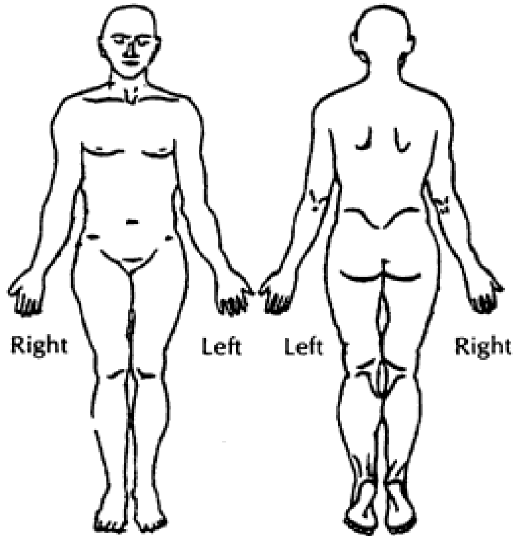
New Patient Office Questionnaire

Patient Name: ____ **Birthdate:** ______________________
Address: ____
City: ____ **State:** ______ **Zip:** ___________________
Cell: ______________________________**Home:** ________________________**Work:** __________________
SS# ____________________________ **Circle one: Single Married Divorced Widowed Other**
Email: ____
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 nighttime 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:		Lightheaded/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 __________ # of Children _________
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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AUTO ACCIDENT QUESTIONAIRE

Date of Accident: ________________ Time: ______________(AM)(PM) Location: ____

Auto Insurance Company: ________________________Policy #: _____________________Claim#: ___________________________

Attorney: ____ Attorney Phone: ____________________________________

Brief Description of the Accident: ____

Patients' vehicle (Yr., make, model) ____Estimated speed ____________MPH

Patients' vehicle hit by (Yr, make, model) ____Estimated speed ____________MPH

Did any part of your body contact the inside of the vehicle? □ Yes □ No If yes, please list: ____

Did vehicle have seatbelts? □ Yes □ No Was seatbelt worn? □ Yes □ No Road Condition? □ Dry □ Damp □ Wet

Did vehicle have airbags? □ Yes □ No Did airbags deploy? □ Yes □ No Police Report? □ Yes □ No

Were you the: □ Driver □ Passenger □ R Back seat □ L Back seat □ Front Middle □ Middle of Back

If vehicle had headrest, describe the position compared with top of your head:
□ Top of headrest w/top of head □ Top of headrest w/middle of head □ Top of headrest aligned w/bottom of head

Did you see accident coming? □ Yes □ No Were you braced for impact? □ Yes □ No

Hands: □ One on Wheel □ Two on Wheel Were Brakes Applied? □ Yes □ No Were you at a complete stop? □ Yes □ No

Were you looking in the side mirrors? □ Yes □ No Were you looking into rear view mirror? □ Yes □ No

Did you lose consciousness? □ Yes □ No First Symptom appeared ____________________________ after the MVA

How many people in the car? _________ Were they Injured? □ Yes □ No

Initial Symptoms: □ None □ Headache □ Dizzy □ Disoriented □ Neck Pain □ Nausea □ Vomiting □ Blurred Vision □ Shock
□ Ringing in Ears □ Mid-Back pain □ Low Back Pain □ Numbness

Did you go the hospital? □ Yes □ No □ Transported by Ambulance □ Drove yourself □ Someone drove you

Name/Location of Hospital: ____

When did you go: □ Immediately □ Later-when? ____

Were you admitted: □ Yes □ No How long did you stay: ____
Please indicate what was performed at hospital: □ X-Rays □ MRI □ CT

Were you prescribed medications: □ Yes □ No List Name(s): ____
Have you seen any other Doctor for this accident? □ Yes □ No List Name(s): ____

Patient Signature: ____Date: ________________________

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1 SOURCE CHIROPRACTIC & PHYSICAL MEDICINE, INC.
FINANCIAL POLICY-AUTO CLAIMS

We would like to take a moment to welcome you to our office and to assure you that you will be receiving the best care available for your condition. To familiarize you with the financial policies of our office, I would like to explain how your medical bills will be handled.

PARTIES RESPONSIBLE

If you were involved in an auto accident and are the owner of the vehicle, we will bill the medical insurance portion of your own automobile policy. If you were a passenger in someone else's car, we will bill the driver's auto insurance company. (These policies will be billed in addition, and prior to, any claim that your attorney may be presenting to an insurance company on your behalf).

If you were the passenger in a vehicle which was not insured, but you own a car which has medical coverage, the insurance company which carries YOUR policy will be responsible to pay your medical bills.

RESPONSIBILITY FOR PAYMENT

As a courtesy to you, we will gladly submit your medical bills to your insurance company(s) and/or your attorney; however, all services rendered by this office will be charged directly to you, and, ultimately, you will be personally responsible for payment for these bills regardless of any settlement you may or may not receive.

