MICHAUX FAMILY CHIROPRACTIC

Patient Demographic Information: **Today's Date: _____**

FULL LEGAL NAME (Last, First, Middle Initial): _____

Date of Birth: _____ Social Security #: _____ Age: _____ Gender: M / F

Relationship Status: ☐Married ☐Single ☐Widowed ☐Divorced ☐Separated ☐CU ☐Domestic Partner

Name of Significant Other: _____

Street Address / Apt No: _____

City: _____ State: _____ Zip Code + 4: _____

Phone Numbers: (Home) _____

(Cell) _____ (Work) _____

Which phone number would you prefer we contact you on? ☐ Home ☐ Cell ☐ Work

E-mail Address: _____

Occupation: _____ Employer: _____

Preferred Language: ☐ English ☐ Spanish: ☐ Other: _____

Smoking Status: ☐ Every Day Smoker ☐ Sometimes Smoker ☐ Former Smoker ☐ Never Smoker

How Did You Hear About Our Office?:

☐ Insurance ☐ Newsleader ☐ Disney Ad ☐ Commercial ☐ Walk / Drive By ☐ Facebook

☐ Family: _____ ☐ Friend: _____ ☐ Website: _____

☐ Event: _____ ☐ Attorney Referral: _____ ☐ Other: _____

Medication Information: Please list any medications that you are currently taking or provide us with a list of current medications. ☐ Not Currently Prescribed Any Medications ☐ See Attached List of Medications

Name of Medication:	Reason for taking this medication?	Dosage Information:	What form of medication is this?	How often do you take this medication?

Any medication allergies?: Yes / No If yes, please list them: _____

Primary Insurance Information: **Insurance Company Name**: _____

Member/ Subscriber ID #: _____ Group #: _____

Phone Number: _____ Are you the primary insured on this policy? Yes / No

If you are not the primary insured, please provide the following information:

Name of Guarantor: _____ Guarantor's Date of Birth: _____

Relationship of Patient to the Guarantor: _____

Secondary Insurance Information: **Insurance Company Name**: _____

Member/ Subscriber ID #: _____ Group #: _____

Phone Number: _____ Are you the primary insured on this policy? Yes / No

If you are not the primary insured, please provide the following information:

Name of Guarantor: _____ Guarantor's Date of Birth: _____

Relationship of Patient to the Guarantor: _____

TERMS OF ACCEPTANCE AND CONSENT FOR CARE

THIS DOCUMENT CONSTITUTES INFORMED CONSENT FOR CHIROPRACTIC CARE

Our office has one goal, to aid the patient in achieving optimal health as quickly and safely as possible, through the removal of interference in the body's ability to heal. We do this through safe and gentle chiropractic care.

We will attempt to identify and diagnose any ailments that the patient may have that may be corrected through chiropractic care, massage therapy, and/or active or passive rehabilitation techniques. If any condition or disease that is out of our scope of practice is found to be present, we will refer the patient to an appropriate physician to diagnose and/or treat that condition.

Our primary focus is the detection and correction of vertebral subluxation. This is the misalignment of one or more spinal bones that can cause interference to the nervous system. Any interference to the nervous system may or may not cause a variety of differing symptoms. Again, our focus is to correct the cause of the interference, not the symptoms themselves.

Vertebral subluxations are brought on by physical, chemical, and/or emotional stress or trauma. Through specific chiropractic adjustments, we reduce and/or correct these subluxations. It is also important to note that the sooner we are able to treat a patient's subluxation and the associated degenerative processes, the faster and more completely the patient's body can respond and heal. It may be necessary to perform an examination of the patient each time a new injury or trauma occurs, and often additional x-rays and/or imaging may be medically necessary to maintain the utmost safety when dealing with the patient's body. The risks of chiropractic care, massage therapy, and active or passive rehabilitation are minimal when dealing with a licensed professional; however, if you have concerns about these risks, please discuss them with the doctor prior to the examination and/or treatment session.

I have read and fully understand the statements and terms listed above. I hereby give consent to MICHAUX FAMILY CHIROPRACTIC to evaluate me to determine my condition and treat me for such condition. I also understand that I may, at anytime, discontinue care with the examination, x-rays, and/or any treatment or therapies if I choose.

_____	_____	_____
Print Patient Name	Patient / Legal Guardian Signature	Date

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for MICHAUX FAMILY CHIROPRACTIC (hereinafter referred to as the PRACTICE) to use and disclose protect 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:

Dr. Kurtis D. Michaux, D.C., Privacy Officer, 4347 South US Highway 27, Clermont, FL 34711

With this consent, the PRACTICE may call my home or other alternative locations and leave a voicemail message or speak to me in person in reference to any items that may assist the PRACTICE in carrying out TPO, such as appointment reminders, insurance questions, and any calls pertaining to my clinical care, including but not limited to, laboratory and imaging results.

