Restore
Injury Health Center

PATIENT INFORMATION (INFORMACIÓN DEL PACIENTE)

GENERAL INFORMATION: (INFORMACIÓN GENERAL)

Patient Name: _____
(Nombre del Paciente) Last (Apellido) First (Primer Nombre) Middle (Medio) Age (Edad)

FL Address (Dirección): _____
Street Address (Calle) City (Ciudad) State (Estado), Zip (Codigo Postal)

Out of State Address: _____
Dirección Fuera de Estado Street Address (Calle) City (Ciudad) State (Estado), Zip (Codigo Postal)

Phone (Teléfono) : **Home** (Casa)_(____)_____-_____ **Cell** (Celular)_(____)_____-_____ **Carrier**(For Appt Reminders)

Email (Correo Electrónico)_____ **Circle**: AT&T-T-mobile-Metro PCS-Sprint -Boost M. -Verizon

May we email you? (Podemos enviarle por correo electrónico?) _____

Emergency Contact: (Contacto de Emergencia)_____ **Phone** (Teléfono):_____

Spouse Name / Nombre del Cónyuge_____ **Spouse Employer** / Empleador del Cónyuge _____

Children? (Los Niños?) **Names & Ages** (Nombres y Edades): _____

Sex (Sexo): Male (Masculino) Female (Femenino)	**Marital Status** (Estado civil): Married Casado Single Soltero Widowed Viudo Divorced Divorciado	**Date of Birth - MM/DD/YYYY** Fecha de Nacimiento
Employer Name: Nombre del Empleador		**Social Security Number (optional):** Número de Seguro Social
Employer Phone: Teléfono del Empleador		
Employer Address: Dirección del Empleador		**Employment/Empleo:** Occupation/Profesión_____ Time/Tiempo: Full/Completo☐ Part/Medio☐ Retired/Jubilado☐ Student/Estudiante☐ Unemployed/Desempleado☐

MEDICAL INSURANCE: MEDICAL/MEDICARE (SEGURO MÉDICO: MÉDICO/ Medicare)

Primary Insurance Company Name Nombre de Seguro Primario	Membership # / Cert # (Numero de miembro#)	
Policy # (Poliza #)	Group # (Grupo #)	Group Name (Nombre del grupo)
Policy Holder's Name (Nombre del asegurado)	Policy Holder DOB (Fecha de nacimiento del aseguarado)	Policy Holder's Employer (Empleador del asegurado)

RELEASE AND ASSIGNMENT / ASIGNACIÓN Y LIBERACIÓN

I authorize release of any information necessary to process my insurance claims. I hereby assign and request payment directly to my physician.(Yo autorizo la divulgación de cualquier información necesaria para procesar mis reclamaciones de seguros. Por la presente asignar y solicitar el pago directamente a mi médico.)

Patient Signature/Firma X_____ **Date/Fecha**_____

747 Fawn Ridge Drive Suite 100, Orange City, FL 32763
Office: (386) 259-9051 Fax: (386) 259-4243

ASSIGNMENT OF BENEFITS, AUTHORIZATION TO SETTLE CLAIM AND DIRECTION TO PAY MEDICAL PROVIDER DIRECTLY

By my signature below, for good and valuable consideration (including but not limited to the extension of credit to me), I hereby assign, transfer and convey to **Restore Injury Health Center, LLC** (hereinafter "the Provider") all of my rights, title and interest in and to medical expense reimbursement in whatever form, including but not limited to any automobile liability medical expense payments or other health benefits indemnification and/or agreement otherwise payable to me. This payment shall not exceed my indebtedness to the above named assignee and I acknowledge that I will timely pay any indebtedness owed by me to the assignee that is not otherwise satisfied by the above-mentioned assigned proceeds. I also acknowledge that any medical expenses not covered under my insurance policy will be my responsibility.

