COMPTON CHIROPRACTIC CARE

Legal Name: _____ Prefers: _____ File #:_____

Mailing Address: _____ City/State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ E-Mail: _____

Social Security #: _____ Birthdate: ____/_____/_____ Gender: M / F

□ Married □ Single □ Separated □ Divorced □ Widowed

Spouses Name _____ Spouse Phone # _____

Emergency Contact (If not the spouse listed above): Name: _____ Phone #: _____

PRIMARY CARE PHYSICIAN

PCP Name _____ PCP Phone _____

PCP City, State: _____ Last Visit Approximately:_____

CHILD MINOR ONLY

Parents Name/DOB/SS# _____

REFERRAL INFORMATION

□ Person _____ □Phone Book □Newspaper □ Billboard □ Insurance □ Other _____

OCCUPATION

What is your **occupation**? _____ □ Full-Time □ Part-Time □ Retired

INFORMED CONSENT

Welcome to Compton Chiropractic Care, LLC offering pain management through chiropractic, physio therapy, rehabilitation, acupuncture, massage therapy, and nutritional counseling. We will strive to help restore or improve your health, but there are no guarantees or promises of improvement or complete recovery. Patients are encouraged to leave valuables at home or with an accompanying family member or friend as this Facility shall not be liable for the loss of or damage to any personal property including, but not limited to, money, credit cards, clothing, jewelry, glasses/contacts, dental devices, hearing aids, furs, documents, or any other items. Your signature below fully authorizes our staff and doctors to perform any examinations, diagnostic tests, referrals and/or treatment as we may consider medically necessary. Our office and staff are committed to providing all patients, regardless of race, color, national origin, age, sex and or sexual identity, disability, or religious or political beliefs, Language barriers; quality health care services delivered with dignity and concern. HIPAA requires that we have you read the federally governed Health Care Privacy Notice. This Notice is detailed on a separate handout which is posted in the lobby of the office or can be requested at any time. This notice will explain when, where, and why your confidential health information may be used, stored, and/or shared and is a permanent part of your medical records, which is maintained in this office. Furthermore, should you feel a violation has occurred in any way please immediately document the event in writing with one of our office managers or the Security Officer or the Civil Rights Officer. Your signature below also confirms that you have read, understand, and agree to comply with all of the terms and conditions of the Health Care Privacy Notice and all policies, consents, terms, and conditions regarding your responsibilities to this Facility and that you grant the physicians, therapists, and/or staff of this Facility to use and share your confidential health information with others in order to treat you and/or in order to arrange for payment of your bill and/or for issues that concern this Facility's operations and responsibilities. Please note that by signing below you authorize the provider to negotiate, collect and settle any claim with an insurance or third party with regard to these services (assignment of benefits). Furthermore, you understand that you will be responsible for charges not covered by your insurance. Failure to pay an outstanding balance will result in accounts being turned over to collections and the addition of $50 collection fee to any outstanding debt. Please direct any questions or concerns to a member of our staff prior to authorizing this statement. We encourage questions and/or concerns to avoid misunderstandings. Office hours allow our patients convenience to schedule appointments before and after work, as well as during lunch. Compton Chiropractic reserves the right to charge a fee of $40.00 for all missed appointments (no shows) and appointments (absent a compelling reason) that are not cancelled with a 24-hour advance notice. "No Show" fees will be billed to the patient. This fee is NOT billed to your insurance, and must be paid prior to your next appointment. Note: A photocopy of this form shall be considered as effective and valid as the original. Listed below are summaries of some key research articles that have addressed both common and rare side-effects/complications associated with chiropractic care. • Local discomfort • Headache • Radiating discomfort … • Rib Fracture •Burns (if certain types of physiotherapy are used in your treatment) •Cauda Equine Syndrome •Compromise of the vertbrobasilar artery (note that several studies have shown that patients are no more likely to suffer this side effect than when leaving their medical doctors office.)

By signing below I state that I have reviewed the informed consent, HIPPA privacy notice, assignment of benefits and office policy for Compton Chiropractic and hereby consent to care.

