A Chiropractic Tradition
Drs. Edwin Roberts

PLEASE PRINT

Date of appointment: _____

Name: _____ **Birth date:**_____
First Middle Last

Address: _____
Please No P. O. Boxes

_____ **Age:**_____ **Sex:** ___**F** ___**M**
City State Zip

Are you Hispanic? Yes No Preferred language:_____ **Race:**_____

E-MAIL ADDRESS: _____
By providing your e-mail address you are allowing our office to use this as a form of communication (ie: correspondence, communication or newsletters)

Home Phone _____ **Cell Phone** _____

Social Security Number_____

Employer_____ **Work Phone** _____

Who is your primary treating physician? _____

Were you referred to us? _____ **If Yes, by who?** _____

MARITAL STATUS (Please circle one) Single Married Divorced Separated

IF THE INSURANCE INFORMATION IS NOT IN YOUR NAME WE MUST HAVE THE FOLLOWING:

Whose name is the insurance under?

_____

Their address:_____

Their social security number: _____

Their date of birth:_____ **Sex: M** _____ **F** _____

What is your relationship to this person? _____

By signing this consent to treat you are also giving us permission to leave messages on your answering machine/voice mail.

Patient consent for treatment_____

Guardian consent for treatment_____

In Case of emergency, notify:_____ **Phone**_____

Name of nearest relative not living with you_____

Phone:_____ **Address:**_____

Fees at this office will be paid by: _____

PATIENT'S SIGNATURE

I will be paying today by ____ **Cash** ____ **Check** ____ **Credit Card**

A CHIROPRACTIC TRADITION

APPLICATION FOR FLOIRDA "NO FAULT" BENEFIT

Date **Policyholder** **Date of accident** **File No.**

To enable us to determine if you are entitled to benefits under the Florida automobile reparations reform act, please complete this form and return it promptly.

To: _____
Claim Department

Your Name **Phone No. Home**

Business

Your Address (Street, City, State and Zip) **DOB** **Social Security #**

Permanent Address, if different. **How long have you lived in Florida?**

Date & Time of Accident **Place of Accident (Street, City & State)**

Brief Description of Accident & Vehicles Involved.

_____

Describe automobiles owned by you or any member of your family:

Automobile	Owner	Insurer	Policy Number

As a result of this accident were you injured? Yes_____ No _____
If you answered yes, complete the rest of this form. If no, sign here and return this form to us.

Signature: _____ Date: _____

Describe your injury.

Were you treated by a doctor? _____ Date of 1st treatment: _____
Doctor's name & address: _____
If you were treated in a hospital, were you an in-patient or an out-patient_____
Hospital's Name & address: _____

_____

Amount of medical bills to date $_____
Will you have more medical expense? _____
Have you received or are you eligible for payments under Medicaid?_____

Did you lose time from work as a result of your injury?_____
If yes, amount lost to date: $_____
What is your average monthly wage or salary? $_____

If you lost wages: Date disability from work began _____
Date you returned to work _____

At the time of your accident were you working for your employer? _____

Have you received or are you eligible for payments under any workmen's compensation or unemployment law? _____ If yes, amount $_____
Per Week Per Month

Who pays you these benefits? _____
List names and addresses of your present employer(s) and give your occupation and dates of employment for each:

Employer & address Your occupation from to

Employer & address Your occupation from to

Employer & address Your occupation from to

As a result of your injury have you had any other expenses? Yes____ No ____
If yes, explain on reverse side.

Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim containing any false, incomplete or misleading information is guilty or a felony of the third degree.

I HEREBY AUTHORIZE RELEAASE OF MEDICAL INFORMATION INCLUDING, BUT NOT LIMITED TO, MEDICAL BILLS AND REPORTS TO SUCH PARTIES AS THE COMPANY MAY DEEM NECESSARY TO PERFECT ITS RIGHTS OF RECOVERY UNDER THE NO-FAULT ACT.

Signature: _____ Date: _____

Important:
1. **To be eligible for benefits complete and sign this application.**
2. **Sign attached authorization(s).**
3. **Return promptly with any medical bills you have received to date.**

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURANCE COMPANY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THIRD DEGREE.

