ALIGNED SRQ

• CHIROPRACTIC •

2415 University Parkway • Suite 217 • Sarasota, FL 34243
941.214.6150 Phone • Fax 863.494.7555
www.alignedsrq.com

Date_____ Patient Title: ○ Mr. ○ Mrs. ○ Ms. ○ Dr.

First Name _____ Middle_____ Last_____

Birth Date_____Social Security #_____Preferred Name _____

Mailing Address_____City_____State_____Zip Code_____

Primary Phone _____Alternate Phone _____

Primary Email_____ Other Email _____

How do you prefer us to contact you for appointment reminders? ☐ Mobile # ☐ Alternate # ☐ Email

Preferred Language: ○ English ○ Spanish ○ Prefer Not to Answer **Gender:** ○ Male ○ Female

Marital Status: ○ Single ○ Married ○ Other

Race: ○ White ○ Black/Afrlcan American ○ Hispanic ○ Multi Racial ○ Prefer Not to Answer

Do you currently smoke or chew tobacco? ○ Yes ○ No ○ Former ○ E Cigarette ○ Other _____

Employment Status: ○ Employed ○ FT Student ○ PT Student ○ Retired ○ Self Employed ○ Not Employed

Business Name _____ Occupation _____

To whom can we thank for referring you to our office:_____

You are here for: ○ Massage ○ Chiropractic ○ Nutritional/DETOX Program ○ Laser Therapy

Physical (If yes, please Indicate) ○ Sports ○ School ○ DOT ○ Non•DOT ○ TRT

Please tell us If you have had any major condition In the last 24 months _____

Are you still under a Doctor's care for this condition? If yes, who _____

Please tell us who is responsible for payment of your visit today:

☐ Self Pay ☐ General Insurance ☐ Work Comp ☐ Auto Liability ☐ Medicare ☐ Other

Name of Insurance Carrier_____Please provide office with card.

_____ _____ _____

Patient Signature Date Staff

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Please tell us why you are here today? _____

If you are experiencing pain today please describe it for us _____

_____

What is the nature of your injury: ○ Auto Accident ○ Work Injury ○ Other:_____

When did your symptoms appear? _____ Any prior similar symptoms? _____

On a scale of 0 -10 with 10 being severe pain, what level of pain are you at today?

Have you had previous Chiropractic care? If so, when and with whom?_____

When was your last physical exam? _____ With whom? _____

Are you pregnant? If so, when Is your due date?_____OB/GYN_____

Do you have any difficulty lying on your front, back or side? If yes, please note_____

_____

_____ _____

Patient Signature **Date**

To Be Completed by Clinical Staff:

Height_____ Weight_____ BP:_____/_____ Eye Dominance: ○ Right ○ Left

Health Scan Results: _____

_____

_____

_____

_____

_____

_____

_____

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Regarding your symptoms:	NO/YES	Details
Do you experience pain everyday?	○ No ○ Yes	_____
Does your pain wake you up?	○ No ○ Yes	_____
Does your pain affect your daily activity?	○ No ○ Yes	_____
Does weather affect your symptoms?	○ No ○ Yes	_____
Do you wear orthotics?	○ No ○ Yes	_____

YOUR HEALTH HISTORY IS EXTREMELY IMPORTANT TO US!

Please tell us if you have been treated for any condition in the last 2 years:

_____

_____

Who was the last Doctor you saw?_____When _____

Have you broken any bones? When_____ Briefly Explain_____

Have you been hospitalized? When_____ Briefly Explain _____

Have you had any surgeries? When_____ Briefly Explain _____

Had a concussion? When_____ Briefly Explain _____

Previous Auto Accidents? When_____ Briefly Explain _____

Please tell us if you currently take: ☐ Multi-Vitamins ☐ Fish Oils/Omegas ☐ Aspirin ☐ Calcium ☐ Weight Loss Products

☐ B Vitamins ☐ Vitamin D ☐ Greens or Protein Powders

Other(s):_____

Our office regularly uses a variety of science based, high quality nutritional supplements.

Do you have any concerns about: ☐ Increasing Energy ☐ Joint Flexibility ☐ Allergies ☐ Digestion ☐ Stress

☐ Weight Control/Loss ☐ Cholesterol ☐ Pain Management ☐ Genetic Predispositions to Disease

Please tell us if you currently take any medications: _____

Who is the Doctor that manages these? _____

Please check if you have a family history of: ☐ CANCER ☐ HEART DISEASE ☐ ARTHRITIS ☐ OTHER _____

Of your habits:	NONE	LIGHT	HEAVY	FREQUENCY?
Alcohol	○ None	○ Light	○ Heavy	_____
Coffee/Tea	○ None	○ Light	⬭ Heavy	_____
Tobacco	○ None	○ Light	⬭ Heavy	_____
Drugs	○ None	○ Light	◎ Heavy	_____
Sugar Foods	○ None	○ Light	⬭ Heavy	_____
Salty Foods	○ None	○ Light	○ Heavy	_____
Soft Drinks/Energy Drinks	○ None	○ Light	⬭ Heavy	_____

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Authorization to Release Health Information To Process Insurance Claims

Aligned SRQ Chiropractic Clinic

I understand and agree that, regardless of my insurance status, I am responsible for the balance on my account for any professional services rendered. I have read the above Patient Financial Policy and have provided the Practice with true and correct insurance information. I verify that I have no other insurance coverage than that listed above. I authorize the release of any medical or other information necessary to process any claims filed on my behalf. I also request payments of any insurance benefits including those from government programs to the party who accepts assignment on any claims filed. I authorize payment of medical benefits to the physician or supplier for services submitted on claims for services provided to me. Finally, I will notify the Practice promptly of any changes in my health insurance coverage.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.

