Congress Chiropractic

7534 Congress St. NPR FL, 34653

E-mail: _____ **Date:** _____

Name: _____ **Date of Birth:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Cell Phone: _____ **Work:** _____

Social Security # _____ **Male** _____ or **Female** _____

Marital Status: _____**Married** _____ **Single** _____ **Divorced** ____**Widow** _____**Other** **Age:** _____

Name of Spouse/Nearest Relative: _____ **Phone:** _____

Referred to this office: Friend/Family Member: _____ **Name?** _____

Your Occupation: _____ **Employer:** _____

Insurance Company: _____ **Your SS #:** _____

Is your visit because of an: Auto Accident _____ **or Worker's Comp:** _____ **When:** _____

Are you covered by more then one insurance company? Y or N Company Name: _____

Medical History

(Circle letter if yes)

Arthritis	Y	Kidney Disorder	Y
Asthma	Y	Bowl Control Loss	y
Back Pain	Y	Multiple Sclerosis	Y
Chest pain	Y	Numbness	y
Concussion	Y	Poor Circulation	Y
Diabetes	Y	Serious Injury	y
Epilepsy	Y	Sinus Trouble	Y
High Blood Pressure	Y		

S (Self) M (Mother) F (Father)

HIV/ARC	S	M	F	AIDS	S	M	F
Heart Trouble	S	M	F				

Have you been treated by a physician for any condition in the last year? Y or N

Describe Condition _____ Date of Last Physical Exam _____

Surgical History:

1. _____ **Date:** _____
2. _____ **Date:** _____
3. _____ **Date:** _____
4. _____ **Date:** _____

Have you had a metal implant? Y or N _____ **Have you ever had gunshot? Y or N**

Accident History:

1. _____ **Date** _____ **Auto** __ **Job** ___ **Other** ___
2. _____ **Date** _____ **Auto** __ **Job** ___ **Other** ___
3. _____ **Date** _____ **Auto** __ **Job** ___ **Other** ___

NAME: _____ DATE: _____

E-MAIL ADDRESS: _____

CONGRESS CHIROPRACTIC CLINIC
ADDITIONAL COMPREHENSIVE HISTORY QUESTIONNAIRE

Chief Complaint: (what brings you into the office today?)...List all areas of complaint.

_____

_____

Onset: (when did the problem(s) begin; how long has it bothered you?

_____

_____

Palliative: (what makes it feel better?...rest, ice, medication(aspirin, tylenol, prescription, etc.)

_____

_____

Provocative: (what makes it worse?...bending, walking, standing, lifting, working, etc.)

_____

_____

Quality of symptoms: (how would you describe the symptoms?...sharp, stabbing, dull, throbbing, numbness or tingling, etc.)

_____

_____

Radiation of symptoms: (does your pain remain localized in one area or does it refer to another area, and if so; where does it go?)

_____

_____

Severity: (how would you rate the severity of pain?)
(please circle one) 1, 2, 3, 4, 5, 6, 7, 8, 9, 10...(10 being the worst)

Timing: (is there a time of day that your condition is worse (please circle one) Morning, Afternoon, Evening and does your condition affect your sleep? Yes / No
if yes, please explain

_____

_____

CONGRESS CHIROPRACTIC CLINIC

DR. KEVIN P. CONNER
CHIROPRACTIC PHYSICIAN

7534 CONGRESS STREET
NEW PORT RICHEY, FL. 34653-1105
TELEPHONE (727) 847-3852
FAX (727) 849-9900

MEMBER
NORTH SUNCOAST CHIROPRACTIC SOCIETY
AMERICAN CHIROPRACTIC ASSOCIATION
FLORIDA CHIROPRACTIC ASSOCIATION

Informed Consent

I, _____ hereby give permission to Dr. Kevin Conner to release any information to my insurance company, hospital, or other Physicians, acquired in the course of my examination or treatment.

I, _____ hereby give Dr. Kevin Conner and/or his Associates permission to administer treatment and perform such general procedures, as he/they may deem necessary in the diagnosis and/or treatment of my condition. If I have insurance, I understand that that I am responsible for **all payments** until my insurance benefits are verified by this office or if I am not covered.

I clearly understand and agree that without insurance coverage all services rendered to me are charged directly to me and that I am personally responsible for payment at the time of service.

Risk of Manipulation

Chiropractic care has been shown to be generally helpful in many health conditions; however, as in all health care, there are risks that may occur such as joint irritation, dizziness, fractures, any unforeseeable injury and rarely, incidence of stroke. Statistics show the risk is as little as one in one million adjustments for stroke and decreases over the age of 45. Alternative care to chiropractic can consist of pain medications, surgery, physical therapy or I can do nothing, but I have elected to have Chiropractic care.

I understand all the above statements and am signing this document freely and voluntarily.

Patient signature: _____ **Date:** _____

Financial Responsibility

I _____ am aware that I have a $_____ deductible. According to my insurance carrier this is an amount that I freely choose. I am also aware that my insurance carrier only covers _____% of all charges after I pay my deductible. I understand that I am fully and legally responsible for the deductible, as well as any percentage not covered by my carrier. If I am not able to pay these charges in full at this time, I will make arrangements to make payments on any and all charges for which I am responsible.

We accept cash, check, credit card and debit card for your convenience. There is a $30.00 fee for any returned checks.

I authorize and request the performance of Chiropractic services for myself or my minor child so designated below, and give consent to any advisable and necessary procedures and X-Rays to be administered by the attending physician or by his supervised staff or diagnostic purposes and chiropractic treatments.

If default be made in payment and if such default is not made good within 10 days, the entire principal sum and accrued interest shall at once become due and payable without notice. Failure to exercise this option shall not constitute a waiver of the right to exercise the same at a later date for the same default and if placed in the hands of a collection agency, or an Attorney of Law for collection, the undersigned agrees to pay all costs of collection including reasonable Attorney's fees. Presentment, protest, and notice is hereby waived.

I understand that it is my responsibility to know the benefits of my insurance policy and any co-payments that I may owe. I also understand that I am ultimately responsible for any balance due on my account for professional services rendered. I also understand that my diagnosis is what I am being treated for. I have read and completed this form and certify that all the above information is correct to the best of my knowledge.

Our confirmation of benefits/coverage on the phone with your Insurance Company is not a guarantee of payment or coverage and that you are responsible for any unpaid balances, deductibles, or if coverage is denied.

Patient Signature: _____ **Date:** _____

Social Security #: _____

Parent/Guardian: _____

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I was provided with a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed info my patient chart and maintained for six years.

Patient signature: _____ Date: _____

Parent/Guardian signature: _____

People and relationship of people the patient wants information shared with

Name: _____ Relation: _____

Name: _____ Relation: _____

Release of Patient records Authorization

I hereby authorize _____,

to release a copy of my patient records or x-rays containing protected health information to

_____.

This authorization is given pursuant to Florida Statute 456.057 and HIPAA regulations. I understand that Florida Statute 456.057(10) makes it clear that any third party to whom records are disclosed to is prohibited from further disclosing of any information in the medical record without the expressed written consent of the patient or the patient's parent/guardian.

_____ _____

Patient / Parent Signature Date of Birth

_____ _____

Patient Name Printed Date Signed

Description of information being requested: _____

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I, _____, have not been in any slip and fall or motor vehicle accidents that are currently open with or without an attorney.

Patient name _____

Date _____

Patient Signature _____