

Today's Date: ____/____/____

Name: _____ Age _____ Date of Birth _____

Local Address _____ City _____ State _____ Zip _____

Out of Town Address _____ City _____ State _____ Zip _____

Marital Status _____ Sex _____ S.S.# _____ Home Phone _____ Cell. Phone _____

Email Address: _____ Employer _____

Occupation _____ Address/Phone _____ Spouse _____

Emergency Contact _____ Phone _____ Relationship _____

How did you hear about our office?

Yellow Pages Drive By Walk-In Internet Referral (Please tell us who) _____ Other: _____

Health Insurance Information

Primary Insurance _____ Policy Holder's Name _____ DOB _____

Policy Holder's Relationship to Patient _____ Policy Holder's Employer _____

Accident Information (SKIP this section if you were not involved in an accident)

Is your condition due to an: **Auto Injury** **Work Injury** **Slip and Fall** **Other Accident (describe below)**

Date of Accident _____ Place (City/State) _____

Auto/Work Insurance Company _____ Insured's Name and DOB _____

If **Auto Injury**, have you reported the accident to your insurance company? No Yes Claim # _____

If **Work Injury**, have you reported the accident to your supervisor/boss? No Yes Claim # _____

If **Slip and Fall or Other Type of Injury**, please describe: _____

Do you have an **Attorney** for your Auto or Work Comp. injury Yes No?

Please provide Attorney Name, address and phone # _____

Current complaint

I. Please list your **worst** complaint: _____ How long have you had it: _____

How did it start: _____ **A) Is it:** Improving Worsening Staying the Same **B) Is it:** Mild Moderate

Severe **C) What worsens it:** General activity Moving Wrong Bending Lifting Walking Sports Getting up from a chair

Using a computer/desk work Other: _____ **D) What makes it better:** Rest General Activity Ice Packs

Heating Pad OTC Meds Rx Meds Massage Chiropractic Other: _____ **E) Is it worse in the:** AM PM

After day wears on Steady Off and on **F) Is the symptom:** Dull and Achy Tight and Stiff Sharp and Stabbing

Numb and Tingly Shooting Burning Cramping

II. Please list your **2nd worst** complaint: _____ How long have you had it: _____

How did it start: _____ **A) Is it:** Improving Worsening Staying the Same **B) Is it:** Mild Moderate

Severe **C) What worsens it:** General activity Moving Wrong Bending Lifting Walking Sports Getting up from a chair

Using a computer/desk work Other: _____ **D) What makes it better:** Rest General Activity Ice Packs

Heating Pad OTC Meds Rx Meds Massage Chiropractic Other: _____ **E) Is it worse in the:** AM PM

After day wears on Steady Off and on **F) Is the symptom:** Dull and Achy Tight and Stiff Sharp and Stabbing

Numb and Tingly Shooting Burning Cramping

MEDICARE PATIENTS (check one): Would you like to be able to Bend and lift with no pain Get up from sitting with no pain
 Get a good night's sleep with no pain Read with no pain Work at a computer with no pain Do your housework with no pain
 Do your yard work with no pain Play sporting activities with no pain

CURRENT HEALTH

- Name and phone number of family doctor: _____
- **CHIEF COMPLAINT** (Why are you here to see the doctor): _____

MEDICAL HISTORY

Please indicate whether you have had or currently have any of the following illnesses.

- | | | | |
|--|---|--|---------------------------------|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Chronic Lung Disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Eye Disease | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Excessive Scarring | <input type="checkbox"/> Other | Please Explain: _____ | |

Current or previous serious illnesses or injuries: _____
 Previous surgeries: _____
 Epidural: Yes No Date: _____

