AQUI CHIROPRACTIC CLINIC, LLC

Confidential Patient Data

1350 E. Main St., Ste B-1 Bartow, FL 33830 (863)534-3288

IF YOU NEED ANY ASSISTANCE COMPLETING THIS FORM, PLEASE ASK THE RECEPTIONIST

PATIENT INFORMATION

Today's Date: ________

Name: ______________________________ Date of Birth: ____________
Address: ____________________ City: ____________ State: ______ Zip: ______
Home Phone: ______________ Work Phone: ____________ Cell Phone: ____________
Email: ____________________ Social Security #: ______________
Age: _____ ❑ Male ❑ Female Marital Status: ❑Married ❑Single ❑Divorced ❑Separated ❑Widow
Person Responsible for this Account (Policy Holder): ____________ Relationship: ________
Date of Birth of Policy Holder: ____________ Policy Holder SS#: ______________
Name of Spouse or Nearest Relative: ____________________ Phone: ____________
How many children: ____ ages: ____________ Your Occupation ______________
Your Employer: ____________________ Phone: ______________________
Referred to this Office by: ❑Friend/Family Member – Name: ______________________
❑Yellow Pages ❑ Mail ❑Clinic Location ❑Other ____________
Race: ______________ Preferred Language: ____________________

Phone Carrier (for text message appointment reminders): ________________

HISTORY OF PRESENT ILLNESS

What are your **primary complaints?** Please Rate Your Pain/Discomfort on a scale of 0-10. 0=none 10=worst

1. ____ Rate Symptoms: ______
2. ____ Rate Symptoms: ______
3. ____ Rate Symptoms: ______
4. ____ Rate Symptoms: ______
5. ____ Rate Symptoms: ______
6. ____ Rate Symptoms: ______

SYMPTOMS ARE WORSE IN ❑MORNING ❑AFTERNOON ❑NIGHT

DATE OF ONSET: ____________ HOW DID THIS CONDITION DEVELOP? ____________________

____

SYMPTOMS DEVELOPED FROM: ❑JOB RELATED INJURY ❑AUTO ACCIDENT ❑OTHER ❑ACCIDENT ❑ILLNESS ❑UNKNOWN CAUSE ❑GRADUAL ONSET
SYMPTOMS HAVE PERSISTED FOR # ____HOUR(S) ____DAY(S) __WEEK(S) ___MONTH(S) ___YEAR(S)
SYMPTOMS/COMPLAINTS: ❑COME & GO ❑ARE CONSTANT ❑ NEARLY CONSTANT
HAVE YOU EVER HAD THIS BEFORE: ❑NO ❑YES, WHEN? ____________________

DO WORK ACTIVITIES AGGRAVATE YOUR CURRENT COMPLAINTS? ❑YES ❑NO
WHICH WORK ACTIVITIES? ______________________________________
DATES MISSED FROM WORK: ______________________________________

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT AGGRAVATE YOUR CONDITION:
❑BENDING ❑REACHING ❑STRAINING AT STOOL ❑COUGHING ❑SITTING ❑TURNING HEAD
❑LIFTING ❑SNEEZING ❑WALKING ❑LYING DOWN ❑STANDING ❑ OTHER ___________________

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT RELIEVE YOUR CONDITION:
❑BENDING ❑SITTING ❑LIFTING ❑STANDING ❑LYING DOWN ❑TURNING HEAD ❑REACHING ❑WALKING
❑OTHER ___________________

PLEASE CHECK ANY ADDITIONAL SYMPTOMS YOU MAY BE EXPERIENCING:
❑blurred vision ❑buzzing in ears ❑cold feet ❑cold hands ❑cold sweats ❑concentration loss/confusion ❑constipation ❑depression /weeping spells ❑diarrhea ❑dizziness ❑face flushed ❑fainting ❑fatigue ❑fever ❑head seems too heavy ❑headaches ❑insomnia ❑light bothers eyes ❑loss of balance ❑loss of smell ❑loss of taste ❑low resistance to colds ❑muscle jerking ❑numbness in fingers ❑numbness in toes ❑pins and needles in arms ❑pins and needles in legs ❑ringing in ears ❑shortness of breath ❑stiff neck ❑stomach upset
❑other ___________________

MEDICAL/FAMILY HISTORY S = Self M = Mother F = Father

(Please indicate which conditions have been experienced by the above by marking appropriate boxes).