With this consent, the PRACTICE may mail to my home or alternative locations 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 locations any items that assist the PRACTICE in carrying out TPO such as appointment reminders, updates to office hours, or 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. If the PRACTICE does agree to my restrictions it is bound to this agreement.

By signing below, 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.

_____	_____	_____
Print Patient Name	Patient / Legal Guardian Signature	Date

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRATICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

_____	_____	_____
Print Patient Name	Patient / Legal Guardian Signature	Date

OFFICE POLICIES

It is our office policy that any patient and/or insurance company that makes a payment up front or in advance of services being provided is entitled to an administrative discount.

The fee paid for the medically necessary x-rays taken upon examination is for analysis only. The film itself is the property of this office as per Florida State Statue 460.413. Once the films are used for treatment purposes, they cannot be released. Films can be duplicated for additional treatment purposes, however, there will be a charge for this and a request must be submitted in writing.

If you have a co-insurance, copayment, deductible, or any other out-of-pocket responsibility due at the time of service, what will be your primary method of payment?

☐ Cash / Check ☐ CareCredit ☐ Credit Card ☐ Attorney Settlement / Letter of Protection

I understand and agree that health insurance and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that MICHAUX FAMILY CHIROPRACTIC will prepare any necessary reports and forms to assist in making collections from my insurance company and that any amount authorized to be paid directly to MICHAUX FAMILY CHIROPRACTIC will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

I also understand that if I suspend or terminate my care at MICHAUX FAMILY CHIROPRACTIC, any outstanding charges for professional services rendered to me will be immediately due and payable. I agree that I will be responsible for all attorney and legal fees if legal action becomes necessary to collect this amount.

_____	_____	_____
Print Patient Name	Patient / Legal Guardian Signature	Date

COMMUNICATION INFORMATION

Emergency Contact: _____ Relationship: _____

Street Address / Apt No.: _____

City: _____ State: _____ Zip Code +4: _____

Phone Number: _____

Please note that your emergency contact should also be listed below as being authorized to receive healthcare information on your behalf.

In the event that we would need to communicate your healthcare and/or financial information, to whom may we do so? Please list the name of the person to which we can release the information, as well as, which information you would like be to released to them.

Spouse: _____ ☐ Healthcare ☐ Financial

Parent: _____ ☐ Healthcare ☐ Financial

Child: _____ ☐ Healthcare ☐ Financial

Other: _____ ☐ Healthcare ☐ Financial

May we leave voicemail messages regarding your PHI on an answering device? Yes / No

PRIMARY CARE PHYSICIAN / SPECIALIST INFORMATION

Please list the name of your primary care physician/specialist, if you have one: _____

Street Address / Suite No.: _____

City: _____ State: _____ Zip Code +4: _____

Phone Number: _____ Fax Number: _____

It is our intention to communicate with your primary care physician/specialist to coordinate with them on the care provided at MICHAUX FAMILY CHIROPRACTIC. This is in an effort to maintain the highest quality of care for you and your family. Please check one of the boxes below to indicate your preference in regards to this communication.

☐ You are welcome to communicate with my primary care physician and/or other treating physicians.

☐ I would prefer that you DO NOT communicate with my primary care physician and/or other treating physicians unless it is medically necessary.

I have read and fully understand the above statements.

_____ _____ _____

Print Patient Name Patient / Legal Guardian Signature Date

RECORDS RELEASE AUTHORIZATION

Print Patient Name: _____ Patient Date of Birth: _____

Patient Social Security Number: _____ Date of Injury / Illness: _____

To Doctor and / or Hospital:

Clinic / Hospital Name: _____

Doctor's Name: _____

Facility's Address: _____

_____

Phone Number: _____ Fax Number: _____

I hereby authorize and request the release of my protected health information to:

Michaux Family Chiropractic
4347 South US Highway 27
Clermont, FL 34711
Phone: 352-243-7300 Fax: 352-243-7355
www.MichauxFamilyChiropractic.com

I would like the following information released to Michaux Family Chiropractic:

☐ History and Records Pertaining to Illness / Treatment During Time Period From: _____ To: _____

☐ Imaging Reports (X-rays, CT Scans, MRIs, ext.) ☐ Lab Reports ☐ Actual Images (Films or CD)

☐ ALL RECORDS IN YOUR POSSESION

_____	_____	_____
Print Patient Name	Patient / Legal Guardian Signature	Date
_____	_____	_____
Print Witness Name	Witness Signature	Date

This records request is effective from the above listed date for one year or until _____ and can be revoked upon request.