GENERAL INFORMATION

Patient first name: _____ Patient last name: _____

Are you a full-time resident of the area? ○ Yes ○ No

Local Address: _____ City, State, Zip: _____

Out of State Address: _____ City, State, Zip: _____

Are you a seasonal resident of the area? ○ No ○ Yes Which months are you here? _____

Are you here on vacation? ○ No ○ Yes When do you leave? _____ Will you be back next year? ○ Yes ○ No

Home Phone: _____ Cell Phone: _____ Email: _____

How do you prefer to receive appointment reminders? ○ Text ○ Email ○ Phone call

Date of Birth: _____ Gender: ○ Male ○ Female Social Security #: _____

Preferred Language: _____ Marital Status: ○ Married ○ Single ○ Divorced ○ Widowed

Occupation: _____ Employer: _____

Emergency Contact Name: _____ Relationship: _____ Phone Number: _____

Who referred you to our office? ○ Internet ○ Insurance Website ○ Phone Book ○ Other _____

○ Friend: _____ ○ Family Member: _____

○ Other Healthcare Provider: _____ ○ Workout Facility: _____

Have you had chiropractic care before? ○ No ○ Yes How was your experience? _____

Women only, are you pregnant? ○ Yes ○ No ○ Not Sure

ELECTRONIC HEALTH RECORDS INFORMATION

Race: ○ American Indian or Alaska Native ○ Asian ○ White (Caucasian) ○ Native Hawaiian or Pacific Islander ○ Black or African American ○ Other ○ Decline to Answer

Ethnicity: ○ Hispanic or Latino ○ Not Hispanic or Latino ○ Decline to Answer

Smoking Status: ○ Everyday Smoker ○ Occasional Smoker ○ Former Smoker ○ Never Smoked

Height: ___' - ___" Weight: _____ Blood Pressure: _____ / _____ Heart Rate: _____ (we will check these)

HEALTH HISTORY

Please circle all that you currently have or have suffered from in the past:

Headaches	Arthritis	Insomnia	High Blood Pressure	Digestive Problems
Migraines	Stroke	Osteoporosis	Diabetes	Gallbladder Issues
Neck Pain	Vision Changes	Shoulder Pain	Urinary Problems	Tuberculosis
Arm/Hand Pain	Ringing in Ears	Allergies	Kidney Problems	Depression
Mid Back Pain	Dizziness	Hearing Loss	Cancer	Heart Problems
Low Back Pain	Leg/Foot Pain	HIV	Joint Swelling	Scoliosis
Hip Pain	Disc Problems	Gout	Numbness	Weakness/ Fatigue

Other: _____

FAMILY HEALTH HISTORY

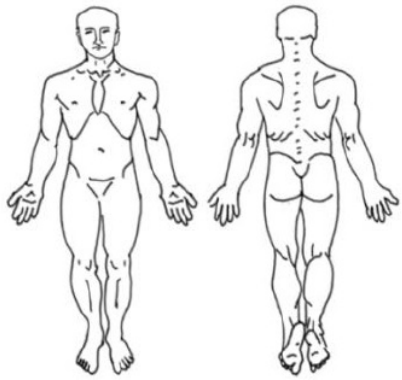
Please Circle all that apply:

Heart Disease High Blood Pressure Stroke Cancer Diabetes Scoliosis Osteoporosis

Other: _____

PRIMARY COMPLAINT

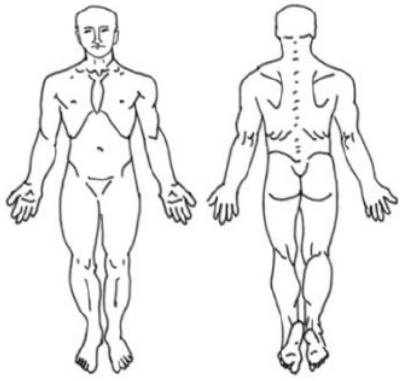
Select area of discomfort:



1. Neck Pain Mid Back pain Shoulder Pain Low Back Pain
   Arm Pain R/L Leg Pain R/L Knee Pain R/L Hip Pain R/L
   Ankle Pain R/L Headaches Other: _____
2. **How long have you had this condition?** _____
3. **Have you had this injury in the past?** ○ No ○ Yes When? _____
4. **Severity:** Severe Moderate Mild
5. **Duration:** Constant Frequent Intermittent
6. **Rate your pain / dysfunction:** 1 2 3 4 5 6 7 8 9 10 (worst)
7. **How did this injury occur?** Overexertion Strenuous Position
   Fall / Slip / Trip Athletic Activity Bending Lifting Auto Accident Work Accident Other: _____
8. **Please circle the activities that are affected:** Work Sitting Sleeping Walking Bending Driving
   Sleeping Computer Work Housework Stairs Other: _____
9. **Quality / Characteristics:** Dull Achy Sharp Shooting Stabbing Burning Throbbing
   Numbness / Tingling Other: _____
10. **Radiation / Referral:** Upper Extremity R/L Lower Extremity R/L Across Shoulders
    Between Shoulders Other: _____
11. **Relieving Factors:** Rest Lying Standing Sitting Ice Heat Movements
    Medications: Aspirin Ibuprofen Naproxen Acetaminophen Other: _____
12. **Aggravating Factors:** Sitting Standing Coughing / Sneezing / BM Lifting Bending Driving
    Walk General Movements Taking Deep Breaths Other: _____
13. **Condition is worse in the:** ○ AM / upon rising ○ Midday ○ PM / end of day ○ While sleeping ○ All day
14. **Relationship to other body systems:** ○ Bladder / Bowel Dysfunction ○ Visual Disturbances / Blurring
    ○ Ringing in ears ○ Difficulty Swallowing / Breathing ○ Swelling
15. **What have you done for this condition?** ○ MRI ○ CT Scan ○ X-Rays ○ Injections ○ Chiropractic

SECONDARY & TERTIARY COMPLAINTS

Select area of discomfort:



Neck Pain Mid Back pain Shoulder Pain Low Back Pain
Arm Pain R/L Leg Pain R/L Knee Pain R/L Hip Pain R/L
Ankle Pain R/L Headaches Other: _____
Doctor's Notes: _____

_____

MEDICATION INFORMATION (Please include regularly used over the counter medications or provide list)

Medication Name:	**Dosage and Frequency:**	**Additional Comments:**
Medication Allergies:	**Reaction:**	**Onset Date:**

ASSIGNMENT OF INSURANCE BENEFITS:
I hereby authorize payment to be made directly to Total Health of Naples, all benefits which may be due and payable under insurance coverage for the above named Patient. I authorize utilization of this application of copies thereof for the purpose of processing claims and effecting payments. I further acknowledge that this assignment of benefits does not in any way relieve me of liability and that I will remain financially responsible to Total Health of Naples. Furthermore, I hereby IRREVOCABLY ASSIGN to Total Health of Naples, the rights and benefits under any policy of insurance, indemnity agreement, or any other collateral source as defined in the state Florida Statutes for any service and or charges provided by Total Health of Naples.

FINANCIAL POLICY (THIS APPLIES TO EVERYONE):
We accept most insurance plans; however, it is ultimately your responsibility to understand what services are covered under your insurance policy. Please understand that while we can call to verify your insurance benefits, verification is not a guarantee of payment from your insurance company. To prevent any misunderstandings about your insurance coverage and our billing/collections procedure, we would like to inform our patients that co-pays, deductibles, and services not covered by your insurance company are your responsibility. You are fully responsible for payment of all charges, including but not limited to, deductibles and copayments related to your care and your balance should not exceed $200.00 at any given time; we do not typically mail monthly statements to patients. If your balance is not paid in a monthly or timely fashion, you must pay any and all collections, court and attorney's fees in the collection of your account. If your insurance company or Medicare declines payment, or does not pay for services within 45 days of the date rendered, you will be responsible to pay upon notice any balance due on your account.

IF YOU ARE HERE ON VACATION:
If you are visiting from out of town, you may be asked to pay our non-insurance fees; $95 for your first visit and $45 for subsequent visits, even if you have insurance – an exception to this policy will only be granted with approval from our billing manager. Once we submit your services to your insurance company and we receive the explanation of benefits, you will be reimbursed or billed for the difference if necessary. If you are uninsured, you are responsible for paying our non-insurance fee at the time of service.

IF YOU HAVE AN OUT OF STATE BLUE CROSS BLUE SHIELD INSURANCE PLAN:
We are in network with Florida Blue Cross Blue Shield plans; however, it is impossible for us to guarantee that we are in network with every Blue Cross Blue Shield plan in the entire country. It is ultimately your responsibility to determine which providers are in your network, not our responsibility. If you have an out of state Blue Cross Blue Shield Plan, you may be asked to pay our non-insurance fees; $95 for your first visit and $45 for subsequent visits – an exception to this policy will only be granted with approval from our billing manager. Once we submit your services to your insurance company and we receive the explanation of benefits, you will be reimbursed or billed for the difference if necessary.

IF YOU HAVE FLORIDA BLUE OR CIGNA MANAGED BY AMERICAN SPECIALTY HEALTH:
As of 2014, American Specialty Health (ASH) manages *most* Florida Blue and Cigna insurance plans. ASH preapproves only 8 chiropractic visits, even though you may have 26 on your insurance plan. In order for your insurance to cover more than 8 visits, we have to request preauthorization from ASH. In our experience, this process can often take up to 60 days and even then, the visits may still be denied. If you have used all 8 of your preapproved chiropractic visits, you may be asked to pay American Specialty Health's allowable amounts until we receive authorization for more visits – an exception to this policy will only be granted with approval from our billing manager.