X_____

Patient Name (Print)

X_____ _____

Signature of Patient or Legal Representative Date

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PATIENT NAME_____

FINANCIAL POLICY

My Account is:

○ Self Pay ○ General Insurance ○ Medicare ○ Auto PIP ○ Work Comp

If you account is not self pay, please complete the following as well as provide our front desk with your insurance card so that we may keep it on file.

Primary Insurance Company_____Phone#_____

Member or Policy #_____Group #_____

Are you the policy holder? If not, who is?_____DOB_____

Other Insurance Company_____Phone#_____

Member or Policy #_____Group #_____

Are you the policy holder? If not, who is?_____DOB_____

I, _____(Print Name) acknowledge, understand and agree that any health/accident/workmen's compensation Insurance policies are an agreement between myself and the Insurance company. I understand that all services rendered are ultimately MY responsibility and that If my Insurance does not cover any services I choose to have that any unpaid fees are my responsibility. I understand that should my account ever be turned over to collections for non-payment, there will be fees associated with such transfer. Fees will be determined by each collection agency, separately from our office. I also understand the office hold the right to charge my account for any appointment I fall to keep without proper notification. _____(Initial)

As a courtesy to you we bill your Insurance weekly. Our goal Is to get accurate healthcare benefits from your Insurance company immediately upon establishing yourself as a patient In our clinics. Often, however, these benefits may not always be accurate. You are responsible for your portion of the services at the time of visit. If you cannot make your scheduled appointment It Is your responsibility to call our office with 24 hours notice. Any unpaid balances will be billed to you monthly and balances may not exceed $150.00 at any time.
Refunds on services, programs of care or prepaid packages will not be given.

_____ _____

Patient Signature Date

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NOTICE OF PRIVACY PRACTICES

I understand the Health Insurance Portability and Accountability Act (HIPPA). I have certain rights to privacy regarding my protected health information. I acknowledge that I have the opportunity to review the privacy practices of this practice and that I may contact the practice at any time to obtain a copy of the Notice of Privacy Practices. I understand this Information can and will be used to 1) conduct, plan and direct my treatment and follow-up among multiple healthcare providers who are involved in my treatment either directly or indirectly and 2) obtain payment from third party payers and Insurers and finally 3) conduct normal healthcare operations such as quality assessments and physician certifications.

Patient Name Printed _____ Date _____

Patient Signature _____

AUTHORIZATION TO RELEASE HEALTH INFORMATION TO PROCESS INSURANCE CLAIMS IF WE ARE FILING INSURANCE CLAIMS ON YOUR BEHALF, PLEASE COMPLETE THE AUTHORIZATION BELOW.

Patient Name _____ DOB _____

As a patient you understand end agree to allow this office to use your patient health Information (PHI) for the purpose of treatment, payment, healthcare operations and coordination of care. Be assured this office will limit the release of all PHI to the minimum needed for what Insurance company may require for reimbursement of payment. As a patient you authorize payment of medical benefits to the physician or supplier of services submitted on claims for services provided to me. Finally, I agree to notify the office immediately of any changes to my health Insurance coverage and I may revoke this authorization at any time.

Patient Signature _____ Date _____

Welcome to our practice! The Doctors and staff here welcome you and Intend to provide you with the best care possible. We will conduct a thorough examination and history to better determine If we can assist you. If we do not believe that your condition will respond to chiropractic care we will refer you to
the appropriate provider. If you are a candidate, a treatment plan will be recommended to suite you.

Patient Signature _____ Date _____

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CONSENT FOR THE RELEASE OF MEDICAL RECORDS
PLEASE FAX ALL RECORDS TO 863-494-7555

Occasionally, we will ask for your medical records,
lab results or imaging reports from other locations.

This form should be filled out and kept on file for this purpose.

Florida Law requires information contained in your medical records to be held in strict confidence and not released without your written authorization.
The authorization you, the patient, sign on this page will remain in effect until your request in writing that they be withdrawn. You have the right to have a copy of this authorization upon your request.

PRINT PLEASE

Patient Name_____ DOB_____

Social Security #_____ Other Names Used_____

To Authorize release, please check any/all that apply.

- ☐ 1) General Medical Record on File with Facility
- ☐ 2) Lab Reports
- ☐ 3) Radiology Reports (X-ray, CT Scans, MRI's)
- ☐ 4) Other

I understand that authorizing the use or disclosure of the information is voluntary and I need not sign this form to ensure my medical treatment.

X_____ _____

Signature of Patient or Legal Representative Date

X_____ _____

Witness Signature Date

Request Faxed to_____ Fax #_____

USE SPACE BELOW ONLY IF PATIENT REVOKES CONSENT

X_____ _____

Signature of Patient or Legal Representative Date

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MEDICARE PATIENTS ONLY

A. Notifier: Arcadia Chiropractic Clinic, Inc.

B. Patient Name: _____

C. Identification Number: _____

Advance Beneficiary Notice of Non-Coverage (ABN)

NOTE: If Medicare doesn't pay for D. Services below, you may have to pay.
Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need.
We expect Medicare may not pay for the D. Services below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
Low Level Laser Therapy	Not a covered charge	25.00
Manual Therapy Percussion	Not a covered charge	25.00
Patient Initial Evaluation	Not a covered charge	55.00

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the D. Services listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. Options: Check only one box. We cannot choose a box for you.

◯ **OPTION 1.** I want the D. Services listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

◯ **OPTION 2.** I want the D. Services listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

◯ **OPTION 3.** I don't want the D. Services listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information:

_____

_____

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call 1-800- MEDICARE (1-800-633-4227/TTY: 1-877-486-2048). Signing below means you have received and understand this notice. You also receive a copy.

_____ _____

I. Signature **J. Date**

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CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.