PuraVida Wellness Center

2945 S Congress Ave, Suite A, Palm Springs, FL 33461
Ph: 561-388-0909

Name: ______________________________ DOB: ____________ Date: __________

Address: ______________________________ City: ____________ State: ________ Zip: ________

Email: ______________________________ Occupation: ______________________

Phone: ________________ Cell: __________________ Work Phone: ____________________

Married Single Divorced Widowed Kids: ______________________________

Referred By: ____

Childhood History: *Circle all that apply*

Did you have any childhood illnesses?	**Yes**	**No**
Did you have any serious falls as a child?	**Yes**	**No**
Did you play youth sports?	**Yes**	**No**
Did you take Medications?	**Yes**	**No**
Did you have surgery?	**Yes**	**No**
Have you fallen / jumped from a height over three feet?	**Yes**	**No**
Were you in any car accidents as a child?	**Yes**	**No**
Was there any prolonged use of medicine such as antibiotics or an inhaler?	**Yes**	**No**
Did you suffer any other traumas (physical or emotional)	**Yes**	**No**
As a child, were you under regular chiropractic care?	**Yes**	**No**

Please share any additional information:

Adult – (18 to present)

Do/did you smoke? **Yes** **No**

Do/did you drink alcohol? **Yes** **No**

Have you been in any accidents? **Yes** **No**

Have you had any surgery? **Yes** **No**
If yes, list here:
____

Do/did you play adult sports? **Yes** **No**

On a scale of 1 – 10 describe your stress level:
(1 = none / 10 = extreme)

Occupational: _____ Personal: _______

Rate these following as Poor, Good, Excellent:

Diet: ________ **What do you eat?** __________________

Exercise: **When and what?** __________________

Sleep: ________ **Hours per day?** __________________

General Health: ______________________

Please list any medications: ____________________
____
____

Please list any vitamins/supplements: ______________
____
____

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Addressing issues that may have brought you to our office

If you have no symptoms or complaints, and are here for wellness services, please check here: ____________ and then skip to Family Health Profile. Otherwise please briefly explain what brought you to our office today:

____

____

Does this interfere with: ___Work ___Sleep ___Walking Hobbies Leisure Other

Have you seen anyone else for this issue? ____yes no If yes, who? ____________________

Please CIRCLE all symptoms you have ever had, even if they do not seem related to your current problem:

Headaches	Pins and needles in legs	Fainting	Neck pain
Pins and needles in arms	Loss of smell	Back Pain	Loss of balance
Dizziness	Buzzing in ears	Ringing in ears	Nervousness
Numbness in fingers	Numbness in toes	Loss of taste	Stomach Upset
Fatigue	Depression	Irritability	Tension
Sleeping problems	Stiff Neck	Cold Hands	Cold Feet
Diarrhea	Constipation	Fever	Hot Flashes
Cold Sweats	Lights bother eyes	Urinary Problem	Heartburn
Mood Swings	Menstrual Irregularity	Menstrual Pain	Ulcers

Family Health Profile:

At our office we are not only interested in your health and wellbeing but also that of your family and loved ones. Please mention below any health conditions or concerns you may have about your:

Children: ____

Spouse: ____

Mother: ____

Father: ____

Brother(s): ____

Sister (s): ____

Others: ____

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Do you:

Belong to health club?	Yes	No	
Use vitamins?	Yes	No	
Watch more than 5 hours of TV a week?	Yes	No	
Spend 1 or more hours on a computer daily ?	Yes	No	
Drink Soda?	Yes	No	(Diet or Regular)

What do you do for stress relief?

____

____

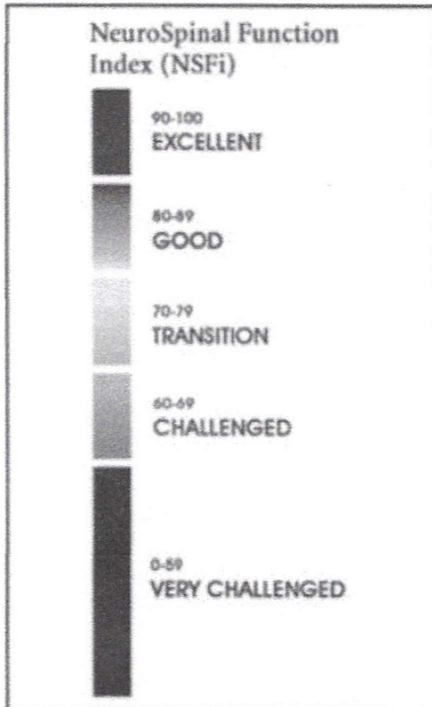
How many times a week do you exercise? ______________________

Are there any other health habits that you could share with us? ______________

____

Below, please mark an "X" where you believe your health is and an "O" where you would like to be.

