Abundant Living Chiropractic Center LLC
705 Park Avenue
Suite B
Lake Park, FL 33403
(561)-223-3340

REGISTRATION & HISTORY

Date: _____

PATENT INFORMATION

Name:_____ Name you prefer to be called:_____

Address:_____ City _____ State_____ Zip _____

Sex: ☐ M ☐ F Age: ____ Birth date ___/___/_____ ☐ single ☐ married ☐ widowed ☐ separated ☐ divorced ☐ partnered

Patient Social Security Number _____ - _____ -_____

Occupation _____ Employer_____

Employer Phone ( )_____ Address _____

Primary Care Provider: _____ Date of last visit:_____

m may we thank for referring you? _____

PHONE NUMBERS	EMERGENCY CONTACT
Home:	Name:
Work:	Relationship:
Cell:	Home:
Preferred contact: ☐ Home ☐ Work ☐ Cell	Work:
Email:	Cell:

INSURANCE INFORMATION

Do you plan to use health insurance for your care? ☐ yes ☐ no *(if yes, please complete the rest of this section)*
Insurance Company: _____
Relationship to insured: ☐ self ☐ spouse ☐ parent /guardian ☐ other

Assignment & Release:
I certify that I have insurance coverage and assign directly to Abundant Living Chiropractic Center LLC, all insurance benefits, if any, for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize use of this signature on all insurance submissions.

SIGNATURE: _____

INJURY/CONDITION

your visit today be for: ☐ Injury/Health Condition/Pain ☐ Wellness/Sports Performance

Was this injury related to an accident? ☐ yes ☐ no If yes, was it ☐ work-related ☐ auto ☐ other

CHIEF COMPLAINT

Reason for visit:

When did it start? How did it start?

Please describe your condition:

Rate your symptoms (0=worst, 10=best) /10 With time is your condition? ☐ getting better ☐ getting worse ☐ not changing

Are your symptoms constant or do they come & go? ☐ constant ☐ comes & goes

What makes your symptoms worse? ☐ standing ☐ sitting ☐ walking ☐ bending/lifting ☐ lying down ☐ sports/exercise ☐ self care

What makes your symptoms better?

What treatments have you already had for this condition: none medical chiropractic surgical physical therapy massage acupuncture other(please describe)

Have you had any recent imaging of the area? x-ray MRI CT scan bone density/DEXA other

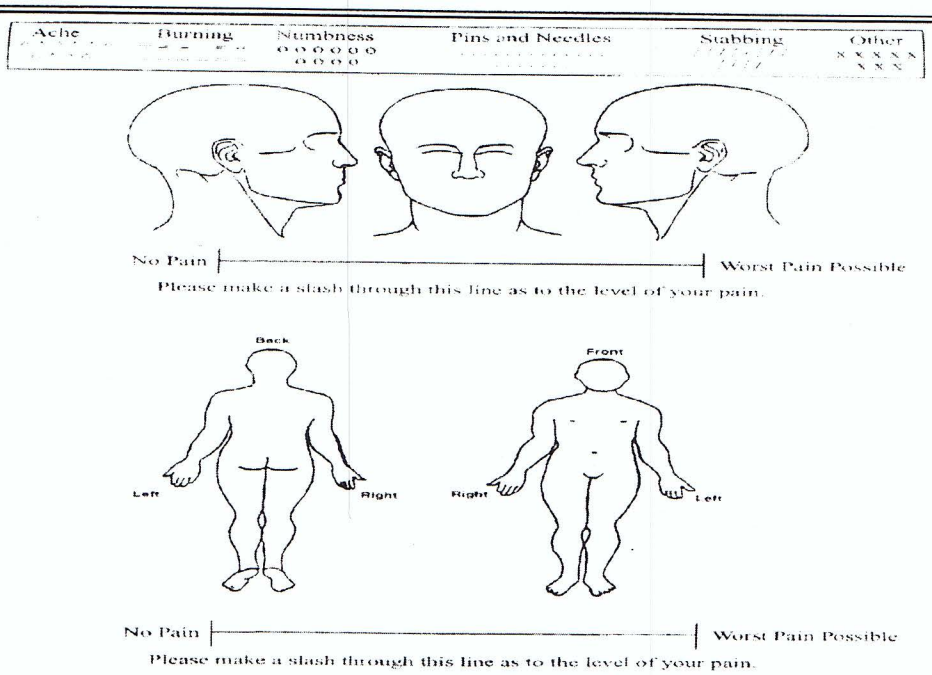
Does your condition interfere with your activities (work duties, daily life, social activities, and/or recreation)? Yes No

