CONFIDENTIAL PATIENT INFORMATION

Date _____

Name _____ Home Phone_____ Cell Phone_____

Address _____ City_____ Zip Code _____

Age _____ Birth Date _____ Marital: M S W D How many children _____

Occupation_____ Employer_____

YOUR EMAIL ADDRESS:_____

YOUR ALTERNATE ADDRESS (North) _____

_____ **Phone** _____

Name of Wife/Husband _____ Cell Phone # _____

Patient's Nearest Relative (son/daughter)_____Phone Number _____

Referred to our office by: _____

Primary Physician's Name _____ **Address** _____

Do you smoke: _____ Yes _____ No _____ Previously How long ago did you stop smoking? _____

Is your present condition due to your employment? _____

Is your present condition due to an automobile accident? _____ Date of Accident _____

Have you been under Chiropractic care in the past? _____ Name of Doctor _____

(Please circle all that apply) Circle M for Mother Circle F for Father Circle S for Self

Allergy	M	F	S	Poor Posture	M	F	S	Tuberculosis	M	F	S	Itching	M	F	S
Dizziness	M	F	S	Sciatica	M	F	S	Bruise Easily	M	F	S	Varicose veins	M	F	S
Fatigue	M	F	S	Spinal Curvature	M	F	S	Hay Fever	M	F	S	Bed Wetting	M	F	S
Headache	M	F	S	Swollen Joints	M	F	S	Nose Bleeds	M	F	S	Frequent Urination	M	F	S
Loss of Sleep	M	F	S	Colon Trouble	M	F	S	Sinus Infection	M	F	S	Kidney Infection or Stone	M	F	S
Ulcers	M	F	S	Diarrhea	M	F	S	High Blood Pressure	M	F	S	Prostate Trouble	M	F	S
Nervousness/Depression	M	F	S	Difficult Digestion	M	F	S	Low Blood Pressure	M	F	S	Cramps or Backache	M	F	S
Numbness	M	F	S	Hemorrhoids	M	F	S	Pain Over Heart	M	F	S	Excessive Menstrual Flow	M	F	S
Arthritis	M	F	S	Nausea	M	F	S	Poor Circulation	M	F	S	Hot Flashes	M	F	S
Bursitis	M	F	S	Asthma	M	F	S	Rapid Heartbeat	M	F	S	Irregular Cycle	M	F	S
Foot Trouble	M	F	S	Colds	M	F	S	Slow Heartbeat	M	F	S	Lumps in Breast	M	F	S
Low Back Pain	M	F	S	Deafness	M	F	S	Anemia	M	F	S	Alcoholism	M	F	S
Neck Pain or Stiffness	M	F	S	Ear Noises	M	F	S	Stroke	M	F	S	Diabetes	M	F	S
				Enlarged Thyroid	M	F	S	Chest Pain	M	F	S	Polio	M	F	S
Tingling or Numbness in:				Eye Pain	M	F	S	Difficulty Breathing	M	F	S	Swelling of Ankles	M	F	S
Shoulders	Hips			Failing Vision	M	F	S	Pleurisy	M	F	S	Cancer	M	F	S
Arms	Legs			Venereal Disease	M	F	S								
Elbows	Knees														
Hands	Feet														
Fingers															

PLEASE TURN THIS SHEET OVER

PURPOSE OF THIS VISIT (Major Complaint): _____

_____

What activities aggravate your condition? _____

Have you ever had a similar condition?_____ If yes, when?_____

Have you lost any days from work?_____ Female: Are you Pregnant?_____

What operations have you had?_____ Serious illnesses_____

Is your condition getting progressively worse? Yes No Constant Comes and Goes

Is your condition interfering with your: Employment Sleep Daily Routine Other _____

How long has it been since you felt really well? _____

Other Doctors you have seen for your condition: _____

Have you been treated for any condition in the past year?_____

Describe the condition: _____

What medications or supplements are you currently taking? _____

Who prescribed these medicines? _____

Allergies: _____

Height: _____ **Weight**: _____ **Blood Pressure:** _____

Is there anything else you want us to know about you? _____

_____

PAYMENT IS EXPECTED AT TIME OF VISIT

HOW WILL YOU BE PAYING FOR TODAY'S VISIT? _____ CASH _____ CREDIT CARD _____ CHECK _____ INS

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making the collections from the insurance company and that any amount authorized is to be paid directly to Incledon Chiropractic and will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. SHOULD I BE REIMBURSED DIRECTLY FROM MY INSURANCE COMPANY, I AGREE TO PRESENT THE EXPLANATION OF BENEFITS AND CHECK TO INCLEDON CHIROPRACTIC UPON RECEIPT.

