Patient Intake Pt. ID:_____ Oxy %:____ Pulse:____ Ht:____ Wt:___ New Spring Chiropractic, Palm Coast, FL

Legal Name: Middle: Last Preferred:

Date of Birth: / / Gender M F Marital Status: S M D W SSN: - -

Home Address: City: State: Zip Code:

Home Phone: Cell Phone: I wish to be opted-out of text reminders.

Email Do you wish to receive email appointment reminders? Y N

Whom may we thank for referring you? Employed? Y N Employer:

Have you seen a chiropractor? Y N *If yes, who was the last chiropractor you saw?

Emergency Contact Name Emergency Contact Phone Number

Please read, sign and date:

- I understand that I am financially responsible to New Spring Chiropractic for all charges incurred and not covered by insurance.
- I understand any balances over 30 days are subject to accrued interest of 1.5 percent per month.
- I have read all information in this sheet and have completed the above answers. I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes in my status of the above information.
- I agree to notify staff immediately if my contact number changes and will not hold New Spring Chiropractic responsible for text messages that are sent to the wrong number because of lack of notification.

Patient Signature Parent (if minor) Date:

I agree to pay a no-call, no-show fee of $25 on subsequent appointments if I have a scheduled appointment and don't show up. (Reschedules are always welcome.)

Patient Signature Parent (if minor) Date:

Reason For Seeking Care (please mark diagram below where pain is present)

1: What event caused the problem?

Date problem began: / / What makes it worse?

What makes it better? Quality: Aching Stabbing Burning Pins and Needles

Rate severity on a scale of 0 to 10: Has been getting worse Staying the same **Frequency:** Intermittent Constant

2: What event caused the problem?

Date problem began: / / What makes it worse?

What makes it better? Quality: Aching Stabbing Burning Pins and Needles

Rate severity on a scale of 0 to 10 Has been getting worse Staying the same **Frequency:** Intermittent Constant

3: What event caused the problem?

Date problem began: / / What makes it worse?

What makes it better? Quality: Aching Stabbing Burning Pins and Needles

Rate severity on a scale of 0 to 10: Has been getting worse Staying the same **Frequency:** Intermittent Constant

Mark if you are experiencing: Dizziness Visual Disturbances

• Mark if any of the below activities are affected:

Work: Severity 0-10 w/ bending forward/backward/left/right

Bathing: Severity 0-10 w/ bending forward/backward/left/right

Cooking: Severity 0-10 w/ bending forward/backward/left/right

Yardwork: level 0-10 w/ bending forward/backward/left/right

Dressing: Severity 0-10 forward/backward/left/right

Sleep: Severity 0-10 forward/backward/left/right

Cleaning: Severity 0-10 forward/backward/left/right

Maintenance:Severity 0-10 forward/backward/left/right

Do you have any numbness or radiating pain? Y N

If yes, please describe:

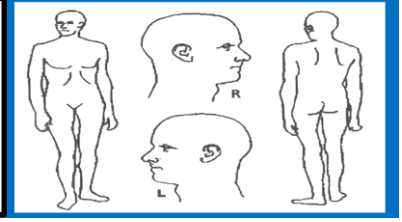
Previous treatments and outcome:

Primary Care Physician:

Are you pregnant?

Y N

Due Date:



REVIEW OF SYSTEMS- Mark Any of These Problems you have NOW or in the PAST– Mark NO if none apply

