

New Patient Office Questionnaire

Patient Name: _____ Birthdate: _____

Address: _____

City: _____ State: _____ Zip: _____

Cell: _____ Home: _____ Work: _____

SS# _____ Circle one: Single Married Divorced Widowed Other

Primary Ins: _____ ID # _____

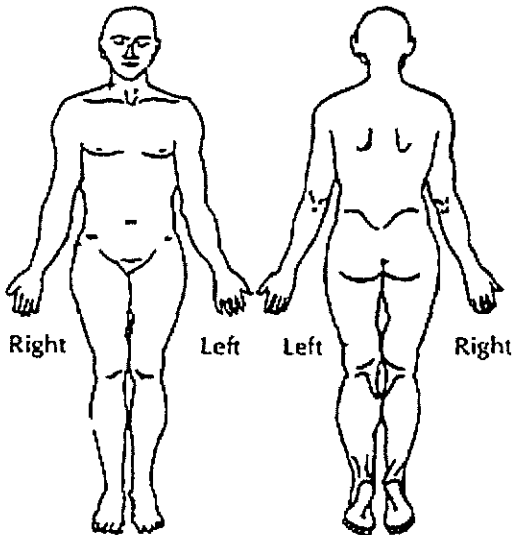
Secondary Ins: _____ ID # _____

Primary care physician: _____ Phone: _____

Emergency contact name: _____ Phone: _____

Reason for visit: _____

Please mark the areas of your pain, use the key below to indicate different types of pain sensations:



Shooting:	-----
Stabbing:	////////
Aching:	xxxxxx
Throbbing:	000000
Pins & Needles:	●●●●●
Burning:	*****

Employment Details:

Are you currently working? (Circle one) Yes/No Full Duty/Light Duty

Employer Name: _____ Phone: _____

Job Title: _____ How many hours do you work each day? _____

Duties: _____

If you are not working, why and what date did you stop?

Pain Details:

Does your pain shoot or affect another part of your body? Yes/No If Yes please describe below:

Describe the frequency of the pain: (Circle one) Constant Intermittent Occasional

How many hours a day do you have the pain?

(If you do not have pain everyday estimate how many hours per week, month, etc): _____

How many weeks, months or years have you been disabled in pain? _____

Does the pain affect your activities: Yes/No Rate your pain on the pain scale: /10

What action relieves your pain? (Circle one) Sitting Standing Walking Massage Medication

What makes your pain worse? (Circle one) Sitting Standing Walking Massage Medication

Do you have severe night time pain? Yes/No

Do you wake up in the middle of the night because of pain? Yes/No

Do you have difficulty falling asleep at night? Yes/No

Review of Systems
(please check all that apply)

Constitutional Symptoms	Eyes	Genitourinary
Good General health lately:	Eye Disease or injury:	Frequent Urination:
Recent weight changes:	Wear glasses/contacts:	Burning/pain during urination:
Fever:	Blurred or Double Vision:	Blood in urine:
Fatigue:	Cardiovascular	Change in force during urination:
Headaches:	Heart trouble:	Incontinence:
Ears/Nose/Mouth/Throat	Chest pain or angina:	Kidney Stones:
Hearing loss or ringing:	Palpitation:	Sexual Difficulty:
Earaches or drainage:	Shortness of breath w/walking:	Male: Testicle pain:
Chronic Sinus problems:	Shortness of breath w/lying:	Female: pain with periods:
Nose Bleeds:	Swelling of feet/ankles/hands:	Female: Irregular periods:
Mouth Sores:	High Blood Pressure:	Female: Vaginal Discharge:
Respiratory	Low Blood Pressure:	Hematologic/Lymphatic
Bleeding Gums:	Persistent cough:	Slow to heal after cuts:
Bad breath/taste:	Spitting up blood:	Bleeding/bruising:
Sore throat/voice change:	Shortness of breath:	Anemia:
Swollen Glands in neck:	Wheezing:	Phlebitis:
Gastrointestinal	Musculoskeletal	Past Transfusion:
Loss of appetite:	Joint Pain:	Enlarged Glands:
Change in bowel:	Joint stiffness:	
Nausea/Vomiting:	Joint Swelling:	
Frequent Diarrhea:	Joint Weakness:	
Painful Bowel:	Muscle pain/cramps:	
Constipation:	Back Pain:	
Rectal bleeding in stool:	Cold extremities:	
Abdominal pain:	Difficulty Walking:	
Integumentary	Neurological	
Rash or itching:	Frequent/recurring headache:	
Changing in skin color:	Light headed/dizzy:	
Change in hair/nails:	Seizures:	
Varicose veins:	Numbness/tingling:	
Breast pain:	Tremors:	
Breast Lump:	Paralysis:	
Breast Discharge:	Head Injury:	
Psychiatric	Endocrine	
Memory loss:	Glandular/hormone issues:	
Confusion:	Excessive thirst/urination:	
Depression:	Heat intolerance:	
Insomnia:	Cold intolerance:	
Suicidal thoughts:	Dry Skin:	
Violent thoughts:	Change in hat/glove size:	

