Confidential Patient Data

IF YOU NEED ANY ASSISTANCE COMPLETING THIS FORM, PLEASE ASK THE RECEPTIONIST

PATIENT INFORMATION

Today's Date:_________

Name: ____

Date of Birth: __________________ E-mail address: _________________________________

Address: ____________________________ City: _________________ State: ___ Zip: _______

Home Phone: _______________ Work Phone: _______________ Cell Phone: _______________

Social Security #:________________ Age: _______ ❑ Male ❑ Female

Marital Status: ❑ Married ❑Single ❑Divorced ❑Separated ❑Other __________

Name of Spouse or Nearest Relative:_________________________ Phone:________________

Your Occupation____________________________ Your Employer:_______________________

Referred to this Office by: ❑Friend/Family Member - Name?_________________________

❑Yellow Pages - Which? _______________________________

❑Clinic Location ❑Other_______________________________

Payment for Services will be by: ❑Cash ❑Check ❑Credit Card ❑Health Insurance

❑Automobile Insurance ❑Worker's Compensation

Name of Insurance Co.:____________________________Insured's Employer: ______________

Insured's Social Security #:_____________________ Employer's Phone #:_____________

Are you covered by more than one insurance company? ❑Yes ❑No Name _________________

MEDICAL/FAMILY HISTORY: S = Self M = Mother F = Father

(Please indicate which conditions have been experienced by the above by marking appropriate boxes).

S	M	F		S	M	F		S	M	F	
❑	❑	❑	AIDS	❑	❑	❑	dislocated joints	❑	❑	❑	neck pain
❑	❑	❑	anemia	❑	❑	❑	epilepsy	❑	❑	❑	nervousness
❑	❑	❑	arthritis	❑	❑	❑	German measles	❑	❑	❑	numbness
❑	❑	❑	asthma	❑	❑	❑	headaches	❑	❑	❑	osteoporosis
❑	❑	❑	back pain	❑	❑	❑	heart trouble	❑	❑	❑	poor circulation
❑	❑	❑	bladder trouble	❑	❑	❑	reproductive disorders	❑	❑	❑	hepatitis
❑	❑	❑	bone fracture	❑	❑	❑	high blood pressure	❑	❑	❑	rheumatic fever
❑	❑	❑	cancer	❑	❑	❑	HIV/ARC	❑	❑	❑	rheumatism
❑	❑	❑	chest pain	❑	❑	❑	kidney disorder	❑	❑	❑	scarlet fever
❑	❑	❑	concussion	❑	❑	❑	bowel control loss	❑	❑	❑	serious injury
❑	❑	❑	convulsions	❑	❑	❑	menstrual cramps	❑	❑	❑	sinus trouble
❑	❑	❑	diabetes	❑	❑	❑	multiple sclerosis	❑	❑	❑	tuberculosis
❑	❑	❑	indigestion	❑	❑	❑	muscular dystrophy	❑	❑	❑	smoke tobacco

How long have you smoked?________

Have you been treated by a physician for any health condition in the last year? ❑Yes ❑No

If yes, please describe the condition____________________________________

Date of Last Physical Exam__________

SURGICAL HISTORY (including any metal implants):

1.____ Date:________________

2.____ Date:________________

3.____ Date:________________

ACCIDENT HISTORY

❑Job ❑Auto ❑Other

1. ____Date:________________

❑Job ❑Auto ❑Other

2.____Date:________________

❑Job ❑Auto ❑Other

3.____Date:________________

PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS:

Please rate your symptoms 1-10, with 1 being the least serious

1.____ ________

2.____ ________

3.____ ________

4.____ ________

5.____ ________

6.____ ________

Symptoms are worse in: ❑morning ❑afternoon ❑night ❑consistent throughout day
When and how did these symptoms begin? ____
Symptoms developed from:
❑Job related injury ❑Auto accident ❑Accident ❑Unknown cause ❑Gradual onset
Symptoms have persisted for # ____hour(s) ____day(s) __week(s) ___month(s) ___year(s)
Symptoms/complaints: ❑Come & go ❑Are constant
Have you ever had this before: ❑No ❑Yes When?
____
If you were to guess, what do you think is causing your complaints?
____
Name and location of doctors see for present condition(s):
____
Please list any severe allergies that you may have:
____
Are you taking any medications ❑No ❑Yes What kind?
____

Are you pregnant? ❑No ❑Yes Date of last menstrual period________________
*X-rays should NOT be taken on pregnant women. Advise Dr. Jacobs if you are pregnant or if you may be pregnant.

