Welcome to Sands Chiropractic

Please fully complete the first three (3) pages Of the New Patient Record, sign the Financial Policy, and Consent to Treat.

Thank you

Sands Chiropractic
1701 NE 28 Street
Pompano Beach, Florida 33064

Patient Information

(Please allow our staff to photocopy your Driver's license and Insurance card)

PATIENT INFORMATION **WELCOME! PLEASE PRINT**

First Name______________________________ Last Name______________________________ M.I.______

Date of Birth____/____/____ Age_____ Gender M F SS#____/____/____ Marital Status S M W D Separated

Home Address____

City____ Apt__________

State______________ Zip______________

Home Phone________________ Cell Phone________________ Work Phone________________

Your Employer______________________________ Occupation______________________________

Primary Insurance Company______________________________ Subscriber's Name______________________

Subscriber's Date of Birth____/____/____ Patient's Relationship to Subscriber O Self O Spouse O Child O Other

Name of Spouse, Parent or Guardian____

Emergency Contact

Name______________________________________ Phone________________________

How did you find out about our office____

Have you ever been to a chiropractor before O Yes O No If yes, when was your last visit________________

MY CERTIFICATION

I certify that the above information is correct

X____

Signature of patient or person acting on patient's behalf Date____________________

MY PRIVACY

I have read a copy of the Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: Conduct, plan and direct my treatment and follow-up among the healthcare providers who may be directly and indirectly involved in providing my treatment; Obtain payment from third party payors; Conduct normal healthcare operations such as quality assessments and accreditation. I may ask for and receive a copy of this notice at any time.

X____ Date____________________

MEDICAL AND HEALTH HISTORY

Patient Name________________________________

Main Problem **Height**________ **Weight**________

What pain causes you to come to the office________________________

What caused this pain______________________________

When did the pain start________________ How bad is the pain (circle one only) 1 = mild – 10 = Intense

1 2 3 4 5 6 7 8 9 10

How often does the pain occur (circle one) Intermittent Occasional Frequent Constant

Circle the word that best describes the pain Aching Dull Sharp Shooting Diffuse Throbbing Nagging Deep Burning Stinging Pressure

Does the pain travel to any other area________________________

What makes the pain better____________________________

What makes the pain worse____________________________

Have you done anything else to treat this pain____________________

Have you had similar symptoms before O Yes O No If yes, when______________

Have you had any other treatment for this condition O Yes O No If yes, when__________

Please describe the treatment and name of treating doctor________________

Other History

Do you smoke O Yes O No If yes, how many per day____________

Do you drink O Yes O No If yes, how much____________

Do you exercise O Yes O No If yes, how often____________

Do you take Medication O Yes O No If yes, list type and amount taken per day

ist Past Major Illnesses, Injuries, Surgeries, and Hospitalizations

General Symptoms

Please check (√) symptoms that you have or have had in the past year.

General		Genito-Urinary		Cardiovascular		Eyes, ears, nose, and throat		Women only	
☐	Bruise easily	☐	Blood in urine	☐	Chest pain	☐	Vision changes	☐	Breast lump
☐	Dental problems	☐	Frequent urination	☐	high blood pressure	☐	Difficulty swallowing	☐	Extreme menstrual pain
☐	Depression	☐	Lack of bladder control	☐	Irregular heart beat	☐	Earache	☐	Hot flashes
☐	Difficulty sleeping	☐	Painful urination	☐	Low blood pressure	☐	Hoarseness	☐	Changes in sexual desire
☐	Dizziness	**Gastrointestinal**		☐	Poor circulation	☐	Loss of hearing	☐	Reproductive changes
☐	Fainting	☐	Change in appetite	☐	Rapid heart beat	☐	Nosebleeds		Date of last menstrual cycle: ______
☐	Fever	☐	Bloating	☐	Swelling of ankles	☐	Ringing in the ears		
☐	Forgetfulness	☐	Bowel changes	☐	Varicose veins	☐	Sinus problems		Are you pregnant: yes or no
☐	Headache	☐	Excessive hunger	**Skin**		**Respiratory**			Number of children: ______
☐	Loss of sleep	☐	Excessive thirst	☐	Hives	☐	Persistent couogh		
☐	Loss of weight	☐	Gas	☐	Itching	☐	Difficulty breathing		
☐	Nervousness	☐	Indigestion	☐	Change in moles	☐	Wheezing		
☐	Numbness	☐	Nausea	☐	Rash	☐	Asthma		
☐	Sweats	☐	Stomach pain	☐	Scars	**Men Only**			
☐	Tiredness	☐	Vomiting	☐	Sores that won't heal	☐	Reproductive changes		
☐	Weight gain	☐	Abdominal pain	☐	bruises	☐	Changes in sexual desire		

Conditions

Please (√) conditions you have or have had in the past.

