Brevard Chiropractic & Injury Center

Dr. Timothy Bortz, DC
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www.BrevardChiro.com

PERSONAL INFORMATION

First Name:_____________________ M.I._____ Last Name:_________________________ Preferred Name: __________________

Address:____ City:______________________ State: ______Zip:__________

Birthdate:______/______/______ Age______ Gender: ☐ Male ☐ Female ☐ Unspecified SSN:_________/______/________

Primary Phone: ______________________ Cell Phone: ________________________ Work Phone: ________________________

Home Email: ____ Work Email:____

By providing my email address, I authorize my doctor to contact me via the email address(es) provided.

Which email would you like us to use to communicate with you? (check one) ☐ Home ☐Work

Contact Method: (check one) ☐ Primary Phone ☐ Cell Phone ☐ Work Phone ☐ Home Email ☐ Work Email

Occupation: _____________________________________ Employer: ____

Drivers License #: ____

Spouse/Parents Name: ______________________________ Spouse/Parents Occupation: _________________________________

Spouse/Parents Employer: ___________________________ Spouse/Parents Social Security #: ______________________________

Spouse/Parents Work #: ____________________________ Spouse/Parents Cell #: ____

Emergency Contact

Name: ____ Relation to You: ____

Home#: ____________________________ Work #: ______________________________ Cell #: ______________________________

How Did You Hear About Us?

Please be as specific as possible so we can track how our patients FIRST heard about us!

☐BrevardChiro.com ☐BrevardDisc.com ☐Google ☐Drive-by ☐Email Blast ☐TV Commercial ☐Radio
☐Facebook ☐Yelp ☐Direct Mailer ☐YouTube ☐School ☐Work ☐Clinic Employee: _________________
☐Magazine Ad:______________ ☐Newspaper:_______________ ☐Referred by Friend:___________________
☐Current Patient of Physician/NP ☐Other: ____

Your Health Attitude

Please mark which one applies to you

____ **Pain Relief** - I only consult with a doctor when I am in pain. I discontinue treatment as soon as it has cleared up.

____ **Prevention** - In addition to symptomatic treatments, I consult with doctors to keep problems from appearing or re-occurring.

____ **Maximizing Health and Wellness** - I actively pursue health so I can feel better and perform better. So I can be the best I can be.

Brevard Chiropractic & INJURY CENTER

Date:	ID #:

INSURANCE OR PRIVATE PAY INFORMATION

Please provide insurance card(s) to receptionist.

Type of Insurance: ☐ Private Ins. ☐ Medicare ☐ Auto Ins. ☐ Worker's Comp ☐ Other________________________________

Primary Insurance Carrier: ____ Phone: ________________________________

Policy#_____________________________ Group #___________________________ Claim#________________________________

Name of Policy Holder: ____ Relationship to Patient: _________________________

Policy Holder's Birthdate: ______/_____/______ Policy Holder's SSN: ______/____/______ Employer: _______________________

Is patient covered by another insurance? ☐ Yes ☐ No

Type of Insurance: ☐ Private Ins. ☐ Medicare ☐ Auto Ins. ☐ Worker's Comp ☐ Other________________________________

Secondary Insurance Carrier: ____ Phone: ________________________________

Policy#_____________________________ Group #___________________________ Claim#________________________________

Name of Policy Holder: ____ Relationship to Patient: _________________________

Policy Holder's Birthdate: ______/_____/______ Policy Holder's SSN: ______/____/______ Employer: _______________________

— —

Reason for today's visit: ____

Is this condition due to an accident? ☐ Yes ☐ No Date of Accident: ____

Type of Accident ☐ Auto ☐ Work ☐ Home ☐ Other ____

To whom have you made a report of your accident? ☐ Auto Insurance ☐ Employer ☐ Worker Compensation ☐ Other

Do you have an attorney? ☐Yes ☐No If So, Name and Number____

Auto Insurance PIP Information

Name of Insurance Company: ____

Name of Insured: ____

Claim#: ____

Name of Adjuster and Phone Number: ____

ASSIGNMENT/AUTHORIZATION/RELEASE:

I certify that I, and/or my dependents, have insurance with the above named insurance company(s) and assign directly to Brevard Chiropractic & Injury Center all benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. I understand that "co pays" are payable at the time of each visit and that I am financially responsible for all charges whether or not paid by insurance. The above named provider's office may use my health care information and may disclose such information to the above named insurance company(s) and their agents for the purpose of obtaining payment for services and determining benefits payable for related services.