Cardiovascular	Past	Present	No	**Respiratory**	Past	Present	No	**Allergic/Immunologic**	Past	Present	No
Poor Circulation	☐	☐	☐	Asthma	☐	☐	☐	Hives	☐	☐	☐
Hypertension	☐	☐	☐	Tuberculosis	☐	☐	☐	Immune Disorder	☐	☐	☐
Aortic Aneurism	☐	☐	☐	Short Breath	☐	☐	☐	HIV/AIDS	☐	☐	☐
Heart Disease	☐	☐	☐	Emphysema	☐	☐	☐	Allergy Shots	☐	☐	☐
Heart Attack	☐	☐	☐	Cold/Flu	☐	☐	☐	Cortisone Use	☐	☐	☐
Chest Pain	☐	☐	☐	Cough	☐	☐	☐				
High Cholesterol	☐	☐	☐	Wheezing	☐	☐	☐	**Ear, Nose and Throat**	Past	Present	No
Pace Maker	☐	☐	☐					Difficulty Swallowing	☐	☐	☐
Jaw Pain	☐	☐	☐	**Eyes**	Past	Present	No	Dizziness	☐	☐	☐
Irregular Heartbeat	☐	☐	☐	Glaucoma	☐	☐	☐	Hearing Loss	☐	☐	☐
Swelling of legs	☐	☐	☐	Double Vision	☐	☐	☐	Sore Throat	☐	☐	☐
Genitourinary	Past	Present	No	Blurred Vision	☐	☐	☐	Nosebleeds	☐	☐	☐
Kidney Disease	☐	☐	☐	**Psychiatric**	Past	Present	No	Bleeding Gums	☐	☐	☐
Burning Urination	☐	☐	☐	Depression	☐	☐	☐	Sinus Infections	☐	☐	☐
Frequent Urination	☐	☐	☐	Anxiety	☐	☐	☐	**Gastrointestinal**	Past	Present	No
Blood in Urine	☐	☐	☐	Stress	☐	☐	☐	Gall Bladder Problems	☐	☐	☐
Kidney Stones	☐	☐	☐					Bowel Problems	☐	☐	☐
Lower Side Pain	☐	☐	☐	**Endocrine**	Past	Present	No	Constipation	☐	☐	☐
Neurologic	Past	Present	No	Thyroid	☐	☐	☐	Liver Problems	☐	☐	☐
Stroke	☐	☐	☐	Diabetes	☐	☐	☐	Ulcers	☐	☐	☐
Seizures	☐	☐	☐	Hair Loss	☐	☐	☐	Diarrhea	☐	☐	☐
Head Injury	☐	☐	☐	Menopausal	☐	☐	☐	Nausea/Vomiting	☐	☐	☐
Brain Aneurysm	☐	☐	☐	Menstrual	☐	☐	☐	Bloody Stools	☐	☐	☐
Numbness	☐	☐	☐					Poor Appetite	☐	☐	☐
Severe Headaches	☐	☐	☐	**Hematologic**	Past	Present	No	**Musculoskeletal**	Past	Present	No
Pinched Nerves	☐	☐	☐	Hepatitis	☐	☐	☐	Gout	☐	☐	☐
Parkinson's	☐	☐	☐	Blood Clots	☐	☐	☐	Arthritis	☐	☐	☐
Carpal Tunnel	☐	☐	☐	Cancer	☐	☐	☐	Joint Stiffness	☐	☐	☐
Vertigo	☐	☐	☐	Bruising	☐	☐	☐	Muscle Weakness	☐	☐	☐
Constitutional	Past	Present	No	Bleeding	☐	☐	☐	Osteoporosis	☐	☐	☐
Weight Loss/Gain	☐	☐	☐	Fever, Chills	☐	☐	☐	Broken Bones	☐	☐	☐
Low Energy Level	☐	☐	☐	Sweating	☐	☐	☐	Joints Replaced	☐	☐	☐

GENERAL HEALTH HISTORY

Please list any surgeries and approximate date: _____

Medications: ☐ None ☐ Yes: Start Date Brand Name Dosage Condition

FAMILY HISTORY

Mother's side: ☐ **Cancer** ☐ **Diabetes** ☐ **Heart Disease** ☐ **Mental Health** ☐ **Stroke** ☐ **Headaches** ☐ **Other:** _____

Father's side: ☐ **Cancer** ☐ **Diabetes** ☐ **Heart Disease** ☐ **Mental Health** ☐ **Stroke** ☐ **Headaches** ☐ **Other:** _____

Any other blood relatives with similar conditions? _____

SOCIAL HISTORY (check all that are true) ☐ Sexually active ☐ Currently use tobacco ☐ Formerly used tobacco

☐ Balanced diet ☐ Eat fast food ☐ Take vitamins ☐ Exercise regularly ☐ Sleep well ☐ Sleep poor ☐ Drink alcohol ☐ Use Drugs

