A Chiropractic Tradition
Drs. Edwin Roberts

PLEASE PRINT

Date of appointment: _____

Name: _____ **Birth date:**_____
First Middle Last

Address: _____
Please No P. O. Boxes

_____ **Age:**_____ **Sex:** ___**F** ___**M**
City State Zip

Are you Hispanic? Yes No Preferred language:_____ **Race:**_____

E-MAIL ADDRESS: _____
By providing your e-mail address you are allowing our office to use this as a form of communication (ie: correspondence, communication or newsletters)

Home Phone _____ **Cell Phone** _____

Social Security Number_____

Employer_____ **Work Phone** _____

Who is your primary treating physician? _____

Were you referred to us? _____ **If Yes, by who?** _____

MARITAL STATUS (Please circle one) Single Married Divorced Separated

IF THE INSURANCE INFORMATION IS NOT IN YOUR NAME WE MUST HAVE THE FOLLOWING:

Whose name is the insurance under? _____

Their address:_____

Their social security number: _____

Their date of birth:_____ Sex: M _____ F _____

What is your relationship to this person? _____

By signing this consent to treat you are also giving us permission to leave messages on your answering machine/voice mail.

Patient consent for treatment_____

Guardian consent for treatment_____

In Case of emergency, notify:_____ Phone_____

Name of nearest relative not living with you_____

Phone:_____ Address:_____

Fees at this office will be paid by: _____

PATIENT'S SIGNATURE

I will be paying today by ____ Cash ____ Check ____ Credit Card

A Chiropractic Tradition
Drs. Edwin Roberts

Please fill out this form with your symptoms you are experiencing today

Patient Name: _____ **Chart #:** _____ **Date:** _____

Subjective Complaints:

Head

( ) Headache
Same Better Worse
Pain level _____ (0-10)
( ) Dizziness
( ) Light-headed
( ) Memory Loss
( ) Tinnitus
( ) Visual Disturbance

Neck

( ) Neck Pain
Same Better Worse
Pain level _____ (0-10)
( ) Spasm
( ) Tightness/Stiffness
( ) Ref. Arm: RT LT Both
( ) Weakness in arm: RT LT Both
( ) Numbness in arm: RT LT Both

Mid Back

( ) Mid back pain
Same Better Worse
Pain level _____ (0-10)
( ) Spasm
( ) Tightness or Stiffness
( ) Right side pain
( ) Left side pain
( ) Rib pain: RT LT Both

Low Back

( ) Low back pain
Same Better Worse
Pain level _____ (0-10)
( ) Spasm
( ) Tightness or Stiffness
( ) Ref. Leg: RT LT Both
( ) Weakness in leg: RT LT Both
( ) Numbness in leg: RT LT Both

Please list any other symptoms:

Please explain what caused your pain and when it happened:

A Chiropractic Tradition
Drs. Edwin Roberts

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR
PRIVATE, GROUP AND ACCIDENT HEALTH INSURANCE

I hereby instruct and direct_____

Insurance company to pay by check made out and mailed to: A Chiropractic Tradition, Drs. Edwin Roberts.

Or

If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows: 4469 Mobile Hwy, Suite D, Pensacola, FL 32506

The professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This Payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay in a current manner any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information from my medical record, pertinent to my case, to my insurance company, adjuster, or attorney involved in this case.

Date: _____

_____ _____
Signature of Patient Witness

_____ _____
Patients name printed Signature of Guardian
Patient under 18 years old

A Chiropractic Tradition
Drs. Edwin Roberts

Informed Consent

PATIENT NAME: _____ DATE: _____

To the patient: Please read this entire document prior to signing it. 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.

The nature of the chiropractic adjustment

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. This may cause an audible "pop" or "click" much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis/Examination/Treatment

As a part of the analysis, examination and treatment you are consenting to the following procedures:

Spinal manipulative therapy	**Ultrasound**	**Hot/cold packs**
Radiographic studies	**Interferential**	**Physical examination**
Intersegmental traction	**Diatherm**	**Myofascial release**
Percussion massage	**Therapeutic exercise**	

Other: _____
_____

The material risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: muscle strain, joint sprain and costovertebral strains. Some patients will feel some stiffness and soreness following the first few days of treatment. However, complications are generally rare. I will make every reasonable effort during the examination to screen for contraindications to care; however if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The availability and nature of other treatment options

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

If you chose to use one of the above noted “other treatment” options you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risk and dangers attendant to remaining untreated
Remaining untreated may allow the formation of adhesion 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.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BLANK AND SIGN BELOW.