☐ **Private Pay/Cash:** By checking this box, I acknowledge that I do not have insurance and understand that I am financially responsible for all services at the time they are rendered.

____ ____

Name of Person Responsible For This Account Relationship to Patient

X ____ ____

Responsible Party Signature Date

Patient Current Condition and Pain Form

Name: ______________________________________ **Date:** _____________________________

Complaint/Pain Location(s) (example: neck, shoulders, upper back, mid-back, low-back, hips, extremities):

____

What previous care/treatment have you received for your condition?

☐Physical Therapy ☐Chiropractic ☐Medication ☐Surgery ☐None ☐Other ___________________________

Usual Pain Intensity

No pain 0 1 2 3 4 5 6 7 8 9 10 Severe pain

Today's Pain Intensity

No pain 0 1 2 3 4 5 6 7 8 9 10 Severe pain

Please list any recent falls and/or injuries:

What have you tried to help alleviate your condition?

Please fill out this portion based on your current condition.

Date of Injury/Onset:_____________________________

How would you describe the character of your condition/pain? (please check all that apply)

☐Sharp ☐Dull ☐Tingling ☐Numb
☐Aching ☐Shooting ☐Radiating ☐Burning
☐Throbbing ☐Cramping ☐Stiffness ☐Swelling
☐Other ___________________

How often do you experience your symptoms?

☐ Constantly (76%-100% of the time)
☐ Frequently (51%-75% of the time)
☐ Occasionally (26%-50% of the time)

When do you experience your symptoms?

____

	Comfortable	Uncomfortable	Painful
Lying down	☐	☐	☐
Sitting	☐	☐	☐
Standing	☐	☐	☐
Stretching	☐	☐	☐
Walking	☐	☐	☐
Running	☐	☐	☐
Bending	☐	☐	☐
Lifting	☐	☐	☐
Kneeling	☐	☐	☐
Pulling	☐	☐	☐
Reaching	☐	☐	☐
Standing from a seated position	☐	☐	☐

Additional Comments:

Personal Medical History

A. Date of last: Spinal Exam: ______________________ Bone Scan: __________________________

Spinal X-Ray: _____________________ MRI: ______________________________

Chest X-Ray: _____________________ CT Scan: ____________________________

Medical Doctor: ___________________________ Previous Chiropractor: ___________________________

Physical Therapist: ________________________ Massage Therapist: _____________________________

B. Injuries, Traumas, and Illnesses

Broken Bones/Fractures: ________________________ Head Injuries: _________________________

Dislocations: ___________________________________ Falls: _______________________________

Please check the box to indicate if you have or have had any of the following:

❑ AIDS/HIV	❑ Cancer	❑ Gout	❑ High Cholesterol	❑ Neuropathy	❑ Prosthesis
❑ Alcoholism	❑ Chemical Dependency	❑ Heart Disease	❑ Kidney Disease	❑ Osteoporosis	❑ Psychiatric Care
❑ Arthritis	❑ Diabetes	❑ Hernia	❑ Liver Disease	❑ Pace Maker	❑ Rheumatoid Arthritis
❑ Asthma	❑ Epilepsy	❑ Herniated Disc	❑ Migraines	❑ Parkinson's Disease	❑ Stroke
❑ Bleeding Disorders	❑ Goiter	❑ High Blood Pressure	❑ Multiple Sclerosis	❑ Pinched Nerve	❑ Thyroid Problems

Please list any other illnesses or injuries: ____

C. Surgeries:

Type of Surgery	Date	Surgeon/Hospital

D. Current Medications: (if certain attributes of your medication(s) are unknown, please write unknown)

Medications or Vitamins/Herbs/Minerals	Dosage (mg)	Frequency	Prescribing Doctor
☐ No Current Medications			