I further authorize the Provider to negotiate, collect and settle any claim with any insurance carrier or other third party payor with regard to these services, which authorization shall include authority to:
(1) request and receive from any insurer or any other party any and all documentation and records that I am empowered to request regarding this claim, including, without limitation, a statement of coverage, policy declarations page and insurance policy pursuant to Section 627.4137. In addition, the provider has the authority to request and receive any Independent Medical Examination Reports, notices sent to me regarding appointments for Independent Medical Examinations and Examinations Under Oath (including proof of mail), Records Review Reports, coverage denial letters, Explanations of Benefits, and Benefit Payment Sheets or Logs (P.I.P. Payout Sheets), without regard as to whether such documentation has already been provided to me and,
(2) to endorse in my name any check issued for payment where benefits were assigned. By way of this assignment and notice, I further instruct you, the insurer, to furnish to Provider copies of all future notices affecting Provider's interest in this claim, including, without limitation, any notices of requested medical examinations or statements.

The Provider hereby objects to any reductions or partial payments. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by the provider shall be done so 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.

I further direct my insurer to direct all payments for services rendered by the Provider directly to Provider at the billing address contained on Provider's medical bills.

THIS IS A DIRECT AND IRREVOCABLE ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER MY POLICY OF INSURANCE.

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

I have read the foregoing and understand and agree to each of the above provisions:

_____ _____

Patient's Signature **Date**

747 Fawn Ridge Drive Ste. 100 Orange City, FL 32763
Phone: 386-259-9051 Fax: 386-259-4243

INFORMED CONSENT

Restore Injury Health Center, LLC maintains equipment, personnel, and facilities to assist in the delivery of chiropractic adjustments, therapeutic procedures, and recommendations of whole food nutritional supplements with the goal of regaining and maintaining health. As with any comparable intervention, there is always a calculated risk of complication, injury, or even death, and no guarantee has been made as to treating, curing, or preventing the occurrence of disease. Chiropractic adjustments and associated procedures are therefore not performed on patients unless and until a patient has been examined and thus had an opportunity to discuss his or her concerns with the doctor. Each patient reserves the right to receive or refuse any proposed procedure or therapy based upon the prescription or explanation received.

OFFICE POLICY

If you are unable to make a scheduled appointment, we respectfully request that you let our office know a minimum of 24 hours in advance and that you reschedule the missed appointment within the same week. This permits you to stay on the treatment schedule that has been prescribed to you by the doctor. Our office staff are not permitted to change or alter your prescription, only the doctor.

PAYMENT OF BILLS

You are responsible for payment of services, and there is no guarantee your insurance company will reimburse you for services or products sold at our office. As a courtesy, and at our discretion, our office will submit insurance claims to your health insurance company. However, please keep in mind that insurance is an agreement between you and your insurance company and not between you and our office. As long as our office is filing your health insurance claims and your insurance company is continuing to cover the charges accrued, collection of payment at time of service will be limited to deductibles and co-payments. We reserve the right to opt out of submitting insurance claims on your behalf at any time and for any reason. You, as the patient, have the right to request a copy of your charges for services rendered in this office to seek reimbursement personally and directly through your insurance carrier.

Patient Name: _____ Date: _____

Signature: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you, or to family and friends you approve.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. You also have the right to request restrictions on disclosure of PHI (Personal Health Information),or alternative means of communication to ensure privacy.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law or national security activities.

Abuse or Neglect: We may disclose your health information to appropriate authorities when we suspect abuse or neglect.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (Such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information with limited exceptions. If you request copies, we will charge you a reasonable fee to locate and copy your information, and postage if you want the copies mailed to you.

Amendment: You have the right to request that we amend your health information.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us with the U.S. Department of Health and Human Services. A Privacy/Contact Officer has been designated for this office. The Privacy Officer can be contacted by simply contacting the office and asking to speak to the Office Manager who serves as the Privacy Officer.

PATIENT ACKNOWLEDGEMENT OF THE NOTICE OF PRIVACY PRACTICES AND CONSENT FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

I,_____, acknowledge that I
(Patient Name)

have either received a copy of **Restore Injury Health Center, LLC** NOTICE OF PRIVACY PRACTICES or that this NOTICE OF PRIVACY PRACTICES was made available to me to receive and hereby consent to the use and disclosure of my personal health information by **Restore Injury Health Center, LLC** for treatment, billing/payment, and health care operations as outlined in the NOTICE OF PRIVACY PRACTICES.

