Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. 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.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Name of Patient _____ Date_____

Do we have your permission to leave a message on your home/business recorder? _____

Dr. Andrew Leverone and Dr. Dan Cooper
Chiropractic Physicians

WELCOME TO OUR OFFICE. WE APPRECIATE YOUR CONFIDENCE IN OUR ABILITY TO PROVIDE YOU WITH QUALITY HEALTH CARE SERVICES. WE ENCOURAGE YOU TO ASK QUESTIONS REGARDING ANY POLICY YOU DO NOT UNDERSTAND.

The following information is given to you to avoid any misunderstanding in the future.

1. Unless **prior arrangements** have been made with this office, payment for all services provided is expected at the time services are rendered.

2. If you have insurance that provides coverage for chiropractic services and you want this office to file your claim, accepting assignment will require the following: a) A copy of your insurance card; b) **Payment** of any deductible or co-payment at the time services are provided. and c) **Payment** of any amount not allowed or any reduction beyond the normal "co-payment" immediately following notice to this office by your carrier.

> *Your insurance coverage is a contract between you and your carrier. This office cannot be responsible for resolving coverage disputes. We agree to provide your carrier with the documentation to treatment they request in order to process your claim. Any unpaid amount remains your responsibility.*

3. If you are covered by **Medicare** this office **does** accept assignment for **"Spinal Manipulation"**, only. All other services that are not covered by Medicare will be the responsibility of the patient, at the time of services rendered.

4. **CANCELLATIONS/MISSED APPOINTMENTS :** Effective 08/01/97, this office will enforce the policy of charging for missed appointments and/or appointments canceled less that 4 hours before the scheduled time. You will be billed for your missed appointment or late cancellation. This is a charge that cannot be billed to your insurance carrier.

"Due to the nature of our practice, we give our patients the utmost in care and service. We will give you the same careful attention as soon as possible"

Read and signed this_____ day of _____,201__

_____
Patient's Signature

INFORMED CONSENT TO CHIROPRACITC CARE

Dr. Andrew Leverone and Dr. Dan Cooper
Leverone Wellness Clinic
3322 DR. M.L.K. Jr. St. N.
St. Petersburg, FL 33704

Patient please discuss any questions or concerns with the Doctor.

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 listed below, for whom I am legally responsible) by the Doctor of Chiropractic named above.

I have had the opportunity to discuss with the doctor and/or with other office or clinic personnel the purpose and benefits of the chiropractic adjustments and other treatment outlined below. Alternatives to treatment have been reviewed.

Though chiropractic adjustments and treatments are usually beneficial and seldom cause any problem, I understand and am informed that there are some risks to treatment. Risks include but are not limited to fractures, disc injuries, strokes, dislocations and sprains.

I understand that chiropractic is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the chiropractic treatment that I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Signature of Patient _____ Date _____

Signature of Guardian _____ Date _____

Witness Signature _____ Date _____

Doctors Signature _____ Date _____

APPLICATION FOR TREATMENT

Name: _____ Date: _____

Social Security # _____ Date of Birth: _____

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

Home Phone: _____ Work Phone: _____

Email: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Name of Spouse: _____ Ages of Children: _____

Place of Employment (you or spouse): _____

Your days off: _____ Referred by: _____

Who is responsible for your bill?: ☐ Self ☐ Spouse ☐ Employer ☐ Insurance ☐ Other

If insurance is responsible, please complete the following:

Type of Insurance: ☐ Major Medical ☐ Workmen's Comp. ☐ Automobile

Name of Company and Address: _____

_____

MAJOR COMPLAINT
(Please describe only your major problem)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