E. Females – Pregnancy:

Are you currently pregnant? ☐No ☐Yes Due Date :______________________________________

Patient/Guardian Signature: ____ Date: ______________

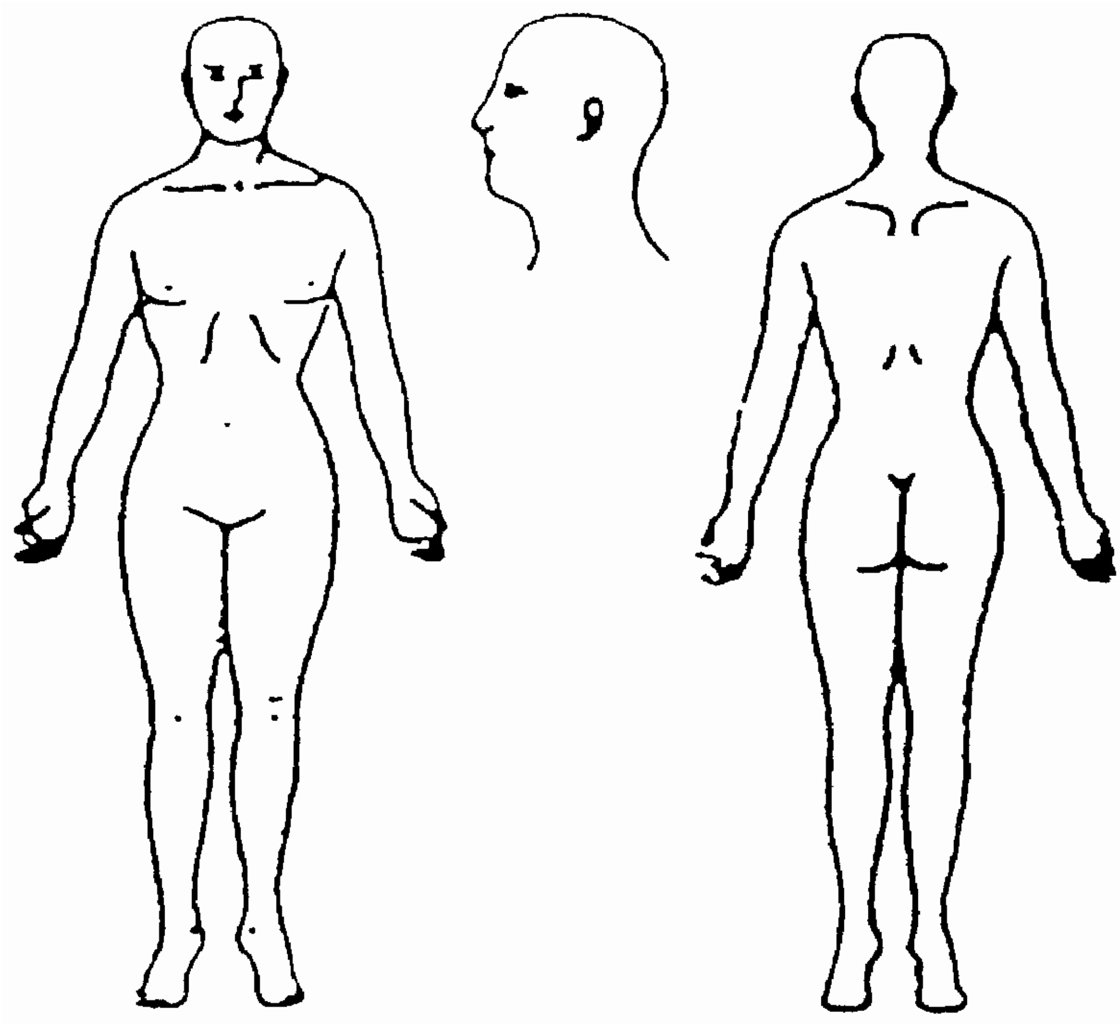
Patient/Guardian Printed Name: ____

SYMPTOM DIAGRAM

Name ____ Number __________ Date ______________

Please be sure to fill this form out extremely accurately. Mark the area(s) on your body where you feel the described sensation(s). Use the appropriate symbol(s). Mark areas of radiating pain, and include all affected areas. You may draw on the face as well.

