

Patient Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_  
 State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_ Patient Primary Language \_\_\_\_\_  
 Occupation \_\_\_\_\_ Employer \_\_\_\_\_ WorkPhone \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Subscriber Name \_\_\_\_\_ Health Plan \_\_\_\_\_  
 Subscriber ID# \_\_\_\_\_ Group # \_\_\_\_\_ Spouse Name \_\_\_\_\_  
 Spouse Employer \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Primary Care Physician Name \_\_\_\_\_ PCP Phone \_\_\_\_\_

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.

**DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:**

- Headache    Neck Pain    Mid-Back Pain    Low Back Pain  
 Other \_\_\_\_\_

Is this?    Work Related    Auto Related    N/A

Date Problem Began \_\_\_\_\_

How Problem Began \_\_\_\_\_

Current complaint (how you feel today):

0	1	2	3	4	5	6	7	8	9	10
No Pain										Unbearable Pain

How often are your symptoms present?

(Occasional)    0-25%    26-50%    51-75%    76-100% (Constant)

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores?)

No interference   0   1   2   3   4   5   6   7   8   9   10   Unable to carry  
on any activities

**In general would you say your overall health right now is:**

- Excellent    Good    Fair    Poor

**HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN FOR YOUR AREA(S) OF COMPLAINT?**    No    Yes

Date(s) taken \_\_\_\_\_

What areas were taken? \_\_\_\_\_

**Please check all of the following that apply to you:**

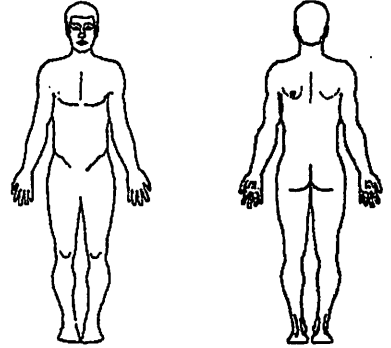
- |  |   |
|--|---|
| <p><input type="checkbox"/> Alcohol/Drug Dependence</p> <p><input type="checkbox"/> Recent Fever</p> <p><input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> High Blood Pressure</p> <p><input type="checkbox"/> Stroke (Date) _____</p> <p><input type="checkbox"/> Corticosteroid Use (Cortisone, Prednisone, etc.)</p> <p><input type="checkbox"/> Taking Birth Control Pills</p> <p><input type="checkbox"/> Dizziness/Fainting</p> <p><input type="checkbox"/> Numbness in Groin/Buttocks</p> <p><input type="checkbox"/> Cancer/Tumor (explain) _____</p><br><p><input type="checkbox"/> Osteoporosis</p> <p><input type="checkbox"/> Epilepsy/Seizures</p> <p><input type="checkbox"/> Other Health Problems (Explain) _____</p> | <p><input type="checkbox"/> Prostate Problems</p> <p><input type="checkbox"/> Menstrual Problems</p> <p><input type="checkbox"/> Urinary Problems</p> <p><input type="checkbox"/> Currently Pregnant, # Weeks _____</p> <p><input type="checkbox"/> Abnormal Weight   <input type="checkbox"/> Gain   <input type="checkbox"/> Loss</p> <p><input type="checkbox"/> Marked Morning Pain/Stiffness</p> <p><input type="checkbox"/> Pain Unrelieved by Position or Rest</p> <p><input type="checkbox"/> Pain at Night</p> <p><input type="checkbox"/> Visual Disturbances</p> <p><input type="checkbox"/> Surgeries _____</p><br><p><input type="checkbox"/> Tobacco use - Type _____</p> <p>Frequency _____ /Day</p> <p><input type="checkbox"/> Medications _____</p> |
|--|---|

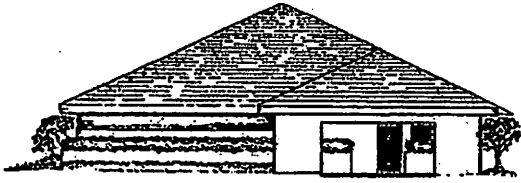
**Family History:**    Cancer    Diabetes    Heart Problems/Stroke    Rheumatoid Arthritis    High Blood Pressure

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor may need to contact my physician if my condition needs to be co-managed. Therefore I give authorization to my chiropractor to contact my physician, if necessary.