S	M	F		S	M	F		S	M	F	
❑	❑	❑	AIDS	❑	❑	❑	dislocated joints	❑	❑	❑	neck pain
❑	❑	❑	anemia	❑	❑	❑	epilepsy	❑	❑	❑	nervousness
❑	❑	❑	arthritis	❑	❑	❑	German measles	❑	❑	❑	numbness
❑	❑	❑	asthma	❑	❑	❑	headaches	❑	❑	❑	polio
❑	❑	❑	back pain	❑	❑	❑	heart trouble	❑	❑	❑	poor circulation
❑	❑	❑	bladder trouble	❑	❑	❑	reproductive disorders	❑	❑	❑	hepatitis
❑	❑	❑	bone fracture	❑	❑	❑	high blood pressure	❑	❑	❑	rheumatic fever
❑	❑	❑	cancer	❑	❑	❑	HIV/ARC	❑	❑	❑	rheumatism
❑	❑	❑	chest pain	❑	❑	❑	kidney disorder	❑	❑	❑	scarlet fever
❑	❑	❑	concussion	❑	❑	❑	bowel control loss	❑	❑	❑	serious injury
❑	❑	❑	convulsions	❑	❑	❑	menstrual cramps	❑	❑	❑	sinus trouble
❑	❑	❑	diabetes	❑	❑	❑	multiple sclerosis	❑	❑	❑	tuberculosis
❑	❑	❑	indigestion	❑	❑	❑	muscular dystrophy	❑	❑	❑	venereal disease

Other conditions: ___________________ Do you have a history of Stroke or Hypertension? ❑Yes ❑No
Father: ❑living, age: ___ ❑deceased, cause: ___________________
Mother: ❑living, age: ___ ❑deceased, cause: ___________________

Have you been treated by a physician for any health condition in the last year? ❑Yes ❑No
Describe Condition___________________ Date of Last Physical Exam___________
Who is your physician? ___________________ Address: ___________________
May we have permission to update your medical doctor regarding your care at this office? ❑Yes ❑No
Name and location of doctors previously seen for present condtion(s): ___________________

Have you ever been treated by a Chiropractor? ❑NO ❑YES, Who/Where? ___________________
Any X-rays, MRI OR CAT SCANS been taken recently? ❑NO ❑YES When/Where? ___________________
Any **Drug** Allergies? ❑NO ❑YES, What kind? ___________________
Are you currently taking any medication: ❑NO ❑YES, Please name them. ***If you have a list, we can make a copy**

1.___________________For What Condition?___________Dosage?___________
2.___________________For What Condition?___________Dosage?___________
3.___________________For What Condition?___________Dosage?___________
4.___________________For What Condition?___________Dosage?___________
5.___________________For What Condition?___________Dosage?___________

Are you pregnant? ❑NO ❑YES Date of last menstrual period: ____________

SURGICAL HISTORY:

1.________________________________ Date: ____________
2.________________________________ Date: ____________
3.________________________________ Date: ____________

Have you ever had a metal implant? ❑Yes ❑No ever was gunshot? ❑Yes ❑No

ACCIDENT HISTORY: ❑Job ❑Auto ❑Other 1. ____________________ Date:____________
❑Job ❑Auto ❑Other 2. ____________________ Date:____________
❑Job ❑Auto ❑Other 3. ____________________ Date:____________

SOCIAL HISTORY:

Do you drink alcoholic beverages? ❑No ❑Yes, how much per week? ____________
Do you use any tobacco products? ❑No ❑Yes Do you smoke? ❑No ❑Yes, how many packs, per day?
____
Do you take vitamin supplements? ❑No ❑Yes, please list: ____________
Do you consume caffeine? ❑No ❑Yes, how much per day? ____________
Do you exercise? ❑No ❑Yes, what is the frequency and type of exercise? ____________
What percentage of time during the day (at home or work) do you spend: lifting____ sitting____ bending ____ computer____

Payment for Services will be by: ❑Cash ❑Check ❑Credit Card ❑Health Insurance ❑Automobile Insurance ❑Worker's Compensation
Name of Primary Insurance Company.: ____________________
Insured's Employer: ____________ Insured's Social Security #:____________
Employer's Phone #:____________
Are you covered by more than one insurance company? ❑Yes ❑No
Name of Secondary Insurance Company: ____________________

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to AQUI CHIROPRACTIC CLINIC, LLC. I authorize AQUI CHIROPRACTIC CLINIC, LLC to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.
The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. 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. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's Signature:________________________________Date:____________

Guardian's Signature Authorizing Care:____________________ Date:____________

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aquichiropracticclinc.com

INFORMED CONSENT

It is our responsibility to fully inform you of all aspects of your treatment. Part of this includes a discussion of any potential side effect or complications. All treatments potentially can cause these reactions, and chiropractic manipulation is no different. It however, has one of the safest records of the wide range of treatments that can be used for spinal disorders.

