COMPTON CHIROPRACTIC CARE - NEW PATIENT INFORMATION (PI)

Legal Name: _____ Prefers: _____ File #:_____

Mailing Address: _____ City/State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ E-Mail: _____

Social Security #: _____ Birthdate: ____/_____/_____ Gender: M / F

□ Married □ Single □ Separated □ Divorced □ Widowed

Spouses Name _____ Spouse Phone # _____

Emergency Contact (If not the spouse listed above): Name: _____ Phone #: _____

PRIMARY CARE PHYSICIAN

PCP Name _____ PCP Phone _____

PCP City, State: _____ Last Visit Approximately:_____

CHILD MINOR ONLY

Parents Name/DOB/SS# _____

REFERRAL INFORMATION

Who recommended you to our office?

□ Person _____ □Phone Book □Newspaper □ Billboard □ Insurance□ Other _____

OCCUPATION

What is your **occupation**? _____ □ Full-Time □ Part-Time □ Retired

INFORMED CONSENT

Welcome to Compton Chiropractic Care, LLC offering pain management through chiropractic, physio therapy, rehabilitation, acupuncture, massage therapy, and nutritional counseling. We will strive to help restore or improve your health, but there are no guarantees or promises of improvement or complete recovery. Patients are encouraged to leave valuables at home or with an accompanying family member or friend as this Facility shall not be liable for the loss of or damage to any personal property including, but not limited to, money, credit cards, clothing, jewelry, glasses/contacts, dental devices, hearing aids, furs, documents, or any other items. Your signature below fully authorizes our staff and doctors to perform any examinations, diagnostic tests, referrals and/or treatment as we may consider medically necessary. Our office and staff are committed to providing all patients, regardless of race, color, national origin, age, sex and or sexual identity, disability, or religious or political beliefs, Language barriers; quality health care services delivered with dignity and concern. HIPAA requires that we have you read the federally governed Health Care Privacy Notice. This Notice is detailed on a separate handout which is posted in the lobby of the office or can be requested at any time. This notice will explain when, where, and why your confidential health information may be used, stored, and/or shared and is a permanent part of your medical records, which is maintained in this office. Furthermore, should you feel a violation has occurred in any way please immediately document the event in writing with one of our office managers or the Security Officer or the Civil Rights Officer. Your signature below also confirms that you have read, understand, and agree to comply with all of the terms and conditions of the Health Care Privacy Notice and all policies, consents, terms, and conditions regarding your responsibilities to this Facility and that you grant the physicians, therapists, and/or staff of this Facility to use and share your confidential health information with others in order to treat you and/or in order to arrange for payment of your bill and/or for issues that concern this Facility's operations and responsibilities. Please note that by signing below you authorize the provider to negotiate, collect and settle any claim with an insurance or third party with regard to these services (assignment of benefits). Furthermore, you understand that you will be responsible for charges not covered by your insurance. Failure to pay an outstanding balance will result in accounts being turned over to collections and the addition of $50 collection fee to any outstanding debt. Please direct any questions or concerns to a member of our staff prior to authorizing this statement. We encourage questions and/or concerns to avoid misunderstandings. Office hours allow our patients convenience to schedule appointments before and after work, as well as during lunch. If you must miss an appointment, please notify us at your earliest convenience to reschedule. As a courtesy to you, we may call you on the telephone, when an appointment is missed and/or you have not completed your six month checkup visit. By default your patient contact preference will be set to phone call and if you do not wish for us to call you or mail you reminder cards, please let us know in writing for your file. Note: A photocopy of this form shall be considered as effective and valid as the original. Listed below are summaries of some key research articles that have addressed both common and rare side-effects/complications associated with chiropractic care. • Local discomfort • Headache • Radiating discomfort … • Rib Fracture •Burns (if certain types of physiotherapy are used in your treatment) •Cauda Equine Syndrome •Compromise of the vertbrobasilar artery (note that several studies have shown that patients are no more likely to suffer this side effect than when leaving their medical doctors office

By signing below I state that I have reviewed the informed consent, HIPPA privacy notice, assignment of benefits and office policy for Compton Chiropractic and hereby consent to care.

