Moss Chiropractic Clinic

4223 Northlake Blvd.
Palm Beach Gardens, FL 33410

1580 SE Port St Lucie Blvd.
Port St Lucie, FL 34952

Welcome
Bienvenido
Thank you for choosing the office of
Gracias por escoger la oficina del
Dr. Damon T. Moss, DC
Please complete all information so we may serve you better.
Favor de completar toda la información para poder servirle mejor.
All information is strictly protected.
Toda la información está estrictamente protegida.

Patient Name: ______________________________________ Date: _______________
Nombre del Paciente: Fecha:

Date of Birth: ____________ Gender: __M or __F Social Security #: _________________
Fecha de Nacimiento: Género: Número de Seguro Social :

Address: ____
Dirección:

City/State/Zip: _________________________________ Email: ______________________
Ciudad/Estado/Código Postal: Correo electrónico:

Home Phone : ____________________ Cell Phone : ___________________
Número de Teléfono: Número de Celular:

Occupation: ______________________
Ocupación:

Emergency contact Name: _________________________ Tel: ___________________
Nombre del contacto de emergencia:

Relationship to patient: __________________________________
Relación con el paciente:

Marital Status: __Single __Married __Divorce __Widow
Estado Civil : Soltero Casado Divorciado Viudo

Race: __ American Indian __ Asian __ African American __ Pacific Island
Raza : __ White Caucasian __ Hispanic/Latino __ Other __________________

Ethnic Group: ___________________ Preferred Language: ________________
Grupo étnico: Idioma preferido:

Case Type : ___Auto ___Slip & Fall ____Workman's Compensation ___ N/A
Tipo de caso : Automóvil Resbalón y caída Compensación de los trabajadores

How did you hear about our practice?: ____________________________________
¿Cómo se enteró de nuestra práctica ?:

Insurance (Seguro)

Insurance Company: ______________________________ Tel : _________________
Member ID ___________________________

What problem(s) or concerns bring you to our office?
¿Qué problema (s) o preocupaciones le traen a nuestra oficina?

____How long have you had these problem(s)?
¿Cuánto tiempo ha tenido estos problemas?

____

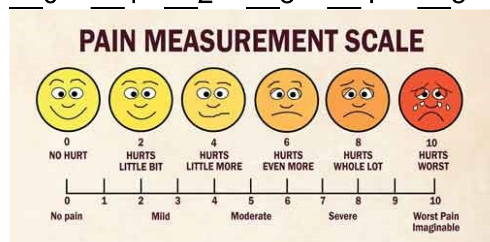
How would you describe your symptom(s)?
¿Cómo describirías tus síntomas?.

__Sharp __Sore __Throbbing __Tingling __Dull Stiff
Dolor agudo Adolorido Punzante Hormigueo / Entumecido origido

__Ache __Spasm __ Numbness __ Weakness __ Burning
Dolor leve Espasmo Entumecimiento Debilidad Ardiente

Please rate the intensity of your pain.
Por favor califique la intensidad de su dolor.

__0 __1 __2 __3 __4 __5 __6 __7 __8 __9 __10



No Pain Moderate Pain Extreme Pain
Sin dolor Dolor moderado Dolor extremo

Is your pain getting …__Worse __Better __Staying the same
Su dolor esta .... Peor Mejor Quedando igual

What makes your pain better?
¿Qué hace que tu dolor mejore?

__Nothing __Walking __Rest __ Moving/Exercise __Medication
Nada Caminar Descanso Moverse / Ejercicio Medicación

Is your condition affecting your ability to Perform routine daily activities? How?
¿Su condición afecta su capacidad para realizar actividades diarias de rutina? ¿Cómo?

____

Are you currently taking any medications, please list: ¿Está tomando algún medicamento actualmente? Por favor, anote cuales son.

____Do you exercise? ______ How often? _____ Do you smoke? ____ How much? _____
¿Hacer ejercicio? ¿Con qué frecuencia? Fumas? Cuánto?

Do you drink? _____ How much? _____ Any special diet? _________________________
¿Tu bebes? ¿Cuánto? ¿Alguna dieta especial?

Please list medical history / chronic conditions: Enumere su historial médico / afecciones crónicas:

____

Surgical history: Historia quirúrgica:

____

Are you pregnant? Yes ___ No ___ Not sure ___ Date of last cycle? __________________
¿Estas embarazada? Si No No estoy segura ¿Fecha del último ciclo?

Family History: Historia familiar:

____

Please list other symptoms/concerns (general, respiratory, abdominal, urinary, etc):
Enumere otros síntomas / preocupaciones (generales, respiratorios, abdominales, urinarios, etc.):

____

____

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4223 Northlake Blvd.
Palm Beach Gardens, FL 33410
Tel: 561-627-7771

1580 SE Port St Lucie Blvd.
Port St Lucie, FL 34952
Fax: 561-627-5948

INFORMED CONSENT FOR CHIROPRACTIC SPINAL MANIPULATION AND TREATMENT
I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of therapy modalities on myself (or on the patient named below for whom I am legally responsible) by the licensed doctors of chiropractic of Moss Chiropractic Clinic or any doctor, who now or in the future, works as a relief doctor. I have had the opportunity to discuss with my doctor the nature and purpose of chiropractic adjustments and other procedures. I also understand that spinal manipulation involved the doctor placing his or her hands on my spine and delivering a quick thrust or impulse to the involved area(s). I also understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to: fractures, disc injuries, strokes, dislocations, sprains, soreness, and physical therapy burns. I understand and comprehend all such risks and complications, I, by my signature below, confirm and accept care and therefore consent to and agree to those treatments deemed necessary by my doctor to be in my best interest.

