Edgewater Chiropractic Clinic, P.A.

201 S. Ridgewood Ave, Suite 11

Edgewater, FL 32132

386-423-7575

***Patient Name**:* ____ ***Date**:* ___________________________

***Address**:* ____ ***City/State/Zip**:* _______________________________

***Phone**: (H)* _____________________________ *(W)* ________________________*(C)* ____________________

M/F ***Date of Birth**:* ___________________ ***Age**:*______ ***Marital Status**: M D S W* ***SSN**:* ________________

***Occupation**:* ____

***Employer**:* ____________________________________ ***Address**:* ____

***Email**:* ____ ***Preferred Language**:* _________________________

Where you referred to us? Who? __________________________________

Have you seen a Chiropractor in the past? Yes/ No

If yes, who and when: ____

***Race**: Not Specified White Am. Indian or Alaska Native Asian Black/African Am. Hispanic*

Emergency Contact: ____ ***Phone:*** ________________________________

Do you have health insurance? Y/N Please Present Card At Window

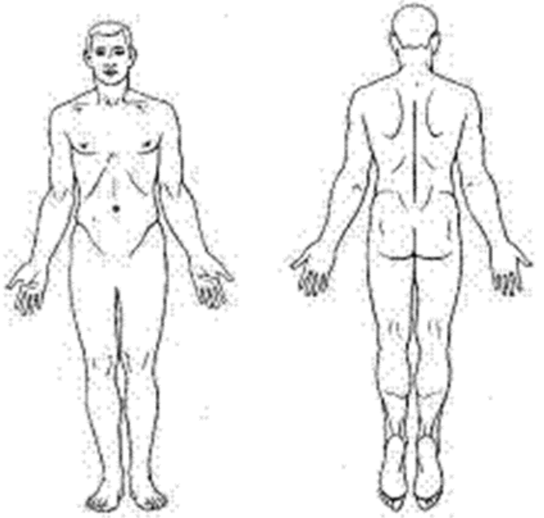
Primary Care Physician: _________________________________ **Where?** __________________________________

Last Physical Exam: _____________________

For sign-in purposes please select a 4 digit pin number ______ ______ ______ ______

What current problem(s) bring you to the clinic today? ____
____

Please circle area(s) where you are feeling symptoms...



Date this condition began: ____

How did this happen: **FALL** **LONG DRIVE** **LONG FLIGHT** **POOR NIGHT'S SLEEP** **SLIP** **LIFTING** **REACHING** **HOUSEHOLD CHORES** **YARD WORK** **CHRONIC ILLNESS**

Frequency of pain: (please circle) **Constant (100% of the time)** **Frequent (< 75% but > 50% of the time)** **Occasional (< 50% but > 25% of the time)** **Intermittent (less than 25% of the time)**

What type of pain are you experiencing? (please circle)
Aching **Annoying** **Burning** **Deep** **Dull** **Heavy** **Intolerable** **Pulling** **Sharp** **"Shock Like"** **Stabbing** **Stiffness** **Throbbing** **"Tightness"** **Tingling**

Is your pain Radiating? Y/N Please Describe ____
____

Since the pain began has it: (please circle) **Improved** **Stayed the same** **worsened** **relief that lasted for a while**

Pain level: (please Cirlce) **1 2 3 4 5 6 7 8 9 10**

Symptoms Relieved By: (circle One) **None** **Chiropractic Adjustment** **Cold Pack** **Heat Packs** **Exercise** **Massage** **OTC Medication** **Physical Therapy** **Prescription Medication** **Rest** **Stretching** **Work**

Has this pain ever happened before? Y/N When: ________________________________

How Long Did It Last? ____

Are you currently being treated for this condition? Y/N By Whom?______________________
____

Have you had any of the following tests? X-rays EMG MRI CT Scan
If yes, When ______________________Where _______________ Why ______________________

Activity of Daily Living Most Effected? (Circle All That Apply)
Employment Homemaking Lifting Personal Care Standing Walking Sitting
Sit to Stand Sleeping Social Life Traveling Yard Work Sitting at Computer
Caring for Family Golfing Exercises

What tasks do you find difficult due to the pain? (Circle All That Apply) bending over caring for family
climbing stairs concentrating dressing self driving car exercising getting in/out of car
getting to sleep grocery shopping performing household chores lifting objects
looking over shoulder making love lying down reaching overhead rising out of chair or bed
showering or bathing sitting standing staying asleep using a computer walking
participating in yard work

How long can you with stand activity before it begins to hurt?
1 5 10 15 20 30 45 60
Second Minute Hour

Is Your pain worse (please circle)? Morning Afternoon Night

Quality:

Dull	Sharp	Throbbing	Burning	Deep	Aching
Tingling	Stabbing	Cramping	Numbness	Radiating	Stiffness

Aggravating Factors:

Sitting	Standing	Walking	Bending	Stooping	Lifting
Sleeping	Sneezing	Coughing	Straining	Reaching	Twisting
Looking Up	Looking Down	Movement	Rest	Lying Supine	Driving
Typing	Scooping	House Chores	Exercise	Lying Prone	Stair Stepping