**Patient Signature** \_\_\_\_\_

**Date** \_\_\_\_\_





**STEPHENS CHIROPRACTIC**  
**375 S.W. 32nd Street**  
**Okeechobee, FL 34974**  
**Phone: (863) 763-0880**  
**Fax: (863) 763-3077**

**INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE**

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or the patient named below, for whom I am legally responsible) but the doctor of chiropractic named above and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as a backup for the doctor of chiropractic named above, including those working at the clinic or office listed above or any other office. I have had the opportunity to discuss with the doctor of chiropractic named above and/or with other office or clinic personnel the nature and purpose of chiropractic and other procedures.

I understand and I am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but no limited to, fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based upon the facts know, is my best interest.

I have read, and or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

**CONSENT TO EVALUATE AND ADJUST A MINOR CHILD**

I, \_\_\_\_\_ being the patient or legal guardian of \_\_\_\_\_ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

**PREGNANCY RELEASE**

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-rays can be hazardous to an unborn child.  
 Date of last menstrual cycle: \_\_\_\_\_

**MEDICARE CONSENT TO RELEASE INFORMATION**

I certify that the information given by me in applying for payment under Title XVII and/or Title XI of the Social Security Act is correct. I authorize any holder of medical or other carriers any information needed for this or related Medicare claim.

**SIGNATURE ON FILE**

- I authorize use of this form on all my insurance submissions
- I authorize the release of information to all my insurance carriers and Doctors unless specified otherwise by me
- I authorize my doctor to act as my agent in helping me obtain payment from my insurance carriers
- I permit a copy of this authorization to be used in place of the original
- I authorize payment directly to my doctor
- I understand I am responsible for my bill
- I authorize the release of any medical or other information necessary to process this claim

\_\_\_\_\_  
 Patient Signature

\_\_\_\_\_  
 Print Patient Name

\_\_\_\_\_  
 Date

# PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

**I wish to be contacted in the following manner (check all that apply):**

- |  |  |
|--|--|
| <input type="checkbox"/> Home Telephone _____<br><input type="checkbox"/> O.K. to leave message with detailed information<br><input type="checkbox"/> Leave message with call-back number only<br><br><input type="checkbox"/> Work Telephone _____<br><input type="checkbox"/> O.K. to leave message with detailed information<br><input type="checkbox"/> Leave message with call-back number only | <input type="checkbox"/> Written Communication<br><input type="checkbox"/> O.K. to mail to my home address<br><input type="checkbox"/> O.K. to mail to my work/office address<br><input type="checkbox"/> O.K. to fax to this number<br><br><input type="checkbox"/> Other _____ |
|--|--|

\_\_\_\_\_

Patient Signature

\_\_\_\_\_

\_\_\_\_\_

Print Name

\_\_\_\_\_

Birthdate

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

**Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.**

## Record of Disclosures of Protected Health Information

Date	Disclosed To Whom Address or Fax Number	(1)	Description of Disclosure/ Purpose of Disclosure	By Whom Disclosed	(2)	(3)

(1) Check this box if the disclosure is authorized  
 (2) Type key: T=Treatment Records; P=Payment Information; O=Healthcare Operations  
 (3) Enter how disclosure was made: F=Fax; P=Phone; E=Email; M=Mail; O=Other

PATIENT NAME: \_\_\_\_\_

**SIGNATURE ON FILE**

- \*\*\*I authorize use of this form on all my insurance submissions
- \*\*\*I authorize the release of information to all my insurance carriers and Doctors unless specified otherwise by me
- \*\*\*I authorize my doctor to act as my agent in helping me obtain payment from my insurance carriers
- \*\*\*I permit a copy of this authorization to be used in place of the original
- \*\*\*I authorize payment directly to my doctor
- \*\*\*I understand I am responsible for my bill
- \*\*\*I authorize the release of any medical or other information necessary to process all claims

PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**SUPPLEMENTAL INSURANCE** (If Applicable)

- Copy of card in chart     Copy of Driver's License in chart

\*\*\*\*\*

I waive the collection of unreimbursed medical charges on the above mentioned patient/family.

AUTHORIZED SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_