X _____ Date: _____

SYMPTOMS SURVEY

Chart # : _____

What is your **main** problem or symptoms? _____

What **caused** the problem or symptoms to occur? *(ex: Accident? Fall?)*_____

When did the problem or symptoms begin? *(ex: Date ?)* _____

What makes the problem: **Better** *(ex: Ice? Heat?)* _____ **Worse** *(ex: Golf, Bending over)* _____

Please **describe** the pain: ☐ Sharp ☐ Dull ☐ Achy ☐ Burning ☐ Stiff ☐ Numb Other:_____

Does the pain **travel or radiate**? ☐ No ☐ Yes If yes, Where?_____

Severity of your pain **Currently**: *(circle)* No pain (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) Extreme pain

Severity of pain **at the worst**: *(circle)* No pain (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) Extreme pain

Have you seen **another doctor** for this problem? ☐ No ☐ Yes If yes, who _____ When:_____

What **imaging/tests/procedures** have been performed? ☐ X-Ray ☐ MRI ☐ Surgery ☐ Hospitalization ☐ _____

Does the pain **wake you at night** from a sound sleep? ☐ No ☐ Yes If yes, explain _____

List **current medical conditions** whether controlled with medications or not *(ex: diabetes, high blood pressure, cancer):*

_____

_____

List **past surgical procedures** performed **with** dates of procedure: *(ex: tonsillectomy, wisdom teeth removed)*:

_____

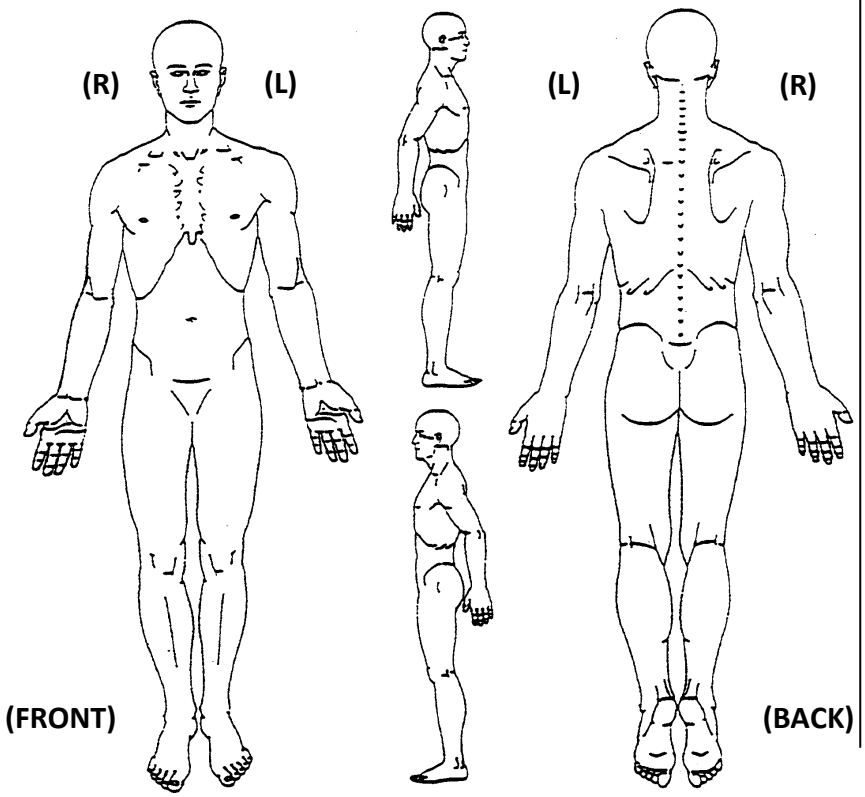
_____

Alcohol use: (Circle One): <2 Drinks Every Day / > 2 Drinks Every Day/ Occasional / Social / None