Possible adverse effects of spinal manipulation can include soreness in the area of treatment, reactive muscle spasm, injury to the disc causing pressure on the nerve tissue, fractures in weakened bone such as ribs, and injury to arteries in the neck resulting in stroke. Soreness or reactive muscle spasm or tightening are common but usually brief reactions to treatment. The other potential complications are rare. It is best to examine the frequency of these potential complications versus the relative frequency of the complications of the other typical treatments which may be used for a spinal disorder.

Disc injury from manipulation causing spinal cord pressure	Neurologic complication from Neck surgery	Back Surgery
1 per 100 million	1 per 64	1 per 333
Artery injury from manipulation causing stroke	**Death rate from neck surgery**	
1 per million	1 per 145	

Perhaps the most common alternative to spinal manipulation is the use of the anti-inflammatory drugs. These drugs cause fairly common and potentially serious complications.

Complication associated with anti-inflammatory drug use:

Serious stomach or intestinal bleeding	1 – 4 per 1000 users
Hospitalizations from complications	20,000 per year
Deaths from complications	2,600 per year

I have read the above and understand the risk of complication that may occur from spinal manipulation. With this understanding, I consent to treatment with spinal manipulation with Dr. Alex Aqui, D.C.

Name______________________

Signature________________________________Date______________________

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PATIENT CONSENT
FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

______________________ hereby states that by signing this Consent, I acknowledge and agree as follows:

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.

2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

3. I understand that, and consent to, the following appointment reminders that will be used by the Practice: a) a postcard mailed to me at the address provided by me; and b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone, or by e-mail.

4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.

5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.

6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for *all future* transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.

7. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.

8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

______________________	______________________
Name of Patient/Individual (Please print)	Signature of Patient/Individual
______________________	______________________
Signature of Legal Representative (e.g., Attorney-In-Fact, Guardian, Parent if a minor)	Relationship to Patient
______________________	______________________
Date Signed	Witness

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FINANCIAL AGREEMENT

Payments for services are due at the time services are rendered. We accept cash, check or credit card. **Returned checks are subject to a $30.00 collection fee.** Balances older than 30 days may be subject to interest charges of 1 ½ % per month.

A charge of $30.00 may also be made for broken appointments and appointments cancelled without a 24 hour advance notice. If, for any reason you discontinue treatment prematurely, any balance on your account will be due and payable immediately.

There is a $3.00 per page charge for any forms completed related to other coverage's such as disability, credit life, etc.).

Your first visit MUST be paid in full at time of service. The only exceptions are PRE-VERIFIED and PRE-AUTHORIZED Worker's Compensation claims and 100% Personal Injury claims. If we can verify that your deductible has been met for the year, we may be able to waive the portion due from insurance and collect only the percentage (co-payment) due from you. You MUST pay your percentage/co-payment at each subsequent visit.

We accept assignment on most insurance after we are able to obtain verification. If through verification we find the insurance company pays to the insured only, we will collect in full for the services rendered. We will file your claims so you can be reimbursed.

YOU MUST REALIZE, HOWEVER; THAT:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. ANY SERVICES NOT PAID BY YOUR INSURANCE COMPANY DUE TO OVER UTILIZATION, LIMITED BENEFITS, UNAUTHORIZED SERVICES, ETC.; WILL BE YOUR RESPONBILITY FOR PAYMENT IN FULL.
2. Our fees are generally considered to fall within the acceptable range by most companies, and are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage of the usual, reasonable, and customary charges. This statement does not apply to companies who reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area.
3. Not all services are covered benefits in all contracts. For this reason, supplements, supports, pillows, ice packs, etc. MUST be paid for in full when received.

We must emphasize that as health care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy we extend to our patients, all charges are your responsibility on/from the date services are rendered. We do utilize a collection agency for overdue balances on accounts.

I HAVE READ AND FULLY UNDERSTAND THE ABOVE POLICIES AND HEREBY ACKNOWLEDGE SAME.

Patient Signature: ______________________________ Date: ____________

Witness Signature: ______________________________ Date: ____________