Please check any past medical history you may have:

Aids/HIV	Bulimia	Gout	Measles	Prostate Problems
Allergy Shots	Cancer	Heart Disease	Migraines	Prosthesis
Anemia	Cataracts	Hepatitis	Mononucleosis	Rheumatic Fever
Anorexia	Chemical Dependency	Hernia	Mumps	Rheumatoid Arthritis
Appendicitis	Chicken Pox	Herniated Disk	MS	Scarlet Fever
Arthritis	Diabetes	High Blood Pressure	Osteoporosis	Stroke
Asthma	Emphysema	High Cholesterol	Pacemaker	Thyroid Issue
Bleeding Disorder	Epilepsy	Kidney Disease	Parkinson's	Tonsillitis
Breast Lump	Glaucoma	Liver Disease	Pneumonia	Tuberculosis
Bronchitis	Goiter	Low Blood Pressure	Polio	Ulcers

Female patients: # of pregnancies _____ # of Miscarriages _____

Do you smoke? Yes/No If yes, how long and how often: _____

Do you drink? Yes/No If yes, how often: _____

Have you ever done drugs? Yes/No Type/frequency? _____

Have you had any surgery? Yes/No Please explain: _____

Please list any allergies: _____

Describe your regular exercise activity: _____

Please list any family medical history: _____

Please list or attach an updated medication list, list the strength, dose, and frequency of the medications you are taking:

I _____ (patient name) attest that above statements are true, which was based on the best of my knowledge.

Patient Signature: _____ Date: _____

AUTO ACCIDENT QUESTIONNAIRE

Date of Accident: _____ Time: _____ (AM)(PM) Location: _____

Auto Insurance Company: _____ Policy #: _____ Claim#: _____

Attorney: _____ Attorney Phone: _____

Brief Description of the Accident: _____

Patients vehicle (Yr, make, model) _____ Estimated speed _____ MPH

Patients vehicle hit by (Yr, make, model) _____ Estimated speed _____ MPH

Did any part of your body make contact with the inside of the vehicle? Yes No If yes, please list:

Did vehicle have seatbelts? Yes No Was seatbelt worn? Yes No Road Condition? Dry Damp Wet

Did vehicle have airbags? Yes No Did airbags deploy? Yes No Police Report? Yes No

Were you the: Driver Passenger R Back seat L Back seat Front Middle Middle of Back

If vehicle had headrest, describe the position compared with top of your head:
 Top of headrest w/top of head Top of headrest w/middle of head Top of headrest aligned w/bottom of head

Did you see accident coming? Yes No Were you braced for impact? Yes No

Hands: One on Wheel Two on Wheel Were Brakes Applied? Yes No Were you at a complete stop? Yes No

Were you looking in the side mirrors? Yes No Were you looking into rear view mirror? Yes No

Did you lose consciousness? Yes No First Symptom appeared _____ after the MVA

How many people in the car? _____ Were they Injured? Yes No

Initial Symptoms: None Headache Dizzy Disoriented Neck Pain Nausea Vomiting Blurred Vision Shock
 Ringing in Ears Mid-Back pain Low Back Pain Numbness

Did you go the hospital? Yes No Transported by Ambulance Drove yourself Someone drove you

Name/Location of Hospital: _____

When did you go: Immediately Later-when?: _____

Were you admitted: Yes No How long did you stay: _____

Please indicate what was performed at hospital: X-Rays MRI CT

Were you prescribed medications: Yes No List Name(s): _____

Have you seen any other Doctor for this accident? Yes No List Name(s): _____

Patient Signature: _____ Date: _____

**1 SOURCE CHIROPRACTIC & PHYSICAL MEDICINE, INC.
FINANCIAL POLICY-AUTO CLAIMS**

We would like to take a moment to welcome you to our office and to assure you that you will be receiving the best care available for your condition. To familiarize you with the financial policies of our office, I would like to explain how your medical bills will be handled.

