

HUDSON CHIROPRACTIC  
 WELLNESS  
 3920 Bee Ridge rd. STE C-B  
 Sarasota, Florida 34239  
 HudsonChiroWellness.com  
  
 Phone: (941) 366-8383  
 Fax: (941) 951-1485

**PATIENT INFORMATION**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
 Address: \_\_\_\_\_ Marital Status: S M W D Race: \_\_\_\_\_  
 \_\_\_\_\_ Email Address: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Cell Carrier: \_\_\_\_\_  
 Work Phone: \_\_\_\_\_ Extension: \_\_\_\_\_  
 Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
 Spouse: \_\_\_\_\_ How many children? \_\_\_\_\_ Names and ages: \_\_\_\_\_  
 Name of nearest relative: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
 \_\_\_\_\_  
 Family Medical Doctor: \_\_\_\_\_ Phone Number: \_\_\_\_\_

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? Y N

How were you referred to our office? \_\_\_\_\_

By signing below, you acknowledge that periodic communications sent by \_\_\_\_\_ via text message, phone, and email, could potentially cause additional charges for you under your cell phone or other data plan. In the event that you do not want to receive such periodic communications, please notify us in writing of your desire to be removed from such communications.

\*\*\*\*\*

**INSURANCE**

Please check any and all insurance coverage that may be applicable in this case:

Major Medical   
  Medicare   
  Auto Accident   
  Worker's Comp.   
  Medical Savings/Flex Plan

Name of Primary Insurance Company: \_\_\_\_\_

Name of Secondary Insurance Company (if any): \_\_\_\_\_

**AUTHORIZATION AND RELEASE:** I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

**The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and your rights concerning the privacy of your Patient Health Information we encourage you to read the HIPPA NOTICE that is available to you before signing this consent. The following person(s) have my permission to receive my personal health information:** \_\_\_\_\_

\_\_\_\_\_  
 Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

For Office Use Only: Treatment Plan: 4/4/4 3/3/3 Other: \_\_\_\_\_  
 Adjustment: Right Upper Left Upper Cox Diversified C T L Activator C T L Tx: US EMS Ice Heat Vibracussion Trigger Point TA TE





**SOCIAL HISTORY**

**Exercise:**  Does not exercise  Avoids exercise because of pain  Exercises regularly  Participates in aerobic activity  Exercise habits are frequent and heavy  Exercises occasionally  Participates in sports

**Work environment:**  No problems  Stressful  Requires constant sitting  Requires constant standing  Requires heavy typing or data entry  Requires lifting

**Smoking Status:**  Former Smoker (years since quitting: \_\_\_\_\_, years smoked: \_\_\_\_\_)  Never Smoker  Heavy Smoker (years smoked: \_\_\_\_\_)  Light Smoker (years smoked: \_\_\_\_\_)  Lives with Smoker

**Alcohol:**  None  Frequently  Heavily  Lightly  Moderately  Rarely

**Caffeine:**  None  Frequently  Heavily  Lightly  Moderately  Rarely

**Current medications:** \_\_\_\_\_

**Allergies:** \_\_\_\_\_

**SYMPTOMS AND CONDITIONS**

Please place the letter **P** by your **PAST** and/or the letter **C** by your **CURRENT** symptoms or conditions.