Signature of Patient or Parent or Legal Guardian: _____

Date: _____

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HEALTH HISTORY INVENTORY

Name:_____ **Date:** _____

Please check an " X " mark in the areas (_) below for those items that apply to you.

1. Health History: Have you ever been *diagnosed* by a licensed health care practitioner for any of the following?

_ Tension Headaches
_ Migraine or Cluster Headaches
_ TMJ Disorder or Jaw Pain
_ Low Back Pain or Sciatica
_ Rheumatoid Arthritis
_ Osteoarthritis
_ Fibromyalgia
_ Tremors or Tics
_ Tendonitis or Bursitis
_ Carpal Tunnel Syndrome
_ Bone Fracture or Joint Sprain
_ Radiculopathy
_ Neuralgia
_ Peripheral Neuropathy
_ Shingles (Herpes Zoster)
_ Dermatitis, Eczema, or Hives
_ Coronary Disorder or Heart Attack
_ Asthma, Bronchitis, or Emphysema
_ Liver Disease or Hepatitis
_ Urinary or Bladder Disorder
_ Kidney Disorder or Stones
_ Gall Bladder Disorder or Stones
_ Irritable Bowel Syndrome or Colitis
_ Hypertension / High Blood Pressure
_ Hemorrhoids or Hernia
_ Diabetes Mellitus
_ Thyroid Disorder
_ Dysmenorrhea or Irregular Menses
_ Peri-Menstrual Syndrome (PMS)
_ Menopause Problems or Hot Flashes
_ Prostate or Genital Disorder
_ Deafness or Tinnitus
_ Stroke
_ Tuberculosis or Pneumonia
_ Brain Seizures or Epilepsy
_ Concussion or Head Trauma
_ Cancer or Tumors
_ AIDS or HIV Disease
_ Multiple Sclerosis or Palsy
_ Polio or Mononucleosis
_ Allergies or Hayfever
_ Chronic Fatigue Syndrome
_ Anorexia or Bulimia
_ Attention Deficit Disorder
_ Panic Attacks or Phobias
_ Depression or Bipolar Disorder
_ Alcohol Abuse Problems
_ Substance Abuse Problems

2. Accidents: Have you ever been left *injured* or *impaired* by any of the following types of accidents?

_ Automobile Accident
_ Athletic Injury
_ Work-Related Accident
_ Accident in Daily Living
_ Surgical Complication
_ Medication Side Effect

3. Current Conditions: In the past 3 months, have you experienced any of the following symptoms?

_ Frequent Headaches
_ Chronic Back Pain or Sore Back
_ Stiff or Sore Neck and Shoulders
_ Pain in Elbows, Wrists, or Hands
_ Pain in Hips, Knees, or Feet
_ Stiff, Aching, or Swollen Joints
_ Cold Hands or Cold Feet
_ Frequent Daytime Sweating
_ Night Sweats
_ Skin Irritation or Skin Rash
_ Dizziness, Fainting, or Vertigo
_ Palpitations / Rapid Heart Beats
_ Shortness of Breath
_ Feeling Restless or Agitated
_ Chest Pain or Chest Tightness
_ Abdominal Pain or Discomfort
_ Abdominal Distension or Bloating
_ Large Weight Gain or Weight Loss
_ Overeating or Binge Eating
_ Undereating or Poor Appetite
_ Craving for Sweets
_ High Level of Sexual Activity
_ Low Sex Drive
_ Overworked or Overstressed
_ Poor Memory or Mental Confusion
_ Bored or Uninterested in Things
_ Thoughts of Killing Your Self
_ Worried About Finances or Job
_ Head Congestion / Runny Nose
_ Dry Mouth or Dry Throat
_ Sore Throats
_ Frequent Coughs
_ Fever or Malaise
_ Chills or Aversion to Cold
_ Nausea or Vomiting
_ Diarrhea or Loose Stools
_ Constipation or Dry Stools
_ Blurred Vision or Dry Eyes
_ Lethargy, Tiredness, or Fatigue
_ Insomnia or Difficulty Sleeping
_ Disturbing Dreams
_ Feeling Anxious or Afraid