AUTHORIZATION FOR MEDICAL INFORMATION

THIS AUTHORIZATION OF PHOTOCOPY HEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY CONDITION WHILE UNDER YOUR OBSERVATION OR TREATMENT, INCLUDING THE HISTORY OBTAINED, X-RAY AND PHYSICAL FINDINGS, DIAGNOSIS AND PROGNOSIS. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE FLORIDA "NO-FAULT" AUTO INSURANCE LAW (CHAPTER 71-252F.S.)

Signature **Date**

AUTHORIZATION FOR WAGE AND SALARY INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY HEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY WAGES OR SALARY WHILE EMPLOYED BY YOU. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE FLORIDA "NO-FAULT" AUTO INSURANCE LAW (CHAPTER 71-252F.S.).

Signature **Date**

Social Security No.: _____

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURANCE COMPANY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THIRD DEGREE.

A Chiropractic Tradition
Drs. Edwin Roberts

Please fill out this form with your symptoms you are experiencing today

Patient Name: _____ **Chart #:** _____ **Date:** _____

Subjective Complaints:

Head

Neck

( ) Headache
Same Better Worse
Pain level _____ (0-10)
( ) Dizziness
( ) Light-headed
( ) Memory Loss
( ) Tinnitus
( ) Visual Disturbance

( ) Neck Pain
Same Better Worse
Pain level _____ (0-10)
( ) Spasm
( ) Tightness/Stiffness
( ) Ref. Arm: RT LT Both
( ) Weakness in arm: RT LT Both
( ) Numbness in arm: RT LT Both

Mid Back

Low Back

( ) Mid back pain
Same Better Worse
Pain level _____ (0-10)
( ) Spasm
( ) Tightness or Stiffness
( ) Right side pain
( ) Left side pain
( ) Rib pain: RT LT Both

( ) Low back pain
Same Better Worse
Pain level _____ (0-10)
( ) Spasm
( ) Tightness or Stiffness
( ) Ref. Leg: RT LT Both
( ) Weakness in leg: RT LT Both
( ) Numbness in leg: RT LT Both

Please list any other symptoms:

Please explain what caused your pain and when it happened:

A Chiropractic Tradition
Drs. Edwin Roberts

Informed Consent

PATIENT NAME: _____ DATE: _____

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. This may cause an audible "pop" or "click" much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis/Examination/Treatment

As a part of the analysis, examination and treatment you are consenting to the following procedures:

Spinal manipulative therapy **Ultrasound** **Hot/cold packs**
Radiographic studies **Interferential** **Physical examination**
Intersegmental traction **Diatherm** **Myofascial release**
Percussion massage **Therapeutic exercise**
Other: _____
_____
____

The material risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: muscle strain, joint sprain and costovertebral strains. Some patients will feel some stiffness and soreness following the first few days of treatment. However, complications are generally rare. I will make every reasonable effort during the examination to screen for contraindications to care; however if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The availability and nature of other treatment options

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain killers
- Hospitalization
- Surgery

If you chose to use one of the above noted “other treatment” options you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risk and dangers attendant to remaining untreated

Remaining untreated may allow the formation of adhesion and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BLANK AND SIGN BELOW.

I have read ( ) or have had read to me ( ) the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Roberts and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to treatment.

Dated: _____ **Dated:** _____

_____ **Dr. Edwin B. Roberts**

Patient Name **Doctor’s Name**

_____ _____

Patient Signature **Doctor Signature**

_____

Signature of Parent or Guardian (If minor)

A Chiropractic Tradition
Drs. Edwin Roberts

PATIENT PRIVACY POLICY AND PRACTICE

Patient privacy is an integral part of ethical service. In our effort to meet your health care needs it is imperative that we collect information about you.

In order to provide you with appointment reminders, information about treatment alternative and/or other health related information, your physician and/or staff member may need to use your name, address, and/or telephone number. (If you are not home when we call to verify your appointment, we will leave a reminder message for you on your answering machine).

