## New Patient Office Questionnaire

**Patient Name:** _____ **Birthdate:** _____

**Address:** _____

**City:** _____ **State:** _____ **Zip:** _____

**Cell:** _____ **Home:** _____ **Work:** _____

**SS#** _____ **Circle one: Single Married Divorced Widowed Other**

**Primary Ins:** _____ **ID #** _____

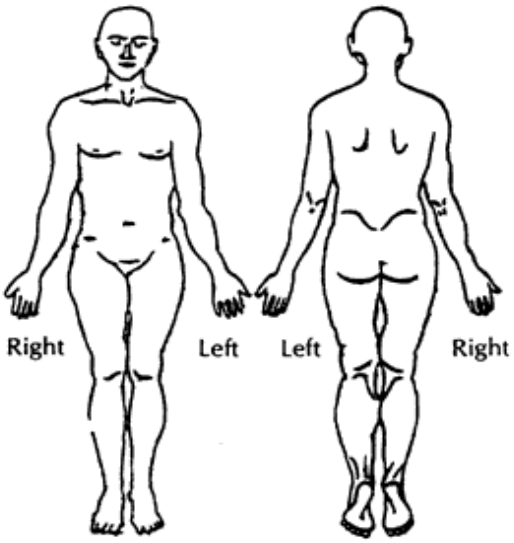
**Secondary Ins:** _____ **ID #** _____

**Primary care physician:** _____ **Phone:** _____

**Emergency contact name:** _____ **Phone:** _____

**Reason for visit:** _____

**Please mark the areas of your pain, use the key below to indicate different types of pain sensations:**




Shooting: - - - - - -

Stabbing: ///////

Aching: xxxxxx

Throbbing: 000000

Pins & Needles: •••••

Burning: ******



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Jorge L. Santana, D.C.

## Employment Details:

**Are you currently working? (Circle one)** Yes/No Full Duty/Light Duty

**Employer Name: _____Phone: _____**

**Job Title: _____How many hours do you work each day? _____**

**Duties:_____**

**If you are not working, why and what date did you stop?**

_____

## Pain Details:

**Does your pain shoot or affect another part of your body?** Yes/No **If Yes please describe below:**

_____

**Describe the frequency of the pain:** (Circle one) Constant Intermittent Occasional

**How many hours a day do you have the pain?**
**(If you do not have pain everyday estimate how many hours per week, month, etc):_____**

**How many weeks, months or years have you been disabled in pain? _____**

**Does the pain affect your activities**: Yes/No **Rate your pain on the pain scale:** /10

**What action relieves your pain?** (Circle one) Sitting Standing Walking Massage Medication

**What makes your pain worse?** (Circle one) Sitting Standing Walking Massage Medication

**Do you have severe night time pain?** Yes/No

**Do you wake up in the middle of the night because of pain?** Yes/No

**Do you have difficulty falling asleep at night?** Yes/No



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# Review of Systems

(please check all that apply)

