COMPTON CHIROPRACTIC CARE | COMPTON INTERNAL MEDICINE CARE | INTERVENTIONAL PAIN INSTITUTE

11974 CR 101, STE 101 & 102

The Villages, FL 32162

(352) 391-9467 Phone (352) 391-9468 Fax

Please send the following to our office via the methods listed below:

melissa@comptoncarefl.com

Fax (352) 391-9468

- Picture of Drivers License and Insurance Cards (front and back)
- **Completed** Intake Paperwork
- Recent lab work, imaging, or other testing please send report.
- Please send copies all reports to melissa@comptoncarefl.com

Failure to have all Intake paperwork COMPLETED PRIOR to your appointment time may result in your appointment being rescheduled.

Please contact the office if you have any questions

(352) 391-9467

AFTER HOURS PHONE NUMBER FOR URGENT MATTERS ONLY

(SEE OFFICE POLICIES FOR DETAILS) (352) 461-8406

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COMPTON CHIROPRACTIC CARE

Legal Name: _____ Prefers: _____ Gender: M / F

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

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

Social Security #: _____ Birthdate: ____/_____/_____ □ Married □ Single □ Widowed □ Divorced

Emergency Contact : _____ Contact Number : _____

PCP Name: _____ Preferred Pharmacy & Location:_____

Other Specialists: _____

Consent to Treat

_____ **Initials**

I hereby voluntarily consent to all healthcare services ordered/provided by our office. The health care ser vice may include, without limitation, routine physical and mental assessment; diagnostic and monitoring tests and procedures; examinations and medical treatment; routine laboratory procedures and test; x-rays and other imaging studies; administration of medications; and alternative healthcare prescribed by the center's healthcare providers. The health care services also may include counseling necessary to receive appropriate services. I consent to examinations, treatments, procedures and blood test ordered by the healthcare provider, which may include blood test for diseases such as hepatitis and HIV AIDS. I understand that if this consent is being signed on behalf of a minor, I may be required to sign a separate paternal consent form in order for the minor to receive family planning services. I understand that there are certain hazards and risks connected with all forms of treatment, and my consent is given knowing this. I understand that this consent is valid and remains in effect until I withdraw my consent, which may be done in writing at any time or until the center changes its services and ask me to complete a new consent form.

Consent Provisions

_____ **Initials**

My initials on this form indicate that: 1. I certify that I have read and fully understand the foregoing consent and that the facts indicated above are true. 2. I realize that although every effort will be made to keep all risks and side effects to a minimum, risks, side effects, and complications can be unpredictable both in nature and severity. 3. I understand that Resident Physicians and other Licensed Healthcare Practitioners may be involved in treatment and I consent there to. 4. I understand that midlevel providers (Physicians Assistants and Advanced Practice Registered Nurses) may be involved in treatment and I consent there to. 5. I understand that I may be asked to sign a separate informed consent form for certain treatment/procedure (s) that require such. 6. I hereby voluntarily give my consent to treatment at our office.

Consent to Bill Insurance and Collect Payment

_____ **Initials**

I understand and agree that health insurance coverage is an agreement between the insurance carrier and myself. I understand that our office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amounts authorized will be paid directly to our office. However, I clearly understand and agree that all services provided to me are charged directly to me and that I am personally responsible for payment. I authorized said office to furnish information to insurance carriers concerning my illness and treatments. I acknowledge my responsibility to pay for that care according to the fees established. In the event that the patient is a minor, I am the parent and/ or guardian of said patient and I agree that I am responsible for all services provided to the patient herein. HIPAA Acknowledgement of Privacy Practices I have received a copy of our offices "Notice of Client Privacy Rights." This Notice details the various rights granted to me, the patient, under the Health Insurance Portability and Accountability Act.

Patient Name _____ Patient Signature _____ Date _____

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COMPTON CHIROPRACTIC CARE

Office Policies

It is our mission to efficiently provide high-quality, comprehensive, medical care to you—our valued patient. To achieve this goal we request all patients adhere to the following administrative policies.

Your cooperation is greatly appreciated. Non-compliance with the practice policies may result in fees as stated below.

