New Patient Paperwork

Please Print

Today's Date: ____/_____/_____

Email Address: _____

Patient's Name: _____ _____ _____

(LAST) (FIRST) (MIDDLE INTIAL)

Are you a: ☐ Florida Resident ☐ Seasonal Resident ☐ Vacationer

Local Address: _____

City: _____ State: _____ Zip Code: _____

Out of State Address: _____

City: _____ State: _____ Zip Code: _____

Billing Address: ☐ Local Address ☐ Out of State Address

Home Phone: (_____)_____ Pref # ☐ Cell Phone: (____)_____Pref: ☐

Age: _____ Date of Birth: ____/ ____/ _____ Sex: ☐ M ☐ F Social Security #: _____-_____-_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Minor

Do You Work: ☐ Full Time ☐ Part Time ☐ Retired ☐ Student ☐ Homemaker ☐ Other _____

Emergency Contact Name & Phone Number: _____ / (____) _____ - _____

If Minor, Responsible Parties: _____

If different address than above: _____

City: _____ State: _____ Zip Code: _____

Primary Insurance Carrier: _____ Policy #: _____

Secondary Insurance Carrier: _____ Policy #: _____

Insurance Policy Holder: _____ Date of Birth: _____/ _____/ _____

Employer: _____ Occupation: _____

Primary Physician: _____ Phone #: (____) _____ - _____

Specialist seen for current problem: _____ Phone #: (____) _____ - _____

Prev. Chiro: _____ Last Appt: _____/ _____/ _____ Phone #: (____) _____ - _____

How did you hear of Twin Palms Chiropractic/Sarasota Medical Center?

☐ Internet ☐ Family/Friend: _____ ☐ Print Media ☐ Other: _____

Chiropractic Patients:

If there is a specific doctor you are seeking for care, please check the box next to that doctor.

☐ **Dr. Dan Busch, D.C.** ☐ **Dr. Erene Romanski, D.C.** ☐ **Dr. Mark Carrano, D.C.**

☐ **Dr. Darren Edmonds, D.C** ☐ **First Available**

SMC SARASOTA MEDICAL CENTER

TWIN PALMS CHIROPRACTIC HEALTH CENTER, INC.

SMC SARASOTA MEDICAL CENTER PHYSICAL THERAPY

Medical History

Please fill out to the best of your ability and focus on what is pertinent to today.

Name:_____ DOB: ____/ ____/ _____ Sex: ☐ M ☐ F Date: ____/ ____/_____

General Health Status:

Please rate your health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Exercise: ☐ Athlete ☐ Daily ☐ Moderate ☐ Occasionally ☐ None

Health Habits: Tobacco: ☐ No ☐ Yes (Packs/day _____) (Years____) Alcohol: ☐ No ☐ Yes _____per week

Caffeine: ☐ No ☐ Yes Water Intake: _____ Hours of Sleep: _____

Special Diet? _____

Allergies: _____

_____

Prescription Medications: _____

_____

Non-Prescription Medications/ Vitamins/ Supplements/ Herbs: _____

_____

Previous Surgeries/ Hospitalizations/ Accidents/ Injuries/ Illnesses/:

1. _____ Year: _____ 2. _____ Year: _____

3. _____ Year: _____ 4. _____ Year: _____

Put a check mark in the empty box if you have or have ever experienced the listed symptom:

Cardiovascular
- ☐ Heart Attack
- ☐ Heart Condition
- ☐ Chest Pain
- ☐ Pacemaker/Defibrillator
- ☐ Leg/Ankle Swelling
- ☐ Palpitations
- ☐ Irregular Pulse
- ☐ Muscle pain/cramps
- ☐ Heart Murmur/Arrhythmia
- ☐ Abnormal EKG
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Poor Circulation
- ☐ Thrombophlebitis
- ☐ Arteriosclerosis

Blood/Lymphatic
- ☐ Bleeding Disorder
- ☐ Anemia
- ☐ Transfusions

Eyes, Ears, Nose, Throat
- ☐ Hearing Loss
- ☐ Uncorrectable Vision Loss
- ☐ Fever Blisters
- ☐ Swallowing Difficulty
- ☐ Sinus Problems

Neurological
- ☐ Stroke/ TA
- ☐ Migraines
- ☐ Headaches
- ☐ Black Out Spells
- ☐ Dizziness
- ☐ Weakness/ Paralysis
- ☐ Motion/Car Sickness
- ☐ Lack of Mental Clarity
- ☐ Tremors