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT AGGRAVATE YOUR CONDITION:
❑Bending ❑Reaching ❑Straining at stool ❑Coughing ❑Turning head ❑Sitting
❑Lifting ❑Sneezing ❑Walking ❑Lying down ❑Standing

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT RELIEVE YOUR CONDITION:
❑Bending ❑Sitting ❑Lifting ❑Standing ❑Lying down ❑Turning head ❑Walking

PLEASE CHECK ANY **ADDITIONAL SYMPTOMS** YOU MAY BE EXPERIENCING:

❑Blurred vision	❑Concentration loss / confusion	❑Cold feet	❑Dizziness
❑Cold hands	❑Cold sweats	❑Buzzing in ears	❑Fatigue
❑Insomnia	❑Depression /weeping spells	❑Diarrhea	❑Fever
❑Light bothers eyes	❑Pins and needles in arms	❑Face flushed	❑Fainting
❑Stiff neck	❑Headaches	❑Muscle jerking	❑Loss of smell
❑Loss of balance	❑Numbness in fingers	❑Loss of taste	❑Stomach upset
❑Frequent colds	❑Numbness in toes	❑Constipation	
❑Shortness of breath	❑Ringing in ears	❑Loss of bowel or bladder control	
❑Head seems too heavy		❑Pins and needles in legs	

Patient's Signature:___________________________________ Date:______________________

Jacobs Chiropractic & Wellness Center
Richard Jacobs D.C.
John Neff D.C.

215 Gulf Breeze Parkway
Gulf Breeze, FL 32561
850.916.7060 Phone
850.916.7061 Fax

2045 N. 12th Avenue
Pensacola, FL 32503
850.912.8485 Phone
850.912.8525 Fax

Please answer the following questions below. The office has to collect this information from every patient for a mandatory government update. Thank you, for your time and cooperation.

Name: ____

What is your ethnicity?
- Hispanic or Latino
- Not Hispanic or Latino

What is your race?
- White
- Black or African American
- American Indian or Alaska Native
- Asian
- Native Hawaiian or other Pacific Islander
- More than one race
- Other Race
- Unknown

What is your preferred language?
- English
- Spanish
- French
- German
- Italian
- Russian
- Portugese
- Chinese
- Japanese
- Korean
- Vietnamese

What is your communication preference?
- Phone - Home:____________Work:____________Cell:_____________
- Email: ____

What is your current smoking status?
- Current, every day smoker
- Current, some days smoker
- Former Smoker
- Never Smoker

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Please update your current medications (prescribed and over the counter) and medication allergies. The office has to collect this information from every patient for a mandatory government update. Thank you, for your time and cooperation.

Name:____ **Date:**___________________________

Current Medications and Supplements - Dosage, Frequency & Date Started:

____ ____
____ ____
____ ____
____ ____
____ ____
____ ____

Current Medication Allergies - Reactions & Onset Date:

____ ____
____ ____
____ ____
____ ____
____ ____
____ ____

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Treatment Authorization

Chiropractic healthcare is primarily concerned with the relationship between structure (primarily the spine) and function (primarily of the nervous system). Dr. Jacobs evaluates the patient using standard examination and testing procedures (orthopedic and neurologic evaluation, labs, x-rays) along with specialized chiropractic evaluation. The chiropractic evaluation focuses on structural and/or functional abnormalities which damage or irritate nearby nerves, joints and/or tissues. The primary goal of chiropractic treatment is to restore normal joint motion, decreasing the bodyøs inflammatory response, resulting in improved function and/or decreased symptomology. This is accomplished by performing a procedure unique to the chiropractic profession called an õadjustmentö. A chiropractic adjustment involves the application of a quick, precise force, by hand, directed over a very short distance to a specific vertebra or bone. In addition to adjustments, other treatments used by Dr. Jacobs include physiotherapy modalities (e.g. ultrasound, ice, electric stimulation, soft-tissue manipulation), nutritional and supplemental recommendations and rehabilitative procedures.

Chiropractic treatments are one of the safest interventions available to the public as evidenced by malpractice statistics. While there are risks involved with treatment, these are seldom great enough to contraindicate care. Nonetheless, they must be considered when making the decision about whether or not to receive care. Local discomfort, headache, tiredness and radiating discomfort are all possible side effects of an adjustment, but most resolve in 24 to 48 hours. Rare complications include rib fracture, burns (with certain physiotherapies), disc herniation, Cauda Equina Syndrome (1 case per 100 million adjustments) and compromise of the vertebrobasilar artery (i.e. stroke) (1 case per 1-5 million adjustments).

I understand that x-rays should NOT be taken on pregnant women. I have advised Dr. Jacobs if I am pregnant or if I may be pregnant.

I am informed and understand that there are some very slight risks with chiropractic adjustments, including, but not limited to, muscle sprain, ligament strain, disc injury and stroke. I expect Dr. Jacobs to exercise judgment, based upon the known facts, and act in my best interest.

I have discussed with Dr. Jacobs the nature and purpose of chiropractic adjustments including any questions that I have.

I have been informed that it is not uncommon for patients to become tired or to be sore after an adjustment. I am aware that I should apply ice to the area and rest if I do experience discomfort. If I am concerned about any symptom, I understand that I may call Dr. Jacobs. If I am unable to contact Dr. Jacobs, I am aware that I can go to the emergency room.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including physical therapy and x-rays, by Dr. Jacobs or his authorized personnel.

Patient Printed Name_____________________________________ Date ____________________

Patient Signature_____________________________________

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Financial Policy

The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services.

