Moss Chiropractic Clinic

4361 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.

Patients Name: _____ Date: _____
Nombre del Paciente: Fecha:

Date of Birth: _____ Gender: M or F Social Security Num.: _____
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 LOP
Tipo de caso : Automóvil Resbalón y caída Compensación de los trabajadores

Date of Accident: _____
Fecha del accidente

HOW DID YOU HEAR ABOUT US?

_____

Insurance (Seguro)

Name of Policy Holder: _____ Tel: _____
Nombre del titular de la póliza: Número de teléfono:

Address: _____ Relationship to policyholder: _____
Dirección: Relación con el asegurado:

City/State/Zip: _____
Ciudad/Estado/Código Postal:

Insurance Company : _____ Tel : _____
Compañía de seguros : Número de teléfono:

Address: _____ Extension: _____
Dirección: Extensión:

City/State/Zip: _____ Fax: _____
Ciudad/Estado/Código Postal:

Policy num.: _____ Claim Num.: _____
Núm. De póliza: Número de reclamo:

Name of Adjuster: _____ Tel: _____ Ext: _____
Nombre del Ajustador: Número de teléfono: Extensión:

Attorney's Information (Información del abogado)

Firm's Name: _____ Tel: _____ Ext.: _____
Nombre de la Firma: Tel: Extensión:

Address: _____
Dirección:

Attorney's Name: _____ Fax: _____
Nombre del abogado:

Brief History Breve Historial)

How long have you had this condition?_____
¿Cuánto tiempo ha tenido esta condición?

Have you seen anyone else for this condition?_____
¿Has visto a alguien más por esta condición?

Authorizations and Consents (Autorizaciones y Consentimientos)

Moss Chiropractic Clinic may need to contact you about test results, appointments, referrals, or billing/insurance information. To protect your privacy and follow federal guidelines, unless we have written permission to do so, we will NOT leave messages or discuss medical information with anyone unless you provide written authorization.

Es posible que Moss Chiropractic Centers necesite comunicarse con usted sobre resultados de exámenes, citas, referencias o información de facturación / seguro. Para proteger su privacidad y seguir las pautas federales, a menos que tengamos un permiso por escrito para hacerlo, NO dejaremos mensajes ni discutiremos información médica con nadie a menos que proporcione una autorización por escrito.

I give my permission for my provider of care and staff at Moss Chiropractic Clinic to leave voice mail messages, Email and or Text regarding my medical care/account information. I fully understand that this consent will remain valid until revoked in writing by me.

Doy mi permiso para que mi proveedor de atención y el personal de Moss Chiropractic Clinic dejen mensajes de correo de voz, correos electrónicos o mensajes de texto con respecto a mi información de atención médica / cuenta. Entiendo perfectamente que este consentimiento seguirá siendo válido hasta que sea revocado por escrito por mí.

___ Voice mail messaging **___ Email** **___Text**
Mensajería de correo de voz Correo electrónico Text**o**

By initialing you authorized (Iniciando usted autoriza)

I authorize: _____ Yo autorizo: _____
I do not authorize: ____ No autorizo: _____

HIPAA Notice (Aviso HIPAA)

I understand Moss Chiropractic Clinic is in compliance with the laws and guidelines of the HIPAA regulations. All services and records are confidential and private to protect the patient.

Entiendo que Moss Chiropractic Clinic cumple con las leyes y pautas de los reglamentos de HIPAA. Todos los servicios y registros son confidenciales y privados para proteger al paciente.

Acknowledgement of Receipt of Notice of Privacy Practices
Acuse de recibo del aviso de prácticas de privacidad

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.

Moss Chiropractic Clinic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail, or by asking for one at the time of my next appointment.

Certifico que he recibido una copia del Aviso de prácticas de privacidad. El Aviso de Práctica de Privacidad describe los tipos de usos y divulgaciones de mi información médica protegida que pueden ocurrir en mi tratamiento, en el pago de mis facturas o en el desempeño de las operaciones de atención médica de Moss Chiropractic Clinic. El Aviso de prácticas de privacidad también describe mis derechos y los deberes de Moss Chiropractic Clinic con respecto a mi información médica protegida. El Aviso de prácticas de privacidad se publica en el área de espera de la oficina.