Informed Consent for Treatment

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, to include, but not limited to, various modes of physical therapy, diagnostic x-rays and spinal decompression, physical examination, or any other medical procedures on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working, or associated with, or serving as back-up for the chiropractor named below, including those working at the clinic or office listed below or any other office or clinic associated with the following clinic: New Spring Chiropractic

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

I have had an opportunity to discuss with the doctor of chiropractic named below the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based upon the facts then known, and is in my best interest. Alternative treatments may include: medication, surgery, or physical therapy procedures. As with any of these alternative procedures there are risks. If no treatment is sought, your condition could get worse, remain the same, or improve.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date:

HIPAA Compliance Acknowledgement of Receipt

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notices of our privacy practice. We protect your health information and what rights you have regarding it, if we need to disclose your health information outside of our office for these reasons we will ask for your written permission. If you would like a copy of this policy please feel free to ask for one.

I acknowledge that I have reviewed this policy and that I was offered a copy of the "Notices of Privacy Practices."

Signature: _____ Date: _____

Release of Information Authorization- I hereby authorize New Spring Chiropractic to release information.

Information to Be Used or Disclosed- The information covered by this authorization includes:

☒ Healthcare and Financial Records (Healthcare records include examination findings, diagnoses, treatments, lab/imaging results)
☐ Healthcare records
☐ Financial Records

Persons to Whom Information May Be Disclosed- Information described above may be disclosed to:

☒ All of the Following:
☐ Primary Insurance Carrier
☐ Secondary Insurance Carrier
☐ Other Healthcare Provider as described above
☐ Personal Attorney
☐ Guardian/ Parent
☐ Spouse
☐ Release to: _____

Signature: _____ Date: _____

Assignment of Benefits and Direction to Pay Benefits Owed

I, the undersigned insured or beneficiary of an insurance policy, irrevocably assign to **New Spring Chiropractic, Inc.** whatever rights, interest, and benefits I have under any policy of insurance and under Florida law, including, without limitation, any and all claims for attorney's fees, injunctive, declaratory, and equitable relief, and costs, interest and/or damages, pursuant to common law, the Florida or US Constitution, and federal or Florida Statutes, including, but not limited to, § 624.155., *Fla. Stat.* This Assignment of Benefits (AOB) includes an assignment of any potential claim or cause of action for common law or statutory bad faith. If the Insurer disputes the validity of this AOB, then the insurer is instructed to notify the provider in writing within 10 days of receipt of this document. Failure to do so shall result in the provider relying on this AOB for direct payment and could constitute a waiver by the insurer to contest the validity of this document. I do hereby confirm that this AOB is irrevocable and instruct any insurance company or other collateral source for which I am entitled to benefits to pay for monies owed as a result of medical services rendered by **New Spring Chiropractic, Inc.** to promptly make payment in the name of and directly to **New Spring Chiropractic, Inc.** or its chosen billing service.

In the event that any insurance company reduces or denies benefits for services or treatment that **New Spring Chiropractic, Inc.** rendered to me, pursuant to this AOB, **New Spring Chiropractic, Inc.** is authorized to file suit in the Provider's own name or on my behalf and prosecute causes of action or claim I might have or that may exist in my favor against the insurance company and to collect any damages awarded or settlement monies for services rendered, plus interest, costs, reasonable attorney 's fees and a contingency fee multiplier. I further authorize **New Spring Chiropractic, Inc.** to compromise, settle or otherwise resolve any such claim or cause of action as it sees fit. I understand that in any such lawsuit, my name or other identifying information will need to be included in and/or portions of my medical file attached to pleadings and/or formal discovery. I waive any confidentiality of my records and/or information but only to the extent necessary to prosecute a claim for unpaid or owed medical expenses against the insurance company or any other responsible party.