X _____ Date: _____

Compton Chiropractic Care, LLC

Put your family's health in our family's hands

Patient Name: _____ Date: ___/____/___

Chief Complaint: _____

Onset: (When did it happen?) _____

Mechanism of injury: (How did it happen?) _____

Palliative: (What makes the pain better?) _____

Provocative: (What makes the pain worse?) _____

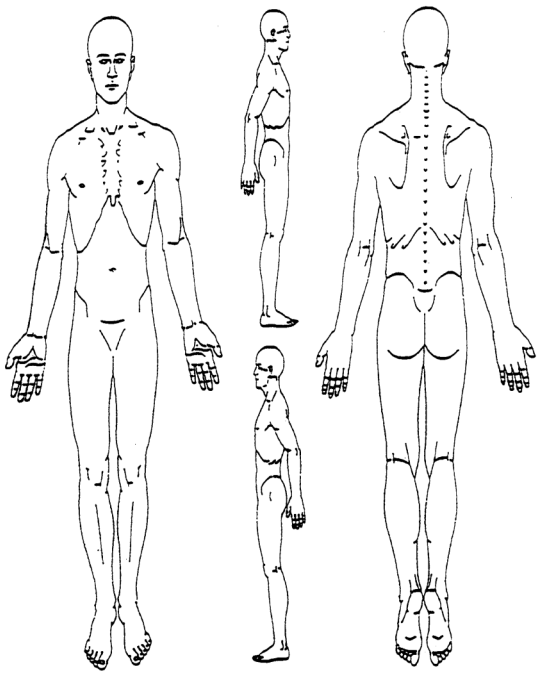
Prior Treatment: (Recent visit to PCP or Specialist, etc.?.) _____

Quality: (Sharp, Burning, Achy, etc.)_____

Timing: (Is the pain worse in the morning or evening?) _____

Radiate (Does the pain travel?) :_____

Severity: Pain Now: ____/10 At its Worst:____/10



Notes :

_____

_____

The informed consent was reviewed; I hereby extend my written consent for evaluation and management from Compton Chiropractic Care, LLC, its physicians, and supporting staff.

Signature: _____ Date : _____

Office Use Only:

Past Medical History : (Since Last Visit ___/___ /____)

Vitals

Height: ___ ft ___in

Weight: _____ lbs

Temp: _____°F

BP Right: ____ /____ Pulse: ____

BP Left: ____ /____ Pulse:____

Surgery: _____

Hospital: _____

Illnesses: _____

Trauma: _____

Imaging:_____

Medications: _____

Reviewed By : _____ Dr. Initials _____

Compton Chiropractic

24 HOUR CANCELLATION AND "NO SHOW" FEE POLICY

Due to high patient demand and limited availability of appointments, we have a no show fee that requires cancellation within 24 hours of your appointment time. Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Compton Chiropractic reserves the right to charge a fee of $40.00 for all missed appointments (no shows) and appointments which (absent a compelling reason) that are not cancelled with a 24-hour advance notice. "No Show" fees will be billed to the patient. This fee is NOT billed to your insurance, and must be paid prior to your next appointment. Thank you for your understanding and cooperation as we strive to best serve the needs of all of our patients.

By signing below, you acknowledge that you have received this notice and understand this policy.

_____ _____

Patient Name Date

_____

Patient Signature

COMPTON CHIROPRACTIC CARE, LLC

11974 CR 101 SUITE 101

THE VILLAGES, FL 32162

(352) 391-9467 PH

(352) 391-9468 FAX

Patient HIPPA Authorization Form (OPTIONAL)

The department of Health and Human Services has established a "Privacy & Security Rule" to help insure that all patients' personal health information is protected. The Privacy Rule was also created in order to provide a standard for healthcare providers to obtain their patients' previous health history.

As our patient, we want you to know that we respect the privacy of all of your personal health records and will do all we can to secure and protect your privacy.

There are times when you may wish for other family members/friends to inquire about your appointments or have access to your medical and/or billing information. We will ONLY release information to those listed below.

Information to be Disclosed (Please check all that apply)

- ☐ Medical Information (diagnoses, treatment, etc.)
- ☐ Billing (insurance claims, payments, etc.)
- ☐ Scheduling and Appointment Changes

Please list anyone that you wish to have access to our records and have authorization to change or make appointments on your behalf at or office.

1. _____ Relation: _____
2. _____ Relation: _____
3. _____ Relation: _____
4. _____ Relation: _____

I understand that I may revoke this authorization at any time.

Name _____ Signature _____ Date _____

Office Use ONLY: VALID FROM 01/01/20___ TO 12/31/20___