| **Constitutional Symptoms** | | **Eyes** | | **Genitourinary** | |
|---|---|---|---|---|---|
| Good General health lately: | | Eye Disease or injury: | | Frequent Urination: | |
| Recent weight changes: | | Wear glasses/contacts: | | Burning/pain during urination: | |
| Fever: | | Blurred or Double Vision: | | Blood in urine: | |
| Fatigue: | | **Cardiovascular** | | Change in force during urination: | |
| Headaches: | | Heart trouble: | | Incontinence: | |
| **Ears/Nose/Mouth/Throat** | | Chest pain or angina: | | Kidney Stones: | |
| Hearing loss or ringing: | | Palpitation: | | Sexual Difficulty: | |
| Earaches or drainage: | | Shortness of breath w/walking: | | Male: Testicle pain: | |
| Chronic Sinus problems: | | Shortness of breath w/lying: | | Female: pain with periods: | |
| Nose Bleeds: | | Swelling of feet/ankles/hands: | | Female: Irregular periods: | |
| Mouth Sores: | | High Blood Pressure: | | Female: Vaginal Discharge: | |
| **Respiratory** | | Low Blood Pressure: | | **Hematologic/Lymphatic** | |
| Bleeding Gums: | | Persistent cough: | | Slow to heal after cuts: | |
| Bad breath/taste: | | Spitting up blood: | | Bleeding/bruising: | |
| Sore throat/voice change: | | Shortness of breath: | | Anemia: | |
| Swollen Glands in neck: | | Wheezing: | | Phlebitis: | |
| **Gastrointestinal** | | **Musculoskeletal** | | Past Transfusion: | |
| Loss of appetite: | | Joint Pain: | | Enlarged Glands: | |
| Change in bowel: | | Joint stiffness: | | | |
| Nausea/Vomiting: | | Joint Swelling: | | | |
| Frequent Diarrhea: | | Joint Weakness: | | | |
| Painful Bowel: | | Muscle pain/cramps: | | | |
| Constipation: | | Back Pain: | | | |
| Rectal bleeding in stool: | | Cold extremities: | | | |
| Abdominal pain: | | Difficulty Walking: | | | |
| **Integumentary** | | **Neurological** | | | |
| Rash or itching: | | Frequent/recurring headache: | | | |
| Changing in skin color: | | Light headed/dizzy: | | | |
| Change in hair/nails: | | Seizures: | | | |
| Varicose veins: | | Numbness/tingling: | | | |
| Breast pain: | | Tremors: | | | |
| Breast Lump: | | Paralysis: | | | |
| Breast Discharge: | | Head Injury: | | | |
| **Psychiatric** | | **Endocrine** | | | |
| Memory loss: | | Glandular/hormone issues: | | | |
| Confusion: | | Excessive thirst/urination: | | | |
| Depression: | | Heat intolerance: | | | |
| Insomnia: | | Cold intolerance: | | | |
| Suicidal thoughts: | | Dry Skin: | | | |
| Violent thoughts: | | Change in hat/glove size: | | | |



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## Please check any past medical history you may have:

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Aids/HIV | | Bulimia | | Gout | | Measles | | Prostate Problems | |
| Allergy Shots | | Cancer | | Heart Disease | | Migraines | | Prosthesis | |
| Anemia | | Cataracts | | Hepatitis | | Mononucleosis | | Rheumatic Fever | |
| Anorexia | | Chemical Dependency | | Hernia | | Mumps | | Rheumatoid Arthritis | |
| Appendicitis | | Chicken Pox | | Herniated Disk | | MS | | Scarlet Fever | |
| Arthritis | | Diabetes | | High Blood Pressure | | Osteoporosis | | Stroke | |
| Asthma | | Emphysema | | High Cholesterol | | Pacemaker | | Thyroid Issue | |
| Bleeding Disorder | | Epilepsy | | Kidney Disease | | Parkinson's | | Tonsillitis | |
| Breast Lump | | Glaucoma | | Liver Disease | | Pneumonia | | Tuberculosis | |
| Bronchitis | | Goiter | | Low Blood Pressure | | Polio | | Ulcers | |

**Female patients: # of pregnancies**_____ **# of Miscarriages** _____

**Do you smoke?** Yes/No **If yes, how long and how often**:_____

**Do you drink?** Yes/No **If yes, how often:**_____

**Have you ever done drugs?** Yes/No **Type/frequency?**_____

**Have you had any surgery?** Yes/No **Please explain:**_____

_____

**Please list any allergies**:_____

**Describe your regular exercise activity:**_____

**Please list any family medical history**:_____

_____

**Please list or attach an updated medication list, list the strength, dose, and frequency of the medications you are taking:**

_____

**I _____ (patient name) attest that above statements are true, which was based on the best of my knowledge.**

**Patient Signature: _____Date: _____**



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## Informed Consent to Treat

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic Procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by **Jorge L. Santana D.C. at 1 Source Chiropractic & Physical Medicine** and/or other licensed doctors of chiropractic who now or in the future work at the clinic.

I have had the opportunity to discuss with the doctor of chiropractic and/or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in 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 upon the doctor to exercise judgment during the course of the procedures which the Doctor feels at the time, based upon the facts then known to him or her, and is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content 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 and for any future condition {s) for which I seek treatment.