Relieving Factors:

Sitting	Standing	Lying	Knees Bent Up	Support
No Movement	Movement	Heat	Ice	Analgesic Topical
Ibuprofen	Medication	Rest	Stretching/Exercise	Adjustments

Please Circle...If YOU have ever been told you have had or are currently experiencing any of the following:

Headaches	Wart/Mole Changes	Stiff Neck
Dizzy	Cancer	Neck Pain
Light Headed	HIV	Shoulder Pain
Loss of Balance	Numbness	Arm/Hand/ Pain
Fainting	Pins/Needles in Arms/Hands	Low Back Pain
Blurred Vision	Loss of Grip/Strength	Pain Down Leg
Loss of Hearing	Pain Into Buttocks	Mid Back Pain
Ringing In Ears	Persistent Cough	Ankle Pain
Head Feels Heavy	Heart Murmur	Knee Pain
Fatigue	Chest Pain	Pain Into Thigh
Difficulty Swallowing	Shortness of Breath	Foot Pain
Nervous	High Blood Pressure	Pain Between Shoulders
Sores That Won't Heal	Low Blood Pressure	Muscle Spasm in Neck
Thyroid Dysfunction	Osteopenia	Muscle Spasm In Shoulder
Weight Loss/Gain	Osteoporosis	Muscle Spasm In Mid Back
Abdominal Pain	Osteomalacia	Muscle Spasm In Low Back
Any Bleeding/Discharge	Rheumatoid Arthritis	Other ______________________
Bladder/Bowel Problems	Psoriatic Arthritis	____________________________
Lump/Thickening Anywhere		

Are you under a lot of stress? Y/N Why? ____

Do You Have Any Allergy or Sensitivity? (Circle all that apply)

Animal dander/fur Dairy Dust Latex Nuts Pollen Seafood Tape or Adhesive Therapeutic cold sensitivity Therapeutic heat sensitivity Wheat

Current medications, including frequency and dosage if known. If there are no current medications, check here: ❑

	Start Date		Start Date
1) ____________________		**5)** ____________________	
2) ____________________		**6)** ____________________	
3) ____________________		**7)** ____________________	
4) ____________________		**8)** ____________________	

List any known allergies you have had to any MEDICATIONS.
If no allergies are known, check here: ❑

1) ____________________________________ **3)** ____

2) ____________________________________ **4)** ____

Briefly list your main health problems: ____

____

Has any doctor diagnosed you with Hypertension presently? ❑ Yes ❑ No If yes, describe: _______

____

Has any doctor diagnosed you with Diabetes presently? ❑ Yes ❑ No If yes, what kind?
❑ Type I ❑ Type II

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%?

❑ Yes ❑ No ❑ Not Sure

If yes, other comments regarding Diabetes: ____

Have you had a knee replacement? Yes / No Right or Left? _____________ When? ____________
Have you had a hip replacement? Yes / No Right or Left? ______________ When? ___________

Do you have any family history in your mother, father, sibling or grandparents of BACK PAIN, HEADACHES, CANCER, DIABETES, STROKE, ARTHRITIS OR HEART DISEASE? Y / N

If yes: Who? _______________ What conditions?____Age deceased______

Who? _______________ What conditions?____Age deceased______

Who? _______________ What conditions?____Age deceased______

Do you have any family history in your mother, father, sibling or grandparents of BACK PAIN, HEADACHES, CANCER, DIABETES, STROKE, ARTHRITIS OR HEART DISEASE? Y / N

If yes: Who?_______________ What conditions?____Age deceased______

Who?_______________ What conditions?____Age deceased______

Who?_______________ What conditions?____Age deceased______

Any broken bone? Y / N

Describe____Year?_____________

Describe____Year?_____________

Had any surgeries? Y/N

Describe____Year?_____________

Describe____Year?_____________

Describe____Year?_____________

Describe____Year?_____________

Do you have a pacemaker? Y / N

Are you or could you be pregnant? Y / N

Due to Insurance guidelines, we must have 3 measurable goals when it comes to your treatment process. Please provide us with your goals.

1. ____

2. ____

3. ____

Edgewater Chiropractic Clinic, PA. **Dr. Carly Meckle D.C.**

201 S. Ridgewood Ave, Suite 11
Edgewater, FL. 32132
Phone: (386)423-7575

Informed Consent for Chiropractic Treatment

TO THE PATIENT: You have a right to be informed about your condition, the recommended chiropractic treatment, and the potential risks involved with the recommended treatment. This information will assist you in making an informed decision whether or not to have the treatment. This information is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or refuse to give your consent to treatment.

I request and consent to chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays. The chiropractic treatment may be performed by the Doctor of Chiropractic named below and/or other licensed Doctors of Chiropractic working at this clinic or office. Chiropractic treatment may also be performed by a Doctor of Chiropractic who is serving as a backup for the Doctor of Chiropractic named below

I have had the opportunity to discuss with the Doctor of Chiropractic named below, my diagnosis, the nature and purpose of my chiropractic treatment, the risks and benefits of my chiropractic treatment, alternatives to my chiropractic treatment, and the risks and benefits of alternative treatment, including no treatment at all.