PATIENT'S SIGNATURE _____ **Date** _____

GUARDIAN'S OR SPOUSE'S SIGNATURE AUTHORIZING CARE _____ **Date** _____

COMMENTS:_____

_____

_____

lncledon Chiropractic
6609 Woolbright Rd Suite 414
Boynton Beach, FL 33437

Notice of Patient Privacy Policy

APPOINTMENT NOTIFICATION (TELEPHONE, TEXT , EMAIL)

I, _____, hereby consent and state my preference to have my physician, **Dr. James Incledon**, and other staff at ***Incledon Chiropractic*** communicate with me by email or standard SMS/text messaging, in addition to or to replace leaving phone messages, which will include appointments reminder. I understand that email and standard SMS/text messaging are not confidential methods of communication and may be insecure.

I give my permission to leave appointment reminders at the following (please fill-in the ones you agree to):

Email messages at the following email address _____@_____

Text messages at the following phone number (_____) _____

Cellular Phone Carrier: _____

Patient Signature: _____ Date: _____

DOCTOR/PATIENT RELATIONSHIP IN CHIROPRACTIC

CHIROPRACTIC

It is important to recognize the difference between Chiropractic and medicine. They both may be important to your health but for entirely different reasons. Chiropractors seek to restore health through natural means and without the use of medicine or surgery. Although a medical diagnosis may be of great importance to a patient, such diagnosis does not necessarily assist the Chiropractor in his efforts. The Chiropractor's purpose is to restore health through the natural flow of energy in the nervous system. This gives the body maximum opportunity to heal itself. The success of Chiropractic procedures often depends upon underlying causes and conditions. It is important to understand what to expect from Chiropractic and medical services in order that you, the patient, can determine whether either or both may be of benefit to you.

ANALYSIS

A Chiropractor conducts a Chiropractic analysis for the express purpose of determining whether there is evidence of spinal subluxations. When such subluxations are found, Chiropractic adjustments are given to restore proper spinal alignment. It is the Chiropractic premise that proper spinal alignment allows free nerve flow throughout the body and gives the body its best chance to restore health. Due to the complexities of nature, no Chiropractor can promise you specific results. This depends upon the recuperative powers of the body.

DIAGNOSIS

Every Chiropractic patient should be mindful of his own symptoms and secure medical opinion if he has any concerns as to the nature of his illness or injury. Your Doctor of Chiropractic may express an opinion as to whether or not you should take this step, but you should take the initiative if in doubt.

CHIROPRACTIC ADJUSTMENTS

The patient, in coming to the Chiropractor, given the Chiropractor permission and authority to adjust him in accordance with the Chiropractic analysis. The Chiropractic adjustment is usually beneficial and seldom causes any problems. In rare cases, underlying physical defects, deformities or pathology may render the patient susceptible to injury. The Chiropractor, of course, will not give a Chiropractic adjustment if he is aware that such condition exists.

RESULT

The purpose of Chiropractic services is to promote health through the release of maximum nervous energy. Since there are so many variables, it is difficult to predict the time schedule and efficiency of Chiropractic procedures. Sometimes the response is phenomenal. In some cases, there is a more gradual but quite satisfactory response. Occasionally, the results are mediocre and dismal. Two or more similar conditions may respond differently to the same Chiropractic care. Many medical failures find quick relief through Chiropractic. In turn, we must admit that conditions which do not respond to chiropractic care may come under control or even be cured through medical science. The fact is, the sciences of Chiropractic and medicine may never be so exact as to provide definite answers to many problems. Both have made great strides in alleviating pain and controlling disease.

QUESTIONS

The patient should discuss any questions or problems with the Doctor before signing the Statement of Policy and fully understand that if care is suspended or terminated, any fees for professional services rendered will be immediately due and payable. Returned checks and balances older than 30 days may be subject to additional collection fees, attorney fees, court costs and interest charges of 1 ½% per month. X-rays will remain the property of this office. If necessary, copies will be made for a charge of $5.00 per plate which covers duplicating film expense.

ACKNOWLEDGMENT

I have read the foregoing and understand it. Signed this _____ day of _____, 20_____.