If yes, please list 3 activities that you have difficulty with :

1. _____

2. _____

3. _____



TH HISTORY

Have you had any of the following:						WOMEN ONLY:		
AIDS/HIV	☐ yes	☐ no	High Blood Pressure	☐ yes	☐ no	Are you pregnant?	☐ yes	☐ no
Anemia	☐ yes	☐ no	High cholesterol	☐ yes	☐ no	Due date: _____		
Anxiety	☐ yes	☐ no	Multiple Sclerosis	☐ yes	☐ no	Abnormal/painful	☐ yes	☐ no
Arthritis	☐ yes	☐ no	Osteopenia	☐ yes	☐ no	menstrual cycle		
Asthma	☐ yes	☐ no	Osteoporosis	☐ yes	☐ no	Miscarriage	☐ yes	☐ no
Bleeding disorders	☐ yes	☐ no	Pacemaker	☐ yes	☐ no	Menopause	☐ yes	☐ no
Cancer	☐ yes	☐ no	Parkinson's disease	☐ yes	☐ no			
Chemical dependency	☐ yes	☐ no	Pinched nerve	☐ yes	☐ no	**PRIOR SURGERIES**	Date	
Depression	☐ yes	☐ no	Polio	☐ yes	☐ no			
Diabetes	☐ yes	☐ no	Prostate problem	☐ yes	☐ no			
Epilepsy/Seizures	☐ yes	☐ no	Prosthesis	☐ yes	☐ no			
Fractures	☐ yes	☐ no	Psychiatric care	☐ yes	☐ no			
Headaches	☐ yes	☐ no	Rheumatoid arthritis	☐ yes	☐ no			
Heart disease	☐ yes	☐ no	Stroke	☐ yes	☐ no			
Hepatitis	☐ yes	☐ no	Suicide attempt	☐ yes	☐ no			
Hernia	☐ yes	☐ no	Thyroid problems	☐ yes	☐ no			
Herniated disk	☐ yes	☐ no	Tumors	☐ yes	☐ no			
Height: feet inches			Ulcers	☐ yes	☐ no			
			Weight: pounds					

Additional Info:

_____

_____

_____

_____

_____

MEDICATIONS	ALLERGIES	VITAMINS/SUPPLEMENTS
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

FAMILY HISTORY

☐ Arthritis-Rheumatism	☐ Osteoporosis	☐ Heart Disease
☐ Autoimmune disorders	☐ Stroke	☐ High blood pressure
☐ Back/Spine Condition	☐ Thyroid disorder	☐ Mental Illness
☐ Cancer	☐ Diabetes	☐ OTHER:

SOCIAL HISTORY

My work duties include: ☐ standing ☐ sitting ☐ light labor ☐ heavy labor ☐ other

My exercise level is: ☐ Intense ☐ Moderate ☐ Light ☐ Minimal ☐ None

My current exercise includes: *(List Activities)*

My habits include: ☐ Smoking/Tobacco use_____ packs/day ☐ Alcohol Consumption _____drinks/week

☐ Caffeine (Coffee, Soda, Tea)_____cups/day ☐ High Stress Level ☐ Recreational drug use

Patient Signature_____ **Date:** _____

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CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

NAME _____

DATE OF BIRTH _____

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. This information is kept private except uses involved in your healthcare. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and prior health information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that:

- I have the right to object to the use of my health information for directory purposes.
- I have access to a copy of the "Notice of Patient Privacy Rights" and they are available in the office.
- I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations, and that the organization is not required to agree to the restrictions requested.
- I have the right to revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.
- I have the right to request a copy of my records. I understand this requires 48 hours notice.
- I understand that the information used or disclosed pursuant to this authorization may be subject to being disclosed again by recipient and that this information will no longer be subject to protection as protected health information.

I request the following additional restrictions to the use or disclosure of my health information:

I authorize Abundant Living Chiropractic Center LLC to speak with the following people regarding my healthcare:

With my consent, Abundant Living Chiropractic Center LLC may call my home or other designated location, and leave a voice message in reference to any items that assist the practice in carrying out treatment, payment and health care operation, such as appointment reminders, insurance items and information pertaining to my clinical care.

