Edgewater Chiropractic Clinic, P.A.
201 S. Ridgewood Ave, Suite 11
Edgewater, FL 32132
386-423-7575

Patient Name: ________________________________ **Date:** ____________________

Address: ____

City_________________________________ **State**__________ **Zip Code**______________

Phone: ____________________ ☐H☐W ☐C **2nd Phone:** ______________________☐H☐W ☐C

Gender: ☐**M** ☐**F** **Date of Birth:** __________________**Age:**__________**Marital Status:** MD S W

Race: ☐ Not Specified☐ White ☐ Am. Indian or Alaska Native ☐ Asian☐ Black/African American☐Hispanic

Occupation: __________________________**Social Security #:** _______________________

Email: __________________________________

If you were referred by someone to our office please tell us who so we may thank them.

____

Have you seen a Chiropractor in the past?☐**Yes** ☐ **No**

If yes, who ____**Year?**______________

Emergency Contact: ______________________________ **Phone:** ________________________

Do you have health insurance? ☐**Y** ☐**N** **Please Present Card at Window**

Primary Care Physician: ________________________**Where?** __________________________

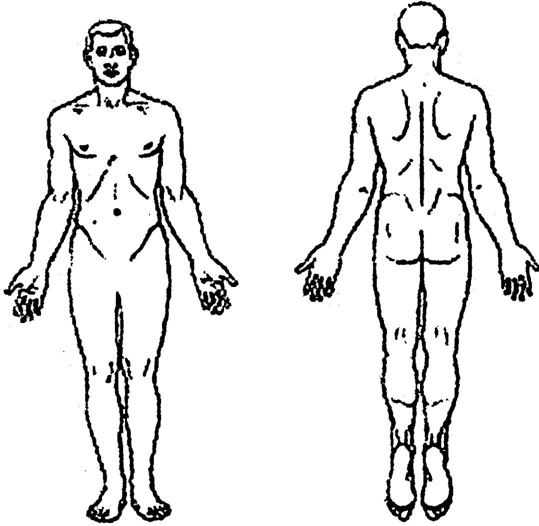
Last Physical Exam: ________________

For sign-in purposes please select a 4-digit pin number _____ _____ _____ _____

Are you currently experiencing any of the following symptoms?

☐ Nausea or vomiting
☐ Numbness on one side of the face or body
☐ Fainting or lightheadedness
☐ Dizziness
☐ Difficulty walking
☐ Rapid eye movement
☐ Difficulty speaking
☐ Headache or neck pain
☐ Difficulty swallowing
☐ Double vision

Please circle area(s) where you are feeling symptoms...



What current problem(s) bring you to the clinic today? ______________________________

____

Date this condition began: ______________________________

How did this happen:

- ☐ FALL
- ☐ LONG DRIVE
- ☐ LONG
- ☐ POOR NIGHT'S SLEEP
- ☐ SLIP
- ☐ LIFTING
- ☐ REACHING
- ☐ HOUSEHOLD CHORES
- ☐ YARD WORK
- ☐ CHRONIC ILLNESS
- ☐ OTHER

Has this pain ever happened before? ☐Y ☐N When: ______________________________

How Long Did It Last? ______________________________

Are you currently being treated for this condition? ☐Yes ☐No

By Whom? ______________________________

Have you had any of the following tests? ☐X-rays ☐EMG ☐MRI ☐CT Scan

If yes, Year__________ Where______________________________ Why ______________________________

Frequency of pain: (please check one)

- ☐ Constant (100% of the time)
- ☐ Frequent (< 75% but > 50% of the time)
- ☐ Occasional (< 50% but > 25% of the time)
- ☐ Intermittent (less than 25% of the time)

What type of pain are you experiencing? (please check all that apply)

- ☐ Aching
- ☐ Annoying
- ☐ Burning
- ☐ Deep
- ☐ Dull
- ☐ Heavy
- ☐ Intolerable
- ☐ Pulling
- ☐ Sharp"Shock Like"
- ☐ Stabbing
- ☐ Stiffness
- ☐ Throbbing
- ☐ "Tightness"
- ☐ Tingling

Is your pain Radiating? ☐Y ☐N Please Describe ______________________________

____

Since the pain began has it: (please circle)