Aches ΛΛΛΛ Numbness oooo Pins/Needles ●●●● Burning xxxx Stabbing ////



Reference: Randsford. Spine, Vol. 1, No 2, June 1976

HIPAA NOTICE OF PRIVACY PRACTICES - FINANCIAL POLICY – MINOR CONSENT
Brevard Chiropractic & Injury Center

Patient Name: ____ Date: ____________________________________

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), commonly known as "HIPAA" is a Federal program that requires all medical records and other individually identifiable health information used or disclosed by us, in any form, whether electrically, on paper or orally, is kept properly confidential. The act gives you, the patient, significant rights and control over your health information. This notice describe certain obligations we have regarding ways in which we may use and disclose health information about you, it also outlines your rights to the health information we keep about you.

We understand that information about you and your health is personal and are committed to your privacy. We create a record of the care and services you receive. We need this record to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of the records of your care generated by this office, whether made by your personal doctor, others working in the office, or associates processing billing and your insurance claims.

We are required by law to:

- Make sure that health information that identifies you is kept private.
- Give you this Notice of our legal duties and privacy practices with respect to health information about you.
- Follow the terms of the Notice that is currently in effect.

A partial list of how we may use and disclose Health Information about you:

- For Treatment, payment, health care and business operations of this office.
- As required by Law, Law enforcement, lawsuits and disputes; protect public safety or assist apprehending criminals.
- Military or Veteran's and Workers Compensation.
- Public Health Risks; Coroners, health examiners and funeral directors.
- To government authorities to prevent child abuse or domestic violence; to avert a serious threat to health and safety
- National security and intelligence activities.
- Security Officials for Inmates:
- To government agencies for audits, investigations and other oversight activities.
- For certain limited research purposes.
- The practice maintains patient sign-in sheets that are visible and accessible to patients, staff and others who may enter this office.

As our patient, your rights regarding Health Information about you:

- Right to Inspect and copy.
- Right to Amend.
- Right to Request Restrictions.
- Right to Request Confidential Communication.
- Right to Accounting Disclosures.
- Right to a Paper copy of this Notice (full Notice is available upon request)

Changes to this Notice: We reserve the right to change this Notice. We will post a copy of a current notice in our facility with the current effective date on the first page.

Complaints: If you believe that your privacy rights have been violates, you may file a complaint with us. All complaints must be in writing. Please contact the administrator at the location where you were treated to file a complaint.

Acknowledgement of Receipt of HIPPA Notice of Privacy Practices:
I acknowledge that I was provided a copy of the Notice of Privacy Practices and have read (or had the opportunity to read if I chose) and understood the Notice. This notice is considered effective dates signed, and shall remain effective for a minimum of 6 years, unless otherwise revoked, in writing, by patient.

Unless you request otherwise, we may use or disclose health information to a family member or other personal representative to the extent necessary to help you with your healthcare or payment for your health care. In addition, we may use your confidential information to remind you of appointments, phone, email, postal service or other method requested by you.

Additional Disclosure Authority: In addition to the allowable disclosures described in the State of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to persons indicated as follows:

________________________________ ________________________________
Name Relationship

________________________________ ________________________________
Name Relationship

HIPAA NOTICE OF PRIVACY PRACTICES - FINANCIAL POLICY – MINOR CONSENT
Brevard Chiropractic & Injury Center

Patient Name: ____ Date: ______________________________

Financial Policy:

Full payment is expected at the time of service. Payments accepted are cash, check or credit card.

IF you have insurance, we will make a copy of your card and collect any co-pay or co-insurance that is due. As a courtesy, our office will contact your insurance company to obtain a benefit quote. If there is a balance after your insurance processes the claim, we will forward you a statement. Insurance coverage varies greatly, if you have questions, feel free to contact our office and we will do our best to assist you. Please be aware that some insurance plans require pre-certification for care. Care will commence once approval has been obtained.

