

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

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

Mensajería de correo de voz

Email

Correo electrónico

Text

Texto

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

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 non-covered services. 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 occur 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 servicios no cubiertos. Autorizo la divulgación de cualquier información médica o de otro tipo de información necesaria para procesar reclamaciones de seguros en mi nombre.

Entiendo que soy responsable de cualquier arancel legal o aranceles de cobro que puedan surgir por falta de pago.

Patient/Responsible Party Signature

Firma paciente / Firma del Partido Responsable

Date

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.

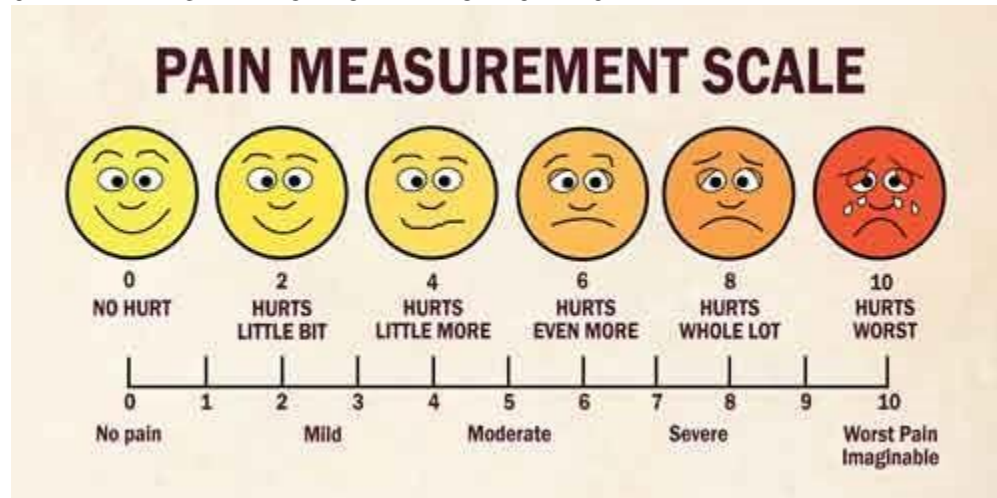
Sharp Sore Throbbing Tingling Dull Stiff
Dolor agudo Adolorido Punzante Hormigueo / Entumecido o rigido
Estremecimiento

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

4361 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:

Name: _____ Moss Chiropractic Clinic
Address: _____ Damon T. Moss, DC
City: _____ 4361 Northlake Blvd.
Tel: _____ Palm Beach Gardens, FL 33410-6253
Fax: _____ 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

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)