- By Law, all Copays are due and payable on the same day that services are rendered. Prompt payment allows us to control costs. Outstanding accounts cost both of us time and money therefore, all patients will be required to establish financial arrangements for payment of their account.
- All new patients will be required to remit full payment to establish an account.
- Your insurance coverage is an agreement between you and your insurer. As a courtesy, our practice will provide an estimate of your insurance benefits. It is your responsibility to remit payment for charges not covered by your claim and insure that your insurance payments are made to our office. If a problem occurs with your claim, you will be required to establish a separate written arrangement with our practice until your insurance claim is resolved.
- In some cases, your insurance company may send a check directly to you as payment for service rendered. ***It is imperative that this check and the Explanation of Benefits be brought to our office as payment for services rendered. Without the Explanation of Benefits, you are liable for the full amount of services rendered.***
- You will receive a statement for services if you have an outstanding balance. This will be due and payable within 30 days. If your payment is late, or if you have not previously made financial arrangements, we will then mail one reminder notice indicating there is a problem with your account. If you are experiencing a set of circumstances out of your control, please call our practice and we will be happy to make special arrangements.
- Please notify us immediately if a mistake appears on your statement.
- All patients refusing to remit payment after 61 days of notice without pending insurance or financial arrangements will force us to send your account to our Collection Agent. You will be responsible for your full account balance and any fees associated with the collection of your account.
- All patients will be required to sign a written legal agreement with our practice to alleviate any discrepancy.

Our practice firmly believes that a good doctor/patient relationship is based upon understanding and open communications. I have instructed our staff to make every effort available to you to clarify any misunderstanding you have concerning your balance. We hope to avoid any misunderstanding over payment for professional services. If you have any questions concerning our policy or need assistance, please contact us immediately.

Richard Jacobs, D.C.

____ ____________
Signature of Patient/Guardian/Legal Representative Date

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ASSIGNMENT OF BENEFITS

I, ____, assign all of the rights and benefits of any applicable personal injury protection, medical payments, or other coverage provided by any insurance policy issued pursuant to Florida Statutes §627.730 - §627.7405, to Dr. Richard Jacobs, for services and supplies provided to me related to my chiropractic treatment.

I agree to pay any co-payment or deductible not covered by the applicable personal injury protection, medical payments, or other insurance coverage.
This assignment includes, but is not limited to:
all rights to collect benefits directly from any insurance carrier obligated to provide benefits for services and supplies I have received;
all rights to take legal or other action against any insurance carrier obligated to provide benefits if for any reason the insurance carrier fails to pay any benefits due; and
all rights to recover attorney fees, legal assistant fees, costs, and any interest on fees and costs, for any legal or other action taken by Dr. Richard Jacobs as my assignee.

This is an assignment of rights only, and is not a delegation of any of my duties under the subject insurance policy. I understand that I remain fully responsible for payment for all expenses incurred for medical and diagnostic treatment, regardless of payment, partial payment or denial of payment by my insurance company.

I agree that Dr. Richard Jacobs may retain any attorney he chooses to bring legal action against any insurance carrier obligated to provide benefits for services and supplies I have received, and that the attorney chosen may be different than any attorney I may have handling any claim I may have for personal injuries.

I have been given a copy of this assignment to retain for my records; I have read this assignment and I am satisfied that I fully understand the purpose and implications of executing this assignment and do so freely and voluntarily.

______________________________________ ___________________
Patient Signature Date

The undersigned, as authorized representative of Dr. Richard Jacobs accepts the assignment of benefits as set forth above.

______________________________________ ___________________
Richard Jacobs D.C. Date

Mailing address:
Jacobs Chiropractic & Wellness Center
Chiropractic Physician
Post Office Box 1103
Gulf Breeze, Florida 32562-1103

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Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I was provided a copy of the **Notice of Privacy Practices** and that I have read them or declined the opportunity to read them, and that I understand the **Notice of Privacy Practices.** I understand that this form will be placed in my patient chart and maintained for six years.

___

Patient Name (please print) Date

___

Parent, Guardian or Patientøs Legal Representative (please print)

___

Signature

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HIPAA Authorization Form

To: ___________________________ Date: ____________________

____

____

Dear Sir/Madam:

I hereby specifically authorize use or disclosure of protected health information about me to be released to Jacobs Enterprises, LLC, dba, Jacobs Chiropractic & Wellness Center, 215 Gulf Breeze Parkway, Gulf Breeze, Florida 32561.

Please be advised that there is no limitation with respect to this Authorization, and as such Jacobs Enterprise, LLC, dba, Jacobs Chiropractic & Wellness Center, should be provided any and all dental, medical, psychiatric, or other health related records of any kind from beginning of treatment to present date. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of person or facility receiving it, and would then no longer be protected by federal privacy regulations.

Furthermore, I understand that I may revoke this Authorization by notifying the above referenced addressee in writing of my desire to revoke this Release/Authorization, or otherwise automatically within seven (7) years from the date of this authorization. However, I understand that any action already taken in reliance on this Authorization cannot be reversed, and my revocation will not affect those actions. Last but not least, I understand that the medical provider to whom this authorization is furnished may not condition its treatment to me on whether or not I sign this Release/Authorization.

____
Signature

____
Printed Name

____
Date of Birth

____
Social Security Number