SIGNATURE _____

lncledon Chiropractic
6609 Woolbright Rd Suite 414
Boynton Beach, FL 33437

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSE D AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient, we may use or disclose personal and health information about you in the following ways:

Your personal health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment. Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, PPO or your employer (if they or may be responsible for the payment of your services). Your name, address, phone number and your health care records may be used to contact you regarding appointment reminders, to provide information about alternatives to your present care or to other health related information that may be of interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization, it will not affect the care proviced to you or the reimbursement avenues associated with your care. Under Federal Law, we are also permitted or required to use or disclose your health information without your consent or authorization in the following circumstances:

*If we are providing health care services to you based on the orders of another health care provider.
*If we provide health care services to you in an emergency.
*If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
*If there are substantial barriers to communicating with you but in our professional judgment, we believe that you intend for us to provide care.
*If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information, other than as described in the examples outlined above, will only be made upon your written
authorization. We normally provide information about your health care to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home, or if you would like the information in a different form, please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date the record was created or for as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health-
related information should be provided to us in writing. We are required by State and Federal Law to maintain the privacy of your patient file and the protected
health inform ation therein and provide you w ith this notice of our privacy practices w ith respect to your health inform ation and the term s of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made t o our privacy notice, we will notify you in w riting as soon as possible following the changes. Any change made in our notice will apply for all of your health inform ation in our files.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person or persons to whom we provide the information and may no longer be protected by the Federal Privacy Rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities or you would like further inform ation about our privacy practices or policies, please contact Dr. James Incledon, D.C.

This office is also in the practice of sending postcards for reasons including recalls, appointment reminders, etc. but is not limited to these events. It is also the practice of this office to have patients sign in for visits. Your name is made visible to other practice members when you sign in. If you choose not to have postcards sent to you or have your name appear on our sign-in sheet, we will gladly make other arrangements for these office procedures. The use of these office procedures is to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information.

This notice is effective as of 4/14/2003. This notice and any alternations or amendments made hereto will expire seven years after the date upon w hich the record was created. My signature acknowledges that I have received a copy of this notice.

_____ _____ _____
Name (Printed Please) Signature Date

If you are a minor, or if you are being represented by another party

_____ _____ _____
Name of Personal Representative Printed Personal Representative Signature Date

Description of authority to act on behalf of the patient: Parent Guardian Other

INCLEDON CHIROPRACTIC MASSAGE THERAPY POLICY

1-hour massages generally run 55 minutes and ½ hour massages run 25 minutes. This is to allow time for the patients to change and enter and exit the massage area.

You must arrive at least 5 minutes before your scheduled appointment time. If you are late for your appointment, the massage cannot run over into the next appointment time and that time you were late is lost. No discount can be offered for the lost time.

CANCELLATION POLICY

Due to the limited number of massage appointments available and the high demand for these appointments, it has become necessary to implement a Massage Therapy Cancellation Policy.

24-HOUR ADVANCE NOTICE is required for all cancellations so this time can be rebooked.

Failure of the patient to notify us of a cancellation with 24-hour advance notice will

1. The patient being responsible for payment of the massage fee, even though the time was lost (this charge cannot be billed to your insurance).
2. Loss of a patient's ability to schedule further appointments.

In the event that an appointment is missed without advance notice, all future appointments will be automatically deleted until the patient contacts our office and conforms to the above policy. We are not responsible, if before you contact our office, other patients book those timeslots.

PATIENTS WILL BE ALLOWED A 1-TIME GRACE FROM THIS POLICY

A reminder call will be made the day before your appointment to help confirm your appointment. In the event we are unable to reach you, WE WILL LEAVE YOU A MESSAGE AND IT IS REQUIRED THAT YOU CALL US BACK TO CONFIRM THE APPOINTMENT.

Signature:_____ **Date:**_____

Signature on File

NAME OF BENEFICIARY _____HICN _____

I authorize that payment of authorized Insurance benefits be made either to me or on my behalf to Dr. James Incledon for any services furnished to me by that physician. I authorize any holder of medical information about me to release to my Insurance company and its agents any information needed to determine these benefits or the benefits payable for related services.

NAME OF BENEFICIARY _____HICN _____
Medigap Policy Number _____
I request that payment of authorized Medigap benefits be made either to me or on my behalf to Dr James Incledon, for any services furnished to me by that physician. I authorize any holder of medical information about me to release to __(Medigap insurer)__ any information needed to determine these benefits or the benefits payable for related services.

Signature _____

Date _____

Neck Index

Form N1-100

rev 3/27/2003

Patient Name _____ ***Date*** _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

Personal Care

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my car as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Headaches

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Neck Index Score

Back Index

Form BI100

rev 3/27/2003

Patient Name _____ ***Date*** _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index Score