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 fee and/or medical report charges which will be billed to your account and may or may not be reimbursable by your insurance as each carrier is different. We will attempt to file these on your behalf.
2. Patients are responsible for deductible, co-insurance payments, and 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.
3. 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. **(This paragraph only applies to cases where your attorney is dropped, you do not obtain an attorney, or we cannot come to any resolution with your attorney to settle your case and no settlement can be made on your case.)**
4. 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.

Patient Signature: ______________________________________Date: _______________

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PROVIDER'S LIEN: PATIENT'S LETTER OF PROTECTION; AUTHORIZATION FOR RELEASE OF INFORMATION; SPECIAL POWER OF ATTORNEY AND ASSIGNMENT OF RIGHTS & BENEFITS WITHIN THE MEANING OF § 627.736, FLORIDA STATUTES

This agreement allows me, __________________________________, to be treated by 1 Source Chiropractic & Physical Medicine, Inc. without paying for my care and treatment in advance.

1 Source Chiropractic & Physical Medicine, Inc. will be paid within (35) days of submission of claims for my care directly by my personal injury protection insurance carrier. The parties agree that this is good and sufficient mutual consideration.

I hereby guarantee full payment to 1 Source Chiropractic & Physical Medicine, Inc. and agree that I will remain personally responsible for any unpaid charges. I also grant 1 Source Chiropractic & Physical Medicine, Inc a lien against any recovery which I may have now or in the future against any responsible insurance carrier. **I promise to sign a letter of protection in favor of 1 Source Chiropractic & Physical Medicine, Inc. and I hereby direct that any attorney representing me now or in the future execute a letter of protection in favor of 1 Source Chiropractic & Physical Medicine.**

I hereby authorize and direct my personal injury protection insurance company or group health insurance companies to pay directly to 1 Source Chiropractic & Physical Medicine, Inc. my personal injury protection benefits for care and treatment rendered to me by 1 Source Chiropractic & Physical Medicine, Inc.

I hereby assign my personal injury protection rights and benefits to 1 Source Chiropractic & Physical Medicine, Inc. If any portion of this document is deemed to be inconsistent with an assignment of rights and benefits within the meaning of Florida Statutes § 627.736, said portion shall be rewritten in order to conform with Florida law to give full effect to the intended purpose of this agreement, said intended purpose being to create an assignment of rights and benefits from **(insurance carrier)** ___________________________ to 1 Source Chiropractic & Physical Medicine, Inc.

I hereby grant 1 Source Chiropractic & Physical Medicine, Inc. a limited Power of Attorney to endorse checks made payable to me for PIP benefits. I grant to 1 Source Chiropractic & Physical Medicine, Inc. full power and authority to endorse and sign checks or drafts for payment of bills submitted by 1 Source Chiropractic & Physical Medicine, Inc.

I authorize and direct my present or future attorneys and my personal injury protection insurance carrier, or carriers, to release medical and legal information about me to 1 Source Chiropractic & Physical Medicine, Inc.

Patient Signature: _____________________________________Date: _____/_____/_____

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Jorge L. Santana, D.C.

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 Doctor 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 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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Jorge L. Santana, D.C.

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

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Jorge L. Santana, D.C.

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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Jorge L. Santana, D.C.

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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Jorge L. Santana, D.C.

Standard Disclosure and Acknowledgement Form
Personal Injury Protection - Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

1. The services or treatment set forth below were **actually rendered.** This means that those services have **already been provided.**

____

____

2. I have the right and the **duty to confirm** that the services have already been provided.
3. I was **not solicited** by any person to seek any services from the medical provider of the services described above.
4. The medical provider has **explained** the services to me for which payment is being claimed.
5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to $500.

Insured Person (patient receiving treatment or services) or Guardian of Insured Person:

Name *(PRINT or TYPE)*	Signature	Date

The undersigned licensed medical professional or medical director, if applicable, affirms the statement numbered 1 above and also:

A. I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.

B. The treatment or services rendered were explained to the insured person, or his or her guardian, **sufficiently** for that person to sign this form with informed consent.

C. The accompanying statement or bill is **properly completed** in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to **truthfully, accurately**, and in a **substantially complete** manner.

D. The coding of procedures on the accompanying statement or bill is proper. This means that **no service has been upcoded, unbundled**, or constitutes an invalid **or not medically necessary diagnostic test** as defined by Section 627.732 (15) and (16), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Licensed Medical Professional Rendering Treatment/Services or Medical Director, if applicable *(Signature by his/ her **own hand**):*

Name *(PRINT or TYPE)*	Signature	Date

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of Claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234(1)(b), Florida Statutes.

Note: The **original** of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may **not** be electronically furnished. Failure to furnish this form may result in non-payment of the claim.