Respiratory
- ☐ Recent Infection
- ☐ Asthma
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ COPD
- ☐ Chronic Cough
- ☐ Shortness of breath
- ☐ CPAP Machine
- ☐ Emphysema
- ☐ Lung Condition

Musculoskeletal
- ☐ Knee Problems
- ☐ Knee Replacement
- ☐ Foot Problems
- ☐ Trouble walking

Musculoskeletal Continued
- ☐ Fractures
- ☐ Dislocations
- ☐ Joint Pains
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ TMJ/Jaw Trouble
- ☐ Back Pain
- ☐ Neck Stiffness
- ☐ Numbness in Arms
- ☐ Numbness in Hands/Fingers
- ☐ Pain in Arms or Hands
- ☐ Rib Pain
- ☐ Elbow Problems
- ☐ Wrist Problems
- ☐ Shoulder Pain
- ☐ Pain between the shoulders
- ☐ Sciatica
- ☐ Low Back Pain
- ☐ Disc Problems
- ☐ Sacral Iliac Problems
- ☐ Fibromyalgia
- ☐ Leg Pain or Numbness
- ☐ Knee Problems
- ☐ Painful Tailbone (Coccyx)
- ☐ Hip Problems
- ☐ Wears Orthotics

Genitourinary
- ☐ Bladder Infection
- ☐ Kidney Infection
- ☐ UTI
- ☐ Stones in Urine
- ☐ Blood in Urine
- ☐ Incontinence
- ☐ Blockage of Urine
- ☐ Prostrate Problem
- ☐ Venereal Disorder
- ☐ AIDS/HIV

Gastrointestinal
- ☐ Hepatitis
- ☐ Jaundice
- ☐ Ulcer
- ☐ Hiatal Hernia
- ☐ Pancreatitis
- ☐ Vomiting Blood
- ☐ Colitis
- ☐ Blood in Stool
- ☐ Hemorrhoids
- ☐ Change in Bowels
- ☐ Nausea
- ☐ Stomach Pain
- ☐ Constipation/Diarrhea
- ☐ Liver Condition

Endocrine
- ☐ Diabetes
- ☐ Thyroid Problems
- ☐ Pituitary Problems
- ☐ Excessive Hunger/Thirst

Other
- ☐ Fatigue
- ☐ Sweats
- ☐ Weight Loss

Females Only

Last Cycle: _____
- ☐ Menstrual Problems
- ☐ Breast Problems
- ☐ Menopause

Do you currently have a:
- ☐ Cardiologist
- ☐ Dentist
- ☐ Gastroenterologist
- ☐ Neurologist
- ☐ OB/GYN
- ☐ Orthopedic
- ☐ Rheumatologist

Family History:

Please list if your father, mother, sibling, grandparent, or aunt/uncle has had any of the following conditions.

Arthritis :_____ Cancer:_____ Cholesterol: _____

Diabetes: _____ Heart Disease: _____ Hypertension: _____

Psychological: _____ Seizure/ Epilepsy:_____ Stroke: _____

Other: _____

SMC SARASOTA MEDICAL CENTER

TWIN PALMS CHIROPRACTIC HEALTH CENTER, INC.

SMC SARASOTA MEDICAL CENTER PHYSICAL THERAPY

Chiropractic

Name: _____ Date: ____/ ____/ _____

Chief Complaint: _____

Cause: _____ Date of Onset: _____

Re-occurring: ☐ Yes ☐ No Degree of Discomfort (10 worst): ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Description of Discomfort: (Sharp, Dull, Burning, Constant, etc.):_____

Secondary Complaint: _____

Cause: _____ Date of Onset: _____

Re-occurring: ☐ Yes ☐ No Degree of Discomfort (10 worst): ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Description of Discomfort: _____

