NEW PATIENT INFORMATION

***NOTE: If this is a Workers' Compensation or Auto Accident Case, please tell Receptionist NOW before you start this form. ***

Date: _____ **Name:** _____
Permanent Address: _____
City: _____ **State:** _____ **Zip:** _____
If here from out of town: **Local Address:** _____
Phones: Daytime _____ **Cell** _____ **Email** _____
Birth Date: Mo _____ **Day** ____ **Yr** _____ **Sex:** ___ **SS#** _____
Married: _____ **# of Children:** _____ **Spouse Name:** _____
Business/Employer: _____ **Type of Work:** _____
Have you been treated here before? Yes _ No _ If so, when? _____
How did you find out about us? _____
(If referred by someone, please give us their name so we can thank them!)

MAJOR COMPLAINT: _____
Previous Chiropractic Care: _____
(Doctor's Name, Location, Last seen?)
Other Doctors seen for this condition: _____
Medications currently taking: Prescribed _____
Over the counter _____
Vitamins currently taking: Regularly _____
Occasionally: _____

Intake	How much, How often	Intake	How much, How often
Cigarettes		**Coffee**	
Alcohol		**Tea**	
Sugar		**Drugs**	
Water		**Exercise**	

FEMALES ONLY: Are you pregnant? Yes __ No __ Unsure __ Date of last period _____
Any other condition you have or symptom you are being treated for or that the doctor should know about? _____
_____

Medical Insurance Company name: _____
ID No: _____ **Group No:** _____

I hereby represent the above named patient as a MINOR and give authorization for full chiropractic care and treatments. I agree to be responsible for payment.
Signature: _____ **Relationship:** _____ **Date:** _____

I authorize (Office Name) to render chiropractic care and treatments. If applicable, I give them permission to bill my insurance co. & accept payment on my behalf. I agree to be responsible for payment. Signature: _____ **Date:** _____

Please turn page over and fill in the back of the form >

SPINE & SPORTS REHAB

CONSENT FOR TREATMENT

I, THE UNDERSIGNED, HEREBY AUTHORIZE PLANTATION SPINE & SPORTS REHAB AND WHOMEVER THEY MAY DESIGNATE AS THEIR ASSISTANTS TO PERFORM AND ADMINISTER THERAPY AND TREATMENT AS IS NECESSARY. I ALSO CERTIFY THAT NO GUARANTEE OR ASSURANCE HAD BEEN MADE TO THE RESULTS THAT MAY BE OBTAINED.

I UNDERSTAND AND AGREE THAT HEALTH AND ACCIDENT INSURANCE POLICIES ARE AN ARRANGEMENT BETWEEN AN INSURANCE CARRIER AND MYSELF. FURTHERMORE, I UNDERSTAND THAT THIS OFFICE WILL PREPARE ANY NECESSARY REPORTS AND FORMS TO ASSIST ME IN MAKING COLLECTION FROM THE INSURANCE COMPANY AND THAT ANY AMOUNT AUTHORIZED TO BE PAID DIRECTLY TO THIS OFFICE WILL BE CREDITED TO MY ACCOUNT UPON REQUEST. I PERMIT THIS OFFICE TO ENDORSE REMITTANCES FOR THE CONVEYANCE OF CREDIT TO MY ACCOUNT. HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT.

PATIENT SIGNATURE_____ DATE_____

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

PLANTATION SPINE & SPORTS REHAB

I hereby give my consent for Plantation Spine & Sports Rehab (hereinafter referred to as the practice) use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

The practice's Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. The practice reserves the right to revise its notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to

Carrie Norton our privacy Officer, at 8267 West Sunrise Blvd., Plantation, FL 33322.

With this consent, the Practice may call your home or other alternative location and leave a message, voice mail or in person reference to any items that assists the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, the Practice may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards, and patient statements as long as they are marked personal and confidential.

With this consent, the Practice may e-mail to my home or alternative location any time to assist the practice in carrying out TPO, such as appointment reminder card and patient statements. I have the right to request that the practice restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by agreement.

By signing this form, I am consenting to the practice's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, the practice may decline to provide treatment to me.

_____ _____

Signature of Patient or Legal Guardian Date