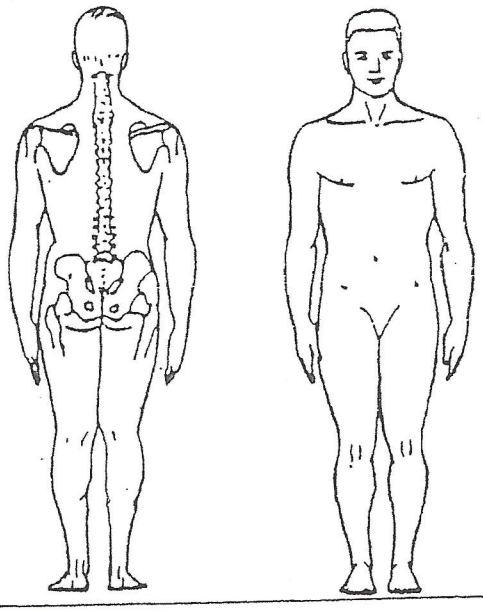
_____

_____

_____

Please mark the exact location of your pain, or the area of present complaint, on the diagram below. Also, if applicable, use the symbols below.

Numbness	Pins & Needles	Burning	Aching	Stabbing
-------	OOOOO	XXXXX	++++++	\\\\\\\\



How and when did this condition develop? _____

_____

What makes your condition better? _____

What makes your condition worse? _____

Is this problem the same, better, or worse? _____

Have you received any treatment for this condition. If yes, where, and what were the results? _____

_____

What aspects of your life have been affected? ☐ Home ☐ Occupational ☐ Recreational ☐ Rest and Sleep

Please describe: _____

Have you ever been in an automobile accident?: ☐ Past Year ☐ Past 5 Years ☐ Over 5 Years ☐ Never

Any other incidents that may have contributed to your present condition (accidents, falls, allergies etc.)?:

_____

Any medical diagnosis of your complaint?: _____

Are you presently diagnosed with any other medical conditions (please list)? _____

Please list any previous surgeries (including plastic surgery): _____

Have you had any dental work done in the past year? When? What? _____

_____

Do you have any shunts, wires, staples, pumps or other post-surgical apparatus embedded in your body?: ☐ Yes ☐ No

Please give dates for the following:

Latest Medical Exam (date) _____

Last x-ray exam (body part, date) _____

Last M. R. I or C-Scan (body part, date) _____

Blood test or urinalysis (date) _____

Do you have any reason to believe that you may be pregnant? _____ Yes _____ No

Do you have or have you been exposed to HIV , AIDS or Hepatitis A, B, or C please explain _____

_____

Have you gained or lost weight in the past year? If so, how much? _____

Please check if taking any of the following and describe amount:

_____ Recreational Drugs _____ Cigarettes _____ Coffee _____ Alcohol _____ Tea

Do you consume dairy products (milk, cheese, cottage cheese, yogurt, ice cream etc.) on a daily basis?: ☐ Yes ☐ No

Do you consume (nuts, seeds, popcorn ect.) on a daily basis? ☐ Yes ☐ No

Do you consume softdrinks/sodas? ☐ Yes ☐ No

How much water do you drink per day?: _____

Below, please check and list any medications or nutritional supplements that you are taking:

Nerve Pills _____ Pain Killers _____ Muscle Relaxers _____ "Pep" Pills _____ Tranquilizers _____

Insulin _____ Birth Control _____ Nutritional Supplements _____ Others:

1) _____ 6) _____

2) _____ 7) _____

3) _____ 8) _____

4) _____ 9) _____

5) _____ 10) _____

Please indicate if your mother or father experienced any of the following:

- ☐ High Blood Pressure
- ☐ Heart Attack
- ☐ Emphysema
- ☐ Seizures-Convulsions
- ☐ HIV Positive
- ☐ Asthma
- ☐ Diabetes
- ☐ Kidney Disease
- ☐ Ulcer or Stomach problems
- ☐ Stroke
- ☐ Arthritis-Rheumatism
- ☐ Mental Illness
- ☐ Thyroid Disease
- ☐ Circulation Problems
- ☐ Cancer

Other: _____

Have you ever consulted or been treated by a chiropractor, acupuncturist, nutritionist, or other non-allopathic health care provider in the recent past?: Names: _____

Dates of treatment or consultation: _____ **For what problem?:** _____

Has any member of your family been treated in this office?: Name: _____

Person to contact in case of emergency: Name: _____

Address: _____

_____

Telephone: _____

Fees are due and payable at the time services are rendered, unless other arrangements have been made prior to treatment received.

Signature: _____ **Date:** _____

Comments (Physician only): _____