I understand that, there are some risks to chiropractic treatment including, but not limited to:

O Broken bones
O Dislocations
O Sprains/strains
O Burns or frostbite (physical therapy)
O Worsening/aggravation of spinal conditions
O increased symptoms and pain
O NO improvement of symptoms or pain
O infection (acupuncture)
O Punctured lung (acupuncture)
O other ________________________

In rare cases there have been reported complications of arterial dissections n (stroke) when a patient receives a cervical adjustment. The complications reported can include temporary minor dizziness, nausea, paralysis, vision loss, locked in syndrome (complete paralysis of voluntary muscles in all parts of the body except for those that control eye movement), and death.

I do not expect the doctor to be able to anticipate and explain all risks and complications. I also understand that no guarantees or promises have been made to me concerning the results expected from the treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions. All of my questions have been answered to my satisfaction. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my current condition.

To be completed by the patient:

____
Print Name

____
Signature of Patient

____
Date Signed

To be completed by the patient 's representative:

____
Print Name of Patient

____
Print Name of Patient's Representative

____
Signature of Patient's Representative

as:______________________________
Relationship/Authority of Patient's Representative

____
Date Signed

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Health Care Authorization:

The patient below authorizes Edgewater Chiropractic Clinic PA and its employees to use and/or disclose protected health information in accordance with the following:

Specific Authorizations: I give permission to Edgewater Chiropractic Clinic PA, and its employees to use my address and clinical records to contact me with appointments, reminders, missed appointments notification, birthday cards, holiday related cards, information about treatment alternatives, or other health related information.

If Edgewater Chiropractic Clinic PA, and its employees contact me by phone, I give them permission to leave a phone message on my answering machine/voice mail.

By signing this form, I am giving Edgewater Chiropractic Clinic PA, and its employees my permission to use and disclose my protected health information in accordance with the directives above.

Right to revoke authorization:

I have the right to revoke the above authorization by mailing or hand delivering a written notice to the privacy official of Edgewater Chiropractic Clinic PA. The written notice must contain the following information: My name, social security number, date of birth, a clear statement of my intent to revoke this authorization, the date and my signature. The revocation will not be effective until it is received by the privacy official. I have the right to refuse this authorization. If I refuse to sign it, Edgewater Chiropractic Clinic PA, will not refuse to provide treatment.

I have the right to inspect or copy the health information to be used/disclosed. I have a right to a copy of the signed authorization.

Patient's PRINTED Name: ____

Patient's Signature: ____Date:______________

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Thank you for choosing Edgewater Chiropractic Clinic, PA. For your chiropractic health care needs. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment process. The following is a statement of our financial policy, which we require that you read and sign prior to any treatment.

Regarding insurance: If you have an insurance plan that we participate in and the services which you are here for are expected to be covered expenses, we will gladly file your insurance claim for you. You will be billed for any amount that your insurance company leaves to your responsibility. We cannot bill your insurance unless you bring in your current insurance card. If your insurance company has not paid your account within 45 days, the balance will be transferred to your responsibility. Please be aware that some considered reasonable and necessary under the Medicare program and/or other medical insurance. If we do not participate with your insurance company, payment is due at the time of service. We accept cash, check, visa, MasterCard, and discover.

- Non-insured patient: if you do not have insurance, payment is expected at the time of service.
- **A $50 New Patient exam fee is responsibility of the patient and payment is expected at the time of service.**
- Usual and customary rates: This practice is committed to providing the best treatment for our patient and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- Adult patients: the adult accompanying a minor and the parents (or guardians) are responsible for full payment of service rendered to the minor.

Edgewater Chiropractic Clinic, PA. is here to provide you with the best possible health care. Our primary concern is your health and wellbeing, not with your insurance company. It is your responsibility to be aware of what your policy details are. Any questions should be directed to our staff.

I have read the above financial policy and I understand and agree to the terms within it.

Patient's PRINTED Name: ____

Patient's Signature: ____Date:______________

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This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your Personal Health Information. In addition, we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as dictated by our office policy, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled 'HIPAA' on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

PERMITTED DISCLOSURES:

1. Treatment purposes discussion with other health care providers involved in your care.
2. Inadvertent disclosures open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes to process a claim or aid in investigation.
5. Emergency in the event of a medical emergency we may notify a family member.
6. For public health and safety in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefit purposes.
9. Deceased persons discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders we may call your home and leave messages regarding a missed appointment or apprize you of changes in practice hours or upcoming events.
11. Change of ownership in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice.
3. To request mailings to an address different than residence.
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance.
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain one copy of your records at no charge, when timely notice is provided (72 hours). Xrays are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call Dr. Carly Meckle (386) 423-7575. If she is unavailable, you may make an appointment with our receptionist to see her within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201

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EDGEWATER CHIROPRACTIC CLINIC:

NOTICE REGARDING YOUR RIGHT TO PRIVACY

I have received a copy of
Patient Privacy Notice. I understand my rights as well as the practice's duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present. I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

____
Printed Name

____
DOB

____
Signature

____
Date