

Tarpon Spine Center

Name: _____ Date of Birth: ____/____/____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell: _____
Email: _____ Social Security #: _____ Age: _____

Male Female Marital Status: Married Single Divorced Other _____

Name of Spouse or Nearest Relative: _____ Phone: _____
Your Occupation _____ Your Employer: _____
Name of Auto Insurance Co.: _____

• **List present complaints, injuries and duration:**

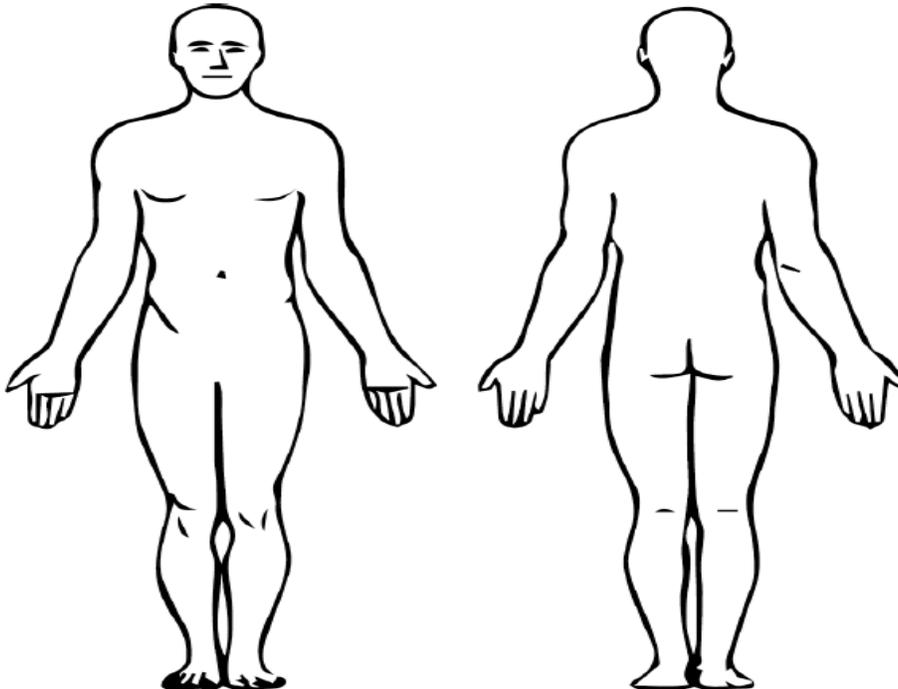
1. _____
2. _____
3. _____

• **Remarks and details of accident:**

Date of Accident: ____/____/____

Please complete the following *Pain Diagram* by using letters at the left to indicated on the diagram your areas of pain:

Pain (P) Tingling (T) Numbness (N) Burning (B) Stiffness (S)



Patient Signature: _____

Date: ____/____/____

Patient Name: _____ DOB: ____/____/____ Date: ____/____/____

List other doctors consulted for present complaints and injuries:

Name: _____ When Consulted: _____

Name: _____ When Consulted: _____

Present Family Doctor: _____

MEDICAL/FAMILY HISTORY

S = Self M = Mother F = Father

(Please indicate which PAST conditions have been experienced prior to present complaint by marking appropriate boxes).

S	M	F	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Back pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bladder trouble
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bone fracture
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Concussion
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Indigestion

S	M	F	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dislocated joints
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Measles
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headaches
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart trouble
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reproductive disorders
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HIV/ARC
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disorder
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bowel control loss
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual cramps
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscular Dystrophy

S	M	F	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neck pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Numbness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Polio
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor circulation
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Serious injury
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus trouble
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Venereal disease

Do you smoke? Yes ____ No ____ If so, how many packs per day? _____

Do you drink alcohol? Yes ____ No ____ If yes, how often and how much? _____

Do you use Illicit drugs? Yes ____ No ____ If yes, describe: _____

What surgeries have you had?

Type/When/Doctor/Remarks: _____

List former serious accidents and falls: (**circle one** ~ auto, work, home, leisure, sports, other)

What/When/Symptoms/Treatment/Results: _____

List broken bones:

What/When/Remarks: _____

List **Medications** and/or **diet supplements** you take and any **Allergies**:

What/Frequency/Doctors/Side Effects/Allergies/Remarks: _____

Patient Name: _____

DOB: ____/____/____

Date: ____/____/____

Review of Systems

General

- Weight Loss or Gain
- Fatigue
- Fever or Chills
- Trouble Sleeping

Skin

- Rashes/Wounds
- Itching
- Dryness
- Color Changes
- Hair/Nail changes

Head

- Headache
- Head Injury

Ears

- Trouble Hearing
- Ear Pain

Eyes

- Glasses or Contacts
- Eye Pain
- Redness
- Blurry/Double Vision
- Flashing Lights
- Seeing Specks