Acknowledgement of Receipt of Notice of Privacy Practices
I certify that I have received a copy of Notice of Privacy Practices. The Notice of Privacy Practice describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of Moss Chiropractic Clinic health care operations. The Notice of Privacy Practices also describes my rights and Moss Chiropractic Clinic duties with respect to my protected health information. The Notice of Privacy Practices is posted in the office waiting area.

Assignment of Benefits, Release of Information and Financial Policy
I hereby authorize my Insurance benefits to be paid directly to Moss Chiropractic Clinic. I understand that I'm financially responsible for all deductibles, co-payments, co-insurances as per my insurance plan, as well as any non-covered services at the established fee rate set forth by Moss Chiropractic Clinic. I authorize the release of any medical or other information necessary to process insurance claims on my behalf. If I do not carry health or auto insurance, I understand that I have the option to pay at the time of service for a discounted rate or I will billed for my services at the full established fee rate set forth by Moss Chiropractic. I understand that I am responsible for any legal fee or collections fees that may incur from non-payment. I am aware that a No-Show fee of $100 can be applied if the appointment is not cancelled at least 24 hours before the scheduled time. I am also aware that if I fail to make my payments and my account goes to collections, I am responsible for all collection and legal fees.

COVID-19 waiver: COVID-19 has been declared a worldwide pandemic by the World Health Organization. COVID-19 is extremely contagious and is believed to spread mainly from person-to-person contact. As a result, federal, state, and local governments and federal and state health agencies recommend social distancing. Your Chiropractor/Therapist has put in place preventative measures to reduce the spread of COVID-19; however, they cannot guarantee that you will not become infected with COVID-19. By signing this agreement, I acknowledge the contagious nature of COVID-19 and voluntarily assume the risk that I may be exposed to or infected by COVID-19 by receiving treatment and that such exposure or infection may result in personal injury, illness, permanent disability, and death. I voluntarily agree to assume all of the foregoing risks and accept sole responsibility for any injury to myself (including, but not limited to, personal injury, disability, and death), illness, damage, loss, claim, liability, or expense, of any kind, that I may experience or incur in connection with my appointment. On my behalf I hereby release, covenant not to sue, discharge, and hold harmless my chiropractor or therapist, Moss Chiropractic Clinic, and any interested parties from the Claims, including all liabilities, claims, actions, damages, costs or expenses of any kind arising out of or relating thereto. I understand and agree that this release includes any claims based on the actions, omissions, or negligence of my chiropractor or the establishment where services are received, whether a COVID-19 infection occurs before, during, or after participation in any treatment session. Please visit www.cdc.gov for more information on COVID-19

____________________________________ ______________
Patient's signature or Legal guardian Date

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4223 Northlake Blvd
Palm Beach Gardens, FL 33410-6253
Tel: 561-627-7771

1580 SE Port St Lucie Blvd.
Port St Lucie, FL 34952-5456
Fax: 561-627-5948

Medical Records Release Form

By signing this form, I authorize you to release confidential health information about me, be releasing a copy of my medical records, or a summary or narrative of my protected health information, on the physician/person/facility/entity listed below.

Patients name: ________________________________ Date of birth: ________________

HIV/AIDS: I consent to the release of any positive or negative test result for AIDS or HIV Infection, antibodies to AIDS, or infection with any other causative agent of AIDS with the rest of my medical records.

The information you may release subject to this signed release form is as follows:

___ Complete Records ___ History & Physical ___ Progress Notes ___ Care Plan
___ Labs Reports ___ Radiology Reports ___ Pathology Reports ___ Treatment Records
___ Operative Reports ___ Hospital Reports ___ Medication Record ___ ER Records

Release my protected health information to the following physician/person/facility/entity:

FROM:

Name: __________________________________
Address: ________________________________
City: ___________________________________
Tel: ________________________
Fax: _______________________

TO:

Moss Chiropractic Clinic
Damon T. Moss, DC
1580 Port St Lucie Blvd
Port St Lucie, FL 33410
Tel: 561-627-7771
Fax: 561-627-5948

TO:

Attorney: _______________________________
Primary Care: _ __________________________
PCP Address: ___________________________
PCP Tel: ________________________
PCPFax: ________________________

FROM:

Moss Chiropractic Clinic
Damon T. Moss, DC
4223 Northlake Blvd.
Port St Lucie, FL 33410
Tel: 561-627-7771
Fax: 561-627-5948

The purpose/reason for this release: ______________________________________

____
Signature of Patient or Legal Guardian

____
Relationship to patient

____
Print Patient Name

____
Date

____
Patient's Date of Birth