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

Family History: Any serious family health conditions?_____

(PLEASE DRAW YOUR PAIN)



Current Medications :

Medication Name	Dosage

Medication Allergies :

Medication Name	Reaction

For Office Use Only:

Height: _____ Temp: _____ Weight: _____

BP (Right): _____/_____ Pulse _____

BP (Left): _____/_____ Pulse: _____

Chart # _____

Patient Name: _____

PLEASE INDICATE BELOW, ARE YOUR **CURRENTLY** EXPERIENCING ANY OF THESE SYMPTOMS

General, Constitutional

Good general health lately_____ no yes
Recent weight change_____ no yes
Fever _____ no yes
Fatigue_____ no yes

Eyes and Vision

Eye disease or injury_____ no yes
Wear glasses or contact lenses _____ no yes
Blurred or double vision **(circle which)**_____ no yes
Glaucoma _____no yes

Ears, Nose and Throat

Hearing loss _____ no yes
Ringing in the ears _____ no yes
Earaches or drainage _____ no yes
Sinus problems _____ no yes
Nose bleeds _____ no yes
Mouth sores _____ no yes
Bleeding gums _____ no yes
Bad breath or bad taste _____ no yes
Sore throat or voice change_____ no yes
Swollen glands in neck _____ no yes

Heart and Cardiovascular

Heart trouble_____ no yes
Chest pains _____ no yes
Sudden heartbeat changes __--_____ no yes
Swelling of feet, ankles, hands **(circle which)**_____ no yes

Respiratory

Frequent coughing _____ no yes
Spitting up blood _____ no yes
Shortness of breath _____ no yes
Asthma or wheezing **(circle which)** _____ no yes

Gastrointestinal

Loss of appetite _____ no yes
Change in bowel movements _____ no yes
Nausea or vomiting _____ no yes
Frequent diarrhea _____ no yes
Painful bowel movements or constipation **(circle which)**_____ no yes
Blood in Stool _____ no yes
Stomach pain _____ no yes

Genitourinary

Frequent urination _____ no yes
Burning or painful urination **(circle which)**_____ no yes
Blood in urine _____ no yes
Change in force or strain with urination _____ no yes
Incontinence or dribbling _____ no yes
Kidney stones _____ no yes
Sexual difficulty _____ no yes
Painful periods _____ no yes
Irregular periods _____ no yes
Vaginal discharge _____ no yes

Musculoskeletal

Joint pain _____ no yes
Joint stiffness _____ no yes
Joint swelling_____ no yes
Weakness of muscles/joints **(circle which)**_____ no yes
Muscle pain or cramps **(circle which)**_____ no yes
Back pain _____ no yes
Cold extremities _____ no yes
Difficulty in walking _____ no yes

Skin and Breasts

Rash or itching _____ no yes
Change in skin color _____ no yes
Change in hair or nails _____ no yes
Varicose veins _____ no yes
Breast pain _____ no yes
Breast lump _____ no yes
Breast discharge _____ no yes

Neurological

Frequent or recurrent headaches _____ no yes
Light headed or dizzy **(circle which)** _____ no yes
Convulsions or seizures **(circle which)** _____ no yes
Numbness or tingling sensations **(circle which)** _____ no yes
Tremors _____ no yes
Paralysis _____ no yes
Stroke _____ no yes
Head Injury

Psychiatric

Memory loss or confusion **(circle which)** _____ no yes
Nervousness _____ no yes
Depression _____ no yes
Sleep problems _____ no yes

Endocrine

Glandular or hormone problem _____ no yes
Thyroid disease _____ no yes
Diabetes _____ no yes
Excessive thirst or urination _____ no yes
Heat or cold intolerance **(circle which)**_____ no yes
Dry skin _____ no yes
Change in hat or glove size _____ no yes

