8401 Balm Street Spring Hill, FL 34607

Patient Name____ Date: __________________________
Email: ____
SS # ____________________ DOB___________ ☐ Male ☐ Female
Home phone_____________________ Cell Phone ____________________________
Check appropriate Box: ☐Minor ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated
Patient's Address ____
City _______________ State______ Zip_______________
Employer Name:
____
Spouse or Patient's Guardian name_____________________________ Spouse's Employer_______________
Whom may we thank for referring you? ____
Person to contact in case of an emergency_________________________________ Phone________________
In case of a medical emergency, if the patient is of school age 15+, is ok to treat in my absence.

____ ___________________________
Parent or Guardian Signature Date

Responsible Party
Name of The Person responsible for this account __________________________Relationship to Patient ________________
Address ____Home Phone __________________________
E-Mail ____Cell Phone ____________________________
Driver's License # _________________________________ Date of Birth: ______________________________________
Is the person currently a patient at our office? ☐ Yes ☐ No
Do you have any Medical insurance? ☐ Yes ☐ No if yes, complete the following:
Name of the insured____ Relationship to patient_____________________
Birthdate_________________ SS#/SIN____________________ Name of Employer_____________ Work Phone __________
Address of Employer_____________________________________ State ____________ Zip___________________________
Insurance Company______________________________ Group #_________________ Union or local # ________________
Ins. Co. Address _________________________________ City _________________ State _________ Zip________________

Health History

Patient Name: ____DOB: __________________Date:____________

Chief Complaint: ____
History of Present illness:
Location: ____
(Where is the pain/problem?)
Severity: ____
(How severe is the pain/problem on a scale of 1-10 with 10 Being the most severe?)
Timing: ____
(Does the pain/problem occur at a specific time?)
Associated Signs/Symptoms __________________________
____
(What other associated problems have you been having?)

Quality: ____
(Example: normal vs abnormal color, activity, etc..)
Duration: ____
(How long have you had this pain/ problem? When did it start?)
Context: ____
(Where were you at the onset of this pain/problem?)
Modifying Factors ____________________________________
____
(What makes the pain/problem worse or better? Have you had previous episodes?)

Past Medical History
(Have you ever had the following: (circle "yes" or "no"/ leave blank if you are uncertain.)

Polio...........NO YES
Ulcer...........NO YES
Stroke.........NO YES
Cancer........NO YES
Hernia.........NO YES
Asthma.......NO YES
Mumps.......NO YES
Measles......NO YES
Arthritis......NO YES
Anemia.......NO YES
Diabetes.....NO YES
Epilepsy......NO YES
Hepatitis.....NO YES
Bronchitis...NO YES

Glaucoma..........NO YES
Small pox............NO YES
AIDS & HIV.........NO YES
Diphtheria..........NO YES
Pneumonia ....NO YES
Chicken Pox........NO YES
Tuberculosis.......NO YES
Scarlet Fever...... NO YES
Back Trouble.......NO YES
Hemorrhoids.......NO YES
Kidney Disease....NO YES
Infectious Mono...NO YES
Hives of Eczema...NO YES
Thyroid Disease...NO YES

Bladder Infection......................NO YES
Venereal Disease......................NO YES
Rheumatic Fever......................NO YES
Whooping Cough.....................NO YES
Bleeding Tendency..................NO YES
High Blood Pressure................NO YES
Low Blood Pressure.................NO YES
Migraine Headaches................NO YES
Mitral Valve Prolepses.............NO YES
Blood or Plasma Transfusion....NO YES
Any Other Disease.....................NO YES
(Please List):
____
Date of Last Chest X-Ray___________

Previous Hospitalizations/Surgeries/Serious Illnesses	When?	Hospital, City, State
______________________________	____________	________________
______________________________	____________	________________
______________________________	____________	________________

Medication: (include nonprescription)
____
____
Have you ever taken Fen-Phen/Redux? NO YES
Are you taking any medications (prescription or over the counter) for acid indigestion?
O yes O no if yes what type: ____

Patient Social History:

Marital Status	Single: ______	Married: ______	Separated: _______	Divorced: ______	Widowed: _______
Use of Alcohol	Never: ______	Rarely: _______	Moderate: _______	Daily: ________	
Use of Tobacco	Never: ______	Rarely: _______	Moderate: _______	Daily: _________	
Use of Drugs	Never: ______	Type/Frequency:			