NeuroSpinal Function Index:



What are your health goals?______________________

____

Are you healthier today than you were 5 years ago?__________

If so, what did you do to improve your health?__________

If not, why do you think your health declined?__________

____

Will you be healthier 5 years from now than you are today?______

____

If so, what are you planning to do to improve your health?______

____

And if not, what could you do to improve your health rather than have it continue to decline?__________________

What would you like your health to be 5 years from now?______

What aspect of your life would you like to have back?________

____

I consent to a professional and complete chiropractic examination and to any radiographic examination that the doctor deems necessary. I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Signature ______________________________ Date: ______________________

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CHIROPRACTIC INFORMED CONSENT

The undersigned Patient (which includes the parent/guardian) understands and acknowledges that the Patient is only receiving chiropractic care from PuraVida Wellness Center.

Dr. Kahook is a "chiropractic physician" as defined in Florida Statute 460.403(5)(2008). Chiropractic physicians examine, analyze, and diagnose the human living body and its diseases by use of (a) any physical, chemical, electrical or thermal methods, (b) x-ray for diagnosing, (c) blood tests, and (d) other chiropractic methods. *See* Florida Statute 460.403(3)(b).

Before you, the Patient, receive chiropractic care, it is important that you read this Consent and understand the nature and risks of chiropractic medicine. The "practice of chiropractic medicine" (or chiropractic care) involves the adjustment, manipulation, and treatment of your body in which vertebral subluxations and other malpositioned articulations and structures may be interfering with the normal generation, transmission, and expression of nerve impulse between the brain, organs, and tissue cells, thereby causing disease. *See* Fla.Stat. 460.403(9)(a). Chiropractic adjustments, manipulations, and treatments are intended to restore the normal flow of nerve impulse which produces normal function and consequent health. *See* Fla.Stat. 460.403(9)(a).

The undersigned Patient understands and acknowledges that there are risks associated with the practice of chiropractic medicine and chiropractic care including but not limited to ataxia, bruising, thermal injuries, dislocations/subluxations, dizziness, "drop attacks," fracture(s), mobility disruption, paralysis, quadriplegia, spinal injury, stroke/disruption of blood flow to brain, vision problems, and death.

The Patient is encouraged to ask questions! Although we are not affiliated with and cannot confirm the content of internet sites, resources such as WebMD, Chiro.org, AmerChiro.org, and others may be helpful. The Patient is specifically instructed to consult a medical doctor before receiving (and during/after) chiropractic medicine.

I, the undersigned Patient, understand the risks and limitations associated with the practice of chiropractic medicine, including the use of chiropractic care, evaluation, diagnosis, adjustments, manipulations, and treatments by PuraVida Wellness Center. I hereby give my informed consent to receive chiropractic medicine from Dr. Kahook.

____
Patient Name/Signature (and date)

____
Guardian/Parent's Name/Signature (and date)

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OFFICE POLICIES

The following are PuraVida Wellness Center's office policies. Please read carefully, and be sure to ask any questions you might have before signing the document.

Consent for Treatment. The Patient and/or the undersigned, give PuraVida Wellness Center my/our permission to evaluate and treat the Patient's injury or condition. I further understand that, in the course of recommended treatment, conditions may worsen on rare occasions. I further understand that **no guarantee or promise** has been made to me concerning the results of evaluation, care treatment.

Appointment Scheduling and Cancellation Policy. At PuraVida Wellness Center, we understand that unanticipated events happen occasionally in everyone's life. Business meetings, project deadlines, flight delays, car problems, and illness are just a few reasons why one might consider canceling an appointment. In our desire to be effective and fair to all of our patients and staff **24 hour advance notice is required when canceling an appointment otherwise the full fee for the missed appointment will be charged to your account.** This allows the opportunity for someone else to utilize our services during that appointment time.

Office Visits. We understand that the undersigned and/or the Patient may come to the office with family, friends or others. The Patient (or, if a minor, the undersigned) acknowledges that the Patient (or undersigned) is solely responsible for children or those in their care. This is an office; we are busy with patients. Please be careful and aware of your surroundings!

