

CONFIDENTIAL HEALTH INFORMATION QUESTIONNAIRE

Dear Patient: This information is considered confidential. We need this information because we care enough to want to know, and your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond favorably, we will not accept your case. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. Thank you. Dr. Peter J. Brockman, D.C.

Patient First Name: _____ Last Name: _____

Address: _____ City: _____

State: _____ ZIP: _____ SS#: _____ Gender: M F

Date of Birth: _____ Age: _____ Drivers License# _____

Marital Status: M S D W Spouse Name: _____

Best number to reach you: _____ Alternate number: _____

Work #: _____ E-mail: _____

Emergency Contact: _____ Phone: _____ Relationship
Other Than Your Spouse to you _____

Occupation: _____ Place of employment: _____

How did you hear about us? _____

What is the reason you are seeing the Dr. today? _____

Is your visit due to an accident? _____ If yes, please notify the receptionist now.

Relevant Medical History. Please circle all the conditions you have or had previously.

Arthritis Asthma Anemia BackPain/Spasm Cancer Concussion Convulsion Diabetes
Digestion Problems Dizziness Epilepsy Fibromyalgia Hand or Wrist Pain Headaches
Heart Problems Hepatitis High Blood Pressure HIV Measles Multiple Sclerosis
Muscular Dystrophy Neck pain/spasms Numbness Neuritis Polio Rheumatic Fever
Sinus trouble Sciatica TB Venereal Disease Other: _____

Please list all medications you are currently taken: _____

Vitamins: _____

Are you allergic to any medications? _____

Patient Name: _____ PAGE 2

Please list any operations you have had and the appointment date: _____

Do you smoke: Y N Amount per day: _____

Drink alcoholic beverages? Y N LIGHT MEDIUM HEAVY

Exercise? NEVER SOMETIMES FREQUENTLY REGULARLY

Please circle the following symptoms you are experiencing:

- | | | |
|-------------------|----------------------|-------------------------------|
| Arm/shoulder pain | Feet/toe numbness | Neck pain |
| Back pain | Head/finger numbness | Neck stiffness |
| Back stiffness | Headaches | Shortness of breath |
| Chest pain | Irritability | Sleep difficulty |
| Dizziness | Jaw problems | Stomach upset |
| Ear buzzing | Leg pain | Tension |
| Ear ringing | Memory Loss | Vision blurred |
| Fatigue | Nausea | Loss of bladder/bowel control |
- Weakness: Y N Where _____

Is your condition: getting better staying the same getting worse

Rate the severity of your pain on a scale of 1 (least pain) to 10 (severe pain) _____

Type of pain: (circle all that apply) Sharp Dull Throbbing Numbness Aching
Shooting Burning Tingling Cramps Stiffness Swelling Other _____

Is the pain worse in the a.m. mid-day p.m. How often do you have pain? Constant Comes and goes

Does your pain interfere with your WORK SLEEP DAILY ROUTINE RECREATION

Circle activities or movements that are painful to perform: SITTING STANDING WALKING
BENDING LIFTING LYING DOWN SNEEZING COUGHING OTHER _____

What makes it feel better? ICE WARM COMPRESS REST STRETCHING
REPOSITIONING PAIN MEDS OTHER: _____

Have you seen any other Dr's for these symptoms: Y N If so, who? _____

Phone # _____

Treatment received: _____

Have you had MRI or CAT SCAN? Where? _____

Have you had x-rays in the last 6-9 months? _____ Where? _____

Phone Number: _____

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Describe specific physical activities that you do at work _____

Describe what activities that you have difficult performing without discomfort or pain? Home or Work _____

Have you had Chiropractic care before? Y N Date: _____ Dr. _____

Did your condition improve Y N

Treatment received: Adjustments Massage Physical Therapy Other _____

Are you RIGHT or LEFT HANDED Have you had similar or same symptoms before? Y N

If yes, please describe _____

Treatment received: _____ Did the symptoms go away? Y N

Are you pregnant? Y N If yes, Due date: _____

By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular moment. Patient initials: _____

Is there anything else you feel the Dr should know to treat your condition today?

I certify that the above information is correct and true to the best of my knowledge. I voluntarily consent to the rendering of care, indicating, treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of Dr. Peter J. Brockman, D.C. and it is the responsibility of the staff to carry out the instructions of Dr. Peter J. Brockman, D.C.

I hereby authorize and direct you, my insurance company, to pay directly to South Lake Wellness & Injury Center, PL ("Assignee"), such sums as may be due and owing Assignee for the services rendered to me both by reason of accident or illness, and by reason of any other bills that are due Assignee. I hereby authorize any insurance company to pay directly to the Assignee the amount of this and/or any future bills for services rendered to me and to release any information requested that is pertinent to my insurance company(s) for which I have benefits available.

X Print Patient Name: _____

X Patient Signature: _____

Staff Witness: _____

Date: _____

Informed Consent for Examination and Treatment

I (we) hereby consent to the performance of examination and treatment on me or on _____, by the licensed doctors of chiropractic, medical doctors, and/or licensed physical therapists who may be employed by or engaged in practice in this clinic.