- ☐Improved
- ☐ Stayed the same
- ☐ Worsened
- ☐ Relief which lasted for a while

Pain level: ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Symptoms Relieved By: (please check all that apply)

- ☐ None
- ☐ Chiropractic Adjustment
- ☐ Cold Pack
- ☐ Heat Packs
- ☐ Exercise
- ☐ Massage
- ☐ OTC Medication
- ☐ Physical Therapy
- ☐ Prescription Medication
- ☐ Rest
- ☐ Stretching
- ☐ Work

Activity of Daily Living Most Effected? (Check All That Apply)

- ☐ Employment
- ☐ Homemaking
- ☐ Lifting
- ☐ Personal Care
- ☐ Standing
- ☐ Walking
- ☐ Sitting
- ☐ Sit to Stand
- ☐ Sleeping
- ☐ Social Life
- ☐ Traveling
- ☐ Yard Work
- ☐ Sitting at Computer
- ☐ Caring for Family
- ☐ Golfing
- ☐ Exercise

What tasks do you find difficult due to the pain? (Check All That Apply)

- ☐ bending over
- ☐ caring for family
- ☐ climbing stairs
- ☐ concentrating
- ☐ dressing self
- ☐ driving car
- ☐ exercising
- ☐ getting in/out of car
- ☐ getting to sleep
- ☐ grocery shopping
- ☐ performing household chores
- ☐ lifting objects
- ☐ looking over shoulder
- ☐ making love
- ☐ lying down
- ☐ reaching overhead
- ☐ rising out of chair or bed
- ☐ showering or bathing
- ☐ sitting
- ☐ standing
- ☐ staying asleep
- ☐ using a computer
- ☐ walking
- ☐ participating in yard work

How long can you with stand activity before it begins to hurt?

☐1 ☐5 ☐10 ☐15 ☐20 ☐30 ☐45 ☐60 ☐ Seconds☐ Minutes☐ Hours

Is Your pain worse (please circle)? ☐Morning ☐Afternoon ☐Night

Are you currently under significant amount of stress? ☐ Yes ☐ No

Reason____

Please select if YOU have ever been told you have, had or are currently experiencing any of the following:

- ☐ Arthritis
- ☐ Low Back Pain
- ☐ Mid Back Pain
- ☐ Arm/Hand Pain
- ☐ Ankle Pain
- ☐ Foot Pain
- ☐ Hip Pain
- ☐ Implant or Plates
- ☐ Knee Pain
- ☐ Neck Pain
- ☐ Stiff Neck
- ☐ Osteoporosis
- ☐ Pins and Screws
- ☐ Scoliosis
- ☐ Shoulder Pain
- ☐ TMJ
- ☐ Cramping
- ☐ Chest Pain
- ☐ Muscle Spasm
- ☐ Any Bleeding/Discharge
- ☐ Anxiety
- ☐ Depression
- ☐ Dizziness
- ☐ Epilepsy or Seizures
- ☐ Headaches
- ☐ Numbness
- ☐ Pins/Needles in Arms/Hands
- ☐ Trouble Sleeping
- ☐ Stroke
- ☐ Temp. loss of vision, smell or hearing
- ☐ Loss of Grip/Strength
- ☐ Loss of Hearing
- ☐ Blurred Vision
- ☐ Ringing in Ears
- ☐ Head Feels Heavy
- ☐ Fatigue
- ☐ Difficulty Swallowing
- ☐ Thyroid Disfunction
- ☐ Abdominal Pain
- ☐ Light Headed
- ☐ Cancer
- ☐ HIV
- ☐ Osteopenia
- ☐ Osteomalacia
- ☐ Sores That Won't Heal
- ☐ Heart Murmur
- ☐ Rheumatoid Arthritis
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Apnea
- ☐ Asthma
- ☐ Emphysema
- ☐ Hay Fever
- ☐ Persistent Cough
- ☐ Pneumonia
- ☐ Shortness of Breath
- ☐ Snoring Issues
- ☐ Tuberculosis
- ☐ Wheezing
- ☐ Weight Loss/Gain