Moss Chiropractic Clinic se reserva el derecho de cambiar las prácticas de privacidad que se describen en el Aviso de prácticas de privacidad. Puedo obtener un Aviso de Prácticas de Privacidad revisado llamando a la oficina y solicitando que se envíe una copia revisada por correo, o solicitando una en el momento de mi próxima cita

PLEASE SIGN ONLY ONE OF THE FOLLOWING:

___(1) I elect to have Moss Chiropractic bill my insurance on my behalf
Elijo que Moss Chiropractic le facture a mi seguro en mi nombre

Assignment of Benefits and Release of Information

(Asignación de Beneficios y Divulgación de Información)

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. I understand that I am responsible for any legal fee or collections fees that may incur from non-payment.

Por la presente autorizo que mis beneficios de seguro se paguen directamente a Moss Chiropractic Clinic. Entiendo que soy financieramente responsable de todos los deducibles y copagos según mi plan de seguro, así como de cualquier servicio no cubierto a la tarifa establecida por Moss Chiropractic Clinic. Autorizo la divulgación de cualquier información médica u otra información necesaria para procesar reclamos de seguro en mi nombre. Entiendo que soy responsable de cualquier tarifa legal o tarifas de cobranza que puedan incurrir por falta de pago. Estoy consciente de que puede haber una cuota de $100 si no cancelo mi cita 24 horas antes de la hora programada.

_____ _____

Patient/Responsible Party Signature **Date**
Firma paciente / Firma del Partido Responsable **Fecha**

___(2) I do not have insurance/I do not want my insurance billed by Moss Chiropractic
No tengo seguro o no quiero que mi seguro sea facturado por Moss Chiropractic

I do not give authorization for Moss Chiropractic Clinic to bill my insurance. I understand that I have the option to pay at the time of service for a discounted rate or I will be billed for my services at the full established fee rate set forth by Moss Chiropractic. By selecting this option, my protected health records (PHI) will never be released to my insurance company without my written permission. I understand that I am responsible for any legal fee or collections fee that may incur from non-payment.

No autorizo que mis beneficios de seguro se paguen directamente a Moss Chiropractic Clinic. Entiendo que soy financieramente responsable de todos los deducibles y copagos según mi plan de seguro, así como de cualquier servicio no cubierto a la tarifa establecida por Moss Chiropractic Clinic. Autorizo la divulgación de cualquier información médica u otra información necesaria para procesar reclamos de seguro en mi nombre. Entiendo que soy responsable de cualquier tarifa legal o tarifas de cobranza que puedan incurrir por falta de pago. Estoy consciente de que puede haber una cuota de $100 si no cancelo mi cita 24 horas antes de la hora programada.

_____ _____

Patient/Responsible Party Signature **Date**
Firma paciente / Firma del Partido Responsable **Fecha**

Patient's name: _____ DOB: _____
DOI: _____
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?

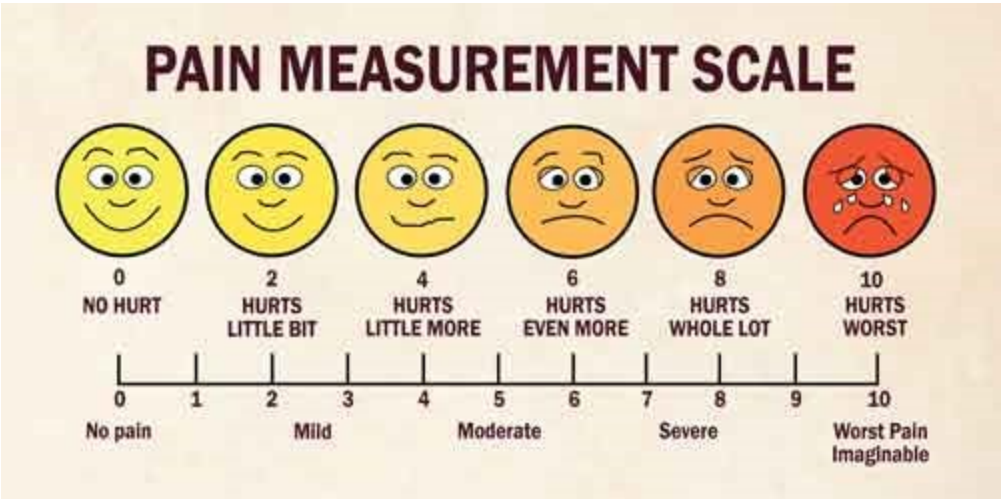
_____

How would you describe your symptom(s)? Circle those that apply.
¿Cómo describirías tus síntomas? Circula todo aquellos que aplican.