IF YOU HAVE MEDICARE OR A MEDICARE REPLACEMENT PLAN: Medicare will cover for 80% of the chiropractic adjustment, per Medicare guidelines, no additional services are covered by Medicare in our office. If you have a supplement or secondary insurance plan, it *should* cover the remaining 20% of the chiropractic adjustment that Medicare does not cover after your deductible is met. We offer additional diagnostic services such as exams and x-rays that will not be covered by your Medicare, Medicare Replacement Plan, secondary or supplement. We also offer additional therapeutic services that the chiropractor may recommend to speed up your healing process such as muscle stimulation, heat/ice therapy, ultrasound, soft tissue therapy, and spinal decompression – these services will also not be covered by your Medicare, Medicare replacement plan, secondary or supplement.

The chiropractor and his staff are VERY familiar with Medicare's guidelines as well as replacement plans, secondary and supplement plans - we know that even though you believe you have "the best insurance", based on our experience, 99% of the time these services still won't be covered; therefore you will have to pay out of pocket for them. We are legally not allowed to receive payment from you and the insurance company for the same services; this is called double-dipping. We also are not legally allowed to give away the services that Medicare does not cover; this is called enticement. If you have further questions about Medicare, Medicare replacement plan, secondary or supplement insurance, please ask us. If you still have questions after we've done our best to answer them, please contact your insurance company or companies about the services that are covered under your plan.

PATIENT OR AUTHORIZED SIGNATURE: _____ **DATE:** _____

RECEIPT OF NOTICE OF PRIVACY PRACTICES:
I have read a copy of Total Health of Naples' notice of Patient Privacy Practices.
The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your patient health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

AUTHORIZATION TO RELEASE MEDICAL RECORD INFORMATION:
I authorize payment of insurance benefits directly to Total Health of Naples. I authorize the doctor to release all information necessary to communicate with personal physicians and other health care providers and payers and to secure the payment of benefits. I understand that I am responsible for all cost of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

In addition, I have read and agree to the above Assignments, Financial Policies, Notices, Releases and Consent forms and acknowledge Total Health of Naples does NOT accept or participate in any HMO's. The undersigned certifies that he/she has read and understands each of the above paragraphs and is the patient or responsible party with the power to execute this document and accept these terms.

PATIENT OR AUTHORIZED SIGNATURE: _____ **DATE:** _____

CHIROPRACTIC INFORMED CONSENT:
"Chiropractic physician" as defined in Florida Statute 460.403(5)(2008).Chiropractic physicians examine, analyze, and diagnose the human living body and its disease by use of (a) any physical, chemical, electrical, or thermal methods, (b) x-ray for diagnosing, (c) blood tests and (d) other chiropractic methods. See Florida Statue 460.403(3)(b).

Before you, the Patient, receive chiropractic care, it is important that you read this consent and understand the nature and risks of chiropractic medicine. The "practice of chiropractic medicine" (or chiropractic care) involves the adjustment, manipulation, and treatment of your body in which vertebral subluxations and other malpositioned articulations and structures may be interfering with the normal generation, transmission, and expression of nerve impulse between the brain, organs, and tissue cells, thereby causing disease. See Fla Stat. 460.403(9)(a). Chiropractic adjustments, manipulations, and treatments are intended to restore the normal flow of nerve impulse which produces normal function and consequence health. See Florida Statute 460.403(9)(a).

The undersigned Patient understand and acknowledges that there are risks associated with the practice of chiropractic medicine and chiropractic care including, but not limited to ataxia, bruising, thermal injuries, dislocations/ subluxations, dizziness, fracture(s), mobility disruption, paralysis, spinal injury, stroke, vision disturbances, and others. The most common side effect following chiropractic manipulation/adjustment is an ache or stiffness at the site of the adjustment.

I, also hereby give authorization for consent for treatment to Total Health of Naples and whomever they may designate as their assistants to perform and administer therapy and treatment as they deem necessary.

I, the undersigned Patient, understand the risks and limitation associated with the practice of chiropractic medicine, including the use of chiropractic care, evaluation, diagnosis, adjustments, manipulations, physical therapy, and therapeutic modalities such as heat, ice, ultrasound, stimulations, traction, muscle stimulation, and other treatments by Total Health of Naples. All of my questions have been answered in detail and I fully understand and certify that no guarantee or assurances have been made to the results or outcome from treatment that may or will be rendered.

PATIENT OR AUTHORIZED SIGNATURE: _____ **DATE:** _____