I have had an opportunity to discuss with the doctor(s) or other clinic personnel the nature and purpose of the different physical therapy procedures and chiropractic treatment (manipulation/adjustment). I understand that neither chiropractic nor medical treatment is an exact science and that my care may involve judgments based upon facts and information known to the doctor. The doctor uses this judgment to attempt to anticipate or explain risks and complications and an undesirable result does not necessarily indicate an error in judgment. No guarantee for results can be made or expected but rather I wish to rely on the doctor to choose and recommend a best course of treatment based upon facts known that is in my best interests.

I further understand that there are certain degrees of risk associated with chiropractic health care and physical therapy, which includes rarely, but not limited to fractures, disc injuries, strokes, and strain/sprains and am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

I have read, or the above information has been explained regarding consent. I have had an opportunity to ask questions about my examination and treatment. By signing below, I agree and intend this consent form to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment.

Female Patients: By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time. Date of last menstrual period _____.

X _____
Patient's Name (Print)

X _____
Patient's Signature

Date

Relationship or authority if not signed
By patient

Witness

NOTICE OF INFORMATION PRACTICES

Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on disclosures.

Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical records for treatment.

You may inspect and receive copies of your records within 30 days of a request to do so. There may be a reasonable cost-based fee for photocopying, postage, and preparation. X-rays taken in this office are property of South Lake Wellness & Injury Center and are only loaned out to a patient for 30 days. You will be required to return them to us within that time frame.

You may request changes to your records. Our practice has the right to accept or deny your request.

We maintain a history of protected health information disclosures that is accessible to you.

In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and staff.

Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office.

You may file a complaint about privacy violations by contacting our Office Manager, Mary Beth, at 352-241-4111.

The effective date of this Notice of Information Practices is March 9, 2007.

X **Patient Signature:** _____ **Date:** _____

Staff Witnessed by: _____

South Lake Wellness & Injury Center, PL

2560 East Highway 50

Suite 106

Clermont, Florida 34711

Financial Policy and Insurance Policy

Thank you for choosing South Lake Wellness & Injury Center, PL as your health care provider. As a part of our services, we try to contain the ever-rising cost of health care. In an effort to do that, we request you read and sign the following financial policy prior to treatment. Patient or responsible party must complete our information and insurance form before seeing the doctor. This form must be updated every two years, or upon any change of information, i.e. condition, address, phone, employer, insurance, etc.

- **FULL PAYMENT, CO-PAYMENT, PERCENTAGES AND/OR DEDUCTIBLE ARE DUE AT THE TIME SERVICES ARE RENDERED, AT THE END OF EACH WEEK OR BY AN AUTHORIZED PAYMENT PLAN.** We accept cash, checks and major credit cards. If you are a cash patient, our payment plans make care an affordable part of your family budget. Other payment arrangements can be made in advance of treatment. X Initial _____

- **Office Policy:** Insurance is billed as a courtesy to our patients; however, the patient is the final responsible party. This policy reduces your out-of-pocket expenses and allows you to place your family under care. We do not accept assignment for secondary insurance carriers, but will be happy to provide you with a claim form for your secondary carrier. If your insurance has not paid in 60 days, you (the patient) will be notified, and will need to take an active part in the recovery of your claim. If your insurance carrier has not paid in 90 days, you (the patient) will be responsible for payment in full for any outstanding balances. X Initial _____

When your schedule of visits is once per month or longer; you may not be eligible for insurance assignment. Charges for services rendered may be due as they are rendered. We will continue to provide you with an insurance claim form. If you discontinue care for any reason other than discharge by the doctor, all balances will become immediately due and payable in full by you, regardless of any claim submitted. X Initial _____

- **Minor Patients (under the age of 18):** The adult accompanying a minor (parent/guardian) is responsible for full payment at the time of service. We must have parents/guardians permission prior to treatment of a minor. I hereby request and authorize the doctors to perform diagnostic tests and render chiropractic adjustments and other treatment to my minor daughter/son, _____ My relationship to the patient is _____. Initial _____

- You must realize; however, that;
 1. Your insurance is the contract between you, your employers and the insurance company. We are not a party in the contract.
 2. You are responsible for all reasonable/necessary charges that you are denied/not covered by your insurance company.

- I authorize release of all information and records, including diagnostic reports, consulting reports, x-ray reports and x-rays, concerning my health care and treatment to my insurance company. I hereby authorize payment of insurance benefits directly to South Lake Wellness & Injury Center, PL, otherwise payable to me.

- I have read and understand the above. (Please sign below..)

X Patient name (print): _____

X Signature: _____

Date: _____

Witness:

Date:



South Lake Wellness and Injury Center, PL

2560 East SR 50
Suite 106
Clermont, FL 34711

V: 352-241-4111
F: 352-241-4113

February 20th, 2006

Re: TOS Fee Schedule

Attention Patients and Insurance Carriers:

Effectively immediately, all patients are eligible to receive a 30% discount if they pay at the time of service. No Insurance will be billed or researched. Payment must be received in full and at the time services are rendered. No exceptions will be made. Supplies are excluded from this discount.

I agree to pay for all services on the date rendered. No insurance will be billed.

Signature _____ Date: _____

At this time, I am waiving my rights to the 30% discount. I am authorizing you to bill my insurance company. I am agreeing to pay any deductible, co-payment or co-insurance related to my insurance at regular price.

X Signature _____ Date: _____

Witnessed by: _____ Date: _____