MEDICATIONS

MEDICATION	DOSAGE	QTY	FREQ	MEDICATION	DOSAGE	QTY	FREQ
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____

- Please list any medications you are allergic to: _____
- Please indicate your height and weight _____ What is your usual blood pressure ____/____
- Any current loss of bowel or bladder control: Yes No Any current seizures, paralysis, speech, vision problems: Yes No
- Any unexplained recent weight loss: Yes No Current fever: Yes No Current nutritional problems: Yes No
- Have you had spinal X-Rays within the past 5 years? If yes, when and where _____
- **Do you have a pacemaker?** Yes No **If yes, please ALERT our doctor and/or assistant**
- Do you have any blood/lymph disorders? Yes No If yes, please list _____
- Do you have osteoporosis or rheumatoid arthritis? Yes No
- Please list any other electrical device that you currently wear _____
- Please select one: I have never smoked Former smoker Current smoker, if so how much: ____ pk./day ____ pk./wk.
- Please select one: I don't drink alcohol Rarely drink Social drinker Heavy drinker (____ oz. per day/week)
- Have you ever had chiropractic care Yes No If yes, last date of treatment _____ By whom: _____
- Similar or difference condition: _____ Results: _____
- What are your overall expectations from your treatment with our doctor: _____

FAMILY HISTORY

	MOTHER:	FATHER:	SIBLING:	GRANDPARENT:	CHILDREN:
Arthritis					
Cancer					
Diabetes					
Heart Problems					
High Blood Pressure					
High Cholesterol					
Stroke					
Thyroid Problems					
Obesity					
Liver Problems					
Kidney Problems					
Depression/Anxiety					
Blood Disorders					

• **WOMEN ONLY** I hereby declare that to the best of my knowledge I am I am not pregnant. If there is a chance that I may be pregnant, I will inform the doctor prior to my examination.

I, the undersigned, voluntarily give my consent for to receive medical and health care services by the doctor and/or nurse practitioner to examine and treat my condition as he/she deems appropriate through the use of chiropractic care and/or medical care. I also give my consent for the doctor to take x-rays (if needed) or to perform other diagnostic aids as he/she deems appropriate.

Patient Signature _____

(Parent/Guardian signature if under 18 years of age)

NOTICE OF PRIVACY PRACTICES

Patient Health Information

Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing, and insurance information.

How We use your Patient Health Information

We use health information about you for treatment, to obtain payment, and for health care operations, including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances, we may be required to use or disclose the information even without your permission.

Examples of Treatment, Payment, and Health Care Operations

Treatment: We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to family members who are helping with your care.

Payment: We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payment from your health plan.

Health Care Operations: We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, and to assess the care and outcomes of your case and others like it.

Special Uses

We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Other Uses and Disclosures

We may use or disclose identifiable health information about you for other reasons, even without your consent. Subject to certain requirements, we are permitted to give out health information without your permission for the following purposes:

Required by Law: We may be required by law to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.

Research: We may use or disclose information for approved medical research.

Public Health Activities: As required by law, we may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.

Health oversight: We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.

Judicial and administrative proceedings: We may disclose information in response to an appropriate subpoena or court order.

Law enforcement purposes: Subject to certain restrictions, we may disclose information required by law enforcement officials.

Deaths: We may report information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies.

Serious threat to health or safety: We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Military and Special Government Functions: If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.

Workers Compensation: We may release information about you for workers compensation or similar programs providing benefits for work-related injuries or illnesses.

In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

Individual Rights

You have the following rights with regard to your health information. Please contact the person listed below to obtain the appropriate form for exercising these rights.

Request Restrictions: You may request restrictions on certain uses and disclosures of your health information. We are not required to agree to such restrictions, but if we do agree, we must abide by those restrictions.

Confidential Communications: You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments.

Inspect and Obtain Copies: In most cases, you have the right to look at or get a copy of your health information. There may be a small charge for the copies.

Amend Information: If you believe that information in your record is incorrect, or if

important information is missing, you have the right to request that we correct the existing information or add the missing information.

Accounting of Disclosures: You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or health care operations.

Our Legal Duty

We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the Notice currently in effect.

Changes in Privacy Practices

We may change our policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice in the waiting area and each examination room. You can also request a copy of our Notice at any time. For more information about our privacy practices, contact the person listed below.

