Brooksville Chiropractic Inc.
813 S. Broad Street
Brooksville, Fl. 34601
P:352-799-3433
F:352-799-3320

PATIENT INFORMATION

Full Name:_____ Birth Date:_____ Gender: M / F

Address:_____City:_____State:____Zip:_____

Email address :_____

Would you prefer a text or e-mail reminder for your appointments? Text E-mail

Home Phone:_____ Evening/Cell:_____
Work Phone:_____ SS#_____-___-_____

Marital Status: S M W D Sep Spouse Name:_____Birth Date:_____

Are You A Minor Y / N Are You A Student Y / N

Your Employer:_____Your Occupation:_____
Employer Address:_____

Spouse Employer:_____Spouse Occupation:_____

Insurance (Please allow our staff to photocopy your health insurance cards)

Name of Primary Insurance:_____ID#:_____

Name of Seconday Insurance:_____ID#:_____

Please Tell Us How You Were Referred Here:_____

- I authorize payment of medical benefits to this office.
- I will allow this office to treat me, with other health care providers present, and to record my medical information, including consultation and examination, for documentation purposes, if necessary.

Patient's Signature:_____ Date:_____
Spouse / Guardian's Signature:_____ Date:_____
(Authorization expires 3 years from date above)

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CASE HISTORY

Full Name:_____Date:_____

History of Present Injury/Illness
Please list below complaint(s) you have in order of importance. Also the length of time you have had these complaint(s).

1. **_____How long?_____**
2. **_____How long?_____**
3. **_____How long?_____**

Is your condition(s) related to an accident: __YES __NO
Date of accident:_____Type of accident: __Auto __Work Related__Other_____
Have you had any previous Trauma or Accidents? When _____

What makes your condition feel worse? _____
What makes your condition feel better? _____

Have you seen any other health care provider for you present condition? __YES __NO
Who? _____
Current Medications _____ ( ) None
Allergies _____ ( ) None

Are you or could you be pregnant? __YES __NO 1st day of last menstrual period _____

Do you use __Alcohol __Tobacco __Other Substances: _____ ( ) None
Water Intake_____oz Coffee_____oz Tea_____oz Soda Reg/Diet____oz

Are you experiencing or do you have any of the following?

__ A sore that won't heal/rash	**__ Difficulty swallowing**	**__ Persistent cough/hoarseness**
__ Any bleeding/discharge	**__ Lump/thickening anywhere**	**__ Wart/mole changes**
__ Bladder/bowel problems	**__ Night pain**	**__ Weight loss without trying**
__Earache/loss of hearing	**__Nosebleeds**	**__Ringing in ears**
__Sinus problems	**__Vision flashes/halos**	**__Bruise easily**

<u>Review of Systems</u>
In addition to the symptom(s)/dysfunction(s) listed above, are you experiencing any of the following?
Neuromusculoskeletal System

__ Anxiety	**__ Facial drooping**	**__ Loss of balance**	**__ Seizures**
__ Atrophy	**__ Headache**	**__ Memory loss**	**__ Sensory changes**
__ Concussion	**__ Joint deformity**	**__ Mood swings**	**__ Speech problems**
__ Depression	**__ Joint locking**	**__ Muscle weakness**	**__ Stiffness**
__ Tremors	**__ Joint swelling**	**__ Numbness**	**__ Difficulty walking**
__ Dizziness	**__ Lack of coordination**	**__ Popping noises**	**__ Twitches**
__ Vision trouble	**__ Limited range of motion**	**__ Extremity deformity**	**__ Psychiatric disorders**
			__ None of the above

Cardiovascular System

__ Ankle Swelling	**__ Chest pain**	**__ Jaw pain**	**__ TIA**
__ Blood clots	**__ Dizziness**	**__ Known vascular disease**	**__ Previous stroke**
__ Fainting	**__ Carotid blockage**	**__ Mitral valve prolapse**	**__ Shortness of breath**
__ Hypertension	**__ Changes in skin color**	**__ Phlebitis**	**__ Varicose veins**
__Irregular/Rapid heart beat		**__Low blood pressure**	**__ Poor circulation**

__

<u>Past History</u>
List any surgeries you have had (including appendix, tonsils, and wisdom teeth)
1. _____Date_____ 3. _____Date_____
2. _____Date_____ 4. _____Date_____

Have you ever been hospitalized in addition to surgeries? __YES __NO
If so, when and for what reason? _____
Have you ever been diagnosed with any condition? (diabetes, heart trouble, cancer, stroke, rheumatoid, etc.)
__YES __NO _____
Do you have a family history of any disease? (diabetes, heart trouble, cancer, stroke, rheumatoid, etc.)
__Yes __NO _____
Are you currently under a doctor's care for conditions other than ones you are seeking care for today?
__YES __NO _____