Please be prepared to arrive 15 minutes prior to your appointment time. If you arrive **5 minutes past** your scheduled time it will be considered a miss and your appointment will be rescheduled.

Fee Policies

1. If you cannot keep an appointment, you are responsible for notifying the office a minimum of 24 hours in advance. **Fee for missed appointment without notifying office.** _____ **$40.00**
2. We accept cash, check, credit, and debit cards. **Returned check fee** _____ **$35.00**
3. Unaddressed overdue bills of 120+ days will be sent to collections. **Collection Fee** _____ **$50.00**
4. FORMS— Completion of health forms requiring a physician signature **Form Fee** _____ **$10.00**
5. Credit Card Processing Fee. 3.5 % **Processing fee** applied to all terminal transactions _____ **3.5%**

Insurance Referrals

- If your insurance requires a referral it is your responsibility to make sure it is on file with our office and your responsibility to manage the approved treatment limits.

I have read, understand, and agree to the above office policies.

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COMPTON CHIROPRACTIC CARE

Patient Name: _____ Date: ___/___/___

CHIEF COMPLAINT ** ALL FIELDS REQUIRED**

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?) _____

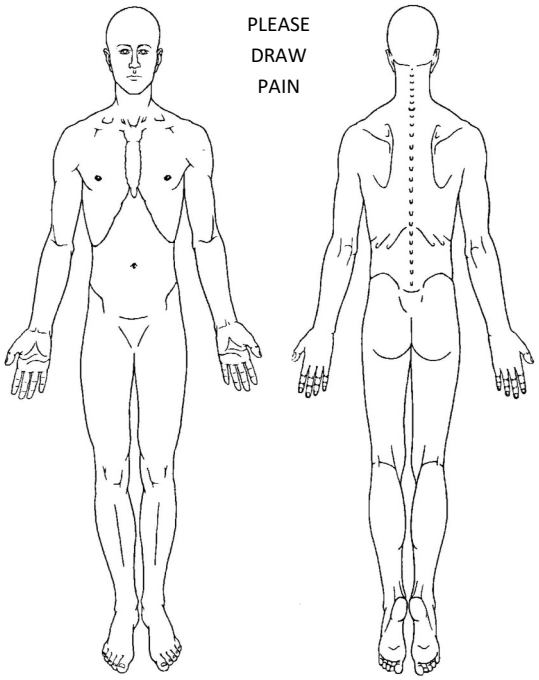
Quality: (Sharp, Burning, Achy, etc.)_____

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

Radiate (Does the pain travel?) :_____

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

PLEASE DRAW PAIN



Prior Treatment: ANSWER YES, NO, CURRENTLY ACTIVE AND WAS IT HELPFUL

Home Exercises: _____

Physical Therapy: _____

Chiropractic: _____

Failed Medications: _____

Effective Medications: _____

Pain Treatments, Injections, Surgeries: _____

_____

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Patient Name: _____ Date: _____

WELLNESS SCREENING HISTORY : DATE

Wellness/Routine Physical Exam	
Colonoscopy	
Mammogram	
DEXA (Bone Density) Scan	
Pap Smear	
PSA	
Hepatitis C Screening	
Diabetic Eye Exam	

