ICHIROPRACTIC AND WELLNESS

DR. MARC J. BROWNER

5500 Bryson Drive #303 * Naples, Florida
34109

CONFIDENTIAL PATIENT ENTRANCE INFORMATION
PLEASE PRINT

Date: _____/_____/_____
Name: _____
SS#: _____ - _____ - _____ Home Phone: _____
Cell Phone: _____ Email: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Birth Date: ____/ ____/____ Age: _____ Sex: M F Marital Status: M S D W
Occupation: _____ Employed By: _____
Work Phone: _____ Work Address: _____
Spouse's Name: _____ Spouse's Employer: _____
Emergency Contact: _____ Phone: _____
How were you referred to our office? _____
Appt reminders through text messaging? yes ☐ no ☐

List your chief complaints in order of severity and for how long you have been experiencing them:

1. _____For how long? _____
2. _____For how long? _____
3. _____For how long? _____
4. _____For how long? _____

Have you ever been to a Chiropractor before? Yes No If yes, when? _____
List doctors consulted for these conditions:

1. _____ Address/Phone: _____
2. _____ Address/Phone: _____

If this is an injury:

1. Work-related? Yes No If yes, have you reported it to your employer?
2. Related to a motor vehicle crash? Yes No
   If this is due to a crash, fill out the appropriate report forms which will be provided to you.

1. ALL FIRST VISIT CHARGES ARE PAYABLE WHEN SERVICES RENDERED.
   NAME OF PARENT OR FINANCIALLY RESPONSIBLE PERSON: _____
2. THE FEE PAID FOR CHIROPRACTIC X-RAYS IS FOR STRUCTURAL ANALYSIS ONLY.
3. METHOD OF PAYMENT YOU PLAN TO TAKE CARE OF TODAY'S CHARGES
   Cash____ Check____ Visa/MC____
4. Do you have any type of insurance? Yes No

FEMALES: Are you pregnant? Yes No Not Sure

HEALTH HISTORY

Are you taking any of the following medications?

o Nerve Pills o Pain Killers (including aspirin) o Muscle Relaxers o Stimulants o Blood Thinners o Insulin o Other(s)_____

Do you have or have you ever had any of the following diseases or conditions?

oHeart Attack/Stroke	oHeart Surgery/Pacemaker	oHeart Murmur
oCongenital Heart Defect	oMitral Valve Prolapse	oArtificial Valves
oAlcohol/Drug Abuse	oVenereal Disease	oHepatitis
oHIV/Aids	oShingles	oCancer
oFrequent Neck Pain	oEmphysema/Glaucoma	oAnemia
oHigh/Low Blood Pressure	oPsychiatric Problems	oRheumatic Fever
oSevere/Frequent Headaches	oKidney Problems	oUlcers/Colitis
oFainting/Seizures/Epilepsy	oSinus Problems	oAsthma
oDiabetes/Tuberculosis	oDifficulty Breathing	oChemotherapy
oLower Back Problems	oArtificial Bones/Joints	oArthritis
oDigestive Problems	oRinging in Ears	oNose Bleeds

Please list any other serious medical condition(s) you have or ever had:_____

_____

Please list anything that you may be allergic to: _____

List previous surgeries/treatments with dates: _____

_____

List any PAST serious accidents with dates:_____

_____

Family Health History: _____

_____

Do you: Take supplements or vitamins? Y N Exercise? Y N If yes, describe:

_____

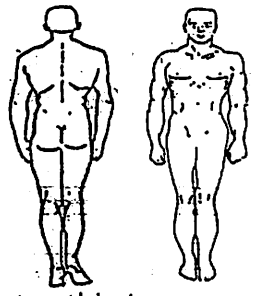
Do you smoke? Y N If yes, how much? _____ How long? _____

Are you wearing: oHeel lifts oSole lifts oInner Soles oArch Supports oOrthotics

Current Weight: _____ **Height:** _____

Women: Are you taking Birth Control? Y N Are you pregnant? Y N If yes, how far along? _____ Are you nursing? Y N

All Patients: Please Mark Problem Area(s):



Is the Pain:

oSharp/Stabbing oAching

oPins & Needles oBurning

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ **Date** _____

Insurance Information

Please provide a copy of your insurance card, driver's license and any secondary insurance information to our front desk.

Insurance Company: _____ Phone #: _____
Policy No.: _____ Claim #: _____
Insured's Name: _____ Sex: M F
Insured's Birth Date: _____/_____/_____ Relationship to Insured: _____
Do you have health insurance? Yes No

FOR BLUE CROSS/BLUE SHIELD AND UNITED HEALTH CARE PATIENTS:
As a courtesy to you, we will file your claims on your behalf. Please be advised that all insurance monies will be **paid directly to you/the insured. You will be responsible for forwarding the checks to our office.** Furthermore, you will allow IChiropractic and Wellness to call BCBS to verify insurance payment and allow BCBS to disclose the amount of payment for services rendered.

Patient Acknowledgment: I have been given a copy of IChiropractic and Wellness's Notice of Privacy Practice, version effective April 14, 2003. By signing this form, I give my consent to this office's use and disclosure of protected health information about myself for treatment, payment and health care operations, as well as those purposes set forth in the Notice of Privacy.

