Patient Health History

Today's Date [. .] **Signature of Patient** _____

Patient Title: *(check one)* ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. ❑ Prof. ❑ Rev.

First Name _____ **Nick Name** _____

Last Name _____ **Middle Name** _____ **Suffix** _____

Address 1 _____

Address 2 _____

City _____ **State** _____ **Zip Code** _____

Primary Phone _____ **Secondary Phone** _____

Referred By: _____

_____

_____

Home email _____ **Work Email** _____

By providing my email address, I authorize my doctor to contact me via the email address(es) provided.

Which email address would you like us to use to communicate with you? *(check one)* ❑ Home ❑ Work

Contact Method *(check one)*

❑ Primary Phone ❑ Secondary Phone ❑ Mobile Phone ❑ Home Email ❑ Work Email

Date of Birth [. .] **Age** _____ **Gender** *(check one)* ❑ Male ❑ Female ❑ Unspecified

Marital Status *(check one)* ❑ Single ❑ Married ❑ Other **SSN** _____

Employment Status *(check one)*

❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed

Race *(check one)*

❑ White ❑ Black/African American ❑ Hispanic ❑ American Indian/Alaskan Native
❑ Asian ❑ Asian Indian ❑ Chinese ❑ Filipino
❑ Japanese ❑ Korean ❑ Vietnamese ❑ Native Hawaiian or other Pacific Island
❑ Samoan ❑ Guamanian or Chamorro ❑ Other_____ ❑ I choose not to specify

Multi-Racial *(check one)* ❑ Yes ❑ No ❑ Unknown

Ethnicity *(check one)* ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ I choose not to specify

Preferred Language *(check one)*

❑ English ❑ Spanish ❑ American Sign Language ❑ Chinese ❑ French ❑ German
❑ Tagalog ❑ Vietnamese ❑ Italian ❑ Korean ❑ Russian ❑ Polish
❑ Arabic ❑ Portuguese ❑ Japanese ❑ French Creole ❑ Greek ❑ Hindi
❑ Persian ❑ Urdu ❑ Gujarati ❑ Armenian ❑ I choose not to specify

Continued ...

Verification Question *(choose only one question by circling the question, then give the answer to that question)*

❑ What is the name of your favorite pet? ❑ In what city were you born? ❑ What high school did you attend?
❑ What is your favorite movie? ❑ What is your mother's maiden name? ❑ On what street did you grow up?
❑ What was the make of your first car? ❑ When is your anniversary?

Verification Answer to the Chosen question: _____
Answers must be at least 6 characters.

Do you currently smoke tobacco of any kind? ❑ Yes ❑ Former smoker ❑ Never been a smoker

If yes, how often do you smoke: ❑ Current every day smoker ❑ Current sometimes smoker

If yes, what is your level of interest in quitting smoking?

❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10
No interest *Very Interested*

Current medications, including frequency and dosage if known. If there are no current medications, check here: ❑

		Dosage
1)		
2)		
3)		
4)		
5)		
6)		
7)		
8)		

List any known allergies you have had to any medications.
If no allergies are known, check here: ❑

1) _____ **3)** _____

2) _____ **4)** _____

Briefly list your main health problems: _____

_____

Has any doctor diagnosed you with Hypertension presently? ❑ Yes ❑ No If yes, describe: _____

_____

Has any doctor diagnosed you with Diabetes presently? ❑ Yes ❑ No If yes, what kind? ❑ Type I ❑ Type II

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%? ❑ Yes ❑ No ❑ Not Sure

If yes, other comments regarding Diabetes: _____

Have you had an X-ray or CT scan or MRI of your <u>low back</u> spine in the past 28 days? ❑ Yes ❑ No

To be performed by clinic staff:

Height: _____inches **Weight:** _____ pounds **BP:** _____ / _____

Cape Coral Chiropractic And Massage Center
HIPAA OMNIBUS RULE

Authorization for Disclosure of Health Information

Patient Name: _____ Date of Birth: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____ Member I.D.# _____

I authorize the release of the following protected health information:

□ Office Notes /Name of Physician_____

□ Radiology Reports □ Laboratory Reports Date(s): _____

□ Other: _____ □ Paper Copy □ Electronic Copy

The purpose for this request to release medical information is:

□ Medical Care / Treatment □ Insurance □ Other (specify)_____

Send my medical information to: Name: _____

Address: _____ City: _____ State: ____ Zip: _____

I understand that:

- By signing this form, I am authorizing the use or disclosure of protected health information as indicated above.
- I may refuse to sign this authorization, which will not affect my treatment or payment for health care.
- I may revoke this authorization at any time by submitting a request in writing to the office Compliance Officer. Revoking this authorization will not affect any action taken prior to receipt of your written request.
- If the receiving party is not subject to medical records privacy laws, the information may be re-disclosed by the recipient and may no longer be protected by federal or state law. This office shall not be held liable for any consequences resulting from re-disclosure
- If the information to be released contains any information about HIV/AIDS an additional HIPAA release of medical information for will be requested.
- Alcohol or substance abuse, mental health or psychiatry notes may have additional compliance requirements that must be met before the information can be released. A copy of this signed form will be provided to me.
- The Office may charge an administrative fee to cover the cost of labor, copying, and postage. The physician's office will inform me of any charges and arrange for payment.

This Authorization expires on __ / / __ or if date not completed / one year after signed.

_____ _____

Patient / Representative Signature Date

_____/ _____

Print Name and Relationship to patient if minor or unable to sign

[Retain this form in the patient's medical record and provide a copy to the patient]

Cape Coral Chiropractic And Massage Center
HIPAA OMNIBUS RULE

Patient Acknowledgement of Receipt of Notice of Privacy Practices

Print Patient Name: _____

I acknowledge that I have been provided a copy of the currently effective Notice of Privacy. A copy of this signed, dated document shall be as effective as the original.

DATE:_____

_____
Signature of Patient or Personal Representative

_____
Signature of Witness / Office Representative

You may *refuse to sign the acknowledgement* & authorization. In refusing, this practice will not be allowed to process your insurance claims.

I acknowledge that I declined the Notice of Privacy Practices provided:

DATE:_____

_____
Signature of Patient or Personal Representative

_____
Signature of Witness / Office Representative

****

Office Use Only: I attempted to obtain written authorization of receipt of Notice of Privacy Practices, but acknowledgement could not be obtained because: ___ Individual refused to sign ___ Communication barrier ___ Emergency situation occurred with patient ___ Other (explain):_____

_____

_____
Signature of Office Representative

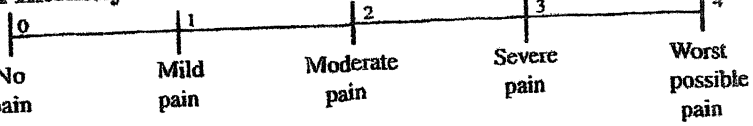
Functional Rating Index

For use with **Neck and/or Back Problems** only.

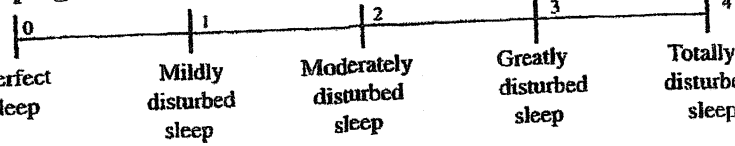
In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.

For each item below, please circle the number which most closely describes your condition right now.

