Application For Treatment

Todays Date:____/____/____ Date of Injury: ____/____/____

Personal Information

Patient Name: _____ Preferred Name: _____

Birthdate: _____/_____/_____ Age: _____ □ Male □ Female SSN: _____/_____/_____

Mailing Address: _____City: _____State: _____ Zip: _____

Daytime Phone: _____ Mobile Phone: _____ E-mail: _____

Mobile Provider _____ Status: □ Single □ Married □ Divorced □ Widowed

Employment Information

Employment Status: □ Employed □ Unemployed □ Retired □ Disabled

Employer: _____ Occupation: _____ Work Schedule: _____

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

Reason for Visit

The reason for this visit is a result of: □ Work Injury □ Sports Injury □ Chronic Injury Other:_____

Explain what happened: _____

Please describe the pain and its location: _____

_____

When did condition begin? _____/_____/_____ Is it getting worse? □ Yes □ No □ Constant □ Comes and Goes

Does it interfere with your □ Work □ Sleep □ Daily Routine Explain: _____

Have you had this or similar conditions in the past? □ Yes □ No If yes, Explain: _____

Have you ever had treatment for this condition? □ Yes □ No

If so, where and by whom? _____

Have you ever been treated by a Chiropractor before? □ Yes □ No

If so, whom? _____

Insurance Information

Primary Insurance

Type of Insurance: (Health, Auto, etc.)_____ Insurance Company: _____

Address: _____ Phone Number: _____

Insured's Name: _____Policy Number: _____

Group # (Plan, Policy #): _____ Insured's SSN: _____

Insured's Date of Birth: _____ Insured's Employer: _____ Agent's Name: _____

Secondary Insurance

Type of Insurance: (Health, Auto, etc.)_____ Insurance Company: _____

Address: _____ Phone Number: _____

Insured's Name: _____Policy Number: _____

Group # (Plan, Policy #): _____ Insured's SSN: _____

Insured's Date of Birth: _____ Insured's Employer: _____ Agent's Name: _____

HEALTH HISTORY

Do you have or ever had any of the following conditions? (Please check all that apply).

□ Heart Attack	□ Congestive Heart Failure	□ Heart Murmur	□ Congenital Heart Defect
□ Mitral Valve Prolapse	□ Artificial Valves	□ Alcohol/Drug Abuse	□ Venereal Disease
□ Hepatitis	□ HIV+/AIDS	□ Shingles	□ Cancer
□ Frequent Neck Pain	□ Emphysema/Glaucoma	□ Anemia	□ High/Low Blood Pressure
□ Psychiatric Problems	□ Rheumatic Fever	□ Kidney Problems	□ Severe/Frequent Headaches
□ Ulcers/Colitis	□ Fainting/Seizures/Epilepsy	□ Sinus Problems	□ Asthma
□ Diabetes	□ Difficulty Breathing	□ Chemotherapy	□ Lower Back Problems
□ Artificial Bones/Joints	□ Arthritis	□ Tuberculosis	□ Other: _____

Please list any other serious medical conditions you have **or** ever had: _____

_____

Previous surgeries/treatments with dates: _____

Any past serious accidents with dates: _____

Have you ever been diagnosed with cancer? □ Yes □ No If so, what type: _____
Are you in remission? □ Yes □ No If so, how long have you been in remission? _____

Do you have any metal implants? □ Yes □ No If so, where are they? _____

Family health history: _____

_____

Do you take supplements/vitamins? □ Yes □ No If so, explain: _____

Are you taking any medications? □ Yes □ No If so, explain: _____

_____

Do you Exercise? □ Yes □ No Are you on a special diet? □ Yes □ No Since: _____/_____/_____

Do you smoke? □ Yes □ No If so, How Often? _____ How Many Years: _____ Do you drink? □ Yes □ No If so, how often: _____

Do you wear: □ Heel Lifts □ Sole Lifts □ Inner Soles □ Arch Supports Are you: □ Left Handed □ Right Handed

What is the age of your mattress?: _____ Is it comfortable? □ Yes □ No

Are you pregnant? □ Yes □ No How far along? _____ **Do you have a pacemaker? □ Yes □ No**

We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed car organization, to release any information required to process insurance claims.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature: _____ Date: _____