Nose

- Sinus Pain
- Nasal Discharge
- Hay Fever
- Nose Bleeds
- Trouble Smelling
- Post-Nasal Drip

Throat

- Sore Tongue
- Sore Throat
- Hoarse Voice
- Thrush
- Non-healing Sores

Neck

- Lumps
- Swollen Glands
- Neck Pain
- Neck Stiffness

Respiratory

- Cough
- Coughing up Blood
- Shortness of Breath
- Wheezing
- Painful Breathing

Cardiovascular

- Chest pain
- Tightness
- Palpitations
- Swelling

Vascular

- Calf Pain with Walking
- Leg Cramping

Gastrointestinal

- Swallowing Difficulties
- Heartburn
- Change in Appetite
- Nausea or Vomiting
- Change in Bowel Habits
- Rectal Bleeding
- Constipation
- Diarrhea
- Incontinence
- Yellow Eyes or Skin

Urinary

- Frequency
- Urgency
- Burning or Pain
- Blood in Urine
- Incontinence

Genital

Male

- Pain with sex
- Hernia
- Penile Discharge
- Penile Sores
- Lumps or Masses
- Erectile Dysfunction
- STD's

Female

- Pain with Sex
- Vaginal Dryness
- Hot Flashes
- Vaginal Discharge
- Itching or Rash
- STD's

Breasts

- Lumps
- Pain
- Discharge
- Self Exams

Musculoskeletal

- Muscle Pain
- Joint Pain
- Stiffness
- Redness of Joints
- Swelling of Joints
- Trauma

Neurological

- Dizziness
- Fainting
- Seizures
- Weakness
- Numbness
- Tingling
- Tremors

Hematologic

- Bleeding Disorder
- Easy Bruising

Endocrine

- Hot Intolerant
- Cold Intolerant
- Frequent Sweating
- Frequent Urination
- Frequent Thirst
- Frequent Hunger

Psychiatric

- Nervousness
- Anxiety
- Depression
- Memory Loss
- Stress

Patient Name: _____ DOB: ____/____/____ Date: ____/____/____

Certification and Assignment

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and or my dependent(s), have **Auto** insurance coverage with _____ and **Medical Health** insurance coverage with _____ and assign directly to **Tarpon Spine Center** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor/practice may use my health care information to the above-named Insurance Companies and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient or Guardian

____/____/____
Date

Financial Responsibility Agreement

I, the undersigned, have read and agreed to the following office procedure policies of: **Tarpon Spine Center**.

1. The patient is responsible for any portion of an insurance claim which is not paid by their insurance company.
2. Patients involved in legal suits are responsible for any portion not paid by their insurance company. In the event of a legal settlement, all medical bills to **Tarpon Spine Center** shall be paid out of settlement funds. I acknowledge that any remaining balance is my financial responsibility.
3. Any outstanding balances of thirty (90) days of age or greater are automatically presented to a collections attorney. A 30% fee is assessed to each account and the patient is responsible for all attorney fees and court fees.
4. Payment plans are available and will be privately discussed between the Doctor/Office Manager and patient upon the patient's request.

Financial Responsibility Statement: I understand and agree that insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, against the Doctor's recommendations, my account balance will be immediately due and payable.

Signature of Patient or Guardian

____/____/____
Date

Patient Name: _____ DOB: ____/____/____ Date: ____/____/____

Authorization Notice for the Use and Disclosure of Patient’s Protected Health Information

1. I am authorizing Tarpon Spine Center and staff to use my name out loud in order to call me back to a room for treatment.
2. I understand that in this practice, open bay adjusting and open bay therapy are used. If at any time I need to speak with the doctor in private, I can make this request and set up a special consultation time with the receptionist.
3. I understand that if the practice intends to use my name for advertising purpose or for testimonial purpose, they must further get my permission.
4. I understand that this authorization is voluntary.
5. I am authorizing Tarpon Spine Center and staff to use and/or disclose my protected health information (PHI) **to Insurance Companies, Lawyers, and Doctors** for all health care delivery purposes, which are known as treatment, payment, and health care operation (TPO).
6. I understand that this office will not receive financial or in-kind compensation in exchange for using or disclosing any of my health information.
7. I understand that I may request a copy of this form at any time for any reason and it will be provided for me.
8. This form and the Notice of Privacy Practices for Protected Health Information were completely read and filled in by me before I signed it. I certify that all my questions were answered to my satisfaction and that I understand this authorization form and its contents.
9. I further understand that this authorization is valid from today until I ask for a change in this policy in writing.
10. Chiropractic care and medical care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instances per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke.
Prior to receiving chiropractic care in our office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spine health. These procedures will assist us in determining if chiropractic care is needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.
11. By supplying my home phone number, mobile phone number, email address and any other personal contact information. I authorize my healthcare provider to employ a third-party automated outreach and messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s) and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balances due, lab results or other communications.