Sharp	Sore	Throbbing	Tingling	Dull Stiff
Dolor agudo	Adolorido	Punzante	Hormigueo / Estremecimiento	Entumecido o rigido

Ache	Spasm	Numbness	Weakness	Burning
Dolor leve	Espasmo	Entumecimiento	Debilidad	Ardiente

Please rate the intensity of your pain. (Circle)
Por favor califique la intensidad de su dolor. (Circundar)
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?

Have you ever had heart, lung, bowel or bladder problems? If yes please describe.
¿Alguna vez ha tenido problemas de corazón, pulmón, intestino o vejiga? En caso afirmativo, describa.

_____

_____

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

Is there any other information you feel is important for us to know regarding your treatment?
¿Hay alguna otra información que considere importante para nosotros con respecto a su tratamiento?

_____

_____

Moss Chiropractic Clinic

4361 Northlake Blvd.
Palm Beach Gardens, FL 33410
Tel: 561-627-7771

158 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.

_____ _____

Patients signature or Legal guardian Date

Moss Chiropractic Clinic

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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, by releasing a copy of my medical records, or a summary or narrative of my protected health information, on the patient 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

The below listed provider/facility has permission to 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
4361 Northlake Blvd.
Palm Beach Gardens, FL 33410-6253
Tel: 561-627-7771
Fax: 561-627-5948

The purpose/reason for this release: _____

_____ _____
Signature of Patient or Legal Guardian Relationship to patient

_____ _____
Print Name Date

_____
Patient's Date of Birth

Moss Chiropractic Clinic

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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

Release of Information:

By signing this form, I authorize Moss Chiropractic to release confidential health information about me, by releasing a copy of my medical records or a summary or narrative of my protected health information on the patient listed below.

Patient's 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.
_____ Initial

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

Please provide your primary care physician and any other providers or attorney acting on your behalf that you want your records and treatment plan released to:

TO:

Primary Care: _____
Tel: _____
Fax: _____
Provider/Attorney: _____
Tel: _____
Fax: _____

FROM:

Moss Chiropractic Clinic
Damon T. Moss, DC
4361 Northlake Blvd.
Palm Beach Gardens, FL 33410-6253
Tel: 561-627-7771
Fax: 561-627-5948

The purpose/reason for this release: Circle of Care / Other:_____

_____ _____
Signature of Patient or Legal Guardian Relationship to patient

_____ _____
Print Name Date

_____
Patient's Date of Birth

SUMMARY OF THE FLORIDA PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES

Florida law requires that your health care provider or health care facility recognize your rights while you are receiving medical care and that you respect the health care provider's or health care facility's right to expect certain behavior on the part of patients. You may a copy of the full text of this law from your health care provider or health care facility. A summary of your rights and responsibilities follow:

A patient has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.

A patient has the right to a prompt and reasonable response to questions and request.

A patient has the right to know who is providing medical services and who is responsible for his or her care.

A patient has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.

A patient has the right to know what rules and regulations apply to his or her conduct.

A patient has the right to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.

A patient has the right to refuse any treatment, except as otherwise provided by law.

A patient has the right to be given, upon request, full information and necessary counseling on the availability of know financial resources for his or her care.

A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.

A patient has the right o receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.

A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.

A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, physical handicap, or source of payment.

A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.

A patient has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.

A patient has the right to express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievances procedure of health care provider or health care facility which served him or her and to the appropriate state licensing agency.

A patient is responsible for providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.

A patient is responsible for reporting unexpected changes in his or her condition to the health care provider.

A patient is responsible for reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.

A patient is responsible for following the treatment plan recommended by the health care Provider.

A patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider or health care facility.

A patient is responsible for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.

A patient is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.

A a patient is responsible for following health care facility rules and regulations affecting patient care and conduct.

(Patient's copy)