COMPTON CHIROPRACTIC CARE NEW PATIENT INFORMATION

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

Who recommended you to our office?

□ 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.
11974 C.R. 101 Suite 101
The Villages, FL 32162
Ph: (352) 391—9467

Chart # _____

Patient Name: _____

SYMPTOMS SURVEY

What is your **main** problem or symptoms? _____

What **caused** the problem or symptoms to occur? *(ex: Accident? Fall?)* _____

When did the problem or symptoms begin? *(ex: Date ?)* _____

What makes the problem: **Better** *(ex: Ice? Heat?)* _____ **Worse** *(ex: Golf, Bending over)* _____

Please **describe** the pain: ☐ Sharp ☐ Dull ☐ Achy ☐ Burning ☐ Stiff ☐ Numb Other:_____

Does the pain **travel or radiate**? ☐ No ☐ Yes If yes, Where?_____

Severity of your pain **Currently**: *(circle)* No pain (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) Extreme pain

Severity of pain **at the worst**: *(circle)* No pain (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) Extreme pain

Have you seen **another doctor** for this problem? ☐ No ☐ Yes If yes, who _____ When:_____

What **imaging/tests/procedures** have been performed? ☐ X-Ray ☐ MRI ☐ Surgery ☐ Hospitalization ☐ _____

Does the pain **wake you at night** from a sound sleep? ☐ No ☐ Yes If yes, explain _____

List **current medical conditions** whether controlled with medications or not *(ex: diabetes, high blood pressure, cancer)*:

_____

_____

List **past surgical procedures** performed **with** dates of procedure: *(ex: tonsillectomy, wisdom teeth removed)*:

_____

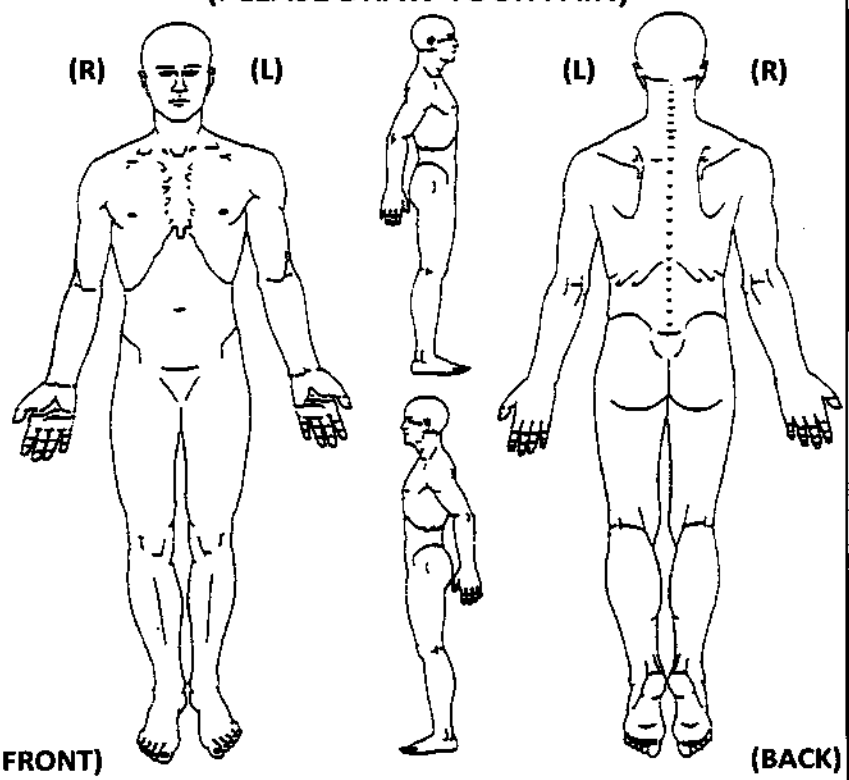
_____

Alcohol use: (Circle One): <2 Drinks Every Day / > 2 Drinks Every Day/ Occasional / Social / None

Smoking Status: (Circle One): Every Day Smoker/Occasional Smoker/Former Smoker/Never Smoked

Family History: Any serious family health conditions?_____

(PLEASE DRAW YOUR PAIN)



Current Medications:

Medication Name	Dosage

Medication Allergies:

Medication Name	Reaction

For Office Use Only:

Height: _____ **Temp:** _____ **Weight:** _____

BP (Right): _____/_____ **Pulse** _____

BP (Left): _____/_____ **Pulse:** _____

Compton Chiropractic Care, LLC.
11974 C.R. 101 Suite 101
The Villages, FL 32162
Ph: (352) 391—9467

Chart # _____

Patient Name: _____

PLEASE INDICATE BELOW, ARE YOUR **CURRENTLY** EXPERIENCING ANY OF THESE SYMPTOMS

General, Constitutional
Good general health lately _____ no yes
Recent weight change _____ no yes
Fever _____ no yes
Fatigue _____ no yes