With my consent Abundant Living Chiropractic Center LLC may mail to my home any items that assist the practice in carrying out the above listed operations.

With my consent Abundant Living Chiropractic Center LLC may send a narrative to my primary care doctor explaining my evaluation and treatment plan.

PATIENT:

X

Signature of patient/ Legal Representative Date Witness Signature

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Informed Consent

My signature below indicates that I have read and understand and am informed about the minimal inherent risk of injury which could be associated with the practice of chiropractic care. I now know that these include but are not limited to muscle strains, sprains, fractures, dislocations, intervertebral disc injury and cardiovascular accident. I understand that my doctor will be able to use his/her expertise and clinical judgment to determine the correct course of treatment. Considering all these facts, my doctor will select treatment in my best interest. However I also understand that as with all medical procedures, results are not guaranteed and that I have the opportunity to discuss the need for and risks associated with all recommended evaluation and treatment procedures at any time during the course of treatment.

My consent for treatment is voluntary. I am aware that I will be participating in manipulative exercise and rehabilitative therapies, neurological and orthopedic exams as well as physical performance testing. I understand that if at any time I should decide to discontinue treatment, I have the right and also that it is my responsibility to notify my doctor of my decision.

_____ _____ _____

Print Patient Name Signature Date

If minor patient:

_____ _____ _____

Print Parent/Guardian Name Signature Date

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Authorization for Release of Case Records

I _____ hereby authorize any hospital physician or other medical provider to release any information regarding my medical history, diagnosis, diagnostic tests, exam results and treatment to Abundant Living Chiropractic Center LLC for continuation/coordinator of my health care.

Name: _____

Date of Birth: _____

SSN: _____

Address:

_____

_____

_____ _____ _____

Print Name Signature Date

If minor patient:

_____ _____ _____

Print Name/ Parent Guardian Signature Date

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Assignment of Benefits

I authorize and direct my insurer or payor to pay directly to Abundant Living Chiropractic Center LLC and the physicians, any or all benefits, that would otherwise be payable to me (or the patient, if signed by a responsible party), up to the amount of my bill, accruing to me in connection with my treatment at Abundant Living Chiropractic Center LLC.

I request that payment of authorized Medicare, Medicaid or other health insurance policy benefits for services furnished to me by Abundant Living Chiropractic Center LLC be made on my behalf to Abundant Living Chiropractic Center LLC. In an event that payments are made on my behalf to Abundant Living Chiropractic Center LLC and me as joint payees, I agree to cooperate with Abundant Living Chiropractic Center LLC to ensure that the center/practice receives all amounts due to Abundant Living Chiropractic Center LLC.

I hereby authorize Abundant Living Chiropractic Center LLC to pursue any means necessary to collect all charges on my account including follow-up calls, appeals, arbitration and civil suit, if allowable under law. In the event that Abundant Living Chiropractic Center LLC or physician elects to bring an appeal, lawsuit or petition for arbitration against the insurance carrier, I hereby assign to them my rights, title, and interest under any insurance policy under which I am entitled to proceed for benefits, if allowable under law. This assignment shall allow an attorney of their choosing to bring suit or submit to arbitration their claim of any unpaid or underpaid bills for treatment rendered at Abundant Living Chiropractic Center LLC.

_____ _____ _____

Print Name Signature Date

If minor patient:

_____ _____ _____

Print Name/Parent or Guardian Signature Date

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In order to provide the highest quality of care for our patients, it is the policy of Abundant Living Chiropractic Center LLC that all patient be x-rayed prior to beginning spinal adjustments. All diagnostic imaging will be performed at Diagnostic Centers of America. My signature below indicates understanding of this policy.

_____ _____

Patient Signature Date

Revised 3/20/14

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Fax: 561-223-3249

Cancellation Policy

Effective September 1, 2014, it is now a policy at Abundant Living Chiropractic Center LLC that all cancellations/reschedules be made a minimum of 24 hours prior to scheduled appointment. Failure to cancel or reschedule during this time frame, will result in a $60.00 cancellation fee. In addition, failure to adhere to prescribed treatment plan or no-show, will also result in a $60.00 charge. If for any reason this office should need to pursue collection actions, you agree to reimburse us the fees of any collection agency, which will be $18.00 and all costs, and expenses, including reasonably attorney fees, we incur in such collection efforts. My signature below indicates my understanding of said policy.

_____ _____

Signature Date

Revised 12/4/14