**Patient Name: _____ Date: _____**

**Patient Signature (or signature of guardian): _____**



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**HIPAA Compliant Authorization for Release of Patient Information**
**Pursuant to 45 CFR 164.508**

**Section I – Patient Information**

Name: _____DOB: _____ Last 4 of social: _____

Address: _____City: _____ State: _____ Zip: _____

Patient Phone: _____ Facility Phone: _____Facility Fax: _____

**Section II: Authorization for Release of Patient Information:**

I, or my authorized representative, hereby authorize
_____(name of entity holding the requested records) and their respective employees, agents and subcontractors to disclose my Personal Health Information (PHI) and Insurance Record to:

**1 Source Chiropractic & Physical Medicine, Inc.**
**19409 Shumard Oak Dr. #102 Land O' Lakes, FL 34638**
**Ph: 813-448-2222 Fax: 813-948-7111**

**Section III – Specific Information to be Released**:

☐ Please release my Medical Record from (insert date) _____ to (insert date) _____

☐ Please release my entire Medical Record, including patient histories, office notes (excluding psychotherapy notes, test results, radiology studies, films, referrals, consults, billing records, insurance records sent to Freedom Health by health care providers.

☐ Other: (please explain) _____

**Reason for release of information:**

☐ Include: (Indicate by Initialing) _____ Alcohol/Drug _____ Mental Health_____ HIV-Related Information_____

☐ At the request of the individual

☐Other:_____

Section IV: I understand that Section 460.413 (1) (m), Florida Statutes, and Board of Chiropractic Medicine Rule 64B2-17.006 require chiropractic physicians to retain records and x-rays for at least four years. Therefore, a chiropractic physician receiving a request for a patient's x-ray within that four-year period must retain the x-ray and provide a copy of it in lieu of the original x-ray. I, further, understand that Section 456.057 (18), Florida Section 457.057 (16), Florida Statutes, authorizes a health care practitioner or patient records owner furnishing copies of reports or records or making the reports or records available for digital scanning pursuant to this section to charge no more than the actual cost of copying, including reasonable staff time, or the amount specified in administrative rule by the appropriate board, or the department when there is no board. The Board of Chiropractic Medicine Rule 64B-17.0055, Florida Administrative Code, authorizes chiropractic physicians to charge patients $1.00 per page for the first 25 pages, and 25 cents for each page in excess of 25 pages. The Board of Chiropractic Medicine Rule defines the reasonable costs of reproducing x-rays, and such other special kinds of records as the actual costs. The phrase "actual costs" means the cost of the material and supplies used to duplicate the record, as well as the labor costs and overhead costs associated with such duplication. The Board of Chiropractic Medicine Rule 64B-17.0055, Florida Administrative Code, authorizes chiropractic physicians to charge people who are not patients authorized to seek copies of my patient records $1.00 per page. I understand that the HIPAA regulations authorize the practice to charge the cost of labor and hardware onto which the records are electronically copied unless the Board of Chiropractic Medicine sets lower costs. I understand that there is no cost for transmitting the electronic records by email.

This authorization will be in effect for one year from the date signed, unless you indicate a shorter period below:

Date or event on which this authorization will expire: _____.

If an authorized representative is making this request, please provide your information below and attach certifying documentation of your status as the authorized representative, such as a Power of Attorney or Guardianship papers.

**AUTHORIZED REPRESENTATIVE**

By signing this form, I am confirming that it accurately reflects my wishes. In addition, I have kept a copy of this form for my records.

_____ _____

Signature of Member or Authorized Representative Date

## HIPAA PRIVACY AUTHORIZATION FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et. seq., and regulations promulgated there under, as amended from time to time (collectively referred to as "HIPAA").

This authorization affects your rights in the privacy of your personal healthcare information. Please read it carefully before signing.