Eyes and Vision
Eye disease or injury _____ no yes
Wear glasses or contact lenses _____ no yes
Blurred or double vision **(circle which)** _____ no yes
Glaucoma _____ no yes

Ears, Nose and Throat
Hearing loss _____ no yes
Ringing in the ears _____ no yes
Earaches or drainage _____ no yes
Sinus problems _____ no yes
Nose bleeds _____ no yes
Mouth sores _____ no yes
Bleeding gums _____ no yes
Bad breath or bad taste _____ no yes
Sore throat or voice change _____ no yes
Swollen glands in neck _____ no yes

Heart and Cardiovascular
Heart trouble _____ no yes
Chest pains _____ no yes
Sudden heartbeat changes _____ no yes
Swelling of feet, ankles, hands **(circle which)** _____ no yes

Respiratory
Frequent coughing _____ no yes
Spitting up blood _____ no yes
Shortness of breath _____ no yes
Asthma or wheezing **(circle which)** _____ no yes

Gastrointestinal
Loss of appetite _____ no yes
Change in bowel movements _____ no yes
Nausea or vomiting _____ no yes
Frequent diarrhea _____ no yes
Painful bowel movements or constipation **(circle which)** _____ no yes
Blood in Stool _____ no yes
Stomach pain _____ no yes

Genitourinary
Frequent urination _____ no yes
Burning or painful urination **(circle which)** _____ no yes
Blood in urine _____ no yes
Change in force or strain with urination _____ no yes
Incontinence or dribbling _____ no yes
Kidney stones _____ no yes
Sexual difficulty _____ no yes
Painful periods _____ no yes
Irregular periods _____ no yes
Vaginal discharge _____ no yes

Musculoskeletal
Joint pain _____ no yes
Joint stiffness _____ no yes
Joint swelling _____ no yes
Weakness of muscles/joints **(circle which)** _____ no yes
Muscle pain or cramps **(circle which)** _____ no yes
Back pain _____ no yes
Cold extremities _____ no yes
Difficulty in walking _____ no yes

Skin and Breasts
Rash or itching _____ no yes
Change in skin color _____ no yes
Change in hair or nails _____ no yes
Varicose veins _____ no yes
Breast pain _____ no yes
Breast lump _____ no yes
Breast discharge _____ no yes

Neurological
Frequent or recurrent headaches _____ no yes
Light headed or dizzy **(circle which)** _____ no yes
Convulsions or seizures **(circle which)** _____ no yes
Numbness or tingling sensations **(circle which)** _____ no yes
Tremors _____ no yes
Paralysis _____ no yes
Stroke _____ no yes
Head Injury

Psychiatric
Memory loss or confusion **(circle which)** _____ no yes
Nervousness _____ no yes
Depression _____ no yes
Sleep problems _____ no yes

Endocrine
Glandular or hormone problem _____ no yes
Thyroid disease _____ no yes
Diabetes _____ no yes
Excessive thirst or urination _____ no yes
Heat or cold intolerance **(circle which)** _____ no yes
Dry skin _____ no yes
Change in hat or glove size _____ no yes

Hematologic/Lymphatic
Slow to heal after cuts _____ no yes
Easily bruise or bleed _____ no yes
Anemia _____ no yes
Phlebitis _____ no yes
Transfusion _____ no yes
Swollen glands _____ no yes

If you have not had a hysterectomy, please give the date of your last menstrual period _____

Patient Sign Here: _____

Physician/PA Sign Here: _____

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 _____

CONFIDENTIAL

Office Use ONLY: VALID FROM 01/01/2021 TO 12/31/2021

Patient Name : _____ Chart No. _____

Accident Report

Date of Accident: _____

☐ Driver ☐ Passenger (Front Seat / Back Seat) ☐ Pedestrian

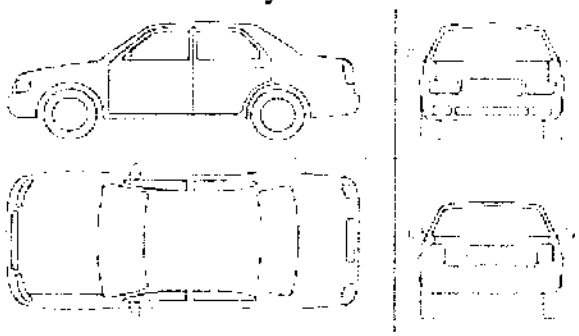
Year/Make/Model of **Your Vehicle**: _____

Year/Make/Model of **Other Vehicle**: _____

Position of Vehicle:

☐ Stopped ☐ Proceeding Along ☐ Turning (Left / Right)

