☐Pinecrest ☐Coconut Grove
☐Downtown Miami ☐Ft. Lauderdale

Patient Intake

Name: ____ Jr / Sr
Last First M.I.

Address: ____
Street Address Apartment/ Unit #

____
City State ZIP Code

Cell Phone: ________________ Alternate Phone: ________________ Email: ________________

Birth Date: ____/____/_____ Gender: ☐ Male ☐ Female ☐ Non-binary Height:_______ Weight:_______ Handed: ☐ Right ☐ Left

Emergency Contact: ______________________ Emergency Contact Phone: ______________________

Health Insurance? ☐ Yes ☐ No How did you hear about us: ______________________
Primary Insurance: ____________ Secondary Insurance:____________
Is visit due to a car accident? ☐ Yes ☐ No Is visit due to a Slip or Fall? ☐ Yes ☐ No
Did this accident happen at: ☐Home ☐Work ☐Auto ☐School ☐Other: _______ Date of Accident: __________

Description of Accident: ____
Were you treated at an emergency facility? ☐Yes ☐No Which facility: ______________________

Are you taking any Medications? ☐ Yes ☐ No
Please list the medications you are currently taking below:

____
____
____

Are you taking any Supplements ☐ Yes ☐ No
Please list the supplements you are currently taking below:

____
____
____

Allergies: ____

Health History

What treatment have you already received for your condition?
☐ Medications ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Services ☐ None ☐ Other __________
Name and address of other doctors(s) who have treated you for your current condition?
____
____
Have you ever had any Fractures or Dislocations? ☐ Yes ☐ No
Which part of the Body? ______________________________ When? __________
Have you had Surgery? ☐ Yes ☐ No What Surgery?______________________

Check off to indicate if you have/had any of the following:

☐ AIDS/HIV	☐ DVT/Blood Clot	☐ Kidney Disease	☐ Pregnancy
☐ Anemia	☐ Epilepsy	☐ Liver Disease	☐ Pinched Nerve
☐ Appendicitis	☐ Fractures (see above)	☐ Measles	☐ Polio
☐ Arthritis	☐ Gout	☐ Migraine headaches	☐ Rheumatoid Arthritis
☐ Asthma	☐ Heart Disease	☐ Mononucleosis	☐ Stroke
☐ Bleeding disorders	☐ Hepatitis	☐ Multiple Sclerosis	☐ Thyroid Problems
☐ Balance Disorder	☐ Hernia	☐ Osteoporosis	☐ Tuberculosis
☐ Cancer	☐ Herniated Disk	☐ Pacemaker	☐ Tumors, Growths
☐ Diabetes	☐ High blood pressure	☐ Parkinson's Disease	☐ Vestibular Disorder

☐ To the best of my knowledge, I do not have any of the following listed above.

Description and Date of Last

Orthopedic Exam ____________ X-ray ________________ CT scan ________________

Spinal Exam ______________ MRI ________________ Bone scan ________________

Please check the box if you have not had any of Exams/Imaging/or Scans listed of above. ☐

Tell us about your symptoms?

On the Figure below, please draw the exact location of your symptoms.

In your own words, describe your symptoms/injury:

____
____
____
____
____
____
____
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____
____

What do you feel? ☐ Pain ☐ Pressure ☐Tingling ☐ Pulling ☐ Restriction

When did your symptoms start? _________Symptoms are a result of what? _____________or ☐ No Apparent Reason

How often are you experiencing these symptoms?

☐ Rare (10%) ☐ Occasional (25%) ☐ Intermittent (50%) ☐ Frequent (75%) ☐ Constant (100%)

Rate your symptoms today, 0 to 10 (10 is unbearable)? 0 1 2 3 4 5 6 7 8 9 10

Rate your symptoms at worst, 0 to 10 (10 is unbearable)? 0 1 2 3 4 5 6 7 8 9 10

Symptoms are currently: ☐ Improving ☐ Unchanging ☐ Worsening

Symptoms are worse with? ☐ Bending ☐ Sitting/Rising ☐ Standing ☐ Walking ☐ Turning

Symptoms are better with? ☐ Bending ☐ Sitting ☐ Standing ☐ Walking ☐ Lying

How many previous episodes? 0 1-5 6-10 11+ Year of first episode? ____________________

Have you treated this previously? ☐ Yes ☐ No What treatment? ______________________

Circle the **TOP 3** activities which are most affected by your symptoms. Circling an activity does not necessarily mean you are unable to perform it. It simply means your symptoms affect the activity, even just your enjoyment. (Example: If you can still sit in a chair, but only for 20 minutes before your back starts to hurt, then you would circle “sitting”)

Walking Sitting Reading Working Driving Gym Showering Sex Sleeping Sailing Cycling

Jogging Standing Shaving Bending Dressing Swimming Dishes Chores Gardening Lifting

Tell us if we are missing ANY activity affected by your symptoms. Even if you can still do it, ask yourself if your symptoms distract from this activity:

____
____

Authorization and Releases

Patient Health Information and Privacy Policy

This policy outline the way Patient Health Information (PHI) will be used in this office and the patient's right concerning those records. You must read and consent to this policy before receiving services. A complete copy of the Health Information Portability and Accountability Act (HIPAA) is available here:

http://www.cms.hhs.gov/SecurityStandard/Downloads/securityproposedrule.pdf

1. The patient understands and agrees to allow this office to use their PHI for the purpose of treatment, payment, health care operations and coordination of care. The patient agrees to allow this office to submit requested PHI to the payor(s) named by the patient for the purpose of payment. This office will limit the release of all PHI to the minimum necessary to receive payment.
2. The patient has the right to examine and obtain a copy of their health records at ant rime and request corrections. The patient may request to know what disclosures have been made, and submit in writing ant further restrictions on the use of their PHI. This office is not obligated to agree to those restrictions.
3. The patient's written consent shall remain in effect for as long as the patient receives care at this office, regardless of the passage of time, unless the patient provides written notice to revoke their consent. A revocation of consent will not apply to any prior care or services.
4. This office is committed to protecting your PHI and meeting its HIPAA obligations: Staff have been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures.
5. Patients have the right to file a formal complaint with our privacy official about any suspected violations.
6. This office has the right to refuse treatment if the patient does not accept the terms of this policy.

Initial _________

Consent to Professional Treatment

The patient certifies that all information provided to this office is true and correct, to the best of their knowledge. The patient grants their consent to this office and its staff to render treatment as deemed necessary by the attending physician. If the patient is a minor child, under the age of eighteen (18) at the date of treatment, I hereby stipulate that I am the legal guardian of the child, and grant my consent for the treatment of the child as provided for herein. The patient may refuse treatment at any time.

Initial _________

Assignment of Benefit and Release of Records

The patient hereby assigns benefits to be paid directly to this provider by all of their third party payors. This assignment is irrevocable. Failure to fulfill this obligation will be considered a breach of contract between the patient and this offices.

The patient authorizes this office to release any information required by a third party payor necessary for reimbursement of charges incurred.

Initial _________

Signature: ______________________________ Date: __________

Printed Name: ____

Patient Polices

Patient Payment Responsibility:

All payments must be made by cash, check, or credit card on the **day services are rendered** unless we agree to bill your insurance directly based upon prior approval and authorization. If we do bill your insurance directly and for any reason your insurance company sends you the check, you are legally and contractually obligated to forward such funds and related explanation of benefits to our office upon receipt. Any dishonored checks will be charged all outstanding funds, plus a $25 processing fee and any related bank charges, must be paid within five (5) days of notice.

Individual's Financial Responsibility:

I understand that I am financially responsible for my health insurance deductible, coinsurance or non-covered service. Co-payments, deductible, coinsurances are due at time of service. If my plan requires a referral, I must obtain it prior to my visit. In the event that my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided. If I am uninsured, I agree to pay for the medical services rendered to me at time of service.

Patient Cancellation/Missed Appointment Policy:

Our goal is to provide quality medical care in a timely manner. In order to do so, we have had to implement an appointment/cancellation policy. This policy enables us to better utilize available appointments for our patients in severe pain needing immediate care.

Cancellation of an Appointment:

In order to be respectful of the medical needs of other patients, please be courteous and call the office promptly if you are unable to attend an appointment. This time will be reallocated to someone who is in urgent need of treatment. If it is necessary to cancel your scheduled appointment, we require that you call at least 8 hours in advance. Calling early in the day is appreciated. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care, secondary to high demand of Saturday appointments, you must cancel your Saturday appointment by 12:00pm Friday.

How to Cancel Your Appointment:

Please call to cancel appointments, if you do not reach the receptionist you may leave a detailed message on the voicemail, please leave your full name, phone number, day and time of appointment. If you would like to reschedule your appointment, please be sure to leave us your phone number and let us know the best time to return your call.

No-Show Policy:

A "no-show" is someone who misses an appointment without calling 8 hours in advance to cancel. "No-shows" inconvenience those individuals who need access to medical care in a timely manner, as well as the clinicians. A failure to show up at the time of a scheduled appointment will be recorded in the patient's chart as a "no-show". The first time there is a "no-show" there will be no charge to the patient. Any additional "no-shows" will result in a fee of $50.00 for regular appointments. All fees must be paid prior to future appointments.

Late Cancellations:

Late cancellations will be considered as a "no-show". Exceptions will only be made in extraordinary circumstances. Cancellations made more than 8 hours in advance of your scheduled appointment time will not be assessed a cancellation fee. All fees must be paid prior to future appointments.

I have read and agree to my payment and financial responsibilities as a patient and the patient cancellation and missed appointment policy. Even though I may be paying for services rendered with cash, check, or insurance.

Signature: ____ Date: __________________

Printed Name:____