I also authorize my healthcare provider to disclose to third parties who may intercept these messages, limited protected health information (PHI) regarding my healthcare events.

I understand and accept there are risks associated with treatment and give my consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment. I also understand all of the above procedures used by this office and give my consent to those.

Signature of Patient or Guardian

____/____/____
Date

Signature of Witness (Office Representative)

____/____/____
Date

Patient Name: _____ DOB: ____/____/____ Date: ____/____/____

Office Rules and Guidelines

1. I agree to the following appointment schedule. I understand that I will be expected to make up any missed appointments. All missed appointments must be made up within 7 days or there will be a \$50 fee if appointment is not made up.
2. I agree to follow all other recommendations made by the doctor(s), including the proper use of rehabilitation equipment, doing my exercises as prescribed, etc.
3. I agree to make a personal financial agreement and promptly fill out all necessary medical, legal, and insurance forms to aid in the timely payment for my care.
4. Our appointment space is very valuable. **There is a \$50 fee for all missed appointments. You may reschedule your appointment in the same week, or make up your appointment the following week without being charged.** We prefer a 24 hour notice if you are going to cancel your appointment.

Our office hours are:

Monday, Wednesday and Thursday 8:00 a.m. ~ 6:00 p.m.

Tuesday 9:00 a.m. ~ 6:00 p.m.

Friday 9:00 a.m. ~ 5:00 p.m.

The office is closed every day between 12:00 p.m. ~ 2:00 p.m.

We have a 24 hour answering service that will take your call if needed. If any emergencies arise the staff/doctor will be notified. The staff/doctor will return the call in a timely manner.

5. Please no use of cell phones in the reception area. Please turn them off while in the treatment areas. If you need to make a call, we ask that you please make it outside the office.
6. If you are going to bring a guest, please have them check in with the front desk before you receive treatment.
7. Please be polite and courteous to all staff members and patients. Please respect all rehab equipment. We use this to correct your spine and improve your treatment progress.
8. You have the right to deny any treatment that you feel is excessive or unnecessary.
9. We are concerned about the safety of your children. Please observe them at all times.
10. If you have an outstanding balance on your account that is not paid within 90 days we will turn your account over for collections. I understand and agree that all legal fees and/or attorney fees associated with collection will be my responsibility and a 30% fee is assessed to each account.
11. We file your insurance as a courtesy to you. We will file your claims 3 times and provide follow up on the claims. If your insurance does not pay after 3 filings, the amount will be turned over to you. The balance will be due and it will be your responsibility.

I have read and understood the above guidelines for Tarpon Spine Center.

Signature of Patient or Guardian

____/____/____
Date

Signature of Witness (Office Representative)

____/____/____
Date

Patient Name: _____ DOB: ____/____/____ Date: ____/____/____

Tarpon Spine Center

Terms of Acceptance

In order to provide for the most effective healing environment, most effective application of chiropractic procedures and the strongest possible doctor-patient relationship, it is our wish to provide each patient with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic.

To that end, we ask that you acknowledge the following points regarding chiropractic care and the services that are offered through this clinic:

- A. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a separate and distinct science, art and practice. It is not the practice of medicine.
- B. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustment of spinal subluxation(s). Subluxations are deviations from the normal spinal structures and configurations that interfere with normal nerve processes.
- C. The chiropractic adjustment process, as defined in the "law of jurisdiction" involves the application of a specific directional thrust to a region or regions of the spine with the specific intent of re-positioning misaligned spinal segments. This is a safe, effective procedure applied over one-million times each day by doctors of chiropractic in the United States alone by doctors of chiropractic.
- D. A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If, during this process, any condition or question about outside the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider or specialist, according to the initial indications of the need.
- E. Chiropractic does not seek to replace or compete with your medical, dental or other type(s) of health professionals. They retain responsibility for the care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.
- F. Your compliance with care plans, home and self-care, etc., is essential to maximum healing and optimal health through chiropractic.
- G. We invite you to speak frankly to the doctor on any matter related to your care at this facility, its nature, duration of cost, in what we work to maintain as a supporting, open environment.

I have read and fully understand the above statements. All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my satisfaction. I therefore accept chiropractic care on this basis.

Signature of Patient or Guardian

____/____/____
Date

Signature of Witness (Office Representative)

____/____/____
Date