____

Excessive Exposure
At home or at work to: Fumes: ______ Dust: ______ Solvents: ______ Airborne Particles: _______ Noise: _______

CLINICIAN SIGNATURE: ____ **DATE REVIEWED:**______________________

Name:____DOB_________________ Date:__________________

Family Medical History:

	Age	Disease	If Deceased, Cause Of Death
Father	_________	____	____
Mother	_________	____	____
Siblings	_________	____	____
	_________	____	____
	_________	____	____
Spouse	_________	____	____
Children	_________	____	____
	_________	____	____
	_________	____	____

Indicate which of the below you have experienced in the last 1-2 months
1=Never; 2=Rarely; 3=Occasionally; 4=Frequently; 5=Constantly

Eyes/Ears/Nose/Throat/ Respiratory	
Asthma	1 2 3 4 5
Stuffy Nose	1 2 3 4 5
Hay Fever	1 2 3 4 5
Sore throat	1 2 3 4 5
Chronic Cough	1 2 3 4 5
Chest Congestion	1 2 3 4 5
Frequent Sneezing	1 2 3 4 5
Itchy/Watery Eyes	1 2 3 4 5
Drainage	1 2 3 4 5
Earache or Infection	1 2 3 4 5
Itching	1 2 3 4 5
Hoarseness	1 2 3 4 5
Shortness of Breath	1 2 3 4 5
Wheezing	1 2 3 4 5

Neurological	
Headaches	1 2 3 4 5
Migraines	1 2 3 4 5
Dizziness	1 2 3 4 5
Numbness	1 2 3 4 5
Tingling	1 2 3 4 5
Lightheadedness	1 2 3 4 5
Pins/needles in hands or feet	1 2 3 4 5

Muscular/Skeletal	
Muscle Aches	1 2 3 4 5
Fibromyalgia	1 2 3 4 5
Arthritis	1 2 3 4 5
Joint Pain	1 2 3 4 5
Low Back Pain	1 2 3 4 5
Neck Pain	1 2 3 4 5
Wrist/Hand Pain	1 2 3 4 5
Elbow Pain	1 2 3 4 5
Shoulder Pain	1 2 3 4 5
Hip Pain	1 2 3 4 5
Knee Pain	1 2 3 4 5
Ankle/Foot Pain	1 2 3 4 5
Pain between shoulder blades	1 2 3 4 5

General	
Fatigue	1 2 3 4 5
Malaise	1 2 3 4 5
Weakness	1 2 3 4 5
Tiredness	1 2 3 4 5
Irritability	1 2 3 4 5
Constipation	1 2 3 4 5
Diarrhea	1 2 3 4 5
Feeling foggy	1 2 3 4 5
Forgetfulness	1 2 3 4 5

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

____ ____________________
Signature of the Patient, Parent or Guardian Date

Doctor's Review

____ ____________________
Signature of Doctor Date

Medical Release

A photocopy of this document shall be sufficient to authorize any person having records of medical treatment, services, or supplies pertaining to me to be true copies of same to **Aligned Integrative Medicine, LLC.** or any Insurer providing coverage to me in connection with processing of any claim for benefits made by me or by the assignee herein. A photocopy of this document shall be as binding as an original signature page.

The undersigned does hereby ratify and confirm any and all actions taken by the said attorney in accordance with this special power and which the attorney shall do or cause to be done by virtue of these presents.

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS
AS WELL AS AN APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE
AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay **Aligned Integrative Medicine, LLC.** as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that ***have been*** **or** ***will be*** rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan or this document is to be considered as valid and as enforceable as the original. **This is to inform you that your insurance company may require you to pay a co-payment, co-insurance, or deductible. Due to several different insurance companies and policies, it is sometimes difficult to determine exactly what your responsibility will be. If we can not determine what your co-payment or co-insurance will be, we will bill the insurance company and the insurance company will inform us the amount of patient responsibility. You will then be billed accordingly. ___________ Please initial that you acknowledge and understand this policy**

Signed this ______ day of _________________, 20 ____.

X____________________________ (SEAL)
(patient signature)

X______________________________(SEAL)
(signature of Guardian if applicable)

X______________________________
(please print patient name)

INFORMED CONSENT

This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s). This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and any other treatment deemed medically necessary by the provider. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing.

