GOLD COAST CHIROPRACTIC

CONFIDENTIAL HEALTH INFORMATION

The 100 Year Lifestyle®

Please allow our staff to photocopy your driver's license and insurance details. All information you supply is confidential. We comply with all federal privacy standards. Please print clearly.

Today's Date: _____

_____
Whom may we thank for referring you?

_____
Your Last Name

_____
Your First Name

_____
Address

_____ ____ _____
City **State** **ZIP**

_____ _____
Home Phone **Cell Phone**

_____
Work Phone

_____
Spouse's Name

Have you consulted a chiropractor before?
❒ No ❒ Yes **When?** _____

Gender : ❒ **Male** ❒ **Female**
Birth Date : _____ **Age** _____

Marital Status: ❒ S ❒ M ❒ D ❒ W ❒ SP

_____
Email Address

(By providing your email address you agree to receive communication from GCC. We absolutely do not share, sell, or rent any personal information collected.)

Preferred Method of Contact: **Phone** **Email** **Text**

_____
Children (Ages)

_____
Emergency Contact

The symptom(s) that have prompted me to see care today include: _____

_____

And are the result of

○ An accident or injury ○ Work ○ Auto ○ Other
○ A worsening long-term problem ○ An interest in ○ Wellness ○ Other _____

Onset (When did you first notice start and your current symptoms?)

_____

Intensity (How extreme are your current symptoms?)

0 ○-○-○-○-○-○-○-○-○-○-10

Absent Uncomfortable Agonizing

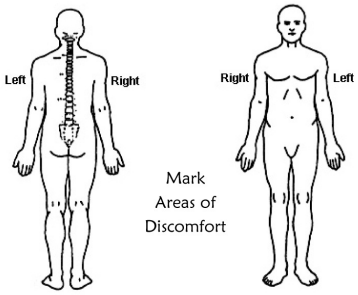
Duration and Timing (When did it how often do you feel it?)

○ Constant
○ Comes and goes. How often? _____

Quality of symptoms (what does it feel like?)

❒ Numbness
❒ Tingling
❒ Stiffness
❒ Dull
❒ Aching
❒ Cramps
❒ Nagging
❒ Sharp
❒ Burning
❒ Shooting
❒ Throbbing
❒ Stabbing
❒ Other

Location (Where does it hurt?)
Circle the area(s) on the illustration



What else should Dr. Ronny know about your condition?

_____
_____
_____

Radiation (Does it affect other areas of your body?) To what areas does the pain radiate, shoot or travel.) _____
_____

Aggravating or relieving factors (What makes it better or worse, such as time of day, movements, certain activities, etc.) _____
_____

Prior interventions (What have you done to relieve the symptoms? _____
_____
_____

Past Personal, Family and Social History

Please identify your past health history, including accidents, injuries, illnesses and treatments. Please complete each section fully.

Illnesses

Check the illnesses you have **Had** in the past or **Have** now

❒AIDS
❒Alcoholism
❒Allergies
❒Arteriosclerosis
❒Cancer
❒Chicken Pox
❒Diabetes
❒Epilepsy
❒Glaucoma
❒Goiter
❒Gout
❒Heart disease
❒Hepatitis
❒Other_____
❒HIV Positive
❒Lyme Disease
❒Measles
❒Multiple Sclerosis
❒Mumps
❒Polio
❒Rheumatic fever
❒Scarlet fever
❒Sexually transmitted disease
❒Stroke
❒Tuberculosis
❒Typhoid fever
❒Ulcer

Treatments

Check the ones you've received in the **Past** or **Currently**

Past	Currently	
❒	❒	Acupuncture
❒	❒	Antibiotics
❒	❒	Birth control pills
❒	❒	Chemotherapy
❒	❒	Chiropractic care
❒	❒	Herbs
❒	❒	Homeopathy
❒	❒	Hormone replacement
❒	❒	Inhaler
❒	❒	Massage therapy
❒	❒	Physical therapy
❒	❒	Nutritional supplements

Social History

Tell Dr. Ronny about your health habits and stress levels.