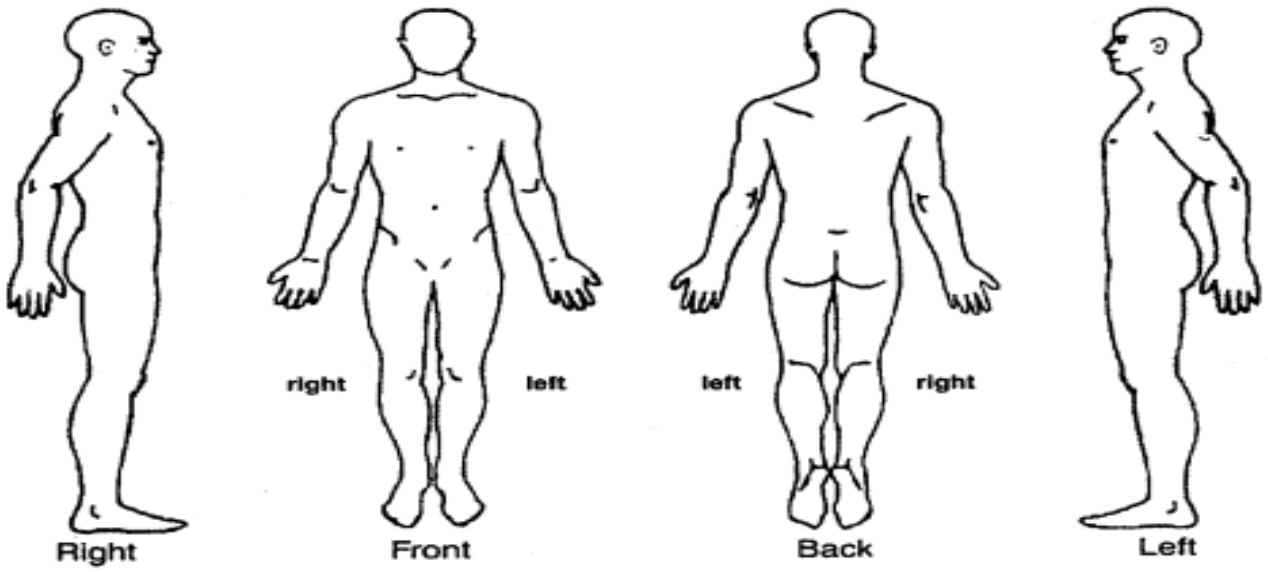
Additional Complaint: _____

Cause: _____ Date of Onset: _____

Re-occurring: ☐ Yes ☐ No Degree of Discomfort (10 worst): ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Description of Discomfort: _____

Please draw on the diagram below all areas of discomfort:



Women: Is there any possibility that you could be pregnant? ☐ Yes ☐ No

Date of last menstrual cycle: _____

SMC SARASOTA MEDICAL CENTER

TWIN PALMS CHIROPRACTIC HEALTH CENTER, INC.

SMC SARASOTA MEDICAL CENTER PHYSICAL THERAPY

Patient Consent for Receipt and Transmittal of Protected Health Information

DOES TWIN PALMS CHIROPRACTIC, INC./SARASOTA MEDICAL CENTER HAVE PERMISSION TO:

1. Mail notices to your home address: ☐ Yes ☐ No

2. Leave the following information on your **HOME/CELL** voicemail:
   - Appointment Information ☐ Yes ☐ No
   - Billing Information ☐ Yes ☐ No
   - Medical Information ☐ Yes ☐ No
   - Prescription Refills ☐ Yes ☐ No
   - Authorizations or Referrals ☐ Yes ☐ No

3. Leave the following information on your **WORK** voicemail:
   - Appointment Information ☐ Yes ☐ No
   - Billing Information ☐ Yes ☐ No
   - Medical Information ☐ Yes ☐ No
   - Prescription Refills ☐ Yes ☐ No
   - Authorizations or Referrals ☐ Yes ☐ No

4. I give permission to Twin Palms Chiropractic, Inc./Sarasota Medical Center to share <u>appointment and billing</u> information with the following people listed below:

   Name: _____ Relationship:_____
   Name: _____ Relationship:_____
   Name: _____ Relationship:_____
   Name: _____ Relationship:_____

5. I give permission to Twin Palms Chiropractic, Inc./Sarasota Medical Center to share <u>medical information</u> with the following people listed below:

   Name: _____ Relationship:_____
   Name: _____ Relationship:_____
   Name: _____ Relationship:_____
   Name: _____ Relationship:_____

Patient Name (printed):_____ Date of Birth: ___/ ___/ _____

Patient Signature: _____ Date : ___/ ___/ _____

Guardian Signature: _____ Date: ___/ ___/ _____
(if patient is under 18 years old)

SMC
SARASOTA MEDICAL CENTER

TWIN PALMS CHIROPRACTIC
HEALTH CENTER, INC.

SMC
SARASOTA MEDICAL CENTER
PHYSICAL THERAPY

Please Read Each Section Carefully, Initial All Boxes and Indicate Your Agreement by Signing at The Bottom
Financial Responsibility and Assignment of Benefits:

☐ All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments. All unpaid balances will be considered delinquent 60 days from the date of service. Any delinquent accounts can be referred to a collection agency and will incur the cost of collection including reasonable attorney fees.