**1 SOURCE CHIROPRACTIC & PHYSICAL MEDICINE**, ("Covered Entity") will not condition treatment payment, enrollment in a health plan, or eligibility for benefits, as applicable, on your providing authorization for the requested use or disclosure. **YOU MAY REFUSE TO SIGN THIS AUTHORIZATION.**

By signing this authorization you acknowledge and agree that Covered Entity may use or disclose Medical Records and/or Medical Billing for the purpose(s) of Collections, and for the sole purpose of referring you out for treatment or diagnostic services.

By signing this authorization you agree that Covered Entity or its Business Associates may disclose your personal health care information only for the sole purposes of which foresaid are mentioned above.

Further, by signing this authorization you acknowledge that you have been provided a copy of and have read and understand Covered Entity's HIPAA Privacy Notice containing a complete description of your rights, and the permitted uses and disclosures, under HIPAA. While Covered Entity has reserved the right to change the terms of its Privacy Notice, copies of the Privacy Notice as amended are available from Covered Entity at any of its offices or by sending a written request with return address to:

**1 Source Chiropractic & Physical Medicine, Inc.**
**19409 Shumard Oak Dr., Ste 102 Land O' Lakes, FL 34638**

In accordance with your rights under, and subject to certain restrictions imposed by, HIPAA, you may inspect or copy your PHI in the designated record set maintained by Covered Entity for as long as the PHI is maintained in the designated record set.

You have the right to revoke this authorization, in writing, at any time, except to the extent that Covered Entity has taken action in reliance on it. A revocation is effective upon receipt by Covered Entity of a written request to revoke and a copy of the executed authorization form to be revoked at the address listed above.

This authorization shall expire upon the earlier occurrence of: (a) revocation of the authorization, (b) a finding by the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights that this authorization is not in compliance with requirements of HIPAA, (c) complete satisfaction of the purposes for which this authorization was originally obtained, to be determined in the reasonable discretion of Covered Entity, or (d) six years from the date this authorization was executed.

By signing this authorization you acknowledge and agree that any information used or disclosed pursuant to this authorization could be at risk for re-disclosure by the recipient and no longer protected under HIPAA.

**Covered Entity will provide patient with a copy of this signed authorization at their request.**

**Acknowledged and agreed to by:**

Patient Signature: _____Date of Birth: _____

Patient Printed Name _____Date: _____



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## FINANCIAL POLICY-COMMERCIAL, MEDICARE & SELFPAY

As a courtesy, the Facility will obtain a verification of applicable insurance benefits as they are quoted to us but some third party payers misquote benefits, coverage and liability. Our Facility and staff are NOT responsible for what a third party payer and/or representative may tell us. Any contractual, written, verbal or other obligation or arrangements between you and your attorney, insurance company, liable or third party payer are between you and said person or party.

1. Our facility will file initial insurance claims for you. Secondary claims submissions and/or additional reports and/or documents sent on your behalf may result in an additional filing and/or medical report charges, which you will be responsible for paying. (These fees and payments will be discussed prior to so that proper payment can be made prior to any further services being rendered).
2. Co-pays, Deductibles and all Non-Covered Services charges will be due at the time of service. Due to our office being a multi-disciplinary practice all providers are subject to separate co-pays. For your convenience this office accepts: **Cash/Check/Debit/Credit Cards.**
3. Patients are responsible for charges on all service(s) and/or product(s) which may exceed the maximum allowable and/or when a third party and/or insurance carrier does not reimburse this Facility enough to meet our cost of service.
4. A service charge is computed by a "periodic rate" of 1 ½% per month. 18% per annum & is added to all balances owed 60+ days. Any balance past due 90 days or more may be submitted to an attorney and/or agency for legal collection for which the undersigned agrees to be 100% responsible for all monthly service charges, interest, costs related to but not limited to all collections related expenses, attorney fees, court & filing fees.
5. Returned checks, debit and credit charges made payable to the facility for insufficient funds, stop payments or other expenses of non-payment will be assessed a $30.00 charge.