Alcohol use	❒Daily	❒Weekly	How much? _____
Coffee use	❒Daily	❒Weekly	How much? _____
Tobacco use	❒Daily	❒Weekly	How much? _____
Exercising	❒Daily	❒Weekly	How much? _____
Pain Relievers	❒Daily	❒Weekly	How much? _____
Soft drinks	❒Daily	❒Weekly	How much? _____
Water intake	❒Daily	❒Weekly	How much? _____

Medications (Please list all prescription or non-prescription medications or Supplements you are currently taking)

_____

_____

_____

_____

_____

Family History

Some health issues are hereditary. Tell Dr. Ronny about the health of your immediate family members.

Relative	Age (if living)	State of health	Illnesses	Age at death	Cause of death
Mother	_____	❒Good ❒Poor	_____	_____	_____
Father	_____	❒Good ❒Poor	_____	_____	_____

Are there any other hereditary health issues that you know about? _____

Your oldest grandparent on record lived to the age of _____. ❒ Still living ❒ Deceased

_____

What is the major stressor in your life?

_____

How much sleep do you average per night (in hours)?

_____

What is the type and approximate age of your mattress and pillow?

_____

What is your preferred sleeping position?

Describe your typical eating habits? ❒Skip breakfast ❒Two meals a day ❒ Three meals a day ❒Snacking between meals

_____

What would be the most significant thing that you could do to improve your health?

_____

In addition the main reason for your visit today, what additional health goals do you have?

Activities of Daily Living
How does this condition currently interfere with your life and ability to function?

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	O	O	O	O
Rising of chair	O	O	O	O
Walking	O	O	O	O
Standing	O	O	O	O
Lying down	O	O	O	O
Bending over	O	O	O	O
Climbing stairs	O	O	O	O
Using a computer	O	O	O	O
Getting in/out of car	O	O	O	O
Driving a car	O	O	O	O
Looking over shoulder	O	O	O	O
Caring for family	O	O	O	O
Grocery shopping	O	O	O	O
Household chores	O	O	O	O
Lifting objects	O	O	O	O
Reaching overhead	O	O	O	O
Showering or bathing	O	O	O	O
Dressing myself	O	O	O	O
Love life	O	O	O	O
Getting to sleep	O	O	O	O
Staying asleep	O	O	O	O
Concentrating	O	O	O	O
Exercising	O	O	O	O
Yard work	O	O	O	O

Upon the completion of your first visit, you will receive a Chiropractic Report to discuss the different types of Active Life Plans that are available to you. Active Plans are designed to get you feeling better quickly and to help you and your family be as healthy as possible.

Please review the Active Life Plan Explanations prior to your Chiropractic Report so you can choose the level of participation that supports you in reaching all of your health goals.

As a result of my chiropractic care, I would like to (Please check all that apply)

- ❒ Feel better quickly
- ❒ Have a healthier spine and nervous system
- ❒ Live a healthier lifestyle

Acknowledgements
To set clear explanations, improve communication and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initial

_____ I instruct the chiropractor to deliver the care that, in his or her professional judgment, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distant healing art from medicine and does not proclaim to cure any named disease or entity.