☐ I the undersigned, have insurance coverage with _____
Name of Insurance Company
and assign directly to Twin Palms Chiropractic Health Center, Inc./Sarasota Medical Center (Good Business LLC) all medical and surgical benefits to include all major medical benefits to which I am entitled, if any, otherwise payable to me for services rendered to myself and/or my dependents. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Twin Palms Chiropractic Health Center, Inc./Sarasota Medical Center to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all of my insurance submissions.

☐ I understand that medical treatment of an immediate nature is necessary and that such care, treatment and procedures will be provided during office hours only. I grant authorization and consent to treatment and certify that no guarantee or assurance has been made at to the results which may be obtained. I acknowledge that neither Sarasota Medical Center nor any of its owners, officers, directors or employees shall have any liability, whether direct or indirect, if I do not follow the prescribed course of treatment, including prescribed return visits or the failure to properly use prescribed medications and/or treatments.

☐ **Medicare Authorization**
I request that payment of authorized Medicare benefits be made either to me or on my behalf to Twin Palms Chiropractic Health Center/ Sarasota Medical Center (Good Business LLC) for any services furnished me by their physicians and staff. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown.
Chiropractic: Medicare covers 80% of the fee for chiropractic manipulations of the spine once the yearly deductible has been met. You are required to pay the deductible and the remaining 20%, as well as any non-covered services. Our office will file claims to Medicare, however, we are not required by Medicare to file secondary/supplemental insurance. Medicare should automatically forward claims to your secondary/supplemental insurance.

☐ **Important Notice from the Government:**
It is unlawful to routinely avoid paying your copay, deductible or coinsurance payments, even if your doctor allows it. Unless you complete a "Financial Hardship" form and qualify for financial assistance under Federal Standards, you may NOT routinely evade paying your responsibility portions for medical care as outlined in your insurance plan even if your doctor allows it. You both may be charged for breaking the law. This includes services deemed as "professional courtesy" and "Take What Insurance Pays." Failure to comply places you in violation of the following laws: Federal False Claims Act, Federal Anti-Kickback Statute, Federal Insurance Fraud Laws, and State Insurance Fraud Laws.

☐ **Late Policy "10 Minute Rule"**
Being late by more than 10 minutes for your scheduled appointment will require you to either reschedule or wait for the next available opening. There are no guarantees since openings due to cancellations are unpredictable. If you are being seen as a "walk-in" visit and want to see a particular provider, you will have to wait for an opening to see that provider instead of seeing the first available provider.

Patient/ Responsible Party Signature: _____

Printed Name: _____ **Date:** ____/ ____/ _____

Chiropractic- Informed Consent

I hereby request and consent to the performance of chiropractic adjustment and other chiropractic procedures, to include, but not limited to, various modes of physical therapy and diagnostic x-rays, 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 office or clinic associated with Twin Palms Chiropractic Health Center, Inc.

I have had the 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 the time, based upon the facts then known, is in my best interest. Alternative treatments may include: medications, surgey, 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 have also had an opportunity to ask questions about this content. And by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition. Any condition other that what I am being treated for will be signed.

_____ _____/ ____/ _____
Print Name Date

_____ ____/ ____/ _____
Patient's Signature Date

_____ ____/ ____/ _____
Doctor's Signature Date

To be completed by patient's represenative if patient is a minor, physically or mentally incapacited.

_____ ____/ ____/ _____
Name of Patient Date

_____
Signarture of Representative

_____
Relationship to patient

New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operations

I, _____, understand that as part of my healthcare, **TWIN PALMS CHIROPRACTIC HEALTH CENTER, INC./SARASOTA MEDICAL CENTER** originates and maintains paper and/or electronic records describing my health history, payments, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which a third-party-payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to examine and obtain a copy of his/her own health records at any time and request corrections.
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations.
- The right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.

I understand that **TWIN PALMS CHIROPRACTIC HEALTH CENTER, INC./SARASOTA MEDICAL CENTER** is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organizations has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that **TWIN PALMS CHIROPRACTIC HEALTH CENTER, INC./SARASOTA MEDICAL CENTER** reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should **TWIN PALMS CHIROPRACTIC HEALTH CENTER, INC./SARASOTA MEDICAL CENTER** change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree e-mail).

I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

I understand that as part of this organization's treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept / decline the terms of this consent.

X_____ ____/ ____/ _____

Patient's Signature (or authorized representative signing for the patient) Date

FOR OFFICE USE ONLY

☐ Consent received by _____ on ____/ ____/ _____.

☐ Consent refused by patient, and treatment refused as permitted.

☐ Consent added to the patient's medical record on ____/ ____/ _____.

TPO CONSENT FORM