Had any surgeries?☐Y☐N

Describe________________________________Year?________

Describe________________________________Year?________

Describe________________________________Year?________

Describe________________________________Year?________

Have you had a knee replacement? ☐Yes ☐No ☐Right ☐ Left Year______________

Have you had a hip replacement? ☐Yes ☐No ☐Right☐ Left Year______________

Current medication, including frequency and dosage if known. If there are no current medications check here: ☐

1) ______________________ **5)** ______________________

2) ______________________ **6)** ______________________

3) ______________________ **7)** ______________________

4) ______________________ **8)** ______________________

List any known allergies you have had to any MEDICATIONS.
If no allergies are known, check here: ☐

1) ______________________ **3)** ______________________

2) ______________________ **4)** ______________________

Do you have a pacemaker? ☐Yes ☐No
Are you or could you be pregnant? ☐Yes ☐No

Briefly list additional health conditions: ______________________

____

Has any doctor diagnosed you with Hypertension presently?☐ Yes ☐No

If yes, describe: ______________________

Has any doctor diagnosed you with Diabetes presently?☐ Yes☐No If yes, what kind? ☐ Type I ☐ Type II
If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%?☐ Yes☐ No☐ Not Sure
If yes, other comments regarding Diabetes: ______________________

Do you have any family history in your mother, father, sibling or grandparents of BACK PAIN, HEADACHES, CANCER, DIABETES, STROKE, ARTHRITIS OR HEART DISEASE? ☐Y ☐N

If yes: Who?______________________

What conditions?______________________Age deceased______

If yes:Who?______________________

What conditions?______________________Age deceased______

If yes: Who?______________________

What conditions?______________________Age deceased______

Had any broken bones? ☐Y ☐N

Describe______________________Year?______

Describe______________________Year?______

Due to Insurance guidelines, we must have 3 measurable goals when it comes to your treatment process. Please provide us with your goals.

1. ______________________

2. ______________________

3. ______________________

____

(Patient or Legal Guardian Signature) (Date)

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Informed Consent for Chiropractic Treatment
TO THE PATIENT:

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including examination tests, diagnostic x-ray(s) and physical therapy techniques, on me (or on the patient named below for which lam legally responsible) which are recommended by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future render treatment to me while employed by, working for or associated with, or serving as back-up for the doctor of chiropractic named below. I understand that, as with any health care procedure, there are certain complications, which may arise during a chiropractic adjustment. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Homers' syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations.

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. I do not expect the doctor to be able to anticipate all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, are in my best interest. l have had an opportunity to discuss with the doctor named below and/or with office personnel the nature, purpose and risks of chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. l understand that the results are not guaranteed.

l have read ___ or have had read to me ___ the above explanation of the chiropractic adjustment and related treatment. By signing below l state that l have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the chiropractic treatment recommended. All of my questions have been answered to my satisfaction. Having been informed of the risks, l hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions(s) for which I seek treatment.

____
Patients Printed Name

____
Signature of Patient

____
Date

____
Patients Printed Name

____
Printed Name of Patient's Representative

____
Signature of Patient's Representative

____
Relationship/Authority of Patient's Representative

____
Date

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Health Care Authorization:

The patient below authorizes Edgewater Chiropractic Clinic PA and its employees to use and/or disclose protected health information in accordance with the following:

Specific Authorizations: I give permission to Edgewater Chiropractic Clinic PA, and its employees to use my phone number, email address, home address and clinical records to contact me with appointments, reminders, missed appointments notification, birthday cards, holiday related cards, information about treatment alternatives, or other health related information.

If Edgewater Chiropractic Clinic PA, and its employees contact me by phone, I give them permission to leave a phone message on my answering machine/voice mail.

By signing this form, I am giving Edgewater Chiropractic Clinic PA, and its employees my permission to use and disclose my protected health information in accordance with the directives above.

Right to revoke authorization:

I have the right to revoke the above authorization by mailing or hand delivering a written notice to the privacy official of Edgewater Chiropractic Clinic PA. The written notice must contain the following information: My name, social security number, date of birth, a clear statement of my intent to revoke this authorization, the date and my signature. The revocation will not be effective until it is received by the privacy official. I have the right to refuse this authorization. If I refuse to sign it, Edgewater Chiropractic Clinic PA, will not refuse to provide treatment.