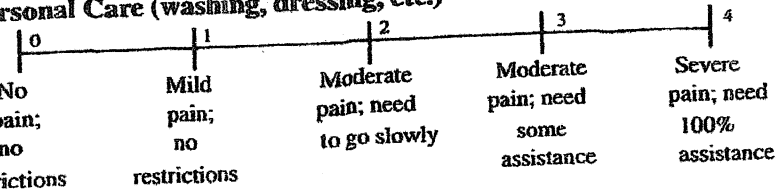
1. Pain Intensity



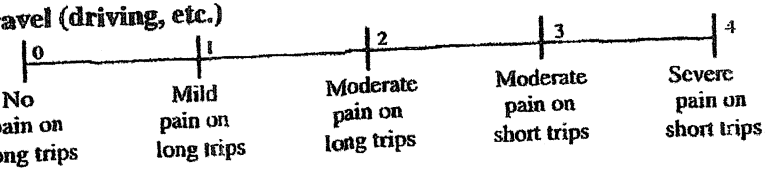
2. Sleeping



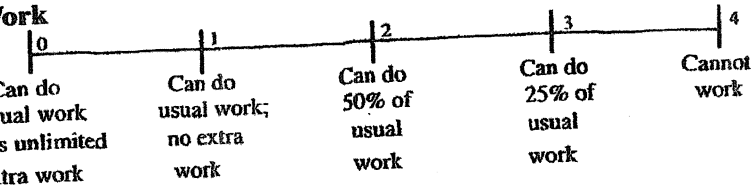
3. Personal Care (washing, dressing, etc.)



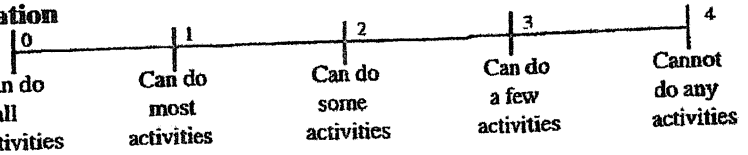
4. Travel (driving, etc.)



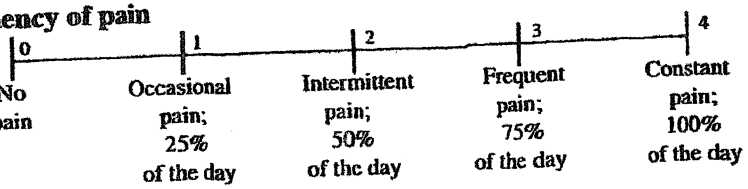
5. Work



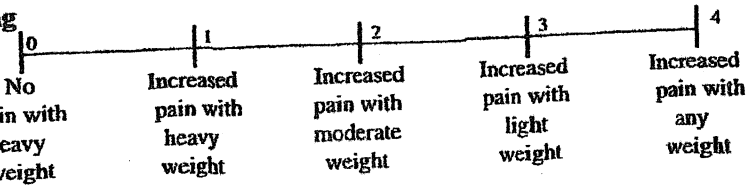
6. Recreation



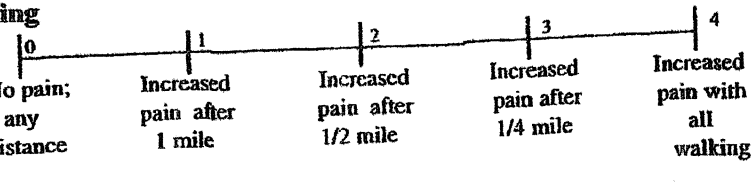
7. Frequency of pain



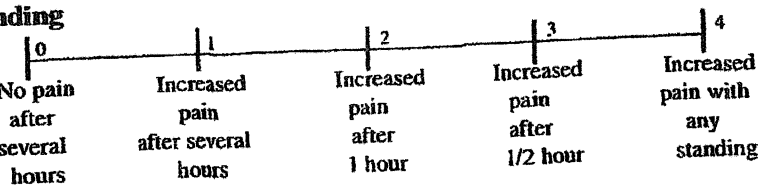
8. Lifting



9. Walking



10. Standing



Total Score _____

Name _____ **PRINTED**

_____ **Signature**

_____ **Date**

FINANCIAL AND OFFICE POLICY

We believe that a clear definition of our financial and office policies will allow both you the patient and us the doctors to concentrate on the big issue – REGAINING AND MAINTAINING YOUR HEALTH!

No treatment will be rendered until this policy has been read, understood and signed.

INSURANCE ASSIGNMENT POLICY

It is important that you realize in this office we offer the option of "INSURANCE ASSIGNMENT" strictly as a courtesy to our patients, and as such our patients must understand and agree to the following:

1. That you are considered a cash patient until your insurance can be verified.
2. That you are ultimately responsible for full payment of any and all services rendered.
3. That you must pay all deductibles in full.
4. That co-insurance must be paid at the time of service. The co-payment must never exceed **$150.00** at any one time. Care will be suspended until said balance is taken care of.
5. That if your insurance company has not paid a claim within 60 days of submission, you are responsible to take an active part in the recovery of your claim and that after 90 days you will be responsible for payment in full of any outstanding balance.