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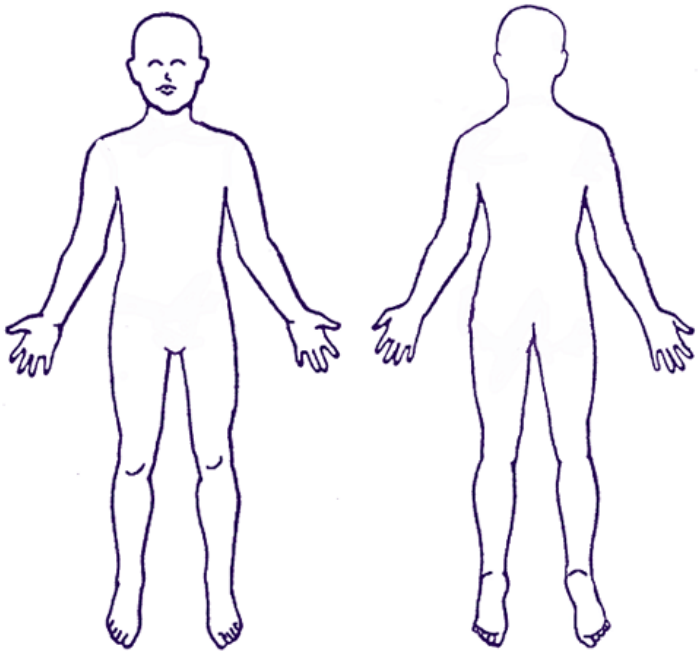
PAIN DRAWING

Patient Name:_____ Date:_____

Please mark the areas where you feel the following sensations:

DULL = D	BURNING = B
NUMBNESS = N	TINGLING = T
ACHE = A	SHARP = S

THROBBING =TH



Indicate severity of pain by marking an X on the appropriate number:
(0 means no pain- 10 means worst possible pain)

How bad is your Neck Pain? 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

How bad is your Back Pain? 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

How bad is your Arm Pain? 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

How bad is your Leg Pain? 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

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Agreement to Office Policies:

By **initialing the statements** listed below, I acknowledge that I have read, understand and agree to abide by the policies of this office:

_____I agree to follow Medicare's guidelines for medically necessary treatment.
_____I understand that it is my responsibility to inform the office of any address or telephone number changes.
_____I understand that my payment is due at the time of service (Self-pay, co-payments, and deductibles)
_____I understand the Cancellation Policy. It states that if I have a scheduled appointment that I will not be able to make, it is my responsibility to call and reschedule the appointment with 24 hours notice.
_____I understand that a **returned** check will result in a $25 service charge.
_____I understand that the office will not complete FMLA, or disability paperwork.
_____I agree to follow all other recommendations made by the doctor(s), including the proper use of spinal supports, doing my exercises as prescribed, etc.
_____I understand that Brooksville Chiropractic offers a time of service discount for patients who do not wish to use or do not have health insurance. **In order to be eligible** for this discount, two requirements must be met: payment must be made in full at the time of service, and Brooksville Chiropractic will not file any insurance claim.
_____I understand that I may be responsible for a $10.00 cost for personal use electrodes for the Electric Muscle Stimulation Unit, if the doctor's determine that I will benefit from this treatment. This charge is not reimbursable by health insurance.
_____I have received a copy of Brooksville Chiropractic's Notice of Privacy Practices. (see last page of paperwork)

If I elect to use my health care coverage:

Brooksville Chiropractic will file my insurance claim as a courtesy; however, I am ultimately responsible for understanding my insurance policy. The office has a relationship with me, the patient, not my insurance company. Although Brooksville Chiropractic does attempt to verify my chiropractic benefits with my insurance policy, I realize this is only an estimate of my coverage based on the information given to Brooksville Chiropractic at the time of inquiry. If a service is not covered and needs to be performed, I am responsible for these fees at the time of service. I will also inform Brooksville Chiropractic of any changes to my insurance policy so my coverage can be re-verified prior to my appointment.

Brooksville Chiropractic realizes that temporary financial problems may affect timely payment of you account. If such problems do arise, we urge you to contact us promptly for assistance in the management of your account. If you have any questions about the above information, please do not hesitate to ask us. **WE are here to help YOU**!

_____ _____

Patient Signature Date

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Consent to Treat Notice

I _____ hereby request and consent to the performance of chiropractic treatments and other chiropractic/medical procedures, including various forms of physical therapy and diagnostic x-rays by Brooksville Chiropractic, Inc. This consent is extended to other licensed chiropractic physicians, chiropractic assistants, or licensed massage therapists, who now or in the future, are employed by, working with or associated with this office.

I certify that I have had the opportunity to discuss, with the doctor of chiropractic and/or other office personnel, the nature and purpose of the care that is being provided. I understand that the results are not guaranteed. Further, I have been informed and I understand that, as in the practice of any of the healing arts, in the practice of chiropractic, there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations, and sprains. I also understand that the doctor, who has explained all of these things to me, is not expected to be able to anticipate and explain all risks and complications. I will rely on the doctor to exercise appropriate judgment during the course of care, based on the facts known at this time, and in my best interest.