PARTIES RESPONSIBLE

If you were involved in an auto accident and are the owner of the vehicle, we will bill the medical insurance portion of your own automobile policy. If you were a passenger in someone else's car, we will bill the driver's auto insurance company. (These policies will be billed in addition, and prior to, any claim that your attorney may be presenting to an insurance company on your behalf).

If you were the passenger in a vehicle which was not insured, but you own a car which has medical coverage, the insurance company which carries YOUR policy will be responsible to pay your medical bills.

RESPONSIBILITY FOR PAYMENT

As a courtesy to you, we will gladly submit your medical bills to your insurance company(s) and/or your attorney; however, all services rendered by this office will be charged directly to you, and, ultimately, you will be personally responsible for payment for these bills regardless of any settlement you may or may not receive.

As a courtesy, the Facility will obtain a verification of applicable insurance benefits as they are quoted to us but some third party payers misquote benefits, coverage and liability. Our Facility and staff are NOT responsible for what a third party payer and/or representative may tell us. Any contractual, written, verbal or other obligation or arrangements between you and your attorney, insurance company, liable or third party payer are between you and said person or party.

1. Our facility will file initial insurance claims for you. Secondary claims submissions and/or additional reports and/or documents sent on your behalf may result in an additional filing fee and/or medical report charges which will be billed to your account and may or may not be reimbursable by your insurance as each carrier is different. We will attempt to file these on your behalf.
2. Patients are responsible for deductible, co-insurance payments, and charges on all service(s) and/or product(s) which may exceed the maximum allowable and/or when a third party and/or insurance carrier does not reimburse this Facility enough to meet our cost of service.
3. A service charge is computed by a "periodic rate" of 1 ½% per month. 18% per annum & is added to all balances owed 60+ days. Any balance past due 90 days or more may be submitted to an attorney and/or agency for legal collection for which the undersigned agrees to be 100% responsible for all monthly service charges, interest, costs related to but not limited to all collections related expenses, attorney fees, court & filing fees. **(This paragraph only applies to cases where your attorney is dropped, you do not obtain an attorney or we cannot come to any resolution with your attorney to settle your case and no settlement can be made on your case.)**
4. Returned checks, debit and credit charges made payable to the facility for insufficient funds, stop payments or other expenses of non-payment will be assessed a \$30.00 charge.

Patient Signature: _____ Date: _____

PROVIDER'S LIEN: PATIENT'S LETTER OF PROTECTION; AUTHORIZATION FOR RELEASE OF INFORMATION; SPECIAL POWER OF ATTORNEY AND ASSIGNMENT OF RIGHTS & BENEFITS WITHIN THE MEANING OF § 627.736, FLORIDA STATUTES

This agreement allows me, _____, to be treated by 1 Source Chiropractic & Physical Medicine, Inc. without paying for my care and treatment in advance.

1 Source Chiropractic & Physical Medicine, Inc. will be paid within (35) days of submission of claims for my care directly by my personal injury protection insurance carrier. The parties agree that this is good and sufficient mutual consideration.

I hereby guarantee full payment to 1 Source Chiropractic & Physical Medicine, Inc. and agree that I will remain personally responsible for any unpaid charges. I also grant 1 Source Chiropractic & Physical Medicine, Inc a lien against any recovery which I may have now or in the future against any responsible insurance carrier. **I promise to sign a letter of protection in favor of 1 Source Chiropractic & Physical Medicine, Inc. and I hereby direct that any attorney representing me now or in the future execute a letter of protection in favor of 1 Source Chiropractic & Physical Medicine.**

I hereby authorize and direct my personal injury protection insurance company or group health insurance companies to pay directly to 1 Source Chiropractic & Physical Medicine, Inc. my personal injury protection benefits for care and treatment rendered to me by 1 Source Chiropractic & Physical Medicine, Inc.