☐	Anemia	☐	Fractures	☐	Osteoporosis
☐	Appendicitis	☐	Goiter	☐	Pacemaker
☐	Arthritis	☐	Gout	☐	Prostate problem
☐	Asthma	☐	Heart disease	☐	Rheumatoid arthritis
☐	Bleeding disorders	☐	Hernia	☐	Stroke
☐	Bronchitis	☐	High cholesterol	☐	Thyroid problems
☐	Cancer (list type)	☐	Kidney disease	☐	Tumors, growths
☐	Diabetes	☐	Liver disease	☐	Ulcers
☐	Emphysema	☐	Migraine headaches		Other:
☐	Epilepsy	☐	Multiple sclerosis		

Sleep ________ hrs/night Do you sleep on your ☐ back ☐ side ☐ stomach

Exercise ________ hrs/week ☐ light ☐ moderate ☐ intense

Do you wear ☐ heel lifts ☐ shoe lifts ☐ arch supports ☐ orthotics

What type of pillow do you use ☐ thick ☐ medium ☐ thin ☐ none ☐ cervical support

Age of mattress ______________

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic treatments (also known as chiropractic adjustments or chiropractic manipulative treatments) and any other associated procedures: physical examination, tests, diagnostic x-rays, physio therapy, physical medicine, physical therapy procedures, etc. on me by the doctor(s) of Sands Chiropractic and/or other assistants and/or licensed practitioners.

I understand, as with any health care procedures, that there are certain complications, which may arise during chiropractic treatments. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Homers' syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke.

I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest.

I have had an opportunity to discuss the nature, purpose and risks of chiropractic treatments and other recommended procedures. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed.

If there is any dispute about my care, I agree to a resolution by binding arbitration according to the American Arbitration Association guidelines.

I have read (or have had read to me) the above explanation of the chiropractic treatments. I state that I have been informed and weighed the risks involved in chiropractic treatment at this health care office. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future conditions(s) for which I seek treatment.

Sign only after you understand and agree to the above.

____
Printed name of Patient

x______________________________
Signature of Patient

______________ Date

x______________________________
Signature of Representative
(if patient is a minor or is handicapped)

______________ Date

x______________________________
Witness to Patient's Signature

______________ Date

FINANCIAL POLICY – Please read and sign below

Services are due in full at the time service is provided, unless other arrangements have been made.

Insurance Patients:
We bill many insurance carriers for you, as well as any secondary insurance. Copayments and Deductibles are due at time of service.

Medicare Patients:
We will bill Medicare and any secondary insurances for payment, and will balance bill the patient. Medicare pays 80% of the allowable charge for Spinal Manipulation only, and will limit these services based on medical necessity. Medicare does not cover any therapy, supports, supplements, x-rays, or examinations done in this office.

Workers Compensation:
If your injury is work related, we will need the claim number and insurance adjustor phone number prior to treatment. It is necessary to verify authorization before treatment is rendered.

Personal Injury/Auto:
We will bill for auto accidents or other liability or lawsuit related cases. We need to have all applicable information relative to filing an insurance claim prior to treatment. We accept Attorney liens on an individual basis, and at the Doctor's discretion.

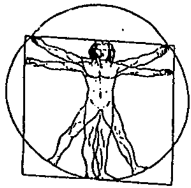
Missed Appointments:
In fairness to the Doctor and other patients, please give as much notice as possible for any appointment you cannot make. We require 24 hours notice for any cancelled massage appointments. If proper notice for cancelled massage appointments is not given, you may be charged for the missed appointment.

Assignment of Insurance Benefits:

I hereby assign all medical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plans, to **SANDS CHIROPRACTIC CLINIC.** This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand I am financially responsible for all charges whether paid by insurance or not. I hereby authorize said assignee to release all information necessary to secure the payment.

I have read, understood, and agreed to the above financial policy for payment of professional services.