Hematologic/Lymphatic

Slow to heal after cuts _____ no yes
Easily bruise or bleed _____ no yes
Anemia _____ no yes
Phlebitis _____ no yes
Transfusion _____ no yes
Swollen glands _____ no yes

If you have not had a hysterectomy, please give the date of your last menstrual period _____

Patient Sign Here: _____

Physician/PA Sign Here: _____

Accident Report

Patient Name : _____ Chart Number : _____

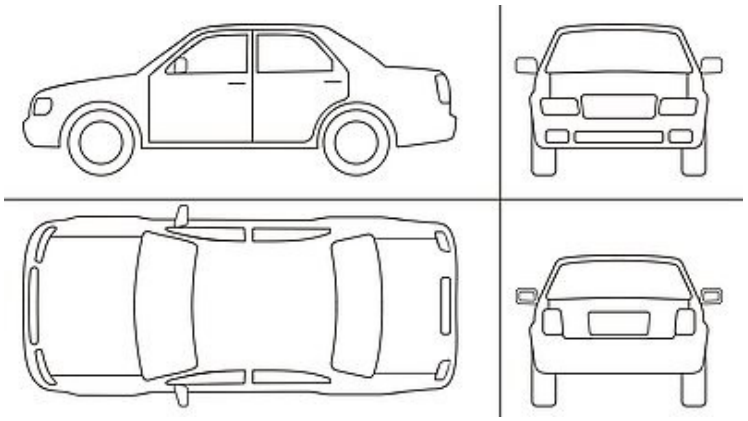
Date of Accident : _____

☐ Driver ☐ Passenger (Front Seat/Back Seat) ☐ Pedestrian

Year/Make/Model of **YOUR VEHICLE** : _____

Year/Make/Model of **OTHER VEHICLE** : _____

Position of Vehicle : ☐ Stopped ☐ Proceeding Along ☐ Turning (Left or Right)



Location of Accident : _____ **Time :** _____

Visibility : ☐ Poor ☐ Fair ☐ Good **Weather :** ☐ Clear ☐ Rainy ☐ Windy ☐ Foggy

Whom Struck Whom? _____

Patient's Estimated Speed : _____ **Other's Estimated Speed :** _____

Was the Vehicle Driven Away or Towed Away ? : _____

Direction of Your Head : ☐ Forward ☐ Left ☐ Right

Who Received a Ticket? : ☐ Self ☐ Other Driver **Returned to Work?** ☐ Yes ☐ No ☐ Retired

Wearing Seatbelt?	☐ Yes ☐ No	**Wearing Seatbelt?**	☐ Yes ☐ No
Did the Airbags Deploy?	☐ Yes ☐ No	**See the Accident Coming?**	☐ Yes ☐ No
Braced for Impact?	☐ Yes ☐ No	**Lose Consciousness?**	☐ Yes ☐ No
Taken to Hospital?	☐ Yes ☐ No	**Police Report Completed?**	☐ Yes ☐ No

Have you Experienced any Additional Problems Since the Accident? _____

_____

Patient Signature : _____ **Date :** _____

Compton Chiropractic

24 HOUR CANCELLATION AND "NO SHOW" FEE POLICY

Due to high patient demand and limited availability of appointments, we have a no show fee that requires cancellation within 24 hours of your appointment time. Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Compton Chiropractic reserves the right to charge a fee of $40.00 for all missed appointments (no shows) and appointments which, absent a compelling reason. Are not cancelled with a 24-hour advance notice. "No Show" fees will be billed to the patient. This fee is NOT billed to your insurance, and must be paid prior to your next appointment. Thank you for your understanding and cooperation as we strive to best serve the needs of all of our patients.