Private Health Insurance. I understand that I am responsible for whatever fees my insurance company does not pay on my claim. (Typically, this includes deductibles and/or co-payments.) It is further understood that I, the undersigned, **agree to pay the full amount** of the charges should my condition be such that it is not covered by my health insurance policy, or if, for any reason, the insurance company and/or my attorney refused to pay my balance at this office.

Patient/Parent or Legal Guardian Signature______________________________**Date** ____________

ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

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.

______________________________ ________

Patient Name (please print) **Date**

____

Parent, Guardian or Patient's legal representative

____

Signature

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.

Medical Information Release Form

(HIPAA Release Form)

Name: ________________________________ **Date of Birth:** ____/____/____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse____________________________________

[ ] Child(ren)__________________________________

[ ] Other_____________________________________

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number:________________

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] ______________________________________

The best time to reach me is (*day*)________________ between (*time*)________

Signed: ___________________________________ Date: ____/____/_____

Witness:___________________________________ Date: ____/____/_____

NOTICE OF HELATH INFORMATION PRACTICES

HIPAA

Dear Patient:

This notice describes how information about you may be used and disclosed by this office and how you can get access to this information. Please review it carefully.

Understand Your Health Record/Information

A record of your visit is made each time you come to our office. This record describes your symptoms, examinations, test results, diagnoses, treatment, and a plan for future care. This record helps us:

- Plan your care and treatment.
- Communicate among the health professionals who contribute to your care.
- Legally describe the care you received.
- Verify to you or a third-party payer that services billed were actually provided.
- Educate health professionals.
- Perform health related research.
- Improve the health of the nation by being a source of information for public health officials.
- Plan and market our facility.

When you understand the information contained in your record and how this information is used, you are able to:

- Ensure its accuracy.
- Understand who, what, when, where, and why others may access your health information.
- Make better informed decisions when authorizing disclosure to others.

Your Health Information Rights

You have the right to:

- Request a restriction of certain uses of your information as provided by 45 CFR 164.522.
- Obtain a paper copy of the notice of information practices upon request.
- Inspect and obtain a copy of your health record as provided for in 45 CFR 164.524.
- Amend your health record as provided in 45 CFR 164.528.
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528.
- Request communication of your health information by alternative means.
- Revoke your authorization to use of disclose health information in the future.

Our Responsibilities

Our practice is required to:

- Maintain the privacy of your health information.
- Provide you with a notice as to our legal duties and privacy practices.
- Abide by the terms of this notice.
- Notify you if we are unable to agree to a requested restriction.
- Accommodate your reasonable requests to communicate health information by alternative means.

We reserve the right to change our procedures and to make the new provisions effective for all protected health information we maintain. Should our information procedures change, we will mail you a revised notice to the address you have furnished us.

We will not use or disclose your health information without your authorization, except as described in this notice.

For More Information or to Report a Problem

If you have questions and would like additional information, please call our office at 386.428.9327.

If you believe your privacy rights have been violated, you can file a complaint with us or with the secretary of Health and Human Services. There is no retaliation for filing a complaint.

Examples of Disclosures for Treatment, Payment and Health Operations

We will use your health information in order to proved treatment.

Example: Information obtained by a nurse, doctor, or other member of your healthcare team will be recorded in your record and used to determine the course of treatment best for you. Your other doctors will be provided with copies of various reports that should assist him of her in treating you once you are discharged from our care.

We will use your health information for payment.

Example: A bill may be sent to you or a third-party payer. The information may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health operations.

Your health record may be used by our staff to assess the care and outcome in your case and others like it in order to continually improve the quality and effectiveness of the care we provide.

Business associates: In order to provide you with the care you need we deal with outside business associates. Examples include testing services and copy services. When these services are contracted, we may disclose your health information to these business associates sot that they can perform the job we have asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require these associates to appropriately safeguard your information.

Notification: We may use or disclose information in order to notify or assist in notifying a family member, personal representative, or another person responsible for your care.

Communication with family: We may, in our best judgement, disclose to family members, other relatives, close personal friends or any other person you identify, health information relevant to that person's involvement in your care of for payment related to your care.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

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

Fund raising: We may contact you as part of a fund-raising effort.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Law Enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

Effective Date:

* PATIENT COPY *
PLEASE KEEP FOR YOUR RECORDS!