _____ Date: _____



## Cancellation/Missed Appointment Agreement

Our goal is to provide quality Chiropractic care in a timely manner. In order to do so, we have had to implement an appointment cancellation or missed appointment policy. This policy enables us to better utilize available appointments for our practice members with serious circumstances needing immediate care.

In order to be respectful of the chiropractic needs of other patients, please be courteous and call the office promptly if you are unable to keep an appointment. If it is necessary to cancel your scheduled appointment, we require you call at least 24 hours in advance.

To cancel appointments, please call 786-227-9402. If you do not reach the Chiropractic Assistant you may leave a detailed message on the voicemail. If you would like to reschedule your appointment, please be sure to leave us your phone number and we will return your call as soon as we can.

A "no-show" is someone who misses an appointment without calling 24 hours in advance to cancel. "No-shows" inconvenience those individuals who need access to chiropractic care in a timely manner. A failure to show up at the time of a scheduled appointment will be recorded in the patient's chart as a "no-show". Any "no-shows" will result in a fee of 50% of the appointment fee.

Late cancellations will be considered as a "no-show". Exceptions will only be made in extraordinary circumstances. Cancellations made over 24 hours in advance of your scheduled appointment time will not be assessed a cancellation fee.

I understand this policy and authorize Evolve Family Chiropractic Center to assess cancellation and no-show fees according to the above outlined policy.

Patient/Minor's Printed Name: _____

Patient Signature: _____ Date: _____

Legal Guardian Printed Name: _____

Legal Guardian Signature: _____ Date: _____