I have read ( ) or have had read to me ( ) the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Roberts and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to treatment.

Dated: _____ **Dated:** _____

_____ **Dr. Edwin B. Roberts** _____
Patient Name **Doctor’s Name**

_____
_____
Patient Signature **Doctor Signature**

_____
Signature of Parent or Guardian (If minor)

PATIENT PRIVACY POLICY AND PRACTICE

Patient privacy is an integral part of ethical service. In our effort to meet your health care needs it is imperative that we collect information about you.

In order to provide you with appointment reminders, information about treatment alternative and/or other health related information, your physician and/or staff member may need to use your name, address, and/or telephone number. (If you are not home when we call to verify your appointment, we will leave a reminder message for you on your answering machine).

All medical records are confidential and are cared for with a high degree of security. Prior to any information being released, you, the patient, are required to sign a medical release form.

Sometimes it is necessary to refer you to another health care provider or hospital for treatment. If this happens it may be necessary for your physician or a staff member to disclose your health information (including all of your clinical records) to the person/establishment you are being referred to.

At other times our insurance and billing staff may have to disclose your examination records and/or billing records to a third party. (Some examples of this might be information needed by an insurance company, an HMO, a PPO or your employer – if they are potentially responsible for payment for services rendered). Receipt of a subpoena or a legal representative's request for information is also honored.

A Chiropractic Tradition's physicians and staff will always respect and protect your right to privacy.

A Chiropractic Tradition

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have been provided with a copy of A Chiropractic Tradition's (the "Practice") Privacy Practices (the "Notice"). The Notice contains information regarding potential uses and disclosures of my protected health information (as the term is defined under the Health Insurance Portability and accountability Act of 1996 "HIPPA") that may be made by the practice, and of my rights and the practice's legal duties with respect to my protected health information. I have had the opportunity to review the notice and take a copy with me if I so choose.

_____ _____

Patient Name **Date**

_____ _____

Patient's Signature **Signature of Guardian if Patient under 18 Years Old**

IF PATIENT REFUSES TO SIGN ACKNOWLEDGEMENT, COMPLETE THIS SECTION:

_____Patient refuses to sign acknowledgement.
_____(A Chiropractic Tradition's EMPLOYEE/POSTION) made the following efforts to attempt to obtain a signature from the patient: _____

X-RAY/MEDICAL RECORDS INFORMATION RELEASE

DATE: _____

TO: _____

_____

I hereby authorize you to release my records to:
A Chiropractic Tradition
Phone: 850-912-4155
FAX: 850-607-6483
Mobile Hwy, Suite D
Pensacola, Florida 32506

_____ **X-rays** _____

_____ **Any and all x-ray reports, MRI reports, CT Scans and Bone Density Reports for the last 5 years**

_____ **Diagnostic Reports** _____

_____ **All records** _____

_____ _____
Witness **Signature of Patient**

_____
Date of Birth_____ **Print Patient Name**

FINANCIAL POLICIES

- We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our payment policy. Your signature on this form allows us to bill your insurance company and allows us to send your insurance company anything they request.

- This form states you understand that you are responsible for your $_____ deductible and/or $_____ co-payment and your co-insurance if applicable. We accept cash, checks, MasterCard, or Visa. We will gladly answer any questions relating to your insurance. You must realize, however:

    1. Your insurance is a contract between you, and the insurance company.
    2. Our fees fall within the acceptable range of most companies, and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this geographical area.

- We must emphasize that as health care providers, our relationship is with you, not your insurance company. While filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

- In the event this note shall be in default and placed with an attorney for collection, the undersign agree to pay all reasonable attorney fees, court cost and cost of collection. We the undersign jointly and severally guarantee the prompt and punctual payment of all monies due under the afore said note and agree to remain bound until fully paid.

_____ _____

Signature of Patient Witness

_____ _____

Patient Name Printed Signature of Guardian if Patient is under 18 years old

_____

Date

PATIENT QUESTIONNAIRE REGARDING CONFIDENTIALITY

1. Please list the family member (s) or other person(s) if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operations).
   _____
   _____
   _____.

2. Please bring the address of where you would like your billing statements and/or correspondence from our office to be sent if other than your home address.
   _____
   _____
   _____.

3. I am fully aware that my health information may be transmitted by electronic transmission via fax transmittal, internet or e-mail.

Patient Name: _____

_____ _____
Patient/Guardian Signature Date

_____
Witness