I hereby assign my personal injury protection rights and benefits to 1 Source Chiropractic & Physical Medicine, Inc. If any portion of this document is deemed to be inconsistent with an assignment of rights and benefits within the meaning of Florida Statutes § 627.736, said portion shall be rewritten in order to conform with Florida law to give full effect to the intended purpose of this agreement, said intended purpose being to create an assignment of rights and benefits from **(insurance carrier)** _____ to 1 Source Chiropractic & Physical Medicine, Inc.

I hereby grant 1 Source Chiropractic & Physical Medicine, Inc. a limited Power of Attorney to endorse checks made payable to me for PIP benefits. I grant to 1 Source Chiropractic & Physical Medicine, Inc. full power and authority to endorse and sign checks or drafts for payment of bills submitted by 1 Source Chiropractic & Physical Medicine, Inc.

I authorize and direct my present or future attorneys and my personal injury protection insurance carrier, or carriers, to release medical and legal information about me to 1 Source Chiropractic & Physical Medicine, Inc.

Patient Signature: _____ Date: ____/____/____



Informed Consent to Treat

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 on the patient named below, for whom I am legally responsible) by **Jorge L. Santana D.C. at 1 Source Chiropractic & Physical Medicine** and/or other licensed doctors of chiropractic who now or in the future work at the clinic.

I have had the opportunity to discuss with the doctor of chiropractic and/or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I 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 and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications and I wish to rely upon the doctor to exercise judgment during the course of the procedures which the Doctor feels at the time, based upon the facts then known to him or her, and is in my best interest.

I have read, 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.

Patient Name: _____ Date: _____

Patient Signature (or signature of guardian): _____

**HIPAA Compliant Authorization for Release of Patient Information
Pursuant to 45 CFR 164.508**

Section I – Patient Information

Name: _____ DOB: _____ Last 4 of social: _____

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

Patient Phone: _____ Facility Phone: _____ Facility Fax: _____

Section II: Authorization for Release of Patient Information:

I, or my authorized representative, hereby authorize

_____ (name of entity holding the requested records) and their respective employees, agents and subcontractors to disclose my Personal Health Information (PHI) and Insurance Record to:

**1 Source Chiropractic & Physical Medicine, Inc.
19409 Shumard Oak Dr. #102 Land O' Lakes, FL 34638
Ph: 813-448-2222 Fax: 813-948-7111**

Section III – Specific Information to be Released:

- Please release my Medical Record from (insert date) _____ to (insert date) _____
- Please release my entire Medical Record, including patient histories, office notes (excluding psychotherapy notes, test results, radiology studies, films, referrals, consults, billing records, insurance records sent to Freedom Health by health care providers.
- Other: (please explain) _____

Reason for release of information:

- Include: (Indicate by Initialing) _____ Alcohol/Drug _____ Mental Health _____ HIV-Related Information _____
- At the request of the individual
- Other: _____

Section IV: I understand that Section 460.413 (1) (m), Florida Statutes, and Board of Chiropractic Medicine Rule 64B2-17.006 require chiropractic physicians to retain records and x-rays for at least four years. Therefore, a chiropractic physician receiving a request for a patient's x-ray within that four-year period must retain the x-ray and provide a copy of it in lieu of the original x-ray. I, further, understand that Section 456.057 (18), Florida Section 457.057 (16), Florida Statutes, authorizes a health care practitioner or patient records owner furnishing copies of reports or records or making the reports or records available for digital scanning pursuant to this section to charge no more than the actual cost of copying, including reasonable staff time, or the amount specified in administrative rule by the appropriate board, or the department when there is no board. The Board of Chiropractic Medicine Rule 64B-17.0055, Florida Administrative Code, authorizes chiropractic physicians to charge patients \$1.00 per page for the first 25 pages, and 25 cents for each page in excess of 25 pages. The Board of Chiropractic Medicine Rule defines the reasonable costs of reproducing x-rays, and such other special kinds of records as the actual costs. The phrase "actual costs" means the cost of the material and supplies used to duplicate the record, as well as the labor costs and overhead costs associated with such duplication. The Board of Chiropractic Medicine Rule 64B-17.0055, Florida Administrative Code, authorizes chiropractic physicians to charge people who are not patients authorized to seek copies of my patient records \$1.00 per page. I understand that the HIPAA regulations authorize the practice to charge the cost of labor and hardware onto which the records are electronically copied unless the Board of Chiropractic Medicine sets lower costs. I understand that there is no cost for transmitting the electronic records by email.

