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 Single Widowed Divorced Casado Soltero Viudo 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**_____

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HIPPA COMPLIANCE CONSENT FORM / FORMULARIO DE CONSENTIMIENTO DE CUMPLIMIENTO DE HIPPA

HIPPA (Health Insurance Portability and Accountability Act 1996) compliance requires each new and existing patient fill out and sign this consent form, which must be placed in the patient's medical records. / Cumplimiento de HIPPA (Ley de Portabilidad e Responsabilidad de los sequros de salud 1996) requiere cada paciente, nuevo y existente, a firmar este formulario de consentimiento y, que se debe colocar en el historial médico del paciente.

Part 1 / Parte 1 - Protected Health Information (PHI): It is the information that can indicate the past, present or future physical or mental health or condition of a patient in a written, verbal or other form of communication, whether created, stored, transmitted or received in any form (paper or electronic). / Información de Salud Protegida (PHI): Es la información que puede indicar el pasado, presente o futuro física o salud mental o condición de un paciente en un escrito, verbal o otra forma de comunicación, ya sea creada, tener en reserva, transmitido o recibido en cualquier forma (papel o electrónico).

I authorize Restore Injury Health Center, LLC, its' physicians and employees to disclose, communicate, receive or transmit my protected health information either verbally, electronically, by phone, fax or mail within and outside this facility to other entities (as described below) involved in my healthcare for the purpose of treatment, financial transaction related to my medical services or other healthcare related issues as provided by law. / Autorizo a Restore Injury Health Center, LLC, sus médicos y empleados para revelar, comunicar, recibir o transmitir mi información de salud protegida ya sea verbalmente, electrónicamente, por teléfono, fax o correo dentro y fuera de esta facilidad a otras entidades (como se describe a continuación) Involucrado en mi salud por el proposito de mi tratamiento, transacciones financieras relacionados a mis servicios medico o otros cuestiones relacionados a el cuidado de mi salud como sea dispuesto por ley.

Other entities include: / Otras entidades incluyen:

1. Referring physician, Primary Care or other physicians involved in my healthcare / Médico referente, atención primaria y otros médicos involucrados en mi atencion medica.
2. Health Insurance plans for the purpose of payments / Planes de seguro de salud a los efectos de los pagos
3. Hospitals, Laboratory, Diagnostic and other facilities involved in my healthcare / Hospitales, laboratorios, Diagnóstico y otras facilidades involucado en mi atencion medica.
4. Attorneys under subpoena or authorized by patient if patient is involved in a lawsuit / Abogados bajo citación o autorizado por el paciente si el paciente está involucrado en una demanda
5. By a court order to any other person or entity or required by law / Por una orden judicial a cualquier otra persona o entidad o requerido por la ley

Sign/Firma_____ **Print** Name/Nombre Deletreado_____ **Date/Fecha** _____

Witness Signature/Firma del Testigo_____ Witness Name/Nombre del Testigo_____

A copy of our NOTICE OF PRIVACY PRACTICES is available to every patient. / Una copia de la madera Salud, AVISO DE PRÁCTICAS DE PRIVACIDAD está disponible a todos los pacientes.

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Part 2 / Parte 2 - Please provide the following information to help comply with the HIPPA privacy law: / Por favor proporciona la siguiente información para ayudar a cumplir con la ley de privacidad HIPPA:

1. Do you authorize your health information to be disclosed to your family member(s) / Usted autoriza su información de salud para ser revelada a miembros de sus familias? **Yes / Si**____ **No**____

2. In case of emergency, list a contact person and telephone number to inform them of your medical condition: / En caso de emergencia, indique juna persona de contacto con un numero de telefono para informarles de su condición médica:

Emergency Contact/Nombre de Contacto de emergencia_____Phone/Teléfono_____

Address (mailing) for billing statements, health information and other correspondences. It is your responsibility to maintain the privacy of the information once it is mailed to this address: / Dirección de correo para facturas, información de salud y otras correspondencias. Es su responsabilidad mantener la privacidad de la información recibido por correo a esta dirección:

_____

Street Address (Calle) City (Ciudad), State (Estado), Zip (Codigo Postal)

Sign/Firma Print Name/Nombre Deletreado_____**Date/Fecha** _____

Witness Signature / Testigo_____Witness / Testigo Name _____

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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

FINANCIAL POLICY

Thank you for choosing **Restore Injury Health Center** as your healthcare provider. We are committed to providing the best medical care possible. Please understand that payment of your bill is considered a part of your treatment. The following statement explains our Financial Policy which we ask you to read, sign and return to us prior to your treatment.

- All patients should provide accurate and complete personal and insurance information prior to being seen by the doctor.
- All applicable co-pays, personal balances, both current and prior, are due at time of service.
- We accept cash, check, or credit cards.

Regarding Insurance

We participate in ***most*** insurance plans, however we require that the guarantor, the person who is financially responsible, is *personally* liable for all balance not covered by insurance. It is your responsibility to understand and comply with any Pre-determination of benefits or referral requirements. Please be aware that some, and perhaps all, of the services provided may be non-covered services or may not be considered medically necessary under the Medicaid Program or by other medical insurance companies.

Initials:_____

Co-Pay Balances

Payment for all co-pays and out of pocket expenses pre-determined is expected at time of service. If co-pay balances are not paid on date of service a $10.00 fee will be charged to your account. This fee is ***not*** covered by insurance so it will be your personal responsibility.

Returned Checks

For checks returned to us as unpaid by your bank, we will charge a $25.00 fee.

Appointment cancellation, rescheduling and no-shows

• We verify appointments prior to your arrival via phone, email and/or text
•If you cannot make our appointment, we kindly ask that you give us a 24 hour notice.

I have read the Financial Policy. I understand and agree to the Financial Policy.

_____
Print Name

_____
Signature Date

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Authorization for the Release of Medical Records

Patient Name:_____Date of Birth:_____
(also list maiden name/other names used)

I hereby request and authorize:

Restore Injury Health Center
747 Fawn Ridge Drive Suite 100
Orange City, FL 32763

Office: (386) 259-9051
Fax: (386) 259-4243

_____**To Disclose information to:** _____**To Receive Information from:**

Provider:_____

Address:_____

City/State/Zip_____

Information to be disclosed include copies of:

_____Entire Record
_____Progress Notes
_____Physical Exam forms
_____Daily chart notes
_____X-ray Reports
_____X-ray Films
_____Other, specify:
_____

Purpose for disclosure:

_____ Treatment, Payment OR
_____Other (Specify)_____

This authorization will be effective for six months 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 Legal Representative/Relationship

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

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INFORMED CONSENT

PATIENT NAME: _____

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. That 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	✓ palpation	✓ vital signs
✓ range of motion testing	✓ orthopedic testing	✓ basic neurological testing
✓ muscle strength testing	✓ postural analysis	✓ EMS
✓ ultrasound	✓ hot/cold therapy	
✓ radiographic studies		
___ Other (please explain)		

_____

_____

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: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and 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. 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 probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

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 risks and dangers attendant to remaining untreated.

Remaining untreated may allow the formation of adhesions 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 BLOCK 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. Jasmine Perez, DC 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 that treatment.**

Dated:_____ **Dated:** _____

_____
Patient's Name

_Jasmine Perez, DC_____
Doctor's Name

_____
Signature

_____
Signature

_____
Signature of Parent or Guardian (if a minor)