4. Substances or Medications: In the past 3 months, did you take any of the following items on a daily basis?

_ 5 or more Cigarettes
_ 4 or more Cups of Coffee
_ 3 or more Glasses of Alcohol
_ Several Aspirin or Tylenol Type Pills
_ Prescribed Pain Reliever Medication
_ Blood Pressure Medication
_ Sleeping Pills
_ Anti-Anxiety Medication
_ Anti-Depressant Medication

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QUESTIONNAIRE GENERAL SYMPTOMS

Check symptoms you are currently experiencing:

☐ Headache	☐ Dizziness	☐ Numbness in toes	☐ Face flushed	☐ Feet cold
☐ Neck pain/stiff	☐ Irritability	☐ Depression	☐ Buzzing in ears	☐ Hands cold
☐ Mid back pain	☐ Chest pain	☐ Fatigue	☐ Loss of balance	☐ Stomach upset
☐ Low back pain	☐ Head seems to heavy	☐ Shortness of breath	☐ Fainting	☐ Constipation
☐ Nervousness	☐ Pins & needles in arms	☐ Lights bother eyes	☐ Loss of smell	☐ Cold sweats
☐ Tension	☐ Pins & needles in legs	☐ Loss of memory	☐ Loss of taste	☐ Fever
☐ Sleeping problems	☐ Numbness in fingers	☐ Ringing in ears	☐ Diarrhea	☐ _____

Symptoms other than above: _____

Is the condition: ☐ Improving ☐ Worsening ☐ Staying the Same

Is the frequency of the pain: ☐ Constant ☐ Comes and goes

Circle the Quality of the pain: dull / aching / sharp / shooting / burning / throbbing / tight/stiff / other: _____

Does any pain radiate or travel to any areas of your body: _____

Do you have any numbness or tingling in your body: _____

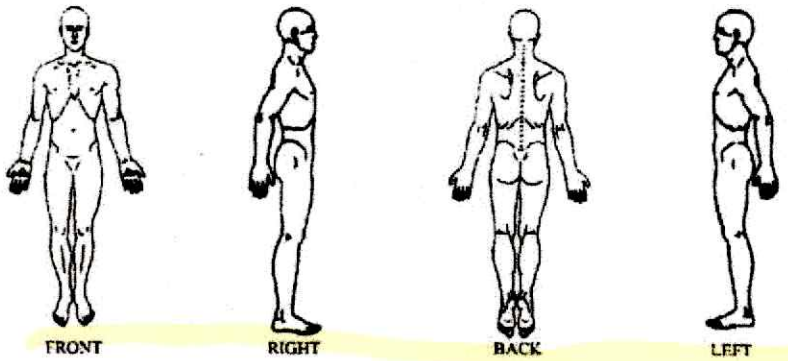
Grade pain Intensity/Severity: (0 = No pain) 0 1 2 3 4 5 6 7 8 9 10 (10 = Worst possible pain)

What worsens it? ☐ General activity ☐ Moving wrong ☐ Bending ☐ Lifting ☐ Walking ☐ Standing ☐ Sitting

☐ Using a computer/desk work ☐ Other _____

What makes it better? ☐ Rest ☐ Ice pack ☐ Heating pad ☐ OTC Meds ☐ Rx Meds ☐ Massage ☐ Nothing

Place an **X** on the areas where you are currently experiencing pain/discomfort.



Patient name: _____ Date: _____

Signature: _____

Authorization to Release Healthcare Information

(Required by the Health Insurance Portability and Accountability Act, 45 C.P.RR. Parts 160 and 164)

Patient Name: _____ DOB: _____

Previous Name: _____ SS#: (Optional) _____

I _____ request and authorize _____ to release my medical records to **Restore Injury Health Center, LLC.**

This request and authorization applies to:

- ☐ Examination, diagnosis, prognosis, treatment/progress notes
- ☐ Imaging reports
- ☐ Financial information
- ☐ Other: _____

Signature: _____ Date: _____

MEDICATION LIST FORMS

Patient Name: _____ **Date of Birth:** _____

Do you have any allergies to any medications? YES ☐ NO ☐

Medication	Reaction

List ALL medications you are currently taking including over the counter medication, vitamins dietary and herbal supplements.

Name of medication	Dose/Strength	How many time a day do you take this?	Prescribed By	Why do you take this medication?