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

_____ _____

Patient Name Date

_____

Patient Signature

COMPTON CHIROPRACTIC CARE, LLC

11974 CR 101 SUITE 101

THE VILLAGES, FL 32162

(352) 391-9467 PH

(352) 391-9468 FAX

Patient HIPPA Authorization Form (OPTIONAL)

The department of Health and Human Services has established a "Privacy & Security Rule" to help insure that all patients' personal health information is protected. The Privacy Rule was also created in order to provide a standard for healthcare providers to obtain their patients' previous health history.

As our patient, we want you to know that we respect the privacy of all of your personal health records and will do all we can to secure and protect your privacy.

There are times when you may wish for other family members/friends to inquire about your appointments or have access to your medical and/or billing information. We will ONLY release information to those listed below.

Information to be Disclosed (Please check all that apply)

Medical Information (diagnoses, treatment, etc.)

Billing (insurance claims, payments, etc.)

Scheduling and Appointment Changes

Please list anyone that you wish to have access to our records and have authorization to change or make appointments on your behalf at or office.

1. _____ Relation: _____
2. _____ Relation: _____
3. _____ Relation: _____
4. _____ Relation: _____

I understand that I may revoke this authorization at any time.

Name _____ Signature _____ Date _____

AUTHORIZATION AND ASSIGNMENT OF BENEFITS TO MEDICAL PROVIDER

Patient's Name _____

Insured's Name_____

Social Security No. _____

Policy No. or Claim No. _____

Insurance Company _____

Address_____

City_____ State_____

Zip_____

Telephone No._____

Medical Provider :

COMPTON CHIROPRACTIC CARE, LLC

11974 CR 101 SUITE 101

THE VILLAGES, FL 32162

(352) 391-9467 PH

(352) 391-9468 FAX

1. I authorize the RELEASE OF ANY INFORMATION concerning my health to any insurance company, attorney or adjuster as necessary to process any claim for payment to the above named medical provider's charges incurred by me. I also authorize the insurance company to furnish to the medical provider named above any information regarding my claims under the policy or Social Security Act.

2. In consideration of the above-named medical provider's rendering of treatment to me without immediate compensation therefore I authorize and I IRREVOCABLY ASSIGN MY RIGHT TO PAYMENT of the above immediate named medical provider's bill for treatment rendered to me out of the proceeds of any judgment or settlement in my case and, furthermore, from any insurance company providing coverage to me for such expenses.

3. With reference to any contracted insurance providing coverage to me for the above medical provider's treatment, I understand, authorize and agree that no payment due me under said contract of insurance shall be made to me for any other medical expenses until the above medical provider's BILL FOR MY TREATMENT IS PAID IN FULL.

4. I give assignment and lien in any claims against in any claims against a third party whose negligence may have cause my injury, up to the amount of the bill for treatment.

5. In the event any insurance company obligated by contractual agreement to make payment to me or to the physician refuses to make such payment upon demand, I hereby IRREVOCABLY ASSIGN AND TRANSFER to the medical provider any CAUSE OF ACTION that exists in my favor against any such company, and authorize the medical provider to prosecute that action either in my name or in his name and further to compromise, settle, or otherwise resolve said claim.

6. I waive the STATUE OF LIMITATIONS regarding my provider right to recover.

7. I permit a COPY OF THIS AUTHORIZATION to be used in place of the original.

8. I, hereby appoint the above named medical provider and any of their duly authorized agents and employees to endorse any and all checks, drafts or money orders which are made payable to the undersigned, for medical services or the like which have been, or are to be, performed by the medical provider.

NOTICE TO INSURANCE COMPANY OF ASSIGNMENT

You are instructed to PAY DIRECTLY TO THE above named medical provider at his office for all professional services rendered to me by his office. This instruction to you is an assignment of my rights under the medical coverage of the insurance policy or my rights under the third party liability claim.

Any Sum of money paid under this assignment shall be credited to my account.

Patient Signature:_____

Insured's Signature:_____

(if different or required)