This authorization will be in effect for one year from the date signed, unless you indicate a shorter period below:

Date or event on which this authorization will expire: _____

If an authorized representative is making this request, please provide your information below and attach certifying documentation of your status as the authorized representative, such as a Power of Attorney or Guardianship papers.

AUTHORIZED REPRESENTATIVE

By signing this form, I am confirming that it accurately reflects my wishes. In addition, I have kept a copy of this form for my records.

Signature of Member or Authorized Representative

Date

HIPAA PRIVACY AUTHORIZATION FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et. seq., and regulations promulgated there under, as amended from time to time (collectively referred to as "HIPAA").

This authorization affects your rights in the privacy of your personal healthcare information. Please read it carefully before signing.

1 SOURCE CHIROPRACTIC & PHYSICAL MEDICINE, ("Covered Entity") will not condition treatment payment, enrollment in a health plan, or eligibility for benefits, as applicable, on your providing authorization for the requested use or disclosure. **YOU MAY REFUSE TO SIGN THIS AUTHORIZATION.**

By signing this authorization you acknowledge and agree that Covered Entity may use or disclose Medical Records and/or Medical Billing for the purpose(s) of Collections, and for the sole purpose of referring you out for treatment or diagnostic services.

By signing this authorization you agree that Covered Entity or its Business Associates may disclose your personal health care information only for the sole purposes of which foreshad are mentioned above.

Further, by signing this authorization you acknowledge that you have been provided a copy of and have read and understand Covered Entity's HIPAA Privacy Notice containing a complete description of your rights, and the permitted uses and disclosures, under HIPAA. While Covered Entity has reserved the right to change the terms of its Privacy Notice, copies of the Privacy Notice as amended are available from Covered Entity at any of its offices or by sending a written request with return address to:

**1 Source Chiropractic & Physical Medicine, Inc.
19409 Shumard Oak Dr., Ste 102 Land O' Lakes, FL 34638**

In accordance with your rights under, and subject to certain restrictions imposed by, HIPAA, you may inspect or copy your PHI in the designated record set maintained by Covered Entity for as long as the PHI is maintained in the designated record set.

You have the right to revoke this authorization, in writing, at any time, except to the extent that Covered Entity has taken action in reliance on it. A revocation is effective upon receipt by Covered Entity of a written request to revoke and a copy of the executed authorization form to be revoked at the address listed above.

This authorization shall expire upon the earlier occurrence of: (a) revocation of the authorization, (b) a finding by the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights that this authorization is not in compliance with requirements of HIPAA, (c) complete satisfaction of the purposes for which this authorization was originally obtained, to be determined in the reasonable discretion of Covered Entity, or (d) six years from the date this authorization was executed.

By signing this authorization you acknowledge and agree that any information used or disclosed pursuant to this authorization could be at risk for re-disclosure by the recipient and no longer protected under HIPAA.

Covered Entity will provide patient with a copy of this signed authorization at their request.

Acknowledged and agreed to by:

Patient Signature: _____ Date of Birth: _____

Patient Printed Name _____ Date: _____



24 Hour Cancellation & No Show Fee Policy

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, 1 Source Chiropractic reserves the right to charge a fee of \$25.00 for all missed appointments (no shows) and appointments that are not cancelled with a 24 hour advanced notice.

This fee is billed directly to the patient and is not covered by insurance. It must be paid prior to your next appointment. Multiple no shows in any 12 month period may result in termination from our practice.

Thank you for your cooperation as we strive to best serve the needs of all of our patients.

By signing below, you acknowledge that you have received and understand this policy.

Printed Name

Date

Signature

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

Name: _____ Birthdate: _____

Email address: _____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

Gender (Circle one): Male / Female Preferred Language: _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Smoking Start Date (Optional): _____

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) / Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

I choose to decline receipt of my clinical summary after every visit

Patient Signature: _____ Date: _____

For office use only:

Height: _____ Weight: _____ B/P _____ / _____ Pulse/BPM: _____