- |   |  |
|---|--|
| <input type="checkbox"/> Neck Pain                    | <input type="checkbox"/> High / Low Blood Pressure         |
| <input type="checkbox"/> Stiff Neck                   | <input type="checkbox"/> Breathing Problems                |
| <input type="checkbox"/> Back Pain                    | <input type="checkbox"/> Osteoarthritis                    |
| <input type="checkbox"/> Shoulder/Arm Pain            | <input type="checkbox"/> Pacemaker                         |
| <input type="checkbox"/> Headaches; Frequency _____   | <input type="checkbox"/> Stroke                            |
| <input type="checkbox"/> Muscle Spasms                | <input type="checkbox"/> Heart Attack                      |
| <input type="checkbox"/> Sleeping Problems            | <input type="checkbox"/> Heart Disease                     |
| <input type="checkbox"/> Weakness in Extremities      | <input type="checkbox"/> Arthritis                         |
| <input type="checkbox"/> Joint Pain/Swelling          | <input type="checkbox"/> Rheumatoid Arthritis              |
| <input type="checkbox"/> Broken Bones/Fractures _____ | <input type="checkbox"/> Diabetes                          |
| <input type="checkbox"/> Disc Injuries/Degeneration   | <input type="checkbox"/> Seizures/Epilepsy                 |
| <input type="checkbox"/> Numbness in Fingers/Toes     | <input type="checkbox"/> Osteopenia/Osteoporosis           |
| <input type="checkbox"/> Dizziness                    | <input type="checkbox"/> Cancer                            |
| <input type="checkbox"/> Tension                      | <input type="checkbox"/> HIV Positive                      |
| <input type="checkbox"/> Ears Ring                    | <input type="checkbox"/> Ulcers                            |
| <input type="checkbox"/> Loss of Smell                | <input type="checkbox"/> Gall Bladder Problems             |
| <input type="checkbox"/> Loss of Taste                | <input type="checkbox"/> Difficulty Urinating              |
| <input type="checkbox"/> Loss of Memory               | <input type="checkbox"/> Unusual Bowel Pattern/Indigestion |
| <input type="checkbox"/> Hands/Feet Cold              | <input type="checkbox"/> Fainting                          |
| <input type="checkbox"/> Eating Disorder              | <input type="checkbox"/> Fatigue                           |
| <input type="checkbox"/> Drug Addiction               | <input type="checkbox"/> Frequent Colds                    |
| <input type="checkbox"/> Alcoholism                   | <input type="checkbox"/> Sinus Problems                    |
| <input type="checkbox"/> Depression                   | <input type="checkbox"/> Congenital Condition: _____       |
| <input type="checkbox"/> Circulation Problems         | <input type="checkbox"/> Allergies: _____                  |
| <input type="checkbox"/> Chest Pain/Tightness         | <input type="checkbox"/> Other: _____                      |

\*\*\*\*\*

**ADDITIONAL INFORMATION**

Additional information you would like the doctor to know: \_\_\_\_\_

I certify that all of the information provided is accurate to the best of my knowledge:

Signature of patient/guardian: \_\_\_\_\_ Date: \_\_\_\_\_

## Authorization for the Release of Medical Records

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

I hereby request and authorize:

\_\_\_\_\_ To Disclose information to: \_\_\_\_\_ To Receive Information from:

Physician/Medical Facility/Hospital: \_\_\_\_\_

Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

\_\_\_\_\_ Fax Number: \_\_\_\_\_

Information to be disclosed includes copies of:

_____ Entire Record	_____ X-ray Reports
_____ Progress Notes	_____ X-ray Films
_____ Physical Exam forms	_____ Other, specify: _____

Purpose for Disclosure:

\_\_\_\_\_ Treatment, Payment, OR \_\_\_\_\_ Other, Specify: \_\_\_\_\_

This authorization will be effective after the date signed, unless cancelled in writing. I understand that the cancellation will have no effect on information released prior to receiving the cancellation. A copy of this authorization is as valid as the original.

\_\_\_\_\_ Date: \_\_\_\_\_

Signature of Patient

OR

\_\_\_\_\_ Date: \_\_\_\_\_

Signature of Parent/Guardian/Legal Representative

If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law.

Notice to recipient of information: This information has been disclosed to you from confidential records, which are protected by law. Unless you have further authorization, laws may prohibit you from making any further disclosures of this information without the specific written consent of the patient or legal representative.

## OFFICE AND FINANCIAL POLICY

*We feel very privileged that you have chosen us as your health care providers. We will make every effort to ensure that your trust is well placed and your confidentiality be protected. It is the goal of this office to provide you with the finest quality chiropractic care available.*

### SCHEDULING

- While we do schedule appointments during regular hours (to reduce waiting time for you and others), patients are welcome to stop in at any time. Please be aware, however, that walk-in patients will be seen after all regularly scheduled patients have been treated.
- Although we do not charge for missed or canceled chiropractic appointments, cancellations for neuromuscular therapy appointments do require 24 hours' notice. A \$25 fee will be charged for missed neuromuscular therapy appointments not canceled within 24 hours prior. All patients are allowed one courtesy cancellation without charge. In consideration of our other patients, we will be unable to schedule further neuromuscular therapy if three neuromuscular therapy appointments are missed or canceled without 24 hours' notice.

### PAYMENT

- Payment is expected in full at the time services are rendered. We do offer a credit guarantee option for patients who prefer to pay once a week, as opposed to each visit.
- For patients without insurance or those receiving non-covered services, we offer ChiroHealth USA for you to benefit from discounted fees. For more information, please ask the front desk assistant.
- For your convenience we accept cash, check, Visa, MasterCard, and Discover.
- Should care be discontinued for any reason other than discharge by the doctor, any outstanding balance will become immediately due and payable in full.
- If your account balance remains past due after 90 days, we will notify you that without a response from you; we may use a collection agency in order to obtain payment in full.

