Caring Concepts, Inc

Patient Intake

Today's Date:_____

PATIENT INFORMTION

Last Name: _____
First Name: _____
Address_____
City _____ **State**_____ **Zip**_____
Birthdate_____ **Age**_____
Sex: M F **Status:** Married Widowed Single
Patient Employer/School _____
Occupation_____

SPOUSE INFORMATION

Spouse's Name_____

IF MINOR , PARENT/GUARDIAN INFORMATION

Parent Name: _____
Relationship: _____
Parent Name: _____
Relationship: _____

CONTACT IN CASE OF EMERGENCY

Name_____**Relationship**_____
Phone _____

PHONE NUMBERS

Cell _____
Home _____
Work _____

HEALTH INSURANCE INFORMATION

Primary Insurance _____
ID# _____ **Group#**_____
Policy Holder's Name_____
Policy Holder's Date of Birth_____
Relationship to Patient: _____
2nd Insurance _____
ID# _____**Group#**_____

ACCIDENT INFROMATION

Is condition due to an accident? __ Yes __ No
Type of Accident __ Auto __ Work __ Other _____
Accident Date: _____
Insurance: _____
Claim #:_____
Attorney Name _____

WOULD YOU LIKE A TEXT OR EMAIL REMINDER?
How much notice would you like before your appointment: 1 day 2days 1 week 1 hour 2 hours 4 hours

___Text (phone carrier) Boost Mobile AT&T Cricket Sprint T-Mobile Verizon Virgin Mobile
___Email _____

What is your reason for coming today? _____
_____
_____

What treatment have you already received for your condition? Medications Surgery Physical Therapy
Chiropractic None Other: _____
Primary Doctor: _____ **Date of Last:** Physical Exam _____
When was the last X-ray: _____ **Body area:** _____ **Where:** _____
When was the last MRI: _____ **Body area:** _____ **Where:** _____
Women: Are you pregnant? __ Yes __ No **Due Date:** _____
Medical History: provide date & description (ex. Auto accident '96, High Blood Pressure, hip replacement 2014, cancer)
_____
_____
_____
_____
Medication: _____
_____

Authorizations:

A. I hereby authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the third party who accepts assignment.

B. I authorize payment of any medical benefits from third-parties for benefits summated for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum I now or hereafter owe this office by my attorney, out of proceeds of any settlement of any case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and services rendered.

C. I understand and agree that health and accident policies are an arrangement between an insurance carrier and me. Furthermore, I understand this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment my care and treatment, any fees for products or professional services rendered will be immediately due and payable.

D. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

My Financial Responsibility

Payment or Co-payment is expected when services are rendered. We will gladly process your insurance. The portion we collect is an estimate only. You are responsible for any amount not paid by your insurance.

I understand that I will be responsible for all co-pays, deductibles and/or portion of fees that my insurance does not cover. If my insurance does not respond to my submitted medical claims within 60 days, I understand that I am responsible for all charges. I also understand that I will be responsible for all costs incurred should legal or other means of recovery for these charges become necessary.

Note: There is a $20.00 fee for all appointments not canceled 24 hours prior to scheduled time.
There is a $35.00 service charge for any returned check.

I have read the above statements and understand that I am personally financially responsible for all services not covered by my insurance company. I am also responsible for applicable annual deductible and/or co-payment.

X_____ _____

Signature of patient or person acting on patients behalf Date

Caring Concepts, Inc
1215 W Baker St.
Plant City, FL 33563
813-754-2273

Consent to use PHI

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information
Your Protected Health Information will be used by Caring Concepts, Inc. or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices
You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office.

_____Patient Initials I have received a copy of the Notice of Patient Privacy Policy.

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Notice of Treatment in Open or Common Areas
Treatment itself will not occur in an open area; however, we may ask about your symptoms in an open are. There are private areas available upon request if you would prefer.

Disclosure Authorization:
I authorize the disclosure of health information about me as described below:
Persons who MAY RECEIVE INFORMATION (relatives, friends, doctors)

_____

_____

If you do not wish for us to contact you by telephone regarding appointments and or test results please indicate this to the front office.

Revocation of Consent
You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

_____ _____ _____

Patient or Legally Authorized Individual Signature | Date

Print Patient's Full Name | Time

Witness Signature | Date

CARING CONCEPTS, INC.

Todd Glenn, D.C.
William Garrison, D.C.
Vel Garrison, Clinic Adm.

1215 W. Baker St.
Plant City, FL 33563
Telephone: (813) 754 -2273
Fax: (813) 754 -5680

Informed Consent

Patient Name_____ Date_____

The primary treatment used by doctors of chiropractic is the spinal manipulation adjustment. I will use my hands or a mechanical device upon your body in such a way as move your joints. You may feel or sense movement. Your treatment may also include one or more of the following therapy modalities: ultrasound, interferential current, electrical muscle stimulation (SINE), hot or cold packs.

Risks:
As with any health care procedure, there are certain complications which may arise during a chiropractic adjustment, those complications may include: disc injuries, dislocations, muscle strain, or fractures. Some types of manipulations of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke. There is very little risk of harm associated with of the therapy modalities used in this office.

The probability of the above risk occurring is rare.
Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of the history and examination and/or x-ray. Stroke has been the subject of tremendous disagreement within and without the profession with a study suggesting that there is at most a one-in-a-million chance of such an outcome. Since even that risk should be avoided if possible we employ tests in our examination which are designed to identify if you may be susceptible to that kind of injury.

Other treatment options may include: self-administered analgesics and rest, medical care with prescription drugs, hospitalization, and surgery.

Do not sign until you have read and understand the above.

I have read the above explanation of the chiropractic treatment. By signing below I state that I have weighed the risk involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risk I hereby give my consent to that treatment.

Signature_____ Date_____

Witness_____

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1 215 W. Baker St.
Plant City, FL 33563
Telephone: (813) 754 -2273
Fax: (813) 754 -5680

Assignment and Instruction for Direct Payment

Patient _____

Ins ID #:_____ Group #: _____

I hereby instruct and direct the _____ Insurance Company to pay by check made out to:

Caring Concepts
1215 W Baker St
Plant City, FL 33563

If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct you to make out the check to me and mail as follows:

C/O Caring Concepts
1215 W Baker St
Plant City, FL 33563

The professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

_____ _____
Signature of Policyholder Date

_____

Signature of Claimant, if other than Policyholder

_____ _____

Witness Date