CASH PATIENT POLICY

1. Payment is required for services on the day they are rendered.
2. The balance on your account can not exceed **$150.00** at any time during your course of treatment. If this occurs your course of treatment will have to be suspended until the balance is brought in line with this policy.
3. **All unpaid balances that have not had a payment received within sixty (60) days, will be collected through an outside agency.**

This **insurance** and **cash** policy must be followed and we ask that you sign this form as acknowledgment that our policy was explained to you, that you understand it and that you accept full responsibility.

Signature Date

LARRY D JOHNSON DC, LLC
1510 Hancock Bridge Pkwy #6
Cape Coral, FL 33990

Consent for Purposes of Treatment, Payment & Healthcare Operations (3/03)

In this document, "I" and "my" refer to the patient, and "Chiropractor" refers to Larry D Johnson DC, LLC. I consent to the use or disclosure of my protected health information by Chiropractor for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Chiropractor. I understand that analysis, diagnosis or treatment of me by Chiropractor may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Chiropractor is not required to agree to the restrictions that I may request. However, if Chiropractor agrees to a restriction that I request, the restriction is binding on Chiropractor.

I have the right to revoke this consent, in writing, at any time, except to the extent that Chiropractor has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of Chiropractor and understand that I have a right to view the Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Chiropractor. The Notice of Privacy Practices for Chiropractor is also available in the waiting room at 1510 Hancock Bridge Pkwy, Unit 6 Cape Coral, FL. This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information.

Chiropractor reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Chiropractor and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Signature of Patient or Personal Representative | Printed Name of Patient

_____ _____

Date of Signing | Description of Personal Representative's Authority

Activator Technique

By Zeel Editorial Staff, Last updated: September 28, 2012

The Activator Method is a low-force chiropractic technique—and one of the top two most commonly used or around the world at that. More than 70 percent of all chiropractors utilize The Activator Method in their practice.

The Activator Method draws upon orthopedic, neurological and chiropractic research to treat joint proble located in the spine and extremities (think the wrists, knees, ankles, etc.). It is based on the theory that analysis of the length of a patient's legs, as well as the activity of the spine and extremities, can determ whether or not a chiropractic adjustment is necessary. Considered a low-force chiropractic modality, treatmen carried out through the use of a device called an Activator Adjusting Instrument®.

The origins of activator technique: The Activator Method Chiropractic Technique® is the brainchild of founder Dr. Arlan W. Fuhr, DC. He is the co-inventor of the Activator Adjusting Instrument®.

Ongoing research continues as to how the Activator protocol can be used to address TMJ, inflammation, lun disc herniation, neurological conditions and other dysfunctions that may be effectively treated through this force chiropractic adjustment method. The Activator Method may be especially useful for geriatric and pedi patients.

The patient first lies face down in a prone position on an examination table. The attending chiropractor compare the lengths of the patient's legs and test specific points along the spine and pelvis, lookinç inequalities and imbalances (a "pelvic deficiency" or "functional short leg") in the body. A series of muscular may also be performed, in which the patient is asked to move various body parts according to the chiroprac direction, thereby activating specific muscles and joints.

Specialized equipment: The Activator Adjusting Instrument® is a specialized low-force tool that makes r adjustments to a patient's spine and the supporting structures. The hand-held device delivers a consistent along several points of the body. Each tap is considered a chiropractic adjustment.

Recommended sessions: The number of sessions required will depend on the patient's individual proble well as their wellness needs and goals. A typical adjustment session lasts approximately 15 minutes. An session, however, may take longer, as a patient history and full physical examination will often preced adjustment.

The Activator Method is considered a low-risk treatment. The low-force instrument offers a safe, relatively pa mode of chiropractic care. It does not involve twisting or joint stress.

SIGNATURE_____ DATE _____