I acknowledge that **New Spring Chiropractic, Inc.** objects to any reductions or partial payments by the Insurer. Any partial or reduced payment, regardless of the accompanying language, issued by the Insurer and deposited by **New Spring Chiropractic, Inc.** shall be done under protest, at the risk of the insurer, and the deposit shall not be deemed a waiver, accord, satisfaction, discharge, settlement or agreement by the provider to accept a reduced amount as payment in full. **New Spring Chiropractic, Inc.** reserves the right to seek the full amount of the bill submitted from the insurance company(ies) or me. Accordingly, the insurer is hereby instructed to set aside (escrow) any and all reduced or denied benefit payments for medical services rendered by this provider and not pay the disputed amount to anyone until the dispute is resolved.

I further instruct my insurance company to cooperate with **New Spring Chiropractic, Inc.** in resolving all billing or other disputes. Cooperation includes, but is not limited to, providing any and all declaration pages, PIP logs, payout ledgers, explanations of benefits, copies of checks, and any and all other documents or information to **New Spring Chiropractic, Inc.** or its attorneys, employees or other representatives acting on behalf of **New Spring Chiropractic, Inc..** If the insurer schedules a defense examination, examination under oath (EUO) or Independent Medical Examination (IME) of the patient, the insurer is hereby instructed to send a copy of said notification to this provider and the provider's attorneys. The provider and/or the provider's attorneys are authorized to appear at any patient EUO or IME set by the insurer.

New Spring Chiropractic
2 Pine Lakes Pkwy N, Suite 3
Palm Coast, Florida 32137
(386) 227-7534 / info@newspringchiro.com

THIS ASSIGNMENT OF BENEFITS DOES NOT ASSIGN ANY RIGHTS OR OBLIGATIONS UNDER THE POLICY OF INSURANCE, TO SUBMIT TO AN EUO OR RECORDED STATEMENT. I further direct and authorize the insurance company to speak to an attorney, employee or any other representative of **New Spring Chiropractic, Inc.** or anyone acting on its behalf over the phone and otherwise and to provide them with any and all information the insurance company may have or documentation not previously listed above that they may request.

I, as the patient, agree to remain personally liable for the amounts billed by **New Spring Chiropractic, Inc.** regardless of the amount paid by the insurance company, unless ordered by a court of law. I fully understand that said services or treatment were provided to me in consideration for an unconditional promise to pay and for me providing these instructions to my insurance company. I, as the patient, further agree to be liable for reasonable attorney's fees and costs incurred in collecting any delinquent accounts or unpaid balances. By executing this document, I am placing my insurance company(ies) on notice that the claims for services or treatment rendered by **New Spring Chiropractic, Inc.** are related to my accident (or my covered conditions) and should be paid directly to **New Spring Chiropractic, Inc.** pursuant to this assignment of benefits and applicable law. Any delay in paying benefits owed under the insurance policy could adversely affect me.

ERISA Authorization

I hereby designate the Provider as my Authorized Representative with respect to insurance coverage for health care services, and thereby authorize, and convey to Provider to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan: (1) the right and ability to act on my behalf in connection with any claim, right, or cause in action that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act on my behalf to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right to act on my behalf in respect to a benefit plan governed by the provisions of ERISA as provided in 29 C.F.R. §2560.5031(b)(4)) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines.

BY EXECUTING THIS DOCUMENT, I AM PLACING MY INSURANCE COMPANY ON NOTICE THAT THIS IS A DIRECT ASSIGNMENT OF BENEFITS PURSUANT TO FLORIDA LAW. AS THE INSURED OR BENEFICIARY OF SAID INSURANCE POLICY, I AM IRREVOCABLY ASSIGNING WHATEVER RIGHTS, INTEREST, AND BENEFITS I HAVE UNDER MY POLICY OF INSURANCE (LESS THE DUTY TO ATTEND AN EUO) AND UNDER FLORIDA LAW TO THIS PROVIDER. **The rights of New Spring Chiropractic, Inc. under this assignment shall not be extinguished upon my death, and my estate shall be subject to the terms and conditions of this AOB and my obligations and representations hereunder. A photocopy of this Assignment/Authorization shall be as effective and valid as the original.**

Patient's Name DOB

Signature of Policy Holder / Date

Name of Policy Holder or Claimant

New Spring Chiropractic, Inc./ Date

New Spring Chiropractic
2 Pine Lakes Pkwy N, Suite 3
Palm Coast, Florida 32137
(386) 227-7534 / info@newspringchiro.com