ADULT VACCINATION/IMMUNIAZTION HISTORY

TETANUS	
TDAP	
PREVINAR 13	
ZOSTER	
SHINGLES	
PNEUMOVAX 23	

Social/History

Tobacco: □ Never □ Prior Use: Quit Date: _____

Alcohol: □ None □ Social □ Daily; Drinks per week _____

Same sex intercourse: □ Yes □ No

Family Medical History: Father: _____ Mother: _____

Occupation: _____

HEALTH HISTORY—HAVE YOU BEEN DIAGNOSED WITH ANY OF THE FOLLOWING? **Reconciled □**

□ Measles/Mumps	□ Gout	□ Seizures/Epilepsy	□ Bone/Joint Disorder	□ Pneumonia
□ Chicken Pox	□ Stomach Ulcer	□ Parkinson's Disease	□ Eye Disease	□ Asthma
□ Rheumatic Fever	□ Reflux Disease	□ Multiple Sclerosis	□ Glaucoma	□ Seasonal Allergies
□ Scarlett Fever	□ Gall Bladder Issues	□ High Blood Pressure	□ Kidney Disease	□ Emphysema/COPD
□ Polio	□ Pancreatitis	□ Stroke/TIA	□ Kidney Stone	□ Pulmonary Clotting
□ Lyme Disease	□ Colitis	□ Heart Disease/CAD	□ Urinary Disorders	□ Depression
□ Tuberculosis	□ Diverticulitis	□ Heart Attack	□ Erectile Dysfunction	□ Anxiety
□ Diabetes	□ Irritable Bowel	□ Heart Murmur	□ Prostate Disease	□ Eating Disorder
□ Sleep Apnea	□ Hepatitis	□ Heart Failure	□ Reproductive Issues	□ Psychiatric Care
□ Anemia	□ Liver Disease	□ High Cholesterol	□ Menstrual Problems	□ Drug Addiction
□ Bleeding Disorder	□ Thyroid Disease	□ Arthritis	□ Vaginal Infection	□ Alcoholism
□ Blood Clots	□ Migraines/Headaches	□ Osteoporosis	□ Breast Lump	□ Sexual Dysfunction
□ Cancer _____	□ Auto Immune Disease _____	□ Peripheral Vascular Disease	□ Skin Disease _____	□ STD _____

OFFICE USE ONLY: Vitals: Ht _____ Wgt _____ PO% _____ BP (rt)_____ P _____ BP (lt) _____ P _____ Temp_____

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HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

1. Authorization

   I _____authorize the above office to Obtain/Release medical information via mail, facsimile, or other appropriate secure means to:

   □ Other healthcare providers involved in my care or to be involved
   □ My Attorney
   □ Family/Friend: _____, _____, _____,
   □ Other: _____

2. Consent to view prescription history (PMP)
   Consent to view imaging, notes, test results from outside facilities
   Consent to communicate with patient via secure email or text for reminders and information

3. **Effective Period**: This authorization for release of information covers the period of healthcare from All past, present and future periods unless otherwise stated here: _____

4. Extent of Authorization

   ☑ I authorize the release of my **complete** health record (including records relating to mental healthcare, communicable diseases, HIV/AIDS and treatment of alcohol/drug abuse)

   I authorize the release of my complete health record with the **exception** of the following:

   □ Mental health records
   □ Alcohol/drug abuse treatment
   □ Diagnosis/appointments
   □ Communicable diseases (including HIV and AIDS)
   □ Other (please specify): _____
   □ Billing

5. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.
6. I understand that I have the right to revoke this authorization, **in writing**, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to consent a claim.
7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Patient Name _____ Patient Signature _____ Date _____

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Full Name: _____ DOB: _____

Medication History

Please list all medications you are currently taking, including prescription drugs, over-the-counter drugs, and dietary supplements.

1. Medication Name: _____ Dosage: _____ Frequency: _____
2. Medication Name: _____ Dosage: _____ Frequency: _____
3. Medication Name: _____ Dosage: _____ Frequency: _____
4. Medication Name: _____ Dosage: _____ Frequency: _____
5. Medication Name: _____ Dosage: _____ Frequency: _____
6. Medication Name: _____ Dosage: _____ Frequency: _____
7. Medication Name: _____ Dosage: _____ Frequency: _____
8. Medication Name: _____ Dosage: _____ Frequency: _____
9. Medication Name: _____ Dosage: _____ Frequency: _____
10. Medication Name: _____ Dosage: _____ Frequency: _____

Allergy Information

Please list any known allergies to medications, food, or other substances.

1. Allergen: _____ Reaction: _____
2. Allergen: _____ Reaction: _____
3. Allergen: _____ Reaction: _____

□ No known drug allergies

Surgical History

Please list any surgeries or major medical procedures you have undergone.

1. Surgery/Procedure: _____ Date: _____
2. Surgery/Procedure: _____ Date: _____
3. Surgery/Procedure: _____ Date: _____
4. Surgery/Procedure: _____ Date: _____

(Attach additional sheet if necessary)