Sickels Clinic of Chiropractic

"Health...Without a Prescription"

503 N. Orlando Ave.
Suite 105
Cocoa Beach, FL 32931
(321) 783-9400
(321) 783-9358

8041 Spyglass Hill Rd.
Suite 102
Viera, FL 32940
(321)610-8908
(321)783-9358

PERSONAL INFORMATION

Name: First _____ M.I. _____ Last _____ Date: _____

Address: _____ City _____ St: _____ Zip: _____

Home Ph: _____ Work Ph: _____ Work Address: _____

Employer: _____ Occupation: _____ Date of Birth: __/__/__ SS# ___-___-____

Marital Status: _____ Spouse's Name: _____ Children (Names & Ages): _____

Whom may we thank for referring you to our office? _____

INSURANCE INFORMATION

Health Insurance Carrier: _____ Policy No. _____ Group No. _____

Name of Insured: _____ Relation: _____

Is your condition due to any auto accident or job-related injury? ☐ Yes ☐ No *IF YES, PLEASE NOTIFY FRONT DESK IMMEDIATELY*

PAST MEDICAL HISTORY

Have you had previous chiropractic care? ☐ Yes ☐ No . If so, when _____ Doctor's Name: _____

Have you been treated for any health condition by a chiropractor or medical physician in the past year: ☐ Yes ☐ No

Doctor's Name _____ Last treatment Date: _____

List any serious diseases or illnesses: _____

Have you undergone any surgery? ☐ Yes ☐ No . If so, what procedures were done and when? _____

_____

List any drugs you now take: _____

WOMEN: Are you pregnant? ☐ Yes ☐ No . ☐ Maybe. Date of last menstrual onset: _____

Initials: _____

PRESENT MEDICAL HISTORY

Major complaint/Reason for today's visit: _____

_____

How & when did this condition start? _____

Activities that aggravate this condition: _____

Condition is: Getting Better ☐ Getting Worse ☐ Staying the Same ☐ What relieves the pain? _____

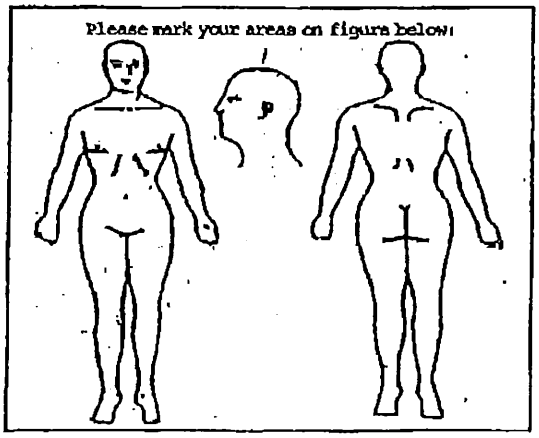
Is this condition interfering with your: Work ☐ Lost work time: ☐ How much _____ Sleep ☐ Daily Routine ☐

Have you had any other personal injury, work injury or accident? ☐ Yes ☐ No If yes, furnish dates & details of injuries: _____

_____

Has anyone in your immediate family suffered from any spinal problems, back pain, neck pain, etc: ☐ Yes ☐ No

Please mark your areas on figure below:



CIRCLE IF YOU HAVE EVER HAD:	Past	Present
1. Dizzines		
2. Backaches		
3. Heart Trouble		
4. Diabetes		
5. Arthritis		
6. Headaches		
7. Asthma		
8. Digestive Disorders		
9. Nervousness		
10. Sinus Trouble		
11. Neck Pain		
12. Poor Circulation		
13. Stroke		

Has your condition (pain) changed in intensity lately? ☐ Yes ☐ No. If Yes, how? _____

_____

_____

Is your condition

☐ Head Only ☐ Head and Neck ☐ Head, Neck, Shoulder(s) R/L and Arm(s) R/L

How far down arm(s) _____

☐ Lower Back Only ☐ Lower Back and one Leg R/L ☐ Lower Back and Both Legs

How far down the leg(s) _____

Describe the pain: _____

Is it constant ☐ or does it come and go ☐ _____

Is there:

Increased pain when you cough or sneeze ☐ Yes ☐ No. If Yes, Where? _____

Numbness or tingling ☐ Yes ☐ No. If Yes, Where? _____

If so, what increases the numbness or tingling? _____

Weakness ☐ Yes ☐ No. If Yes, Where? _____

Increased pain when getting up or down ☐ Yes ☐ No. If Yes, Where? _____

Loss of bladder or bowel control ☐ Yes ☐ No. If Yes, Where? _____

Increased pain when turning head ☐ Yes ☐ No. If Yes, Where? _____

Increased pain when lifting ☐ Yes ☐ No. If Yes, Where? _____

Increased pain when bending ☐ Yes ☐ No. If Yes, Where? _____

Headaches present ☐ Yes ☐ No. If Yes, How often? _____

Describe headache in detail _____

What is your most comfortable position? ☐ Sitting ☐ Standing ☐ Walking ☐ Lying Down ☐ Partially Bent

What is your worse position? ☐ Sitting ☐ Standing ☐ Walking ☐ Lying Down ☐ Partially Bent

Please list the following test you have had for this condition:

	When	Where
☐ Plain X-Rays	_____	_____
☐ CAT Scan	_____	_____
☐ MRI Scan	_____	_____
☐ EMG	_____	_____
☐ Previous Spinal Operations	_____	_____

Do you have any other health conditions you are currently being treated for at this time?

☐ Yes ☐ No. If Yes, Describe _____

Are you covered by Medicare? ☐ Yes ☐ No. If Yes, Medicare # _____

How will today's services be paid for: ☐ Cash ☐ Check ☐ Credit Card ☐ Insurance

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his staff responsible for any errors or omissions that I have made in the completion of this form. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Sickels Clinic of Chiropractic 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 the Sickels Clinic of Chiropractic will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered 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, any fees for professional services rendered me will be immediately due and payable. I also understand that if I am accepted as a patient of the Sickels Clinic of Chiropractic, I am authorizing them to proceed with any treatment. Furthermore, any risks regarding Chiropractic treatment will be explained to me upon request.

_____ _____

Patient's Signature Authorization to Treat Minor

Date: _____ Date: _____

_____

Witness

Date: _____

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DOCTOR-PATIENT RELATIONSHIP IN CHIROPRACTIC
INFORMED CONSENT

CHIROPRACTIC

It is important to acknowledge the difference between the health care specialties of chiropractic, osteopathy and medicine. Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the chiropractic doctor's procedures often depends on environment, underlying causes, physical and spinal conditions. It is important to understand what to expect from chiropractic health care services.

ANALYSIS

A doctor of chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Syndrome (VSS) or Vertebral Subluxation Complexes (VSC). When such VSS and VSC complexes are found, chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. Due to the complexities of nature, no doctor can promise you specific results. This depends upon the inherent recuperative powers of the body.

DIAGNOSIS

Although doctors of chiropractic are experts in chiropractic diagnosis, the VSS and VSC, they are not internal medical specialists. Every chiropractic patient should be mindful of his/her own symptoms and should secure other opinions if he/she has any concern as to the nature of his/her total condition. Your doctor of chiropractic may express an opinion as to whether or not you should take this step, but you are responsible for the final decision.

INFORMED CONSENT FOR CHIROPRACTIC CARE

A patient, in coming to the doctor of chiropractic, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give a chiropractic adjustment, or health care, if he/she is aware that such care may be contraindicated. Again, it is the responsibility of the patient to make it known or to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the doctor of chiropractic. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The doctor of chiropractic provides a specialized, non-duplicating health service. The doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

RESULTS

The purpose of chiropractic services is to promote natural health through the reduction of the VSS or VSC. Since there are so many variables, it is difficult to predict the time schedule or efficacy of the chiropractic procedures. Sometimes the response is phenomenal.