Complaints If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about your records, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

Contact Person

If you have any questions, requests, or complaints, please contact:
Advanced Spinal Care
3628 Harden Boulevard
Lakeland, FL 33803
863-701-2225

Effective Date: April 14, 2003

I,

_____ hereby acknowledge receipt of the Notice of Privacy Practices given to me.

Signed:

Date:

If not signed, reason why acknowledgement was not obtained:

GENERAL/FINANCIAL POLICY

By signing below, you confirm that you have read this policy and understand that:

- It is your responsibility to inform our office of any address or telephone number changes.
- Your account is to be kept current. All self-pay or insurance copayments, co-insurances and deductibles will be collected at the time of service payable by cash, check, Visa, MasterCard, Discover, American Express or Care Credit.
- If you do not have your payment (s), your appointment may be rescheduled.
- If you are unable to keep a scheduled appointment, please notify us 24 hours before your appointment so that we may offer that time to another patient. **There is a \$25.00 charge for missing a half hour massage appointment and a \$50.00 charge for missing a full hour massage appointment without proper notification. Massage appointments must be secured with a credit card on file.**
- A returned check will result in a \$25.00 service charge and all future payments being required in the form of cash or credit card.
- You will only be sent a statement if your balance exceeds \$10.00.
- There is a \$45.00 charge for the completion of paperwork (ex: disability, FMLA, etc).
- If your account is turned over to a collection agency, you will be responsible for any costs incurred in collection of said balance, which may include collection agency fees up to 35% of your outstanding balance, court costs and attorney fees.

IF YOU HAVE HEALTH INSURANCE COVERAGE: As a courtesy to you, our office will attempt to pre-verify your primary insurance coverage for your Chiropractic care. Coverage information is obtained from your insurance company using information provided by you prior to your initial visit. **We must emphasize that as medical providers, our relationship is with you, not your insurance company.** Please be advised that the information provided by your insurance company is not a guarantee of payment, only an estimate of what might be covered under your policy at the time of inquiry.

By signing below you confirm you understand that:

- It is your responsibility to inform us of any changes to your insurance policy so that your coverage can be re-verified.
- Not all services are a covered benefit with all insurance plans.
- It is your responsibility to be aware of what service (s) is being provided to you and if it is a covered benefit under your insurance.
- You are responsible for any non-covered charges not payable by your insurance policy.
- We will send all required claim forms and documentation to ensure your claims are processed in a timely manner.
- Final determination of benefits available is determined when the claim is sent to your insurance company and we receive an explanation of benefits from them.
- After all co-pays, contracted plan reductions and insurance payment credits are applied to your account, any remaining portion will be your responsibility.
- If you are a **MEDICARE PATIENT**, please be advised that Medicare **only covers** Spinal Adjustments in a Chiropractor's office. All services outside of the Spinal Adjustment in our office will be your financial responsibility.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we urge you to contact us promptly for assistance in the management of your account. If you have any questions about the above information, *please* do not hesitate to ask us. **WE ARE HERE TO HELP YOU.**

I understand that services rendered by Ashley Newman, ARNP-C and Dr. James Peterzell, D.O., are NOT reimbursed by insurance and that the office does not provide or fill out forms for insurance purposes. I will be solely responsible for payment for these services.

By signing below, you have read and understand the above Financial Policy and agree to meet all financial obligations.

Printed Name

Signature of Patient/Legal Guardian

Date

CONSENT TO RELEASE INFORMATION: In the event that you ever wish to have a family member or friend come to our office and get a copy of your medical records for whatever reason, we ask that you sign below allowing them to do so. By signing below, I hereby give my consent for Advanced Spinal Care, Ageless Aesthetics & Wellness and Dr. James Peterzell to release my medical records to:

Name of Family Member/Friend

Signature of Patient/Parent/Legal guardian

Date

CONSENT TO TREAT A MINOR: I hereby authorize and give consent for Dr. Michael Majette, Dr. Bradley Bartel, Dr. James Peterzell and Ashley Newman, ARNP-C to examine, and if needed, treat my minor child _____.
Print child's name here

Printed Name

Signature of Patient/Legal Guardian

Date

History of Auto Accident

Patient's Name _____ Date of Birth _____ Today's Date _____

Address _____ Date of Accident _____

City _____ State _____ Zip _____ Time of Accident _____

Please describe in detail how the accident happened _____

I was the driver

I was the passenger sitting in the

middle front seat right front seat left rear seat middle rear seat right rear seat

I was a pedestrian standing sitting riding a bike walking other _____

I was traveling in a vehicle: Year _____ Make _____ Model _____

Transmission type: manual automatic

The vehicle I was traveling in was stopped traveling at _____ m.p.h.