## MEDICARE PATIENTS/MEDICARE REPLACEMENT POLICIES

Patients who qualify for Medicare and those Medicare replacement policies will be limited to the services that are covered under their healthcare insurance. We try to do our very best to notify these types of patients in advance by having you sign an ABN form (Advance Beneficiary Notice). This form outlines the services that ARE and are NOT covered in our office. Please be sure and inquire with our front desk if you have NOT received one of these forms.

**MEDICARE PATIENT CERTIFICATION AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST:** I certify that the information given to me in applying for payment under Title XVIII and/or Title XI of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary carriers any information needed for this or related Medicare claim(s). I request that payment of authorized benefits be made on my behalf; I assign the benefits payable for physician(s) services. I understand that I am responsible for my health insurance deductibles and co-insurance.

## ASSIGNMENT OF BENEFITS

I hereby assign payment directly to the physician(s) accepting this assignment of medical benefits applicable and otherwise payable to me but not to exceed the physician's regular charges. I understand that I am financially responsible for charges not covered by this assignment or for any and all charges that the insurance carrier declines to pay. It is further agreed that any credit or balance resulting from payment of insurance or other sources may be applied to any other accounts owed to said physician by the insured or his/her family.

_____ _____

Signature: Date:



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# Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

**Name**:_____ **Birthdate**: _____

**Email address:** _____

**Preferred method of communication for patient reminders (Circle one):** Email / Phone / Mail

**Gender (Circle one):** Male / Female **Preferred Language:** _____

**Smoking Status (Circle one):** Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

**Smoking Start Date (Optional):** _____

**CMS requires providers to report both race and ethnicity**

**Race (Circle one):** American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) / Native Hawaiian or Pacific Islander / I Decline to Answer

**Ethnicity (Circle one):** Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

**Are you currently taking any medications?** (Please include regularly used over the counter medications)

| Medication Name | Dosage and Frequency (i.e. 5mg once a day, etc.) |
|---|---|
| | |
| | |
| | |

**Do you have any medication allergies?**

| Medication Name | Reaction | Onset Date | Additional Comments |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

□ **I choose to decline receipt of my clinical summary after every visit**

Patient Signature:_____Date:_____

**For office use only:**

Height: _____ Weight:_____ B/ P_____ /_____ Pulse/BPM: _____



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# Medicare patients

**A. Notifier: 1 Source Chiropractic & Physical Medicine Inc.**

**B. Patient Name: _____C. Medicare ID: _____**

## Advance Beneficiary Notice of Non-coverage (ABN)

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. Medicare will not pay for the services in section D listed below.

| D. | E. Reason Medicare May Not Pay: | F. Estimated Cost |
|---|---|---|
| • OFFICE VISITS-NEW PATIENT & ESTABLLISHED<br>• THERAPY SVC (ESTIM, US, MASSAGE,LASER)<br>• EXTREMITY ADJUSTMENTS (SHOULDER, RIBS)<br>MAINTENANCE/WELLNESS ADJUSTMENTS (FILED W/GX OR GY MODIFIER) | • ARE ALL NON COVERED SERVICES WHEN RENDERED BY A CHIROPRACTOR<br>MEDICARE ONLY PAYS FOR ACUTE CARE TREATMENT<br>(FILED W/GX OR GY MODIFIER) | OV- $75-$250.00<br>US- $25.00<br>ESTEM- $25.00<br>MASSAGE- $20.00 per 15min<br>LASER- $40.00<br>HOT/COLD PACKS- $10.00<br>TRACTION- $25.00<br>EXTREMITY ADJ- $20.00<br>(FILED W/GX OR GY MODIFIER) |

**WHAT YOU NEED TO DO NOW:**

Read this notice, so you can make an informed decision about your care.
Ask us any questions that you may have after you finish reading.
Choose an option below about whether to receive the services listed above.

**Note:** If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

**G. OPTIONS: Check only one box. We cannot choose a box for you.**

☐ **OPTION 1.** I want the services listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the services listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**.

☐ **OPTION 3.** I don't want the services listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

**H. Additional Information:**

**This notice gives our opinion, not an official Medicare decision.** If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).

Signing below means that you have received and understand this notice. You may also request a copy.

| I. Signature: | J. Date: |
|---|---|
| | |





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