INFORMED CONSENT FOR TREATMENT

I hereby request consent to the performance of the chiropractic adjustments and other chiropractic procedures, to include, but not limited to, various modes of physical therapy and diagnostic x-rays, on me (or on the patient below, for whom I am legally responsible) by the doctor of chiropractic name below and/or other licensed doctors of chiropractic now or in the future treat me while employed by, working, or associated with, or serving as backup for the chiropractor name below, including those working at the clinic or office listed below or any other office or clinic associated with ***Florida Spine & Injury Institute***

I have had an opportunity to discuss with the doctor of chiropractic name below the nature and purpose of chiropractic adjustments at other procedures. I understand that results are not guaranteed.

I understand and am informed that as in the practice of medicine, the practice of chiropractic there are some risks to treatment including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain, all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels that time, based upon the facts then known, is in my best interests. Alternative treatments may include: medication, surgery, or physical therapy procedures. As with any of these alternative procedures there are risks. If no treatment is sought, your condition could get worse, remained the same, or improve.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about this consent, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition. A new condition or other than what I had been treated for will be explained to me and a new consent will be signed.

Patient's signature:_____ Date:_____

To be completed by patient's representative if patient is a minor or is physically or mentally incapacitated

Name of Patient:_____

Doctors signature:_____ _____ D.C Date:_____

FLORIDA SPINE & INJURY INSTITUTE
MOHAMMAD M. HAMTAEE D.C.

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Lakeland, Florida 33803

PHONE: (863) 688-2200
FAX: (863) 688-2210

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT NAME: _____ Social Security #_____

DATE OF BIRTH:_____ Medical record #_____

I hereby authorize the use or disclosure of the Protected Health Information described below to be provided to or obtained by the following:

Name and Address of Individual/Facility/Company to Receive PHI	Name and Address of Individual/Facility to Disclose PHI
_____	_____
_____	_____
_____	_____

Information authorized for use or disclosure, or to be obtained:

☐History & Physical ☐Discharge Summary ☐Operative Report ☐ER Record ☐Consultation ☐Lab reports

☐Progress Notes ☐**X**-ray reports ☐Other_____

☐Medical information between _____ to _____

The information will be obtained, used, or disclosed for the **following purpose** only:

☐Insurance ☐Continued treatment ☐Legal ☐At the request of the patient or patient's representative

☐Other (specify) _____

I understand:

- I may revoke this authorization at any time, in writing, except revocation will not apply to information already retained, used or disclosed in response to this authorization. I may revoke this document by presenting my written revocation as provided in the Notice of Privacy Rights. Unless revoked, the automatic expiration date will be six (6) months from date of signature or upon occurrence of the following event:_____.
- I release the entities listed above, their agents and employees from any liability in connection with the use or disclosure of the protected health information. The entity authorized to disclose the information will not be compensated by the recipient for such disclosure. Normal applicable fees, such as copy fees, may apply.
- Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by federal law. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.
- I have the right to inspect the health information to be released, unless prohibited by law and I may refuse to sign this authorization.
- Unless the purpose of this authorization is to determine payment of a claim for benefits, the requesting entity will not condition the provision of treatment, payment, enrollment in a health plan, or eligibility for benefits on obtaining this authorization.

I understand that my medical information may indicate that I have a communicable or venereal disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and human immunodeficiency viruses also known as Acquired Immune Deficiency Syndrome (AIDS). I further understand that my medical information may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse.

_____ _____

SIGNATURE OF PATIENT DATE

_____ _____

SIGNATURE OF PERSONAL REPRESENTATIVE DATE

_____

DESCRIPTION OF REPRESENTATIVES AUTHORITY TO ACT FOR THE PATIENT

NOTICE OF RIGHTS: Information in your medical records that you have or may have a communicable or venereal disease is made confidential by law and cannot be disclosed without your permission except in limited circumstances including disclosure to persons who have had risk exposures, disclosure pursuant to an order of the court or the Department of Health, disclosure among healthcare providers or for statistical or epidemiological purposes. When such information is disclosed, it cannot contain information from which you could be identified unless disclosure of that identifying information is authorized by you, by an order of the court or the Department of Health or by law

Processed by (Print Name & Dept):_____

Original: Releasing entity Copy: Originator Copy: Patient or representative (Required)