I have the right to inspect or copy the health information to be used/disclosed. I have a right to a copy of the signed authorization.

Patient's PRINTED Name: ____

Patient's Signature: ____ **Date:** ______________

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INSURANCE AND PAYMENT UNDERSTANDING

Thank you for choosing Edgewater Chiropractic Clinic, PA. For your chiropractic health care needs. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment process. The following is a statement of our financial policy, which we require that you read and sign prior to any treatment.

Regarding insurance: If you have an insurance plan that we participate in and the services which you are here for are expected to be covered expenses, we will gladly file your insurance claim for you. You will be billed for any amount that your insurance company leaves to your responsibility. We cannot bill your insurance unless you bring in your current insurance card. If your insurance company has not paid your account within 45 days, the balance will be transferred to your responsibility. Please be aware that some considered reasonable and necessary under the Medicare program and/or other medical insurance. If we do not participate with your insurance company, payment is due at the time of service. We accept cash, check, Visa, and MasterCard.

- Non-insured patient: if you do not have insurance, payment is expected at the time of service.
- **A $55 New Patient exam fee is responsibility of the patient and payment is expected at the time of service.**
- Usual and customary rates: This practice is committed to providing the best treatment for our patient and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- Adult patients: the adult accompanying a minor and the parents (or guardians) are responsible for full payment of service rendered to the minor.

Edgewater Chiropractic Clinic, PA. is here to provide you with the best possible health care. Our primary concern is your health and wellbeing, not with your insurance company. It is your responsibility to be aware of what your policy details are. Any questions should be directed to our staff.

I have read the above financial policy and I understand and agree to the terms within it.

Patient's PRINTED Name: ____

Patient's Signature: ____________________________________ **Date:** ____________

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EDGEWATER CHIROPRACTIC CLINIC:

NOTICE REGARDING YOUR RIGHT TO PRIVACY

I have received a copy of the Patient Privacy Notice. I understand my rights as well as the practice's duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present. I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

____
Printed Name

____
DOB

____
Signature

____
Date

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MEDICAL RECORDS RELEASE FORM

Printed Name: ____________________________

DOB: _________

You may use or disclose the following health care information:

All my health information including but not limited to, patient notes and charges.

You may disclose this health information to:

Legal Name: ____________________________ Phone Number: __________________

Legal Name: ____________________________ Phone Number: __________________

Legal Name: ____________________________ Phone Number: __________________

This authorization may be revoked at any time by providing written notice of revocation. I understand I cannot revoke this authorization retroactively for information already released.

____
Patients Printed Name

____
Signature of Patient

____
Date

If patient is under 18 years of age.

____
Patients Printed Name

____
Parent/Guardian Printed Name

____
Signature of Parent/Guardian

____
Date

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This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your Personal Health Information. In addition, we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as dictated by our office policy, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled 'HIPAA' on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

PERMITTED DISCLOSURES:

1.Treatment purposes discussion with other health care providers involved in your care.
2.Inadvertent disclosures open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3.For payment purposes to obtain payment from your insurance company or any other collateral source.
4.For workers compensation purposes to process a claim or aid in investigation.
5.Emergencyin the event of a medical emergency we may notify a family member.
6.For public health and safety in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7.To Government agencies or Law enforcement to identify or locate a suspect, fugitive, material witness or missing person.
8.For military, national security, prisoner and government benefit purposes.
9.Deceased persons discussion with coroners and medical examiners in the event of a patient's death.
10.Telephone calls or emails and appointment reminders we may call your home and leave messages regarding a missed appointment or apprize you of changes in practice hours or upcoming events.
11.Change of ownership in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures.
2.To receive a paper copy of the comprehensive "Detail" Privacy Notice.
3.To request mailings to an address different than residence.
4.To request restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5.To inspect your records and receive one copy of your records at no charge, with notice in advance.
6.To request amendments to information. However, like restrictions, we are not required to agree to them.
7.To obtain one copy of your records at no charge, when timely notice is provided (72 hours). X-raysare original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call Dr. Carly Meckle (386) 423-7575.Ifshe is unavailable, you may make an appointment with our receptionist to see her within72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to: DHHS, Office of Civil Rights

200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201