### INSURANCE

- Our office verifies insurance coverage in an effort to determine chiropractic coverage under your current policy. As benefits quoted are not a guarantee of coverage or benefits, it is the responsibility of the patient to contact their insurance if there is a discrepancy or error in benefits processing. Kindly keep in mind that you, as the patient, are responsible for any and all charges incurred in our office.
- Please inform the front office of any change in personal information. For example: phone numbers, address, marital status, etc. Please provide us with your most current insurance card and information. If your insurance changes during the year, please let us know so that we may bill using the most current insurance information.
- Although we are not obligated to accept insurance payments on assignment from all carriers, we may do so as a courtesy to you, based on our experience with your insurance carrier.
- The patient/insured is responsible for any portion of the claim not covered by insurance.
- Please remember it that insurance coverage is a contract between you and your insurance company.
- We do not bill any secondary insurance carriers.

### REFUNDS

- If there is a credit due, the patient will have the option of using the credit towards future visits or calling the office and requesting a refund.

*If you have any questions with regards to your health or any of our policies, please let us know. We welcome your referrals and look forward to a doctor-patient relationship that works for our mutual benefit.*

I have read and agree to the guidelines of this office/financial/insurance policy.

I, the undersigned, have insurance coverage with \_\_\_\_\_ Insurance Company and assign directly to \_\_\_\_\_ all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all changes whether or not paid by insurance. I hereby authorize HCW to release all information necessary to secure the payment of benefits. I authorize the use of the signature on all my insurance submissions whether manual or electronic.

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

## PATIENT HEALTH INFORMATION CONSENT FORM

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions of the use of their PHI. Our office is obligated to agree to those restrictions only to the extent they coincide with state and federal law.
3. A patient's written consent need only be obtained one time for all subsequent care given to the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. Our office may contact you periodically regarding appointments, treatments, products, services, or charitable work performed by our office. You may choose to opt-out of any marketing or fundraising communications at any time.
6. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
7. Patients have the right to file a formal complaint with our privacy official and the Secretary of HHS about any possible violations of these policies and procedures without retaliation by this office.
8. Our office reserves the right to make changes to this notice and to make the new notice provisions effective for all protected health information that it maintains. You will be provided with a new notice at your next visit following any change.
9. This notice is effective on the date stated below.
10. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Name of Patient: \_\_\_\_\_

Date: \_\_\_\_\_

Signature of Patient: \_\_\_\_\_

For further information regarding this notice, please contact our Doctor at \_\_\_\_\_

## Informed Consent

Please read the document in its entirety prior to signing. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

A patient, in coming to \_\_\_\_\_ Chiropractic and Wellness, PA, gives the doctors permission and authority to care for the patient in accordance with the chiropractic exam, analysis, diagnosis, and treatment of the joints and soft tissues.

As with any healthcare procedure, there are certain complications which may arise during the chiropractic adjustment and other clinical procedures. The chiropractic manipulation and other therapy are usually beneficial and seldom cause any problems. In rare cases, possible complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and physical therapy burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications, including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. We will make every reasonable effort during the examination to screen for contraindications to care; however, it is the responsibility of the patient to make it known, or to learn through health care procedures whatever he or she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the doctors.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which is screened for during the consultation, examination, and x-ray. The incidences of stroke are exceedingly rare and are estimated to occur between once in one million and once in ten million cervical adjustments. Once in a million is about the same chance as getting hit by lightning, once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death.

Other treatment options for your condition may include:

- Self-administered, over the counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants, and pain killers
- Hospitalization
- Surgery

Remaining untreated may allow the formation of adhesions and arthritis and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

I have read or have had read to me the above informed consent and I understand that if I am accepted as a patient by the doctors at \_\_\_\_\_ Chiropractic and Wellness, PA, I am authorizing them to proceed with any treatment that may be necessary. Any questions I have had regarding these procedures have been answered to my satisfaction prior to my signing the consent form. I have made my decision voluntarily and freely.

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Signature of Parent or Guardian (if a minor)

\_\_\_\_\_  
Patient's Signature

Dated: \_\_\_\_\_

# HUDSON CHIROPRACTIC OFFICE

## Assignment of Benefits & Authorization to Release Information

### ASSIGNMENT OF INSURANCE BENEFITS

I, the undersigned patient, hereby authorize and assign direct payment of any and all insurance benefits due to me for services rendered by Hudson Chiropractic Office to be made directly to the provider.