Road conditions were: dry damp wet

The road was made of: concrete asphalt gravel dirt other _____

Did your car have a head rest: yes no

If your car had a head rest, what position was it in: up middle down

Were you: wearing your seat belt yes no Wearing your harness yes no

Head position: At the time of the accident my head was looking:

straight ahead to the right to the left up down other _____

Brakes: Were your brakes applied at the time of the impact yes no

Elbows: My left right elbow was on the arm rest. Other _____

Hands: both right left hand was on the steering wheel.

can't remember other _____

Were you aware of the impending collision before it happened: yes no

Did you tighten your body and brace for the collision: yes no

Your hands, as a result of the impact:

grabbed the steering wheel tightly were forced off the steering wheel/stick shift

other _____

As a result of the impact, your body was thrown: forward backward right left
 turned to the right (clockwise) can't remember

As a result of the impact, your head hit the: front windshield rearview mirror
 steering wheel back of the seat ahead of me side driver/passenger – inside window/door
 another person's body nothing other _____

As a result of the impact your shoulders were: Impacted with the inside of the door/car
 pressed firmly against the shoulder harness other _____

As a result of the collision, what other parts of your body struck the inside of the vehicle:
 ankles elbows face chest thighs forearms other _____

Did your vehicle strike or impact with a second object after the first impact: yes no

Did your vehicle strike another car: car truck road/median building
 other _____

Were you wearing glasses at the time of the accident: none yes no

If yes, were your glasses still on following the accident: yes no

Did you lose consciousness as a result of the accident: yes no

If yes, how long were you unconscious: _____

Estimate cost to repair your car: \$ _____

After the accident the car was: totaled drivable not drivable

At the time of the accident, how many people were in the car with you:

Names of other occupants:

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____
- 6. _____

Were the other occupants injured: yes no if yes, explain: _____

Were the police called to the scene: yes no

Was a police report written: yes no

Was a ticket given to you: yes no

Was a ticket given to the other driver: yes no

As a result of the accident I felt my symptoms:

- immediately within one hour within 6 hours during the night
- next morning next day other _____

As a result of the accident I felt:

- headaches upper back pain chest pain/soreness wrist/elbow pain/soreness
- neck pain low back pain stomach pain/soreness knee/ankle pain/soreness
- shoulder pain numb/tingling/burning arms numb/tingling/burning legs
- loss of bowel/bladder control other _____

Please list location of any cuts or bruises if applicable: _____

Did you go to the hospital: yes no

If yes: immediately next day later in same day other _____

Did you go to the hospital by: ambulance private transportation

Name of hospital: _____ City: _____

Were you admitted to hospital: yes no

If yes, how long was your stay: _____

Hospital diagnosis: _____

What recommendations were made: see your own doctor see orthopedist/neurologist

physical therapist braces/collars prescription released other _____

Please list all doctors you have seen since the accident

Name	Address	City	Released
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____

Are you working now: yes no

Are you currently working with restrictions: yes no

Has the doctor placed you on: total disability partial disability

Please list work restrictions: _____

Please list any special test ordered by the hospital or doctor _____

Since the accident do you feel: worse no improvement better other _____

Prior to this incident, have you been involved in any other past Motor Vehicle Accidents: yes no

If yes, approximately what date did the accident occur: _____

Did you experience any trauma: _____

If so, what was your diagnosis: _____

Do you still experience symptoms from your prior accident: yes no

If yes, have the symptoms been exasperated by your most recent accident: yes no