_____ I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

_____ I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

_____ I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.

_____ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

Patient Signature _____ **Date** _____

GOLD COAST CHIROPRACTIC

I certify that I'm the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office, its staff and any fill in doctors to examine and treat my condition as the doctors see fit. If I am pregnant, plan on becoming pregnant or think I am pregnant I will notify the doctor. I will have or have had the opportunity to discuss the nature and purpose of the chiropractic treatments. I understand 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. It is not unreasonable to expect the doctor to be able to anticipate and explain all risks and complications of a given procedure on any particular visit and I wish to rely on the doctors to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interest. There is no promise, implied or otherwise, of a cure for any symptom, disease or condition as a result of treatment in this clinic. By signing this document, I am consenting to treatment. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment. I hereby authorize and direct any and all insurance carriers, attorneys, agencies, governmental departments, companies, individuals, and/or legal entities ("payers"), which may elect or be obligated to pay, provide, or distribute benefits to me for any medical conditions, accidents, injuries, or illnesses, past, present, or future ("condition") to pay directly and exclusively in the name Ronny Bergman, DC PC ("office") such sums as may be owing to Ronny Bergman, DC PC for charges incurred by me at the office relating to my condition ("charges"), with such payments to be made exclusively in the name of Ronny Bergman, DC PC. I further grant a lien to Ronny Bergman, DC PC with respect to my charges. This lien shall apply to all payers and to the full extent permitted by law. For the purposes of this document (herein, "Assignment and Lien"), "benefits" shall include, but not limit to, proceeds for any settlement, judgment, or verdict, as well as any proceeds relating to commercial health or group insurance, attorney retainer agreements, medical payment benefits, personal injury protection, no-fault coverage, uninsured and underinsured motorist coverage, third party liability distributions, disability benefits, worker's compensation benefits, and any other benefits or proceeds payable to me for the purpose stated herein. In the event that I retain one or more attorneys to represent me in this matter, who are not located in New York, I will direct each attorney to issue a letter of protection to this office regarding my charges. Upon issuance, I hereby agree that such letter(s) of protection cannot be revoked or modified without the express written consent of this office. I authorize this office to release any information regarding my treatment or pertinent to my case to all payers as defined above to facilitate collection under this Assignment and Lien. I further authorize and direct all payers to release to Ronny Bergman, DC PC any information regarding any coverage or benefits which I may have including but not limited to, the amount of the coverage, the amount paid thus far, and the amount of any outstanding claims, I hereby direct this Office to file a copy of this Assignment and Lien, together and applicable charges, with any or all payers, regardless of whether a claim has been established with said payers. I hereby Ronny Bergman, DC PC, payment of an account relating to me, my spouse, or any of my dependents. I further authorize Ronny Bergman, DC PC to apply any credit balances on charges incurred by me to any other outstanding charges still owed by me, my spouse, or my dependents, regardless of whether or not these other charges are related to my condition. I understand that I remain personally responsible for the total amounts due to Ronny Bergman, DC PC for their services, even if the services are not deemed medically necessary and/or after a payment has already been issued and made to be returned due to a lack of medical necessity or over utilization. This Assignment and Lien does not constitute any consideration for this Office to await payments and it may demand payments from me immediately upon rendering services at its option. If this office must take an action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse Ronny Bergman, DC PC for all costs of such collection efforts, including, but not limited to, all court costs and all attorney fees. I am aware that Dr. Bergman is an out of network provider and I am aware that I may be financially responsible for services that are not covered by my insurance company, including deductibles, and or co-pays.

This Assignment and Lien shall not be modified or revoked without the mutual written consent of Ronny Bergman, DC PC and myself. I hereby revoke any previously signed authorizations, whether executed at this office or any other office to the extent that the terms of those authorizations conflict with the terms of this Assignment and Lien.

PATIENT SIGNATURE _____ DATE _____

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

EFFECTIVE: January 1, 2006

In the course of your care as a patient at Gold Coast Chiropractic we may use or disclose personal and health related information about you in the following ways:

- *Your protected health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- *Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may responsible for the payment of services provided to you.
- *Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

You have a right to request restrictions on our use of your protected health information for treatment, payment and operations purposes. Such requests are not automatic and require the agreement of this office.

Your name, address, telephone number, e-mail address and health records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you. Patient is consenting to communications via email, detailed voice mail messages left on voice mail, thank you cards for referring, b-day cards.

If you are not home to receive an appointment reminder or other related information, a message may be left on your answering machine or with a person in your household. You have a right to confidential communications and to request restrictions relative to such contacts. You also have the right to be contacted by alternative means or at alternative locations.

We are permitted and may be required to use or disclose your health information without your authorization in these following circumstances:

- If we provide health care services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization. If you provide an authorization for release of information you have the right to revoke that authorization at a later date.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or, if you would like the information in a specific form please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for as long as the information remains in our files. In addition you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the health protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information. We are further required by law to abide by the terms of this notice while it is in effect.

We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to: RONNY BERGMAN, DC

X_____ _____

Patient Signature Date