I understand that although my insurance policy is a contract between myself and my insurance carrier, **Hudson Chiropractic Office** will assist in submitting claims on my behalf as a courtesy. However, I acknowledge that I am ultimately responsible for all charges related to my treatment, regardless of insurance coverage or payment.

If my insurance policy does not allow direct payment to the physician, I hereby instruct and direct my insurance company to make the check payable to:

**"Hudson Chiropractic Office  
3920 Bee Ridge Road, Building C, Unit B  
Sarasota, FL 34233"**

### FOR PIP/AUTO INSURANCE CLAIMS:

This assignment includes, but is not limited to, the right to:

- Request and receive PIP logs and documentation.
- File claims directly with the insurer.
- Pursue interest, penalties, and attorney's fees as allowed under Florida Statute §627.736;
- File suit or participate in arbitration to recover benefits due.
- Endorse insurance checks and/or negotiate payment directly.

### AUTHORIZATION TO RELEASE INFORMATION

I also authorize Hudson Chiropractic Office to release any medical or billing information necessary to my insurance company, claims adjuster, or attorney involved in this case, for the purpose of processing claims and coordinating benefits.

# HUDSON CHIROPRACTIC OFFICE

## PATIENT RESPONSIBILITY ACKNOWLEDGMENT

I have read, understand, and agree to the terms above. I acknowledge that I remain financially responsible for any portion of my bill not covered by insurance, including copayments, deductibles, or non-covered services.

**PLEASE DO NOT SIGN THIS FORM WITHOUT READING AND UNDERSTANDING ITS CONTENTS.**

## SIGNATURE & ACKNOWLEDGMENT

Patient Name (Printed): \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Parent/Guardian Signature (if applicable): \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

# HUDSON CHIROPRACTIC OFFICE

## INSURANCE INTAKE FORM

Patient Name: \_\_\_\_\_

Appointment Date: \_\_\_\_\_

DOB: \_\_\_\_\_

### PRIMARY INSURANCE

Do you have primary health insurance?  Yes  No

Insurance Company Name: \_\_\_\_\_

Member / Subscriber Name: \_\_\_\_\_

Relationship to Subscriber:  Self  Spouse  Child  Other: \_\_\_\_\_

Insurance ID Number: \_\_\_\_\_

Group Number: \_\_\_\_\_

Plan Type: \_\_\_\_\_

Primary Policy Holder (*complete only if policy holder is other than patient*)

- Policy Holder Name: \_\_\_\_\_
- Date of Birth: \_\_\_ / \_\_\_ / \_\_\_
- Phone Number: \_\_\_\_\_
- Address: \_\_\_\_\_
  
- Employer: \_\_\_\_\_
- Subscriber / Member ID (if different): \_\_\_\_\_
- Last 4 of SSN (optional): \_\_\_ - \_\_\_ - \_\_\_
- Is policy holder the guarantor for payment?  Yes  No

### SECONDARY INSURANCE

Do you have secondary health insurance?  Yes  No

Insurance Company Name: \_\_\_\_\_

Member / Subscriber Name: \_\_\_\_\_

Relationship to Subscriber:  Self  Spouse  Child  Other: \_\_\_\_\_

Insurance ID Number: \_\_\_\_\_

Group Number: \_\_\_\_\_

Plan Type: \_\_\_\_\_

Secondary Policy Holder (*complete only if policy holder is other than patient*)

- Policy Holder Name: \_\_\_\_\_
- Date of Birth: \_\_\_ / \_\_\_ / \_\_\_
- Phone Number: \_\_\_\_\_

# HUDSON CHIROPRACTIC OFFICE

## INSURANCE INTAKE FORM

- Address: \_\_\_\_\_
- Employer: \_\_\_\_\_
- Subscriber / Member ID (if different): \_\_\_\_\_
- Last 4 of SSN (optional): \_\_\_ - \_\_\_ - \_\_\_ - \_\_\_
- Is policy holder the guarantor for payment?  Yes  No

### INSURANCE VERIFICATION DICLAIMER

I hereby confirm that the primary and secondary insurance information I have provided above is true, accurate, and complete to the best of my knowledge. I understand that any inaccuracies or omissions may affect the processing of my insurance claims and that I am responsible for any charges not covered by my insurance carrier(s).

Patient Printed Name: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Date: \_\_\_ / \_\_\_ / \_\_\_