Signature _____ **Date** _____

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance in my account for any professional services rendered.

Furthermore, I understand that IChiropractic and Wellness will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to IChiropractic and Wellness will be credited to my account upon receipt.

However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

I also understand that if I suspend or terminate my care, any fees for professional services rendered me will be immediately due and payable.

I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes in my health insurance status or the above information.

RELEASE & ASSIGNMENT

I authorize release of any information necessary to process my insurance claims and assign and request payment directly to my physician.

Signature: _____ **Date** _____
Print Name: _____
Spouse's Name or Guardian Signature: _____

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR PRIVATE, GROUP AND HEALTH INSURANCE

Patient: _____

SS# or ID# _____

I hereby instruct and direct that _____ insurance Company to pay by check made out and mailed to:

IChiropractic and Wellness
5500 Bryson Drive #303
Naples, FL 34109

If my current policy prohibits direct payment to the doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows:

IChiropractic and Wellness
5500 Bryson Drive #303
Naples, FL 34109

The professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT ON MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above the insurance payment.

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

I also authorize the release of any information pertinent to my case to any insurance company, adjustor or attorney involved in this case.

Dated on this _____ day of _____ 20_____

_____ _____
Signature of Policyholder Signature of Witness

_____
Signature of Claimant, if other than policyholder

ICHIROPRACTIC AND WELLNESS

NOTICE OF PRIVACY PRACTICES – SHORT FORM

Our practice is committed to educating our patients about healthcare issues that affect them. As a result, we are providing you with general information about the Privacy Rule, a federal regulation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) along with a brief overview of our Notice Of Privacy. Our practice is complying with HIPAA's regulations.

What is the HIPAA and how does the Privacy Rule affect you?
When the Health Insurance Portability and Accountability Act (HIPAA) was passed in August of 1996 this gave the federal government the ability to mandate how healthcare plans, providers, and clearinghouses store and send a patient's personal information as it relates to healthcare. The Privacy Rule was created to protect your rights as a patient of our practice and we are required by law to be compliant with this regulation on April 14, 2003. Under the Privacy Rule you are guaranteed access to your medical records, allowed control over how your protected health information is used and disclosed and allowed to take action if your privacy is compromised by following the practice's policy. Our practice is dedicated to maintaining the privacy of your personal information.

What is Individually Identifiable Health Information (IIHI)?
Any health information you provide our practice, including your mailing address. Information that is created and retained by our practice or received by another healthcare provider that relates to treatment, payment and/or that identifies you as an individual.

What is the Notice of Privacy Practice?
Our practice has an official Notice of Privacy Practice posted in our waiting room informing our patients about their rights surrounding the protection of your IHII and our obligations concerning the use and disclosure of your IHII. This notice applies to all records created or retained by our practice. We can update our Notice of Privacy Practices at any time. It will be posted in our office and you can ask for a copy of the current notice at any time.

The following categories describe the different ways in which we may use and disclose your IHII:

Treatment	Appointment Reminders	Release of Information to Family/Friends
Payment	Treatment Options	Disclosure Required by Law
Health Care Operations	Health-Related Benefits and Services	

The following categories describe unique situations in which we may use or disclose your identifiable health information:

Public Health Risk	Health Oversight Activities	Lawsuits and Similar Proceedings
Deceased Patients	Organ and Tissue Donation	Serious Threats to Health or Safety
Military	National Security Inmates	Worker's Compensation
Law Enforcement	Research	

What are your rights concerning your individually Identifiable Health Information (IHII)?
You have rights regarding the IIHI that we maintain about you. In our Notice of Privacy you can view the policies and procedures you will need to follow for the areas listed below.

1. Confidential Communications
2. Requesting Restrictions
3. Inspection and Copies
4. Amendment
5. Accounting of Disclosures
6. Right to a Paper Copy of This Notice
7. Right to File a Complaint
8. Right to Provide an Authorization for Other Uses and Disclosures

If you have any questions regarding this notice or our health information privacy policies, please inform us.

Signature _____ Date _____

ICHIROPRACTIC AND WELLNESS

5500 Bryson Drive #303
Naples, FL 34109

CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including 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 the 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 serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office of clinic personnel the nature and purpose of chiropractic adjustments and 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 judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its 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 and for any future condition(s) for which I seek treatment.

Patient Signature Date

Authorization for the Release of Medical Records

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

Date of Birth:_____

I hereby request and authorize: iChiropractic and Wellness, INC
5500 Bryson Dr. Suite 303 Naples, FL. 34109
Phone: (239) 300-1756 Fax: (347) 767-2547

_____To Disclose information to: _____To Receive Information from:

Provider_____

Information to be disclosed include copies of:

_____Entire Record
_____Progress Notes
_____Physical Exam Report
_____Daily Chart Notes
_____X-ray/MRI/CT Reports
_____X-ray/MRI/CT Films or CD
_____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, I hereby state that my parental rights have not been revoked by a court of law.)

Notice to recipient of information: This information has been disclosed to you from confidential records, which are protected by law. Unless you have further authorization, laws may prohibit you from making any further disclosures of this information without the specific written consent of the patient or legal representative.