Like all forms of health care, while offering benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include but are not limited to sprain / strain injuries, irritation of a disc condition, and rarely fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke. Risks for Radiographic Imaging (X-ray) include ionizing radiation that can be harmful to a fetus for those who are pregnant or might be pregnant.

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. You have the right at any time to discontinue services. You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test or treatment ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions. I voluntarily request a physician, and/or mid-level provider (nurse practitioner, physician assistant, or clinical nurse specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s). I certify that I have read, or have had read to me the above consent, and fully understand the above statements and consent fully and voluntarily to its contents.

____ Patient

Name (Printed)   Patient or Guardian Signature

____

Relationship to patient   Date

I,____________________ being parent/legal guardian (circle one) of ________________________, do hereby grant permission for him/her to receive care from a doctor at Family Chiropractic Center For Wellness, Inc. and Aligned Integrative Medicine, LLC. This shall include when necessary standard analysis, including x-rays and corrective spinal adjustments.

Cancellation Policy

Out of respect and consideration to your Therapist, Physician and other clients, we kindly ask that you honor your scheduled appointment time. Please note that appointment space is limited daily and appointments are booked back to back. Aligned Integrative Medicine, LLC understands that unanticipated events occasionally do happen in everyone's life. In our desire to be effective and fair to all our patients' time, we kindly ask that you give at least 24 hour advance notice within normal office hours or leave a voice message on the machine when cancelling and / or changing an appointment. This allows the opportunity for someone else to schedule an appointment.

Massage: In the event that the massage was not rescheduled or cancelled **24 hours** before your appointment, Aligned Integrative Medicine and Family Chiropractic Center for Wellness, Inc. will have authorization to charge you for your full appointment time missed. ___________ Initial

Patient Rights and Responsibilities

- Patients/Clients have the **right** to be treated with dignity and respect.
- Patients/Clients have the **right** to fair treatment, regardless of race, ethnicity, creed, religious belief, sexual orientation, gender, age, health status, or source of payment for care.
- Patients/Clients have the **right** to have their treatment and other patient information kept private. Only by law may records be released without patient permission.
- Patients/Clients have the **right** to access care easily and in a timely fashion.
- Patients/Clients have the **right** to a candid discussion about all their treatment choices, regardless of cost or coverage by their benefit plan.
- Patients/Clients have the **right** to share in developing their plan of care.
- Patients/Clients have the **right** to the delivery of services in a culturally competent manner.
- Patients/Clients have the **right** to information about the organization, its providers, services, and role in the treatment process.
- Patients/Clients have the **right** to information about provider work history and training.
- Patients/Clients have the **right** to information about clinical guidelines used in providing and managing their care.
- Patients/Clients have a **right** to know about advocacy and community groups and prevention services.
- Patients/Clients have a **right** to freely file a complaint, grievance, or appeal, and to learn how to do so.
- Patients/Clients have the **right** to know about laws that relate to their rights and responsibilities.
- Patients/Clients have the **right** to know of their rights and responsibilities in the treatment process, and to make recommendations regarding the organization's rights and responsibilities policy.

I have read and understood my rights and responsibilities.

- Patients/Clients have the **responsibility** to treat those giving them care with dignity and respect.
- Patients/Clients have the **responsibility** to give providers the information they need, in order to provide the best possible care.
- Patients/Clients have the **responsibility** to ask their providers questions about their care.
- Patients/Clients have the **responsibility** to help develop and follow the agreed-upon treatment plans for their care, including the agreed-upon medication plan. • Patients/Clients have the **responsibility** to let their provider know when the treatment plan no longer works for them.
- Patients/Clients have the **responsibility** to tell their provider about medication changes, including medications given to them by others.
- Patients/Clients have the **responsibility** to keep their appointments. Patients should call their providers as soon as possible if they need to cancel visits.
- Patients/Clients have the **responsibility** to let their provider know about their insurance coverage, and any changes to it.
- Patients/Clients have the **responsibility** to let their provider know about problems with paying fees.
- Patients/Clients have the **responsibility** not to take actions that could harm others.
- Patients/Clients have the **responsibility** to report fraud and abuse.
- Patients/Clients have the **responsibility** to openly report concerns about quality of care.
- Patients/Clients have the **responsibility** to let their provider know about any changes to their contact information (name, address, phone, etc).
- Patients/Clients have the **right** and the **responsibility** to understand and help develop plans and goals to improve their health.

____ _____________________

Patient Signature Date