Patient Signature ____ Date________________
(If patient is a minor, person with financial responsibility)



SANDS CHIROPRACTIC CLINIC

1701 N.E. 28th Street • Pompano Beach, FL 33064 • (954) 942-8402

Health Care Privacy Notice
Patient's Rights

Name of Doctor or Clinic: Sands Chiropractic

Compliance Officer: K. Sands

Our staff is committed to maintaining the privacy of your protected health information known as (PHI). PHI is information about you, including demographic information, that may identify you and that may relate to your present, future and past physical or mental health or condition and the care and treatment you receive from our practice.. This notice describes how medical information about you may be used and disclosed and how you can obtain access to this information. Please read this notice and ask any questions, misunderstanding or concern to the Compliance Officer of this office.

This office is required by law to abide by the terms of this health care privacy notice as well as all other applicable federal and state laws governing privacy practices in health care. Our office may change and/or modify the terms of this notice at anytime without additional notice to you except to publicly post in our office and/or make available to patients any updated notices. Photocopy of this notice is available to you upon request.

Use and Disclosure of PHI

Our office use and disclose your PHI for health care delivery purposes. Your PHI may be used by doctors and staff of this office for the purposes of your care and treatment; paying your health care bills; and to support the operations of this practice. Your doctor and the staff will take all reasonable measures to maintain the confidentiality of your PHI. Following is a list of situations in which your PHI can be dissolved without your written authorization..

Business Associate: Your PHI may be used or disclosed to a business associate, from whom we have obtained assurances that they will safeguard your PHI and use it only for the purposes for which it was intended.

Emergency Situations: In an emergency situation, where written acknowledgement from you is not practical until after the emergency situation has ended.

Employee Limitations: Your PHI will be limited to the members of the clinic and its workforce who may need access for treatment, payment or health care operations.

Health Care Operations: For certain administrative, financial, legal and quality control activities that are necessary to run its business and support the core functions of treatment and payment.

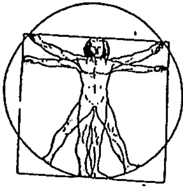
Legal Proceeding: If requested by judicial or administrative proceedings, court order, subpoena or law enforcement purposes.

Minimum Necessary Standard: The disclosure of and requests for your PHI will be the minimum required to accomplish the intended purpose.

Payment: The provider may disclose your PHI to third party and/or other party to obtain reimbursements and/or payments for your health care services.

Personal Representative: Your PHI may be disclosed to a person who is authorized by state law to act on your behalf in making your health care decisions.

Public Health Purposes: Your PHI may be disclosed to legally authorized public health authorities for the purpose of the prevention, control, investigation, intervention, and reporting of disease, injury, disability and vital events such as births or deaths. Your PHI may be disclosed for public health activities such as child abuse, neglect, safety and effectiveness of a product regulated by the FDA, and persons at risk of contracting and spreading disease.



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Treatment: For the coordination or management of your health care services, your health care provider may consult with another health care provider, a third party, or for the referral to another health care provider.
Workers Compensation: State laws may permit disclosure of your PHI to comply with workers' compensation laws without your authorization and no minimum necessary standard is required.
Miscellaneous: We may use or disclose your PHI in the normal course of operations, notifying you of appointments, services, and clinic news.

The Privacy Rule allows you the right to review and receive copies of your records as it relates to your health care. The request must be in writing, allowing your doctor 30 days to respond. Your provider may deny your request if it will cause harm to your or to another person. Your doctor may charge a copy fee, which will not exceed the amount permitted by state law.

Your doctor must comply with any reasonable request to have confidential communication by alternative means or at an alternative location if not doing so endangers you.

You may request to have an amendment placed in your record if you disagree with anything in your record. This does not mean that anything will be removed, or changed and the doctor has the right to respond with a rebuttal statement if he/she feels it is necessary.

You have a right to receive your doctor's Notice of Privacy Practices.

Your may revoke authorization, in writing, at any time, except in the event that the doctor has acted as indicated in the doctor's Authorization Notice.

You have the right to file a written complaint with our Compliance Office if you believe that any of your privacy rights have been violated. You can obtain a complaint form from the Compliance Officer, and it must be filed with 180 days of when you knew or should have known that the violation occurred. You may also oontact a written complaint, either on paper or electronically with the Office of Civil Rights (OCR). The Privacy law prohibits our office from taking any retaliatory actions against anyone who files a complaint.