All medical records are confidential and are cared for with a high degree of security. Prior to any information being released, you, the patient, are required to sign a medical release form.

Sometimes it is necessary to refer you to another health care provider or hospital for treatment. If this happens it may be necessary for your physician or a staff member to disclose your health information (including all of your clinical records) to the person/establishment you are being referred to.

At other times our insurance and billing staff may have to disclose your examination records and/or billing records to a third party. (Some examples of this might be information needed by an insurance company, an HMO, a PPO or your employer – if they are potentially responsible for payment for services rendered). Receipt of a subpoena or a legal representative's request for information is also honored.

A Chiropractic Tradition's physicians and staff will always respect and protect your right to privacy.

A Chiropractic Tradition

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have been provided with a copy of A Chiropractic Tradition's (the "Practice") Privacy Practices (the "Notice"). The Notice contains information regarding potential uses and disclosures of my protected health information (as the term is defined under the Health Insurance Portability and accountability Act of 1996 "HIPPA") that may be made by the practice, and of my rights and the practice's legal duties with respect to my protected health information. I have had the opportunity to review the notice and take a copy with me if I so choose.

_____ _____

Patient Name **Date**

_____ _____

Patient's Signature **Signature of Guardian if Patient under 18 Years Old**

IF PATIENT REFUSES TO SIGN ACKNOWLEDGEMENT, COMPLETE THIS SECTION:

_____Patient refuses to sign acknowledgement.
_____(A Chiropractic Tradition's EMPLOYEE/POSTION) made the following efforts to attempt to obtain a signature from the patient: _____

X-RAY/MEDICAL RECORDS INFORMATION RELEASE

DATE: _____

TO: _____

_____

I hereby authorize you to release my records to:

A Chiropractic Tradition
Phone: 850-912-4155
FAX: 850-607-6483
Mobile Hwy, Suite D
Pensacola, Florida 32506

_____ **X-rays** _____

_____ **Any and all x-ray reports, MRI reports, CT Scans and Bone Density Reports for the last 5 years**

_____ **Diagnostic Reports** _____

_____ **All records** _____

_____ _____

Witness **Signature of Patient**

_____

Date of Birth_____ **Print Patient Name**

A Chiropractic Tradition
Drs. Edwin Roberts

NOTICE TO ATTORNEY OF ASSIGNMENT

To:_____
_____
_____
_____

Doctor: Dr. Edwin B. Roberts

RE: MEDICAL REPORTS AND DOCTOR'S LIEN

I do hereby authorize the above named doctor to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc… of myself in regard to the accident in which I was involved. I also authorize the release of any information from my medical record, pertinent to my case, to said attorney involved in this case.

I hereby authorize and direct you, my attorney, to pay to said doctor such sums as may be due and owing him for medical service rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment or verdict which may be necessary to adequately protect said doctor. I hereby further give a lien on my case to said doctor against any and all proceeds of any settlement, judgment or verdict which may be paid to you, my attorney or myself as a result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered me and that this agreement is made solely for said doctor's additional protection lien in consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

PATIENT:_____ DATE:_____
Signature of patient

DATE OF ACCIDENT:_____

PATIENT:_____ WITNESS:_____
Print name of patient

SIGNATURE OF GUARDIAN:_____

PLEASE SIGN AND RETURN ORIGINAL TO A CHIROPRACTIC TRADITION IF YOU ACCEPT ASSIGNMENT.

ATTORNEY SIGNATURE DATE

A Chiropractic Tradition
Drs. Edwin Roberts

PATIENT QUESTIONNAIRE REGARDING CONFIDENTIALITY

1. Please list the family member (s) or other person(s) if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operations).

   _____
   _____
   _____.

2. Please bring the address of where you would like your billing statements and/or correspondence from our office to be sent if other than your home address.

   _____
   _____
   _____.

3. I am fully aware that my health information may be transmitted by electronic transmission via fax transmittal, internet or e-mail.

Patient Name: _____

_____ _____
Patient/Guardian Signature Date

_____
Witness