Mark X where your Vehicle was hit



Location of Accident: _____ Time: _____

Visibility: ☐ Poor ☐ Fair ☐ Good Weather: ☐ Clear ☐ Rainy ☐ Windy ☐ Foggy

Who Struck Whom: _____ Estimated Speed: _____

Damage to Vehicle: ☐ Mild ☐ Moderate ☐ Extensive ☐ Totaled

Was the Vehicle Driven Away or Towed Away? _____

Direction of Your Head: ☐ Forward ☐ Left ☐ Right Wearing Seatbelt? ☐ Yes ☐ No

Did Airbags Deploy? ☐ Yes ☐ No Did you see the Accident Coming? ☐ Yes ☐ No

Braced for Impact? ☐ Yes ☐ No Did you Lose Consciousness? ☐ Yes ☐ No

Taken to the Hospital? ☐ Yes ☐ No Police Report Completed? ☐ Yes ☐ No

Who Received a Ticket? _____ Have you Returned to Work? ☐ Yes ☐ No

Have you experienced any problems since the Accident? _____

_____

_____

Patient Signature: _____ Date: _____

ASSIGNMENT OF BENEFITS, AUTHORIZATION TO SETTLE CLAIM AND DIRECTION TO PAY MEDICAL PROVIDER DIRECTLY

By my signature below, for good and valuable consideration (including but not limited to the extension of credit to me), I hereby assign, transfer and convey to COMPTON CHIROPRACTIC CARE, LLC (hereinafter "the Provider") all of my rights, title and interest in and to medical expense reimbursement in whatever form, including but not limited to any automobile liability medical expense payments or other health benefits indemnification and/or agreement otherwise payable to me. This payment shall not exceed my indebtedness to the above named assignee and I acknowledge that I will timely pay any indebtedness owed by me to the assignee that is not otherwise satisfied by the above-mentioned assigned proceeds. I also acknowledge that any medical expenses not covered under my insurance policy will be my responsibility. I further authorize the Provider to negotiate, collect and settle any claim with any insurance carrier or other third party payor with regard to these services, which authorization shall include authority to: (1) request and receive from any insurer or any other party any and all documentation and records that I am empowered to request regarding this claim, including, without limitation, a statement of coverage, policy declarations page and insurance policy pursuant to Section 627.4137. In addition, the provider has the authority to request and receive any Independent Medical Examination Reports, notices sent to me regarding appointments for Independent Medical Examinations and Examinations Under Oath (including proof of mail), Records Review Reports, coverage denial letters, Explanations of Benefits, and Benefit Payment Sheets or Logs (P.I.P. Payout Sheets), without regard as to whether such documentation has already been provided to me and, (2) to endorse in my name any check issued for payment where benefits were assigned. By way of this assignment and notice, I further instruct you, the insurer, to furnish to Provider copies of all future notices affecting Provider's interest in this claim, including, without limitation, any notices of requested medical examinations or statements. The Provider hereby objects to any reductions or partial payments. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by the provider shall be done so under protest, at the risk of the insurer, and the deposit *shall not* be deemed a *waiver, accord, satisfaction,* discharge, settlement or agreement by the provider to accept a reduced amount as payment in full. I further direct my insurer to direct all payments for services rendered by the Provider directly to Provider at the billing address contained on Provider's medical bills.

THIS IS A DIRECT AND IRREVOCABLE ASSIGNMENT OF MY RIGHTS AND BENEFITS.

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

I have read the foregoing and understand and agree to each of the above provisions:

_____ _____

Patient Date

OFFICE OF INSURANCE REGULATION
Bureau of Property & Casualty Forms and Rates

Standard Disclosure and Acknowledgement Form
Personal Injury Protection - Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

1. The services or treatment set forth below were **actually rendered.** This means that those services have **already been provided.**

_____

_____

2. I have the right and the **duty to confirm** that the services have already been provided.
3. I was **not solicited** by any person to seek any services from the medical provider of the services described above.
4. The medical provider has **explained** the services to me for which payment is being claimed.
5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to $500.

Insured Person (patient receiving treatment or services) or Guardian of Insured Person:

Name *(PRINT or TYPE)* _____ Signature _____ Date _____

The undersigned licensed medical professional or medical director, if applicable, affirms the statement numbered 1 above and also:

A. I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.

B. The treatment or services rendered were explained to the insured person, or his or her guardian, **sufficiently** for that person to sign this form with informed consent.

C. The accompanying statement or bill is **properly completed** in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to **truthfully, accurately,** and in a **substantially complete** manner.

D. The coding of procedures on the accompanying statement or bill is proper. This means that **no service has been upcoded, unbundled,** or constitutes an invalid **or not medically necessary diagnostic test** as defined by Section 627.732(14) and (15), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Licensed Medical Professional Rendering Treatment/Services or Medical Director, if applicable *(Signature by his/ her own hand):*

Name *(PRINT or TYPE)* _____ Signature _____ Date _____

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of Claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234(1)(b), Florida Statutes.

Note: The **original** of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may **not** be electronically furnished. Failure to furnish this form may result in non-payment of the claim.

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Pub. 1/2004