My signature below certifies that I have read, or have had read to me the above consent. I also certify that I have had the opportunity to ask questions and options to care have been explained. By signing this consent form, I agree to the care being provided to me for the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

_____ Troy M. Robinson, D.C.
Patient or Representative Signature Doctor's Name

_____ _____
Witness's Signature Doctor's Signature

_____
Date

Release of Protected Health Information
Authorization Form

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Patient Information:
Name: _____ Date of Birth:_____
Address:_____
Phone number:_____ SSN:_____

Information Requested From:
Facility releasing information:_____
Address:_____
Phone number:_____ Fax:_____

Information Requested: (Completed by office)
□ Chart Abstract(Specify dictated report/office visit date or range):_____
_____
□ Diagnostic Report(specify date and test type): _____
_____
□ Radiology Films(specify date and type):_____
_____
□ Exclusions:_____
PURPOSE OF DISCLOSURE:_____
I hereby release Brooksville Chiropractic, Inc and it's employees, agents, officers, and affiliates from any and all liability, responsibility, claims and damages which may result from the release of information incurred due to this authorization. I hereby authorize the use or disclosure of my individual, identifiable protected health information about me as described above. I understand that this authorization is voluntary. This release includes complete medical records/reports unless specifically listed above under exclusions. I understand that should I wish to revoke this authorization I must provide written notice to Brooksville Chiropractic, Inc. However, I understand that any action taken in reliance on this authorization can not be reversed and my revocation will not affect those actions. This authorization shall expire ninety (90) days from the date set forth below, or upon the following date, event, or condition:_____
_____
FEES FOR COPIES: Federal law permits a fee to be charged for copying of medical records. You may be required to pre-pay for this copies, if not then you copies will be mailed along with an invoice.

_____ _____ _____
Signature of Patient or Representative Relationship Date

_____ _____
Witness (Provider signature) Date

Patient Copy

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Health Insurance Portability and Accountability Act (HIPAA)

We collect information from you and store it in a medical record as well as on a computer. All such information saved on the computer is password protected. Passwords are only afforded to the appropriate personnel. Charts are stored in a secure area and available only to designated staff and only for designated reasons. Housekeeping, maintenance and other non-office personnel have no access to the chart area. Service technicians may have access to the computer, but only for service of computer operations. Within our office we restrict the disclosure of this information to doctors, nurses, technicians, and insurance and billing personnel. We may use your medical information for treatment and care, payment to insurers, and for health care operations.

Outside of our office, we restrict the disclosure of this information to those people, entities, and agencies for whom you authorize disclosure such as other health care providers (doctors, nurses, extended care facilities), insurance companies, billing agencies, hospitals and surgery sites, or those agencies and entities for whom legal ad administrative requirements demand disclosure such as:

- When required by law
- Public health activities (death, child abuse, neglect, domestic violence, problems with products, reactions to medications, product recalls, disease/infection exposure, disease/injury/disability control/prevention)
- Health oversight activities (audits, investigations, inspections)
- Judicial and administrative proceedings (court order)
- Appropriate law enforcement requests (to identify or locate a suspect fugitive, material witness, or missing person)
- Deceased person information to coroners, medical examiners, funeral directors
- Organ and tissue donation
- Research, provided authorization is IRB-approved or privacy board approved
- Specialized government functions (military, inmates)
- Workers compensation
- Disaster Relief and Fund Raising

We will not use or disclose your medical information for any purpose not listed without specific written authorization. Any specific written authorization you provide may be revoked at any time by your written request.

Patient Privacy Rights

You have the right to:

- Inspect and copy medical information from your chart. You may submit a written request to our office and receive a copy of your records. There will be a copy fee to provide this service to you. We must respond within (30) days if the record is readily available and within (60) days if it is not readily available.
- Amend medical information in your chart. You may identify inaccurate or incomplete information in your chart. You can do this with a written request, directed to our office, to amend your chart. We must response within (60) days.
- Receive an accounting of any disclosures made from your record over the last six years, beginning April 14th 2003. You can do this with a written request, directed to our office, to amend your chart. We must respond within (60) days.
- Request restrictions as to the amount of medical information we disclose. This is limited as noted above, and your request may not supersede the typical disclosure noted above. You may revoke or restrict content.
- Request confidential communications. All communications in our office are confidential. You may specifically request that all communications be confidential with a written request directed to our office.
- Receive a copy of this notice by printing it or with a written request directed to our office, and a copy of this notice will be given with all new patient packets.

We are required by law to maintain the privacy of your personal health information, and to provide you notice of our legal duties and privacy practices and adhere to this notice. We reserve the right to make changes to this notice. We will post a notice that the notice has been changed and the effective date of the change. Copies will be made available.

Patient Copy