In most cases there is more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same chiropractic care. Many medical failures find quick relief through chiropractic. In turn, we must admit that conditions which do not respond to chiropractic care may come under the control or be helped through medical science. The fact is that the science of chiropractic and medicine may never be so exact as to provide definite answers to all problems. Both have made great strides in alleviating pain and controlling disease.

TO THE PATIENT

Please discuss any questions or problems with the doctor before signing this statement of policy.

I have read, and understand the foregoing.

_____ DATE

_____ SIGNATURE

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PATIENT _____

AUTHORIZATION and RELEASES

CONSENT FOR TREATMENT:

I, the undersigned, hereby authorize Dr. Daniel L. Sickels and whomever he may designate as his assistant(s) to perform diagnostic treatments including but not limited to radiographs and to administer treatment as necessary. I also certify that no guarantee or assurance has been made to the results that may be obtained.

I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself. Furthermore, I understand that 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. I permit this office to endorse remittances for the conveyance of credit to my account. HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME (OR MY CHILD) ARE CHARGED DIRECTLY TO ME, AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT. WE RESERVE THE RIGHT TO CHARGE 18% OF TOTAL BILL FOR ALL ACCOUNTS OVER THIRTY (30) DAYS OLD.

Patient's Signature _____ Date _____

Witness _____

IMPORTANT INSURANCE INFORMATION

IT IS YOUR RESPONSIBILITY TO CONTACT YOUR INSURANCE COMPANY REGARDING YOUR CHIROPRACTIC COVERAGE. WE WILL CALL AS A COURTESY, BUT ARE NOT RESPONSIBLE FOR MISREPRESENTATION GIVEN BY INSURANCE COMPANIES.

I HAVE READ THE ABOVE INSURANCE STATEMENT AND CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME (OR MY CHILD) ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT.

Patient's Signature _____ Date _____

Guardian's Signature _____ Date _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize the release of any medical information necessary to process my insurance claim(s) and also certify all insurance information given to this clinic is correct and complete.

Patient's Signature _____ Date _____

Witness _____

Permission to Bill Insurance

I assign all medical benefits to Dr. Daniel L. Sickels, from any health plans including Medicare, all major medical, and supplemental insurances. I understand that I am responsible for all claims and expected to pay Co-pays and deductibles in advance. I agree to the release of any information necessary to process these claims.

Name Printed _____

Signature IF adult _____ Date _____

Signature guardian if appropriate _____ Date _____

Guardian relationship _____

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

_____ _____

Patient Name (please print) Date

_____

Parent, Guardian or Patient's legal representative
(please print)

_____

Signature

****

***THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS

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Consent for Communication And/Or Disclosure

I request the following alternatives or limitations relating to communications directed to me by my healthcare provider or employee.

Do we have permission to:

Call you at home? YES NO

If yes, can we leave the following information on your answering machine or voicemail:

Appointment information YES NO Billing information YES NO Medical Information YES NO

Can we call you at work? YES NO

If yes, can we leave the following information on your answering machine or voicemail:

Appointment information YES NO Billing information YES NO Medical Information YES NO

I give my permission to share the following information with the person(s) names below:

Name_____ Relationship_____

Appointment: YES NO Billing: YES NO Medical: YES NO

Name_____ Relationship_____

Appointment: YES NO Billing: YES NO Medical: YES NO

Patient Signature_____ **Date**_____

Witness_____ **Date**_____

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HIPPA Information and Consent Form

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matter related to your care is handled appropriately. This specifically includes the sharing of information with other health care provider, laboratories and health insurance payers as is necessary and appropriate for your care. Patients files may be stored in open files racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc... Those records will not be available to persons other than office staff. You agree to the normal procedures within the office for the handling of charts, patient's records, PHI (Protective Health Information) and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, US mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentially rules of HIPPA.
4. You understand and agree to inspections of the office and reviews of documents which may include PHI government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal practices to conform to your request.

I,_____Date_____do hereby consent and acknowledge my agreement to the terms set forth in the HIPPA INFORMATION FORM and any subsequent changes in office policy.

I understand that this consent shall remain in force from this time forward.

Office Staff Witness/Signature_____Date_____