As a courtesy to our patients we will provide a copy of your medical records at a cost according to Florida Statutes and per written request. Additionally, should you or your insurance company require forms or information, this office reserves the right to charge for time spent in preparation of those forms or requested medical information. It is your responsibility to make sure your insurance company is paying this office. Although this office may bill your insurance carrier for services rendered, all charges for services rendered are the patients' responsibility.

We will notify you as soon as we know of any difficulties we are having collecting monies from your insurance carrier. Should difficulties arise, you may need to contact your insurance company. If our office determines that your insurance carrier will reimburse you directly and not pay our office, you will be required to pay in full for all services at the time they are rendered. Our office makes every attempt to correspond with insurance carriers to assist them in correctly paying your claims.

All patients who have insurance, no matter the type it is, are required to pay co-payments, deductibles and/or percentages required each visit. If our office is a non-participating provider with the insurance company you have, we will gladly file those claims for you but you will be responsible for payment at the time service is rendered. If you are a Medicaid enrollee, your eligibility status must be verified each month. If your eligibility is terminated, you become responsible for services rendered. If you have been injured on the job, you must have authorization for care from the Worker's Compensation Insurance Company before an appointment or treatment can be rendered by our office. Your employer will assist you in securing that information.

Brevard Chiropractic & Injury Center also accepts Personal Injury Protection claims resulting from motor vehicle accidents and Workers Compensation claims to treat injured workers. Prior approval must be obtained with these cases before care can commence. You will also be required to complete an "Accident Form" in addition to the regular "Intake Forms" Brevard Chiropractic & Injury is also a provider for Medicare. You will be required to read and sign the separate Medicare policy documentation.

By signing below, I agree to the following: "I have read and understand "HIPPA Notice of Privacy Practices" &"Financial Policy" I understand that health and accident insurance policies are an agreement between and insurance carrier and me. I authorize payment from my insurance carrier directly to this office and with the understanding that all monies be credited to my account upon receipt. I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. We will require you to honor the financial agreements you make with our office. If you find that you cannot fulfill the agreement you have made with us, please advise our financial department immediately so new arrangements can be made. Any insurance checks sent to your home should be brought or sent to our office within three (3) days with Explanation of Benefits (stub/statement) to indicate which services were paid.

**Our office will submit your insurance claims for you as a courtesy. However, your insurance is an agreement between you and your carrier, not between your insurance company and this office.

Patients without insurance are expected to pay in full at the time services are rendered, unless other arrangements have been made with our financial department

Patient Signature: ____ Date: __________________________

Consent to Treatment of Minors:

By my signature below, I consent to any x-ray, examination, and chiropractic or rehabilitative diagnosis or treatment, which is deemed advisable by a licensed chiropractor, be rendered under the general of special supervision of any licensed chiropractor or trained professionals at Brevard Chiropractic & Injury Center.

Patient/Guardian Signature: ______________________________________ Date: __________________________

Patient/Guardian Printed Name: ____

Relation to Minor: ____

Informed Consent to Chiropractic Adjustments and Care

I have been informed that it is not uncommon for patients to have some increased discomfort after an adjustment. If that happens, I will apply ice to the area and rest it. If I am concerned about the discomfort or develop any new symptoms, I can call the office and speak to the staff. If I am out of town or unable to contact the doctor, I can present myself to the emergency room.

If any test were performed outside of this office (laboratory or other diagnostic procedures) I understand the doctor will notify me of the results at my next scheduled appointment or when the reports are available.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various methods of physical therapy and if necessary, diagnostic x-rays, on me by the doctor of chiropractic in this office and or anyone working in this clinic authorized by the doctor of chiropractic.

I further understand and have been informed that, as in all health care, in the practice of chiropractic there are some very slight risks to treatment, including, but not limited to muscle strains and sprains. I do not expect the doctor to be able to anticipate and explain all the risks and complications and I wish to rely on the doctor 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 interests.

I have read the above consent, 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 for which I seek treatment.

_______________________________________ _________________

Patient Date

_______________________________________ _________________

Parent or Guardian Date

_______________________________________ _________________

Witness Date

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