ChiroMed Health Spa

Dr. Curtis Reynolds, D.C., 721 7th Street West, Palmetto, Florida 34221

Patient Last Name_____First Name_____

DOB_____ Age _____ SS# _____

How did you hear about us _____

Address _____

City _____ State_____ Zip _____

Phone (Cell)_____ Cell Phone Carrier_____

Email_____

Emergency Contact _____ Relationship _____

Phone _____

Your Occupation _____ Employer _____

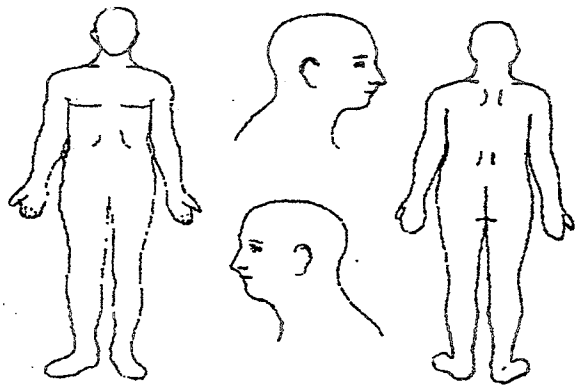
FEMALES: Are you pregnant? __yes__no If yes, How many weeks____

Chief Complaint for today's visit_____

When was your last visit to a Chiropractor?_____Did it help? __yes __no

Any Surgeries? __yes__no If yes, Please list them_____

_____



Place an "X" on the drawing to the left on the areas causing you pain and a letter describing it

S-STABBING N-NUMBNESS
B-BURNING A-ACHING
P-PINS AND NEEDLES

Please circle the number that best describes your pain

0 1 2 3 4 5 6 7 8 9 10
NONE LITTLE MEDIUM SEVERE

Patient Signature_____

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THIS DOCUMENT CONSTITUTES INFORMED CONSENT FOR CHIROPRACTIC CARE

Our office has one goal, to aid the patient in achieving optimal health as quickly and safely as possible, through the removal of interference in their body. We do this through safe and gentle chiropractic care.

We will attempt to identify and diagnose any ailments you may have that may be corrected through chiropractic care, massage therapy and/or active/passive rehabilitation. If any condition or disease appears to be present out of our scope of practice, we will refer you to an appropriate physician to diagnose and/or treat that condition.

Our primary focus is the detection and correction of vertebral subluxation. This is the misalignment of one spinal bone or multiple bones with interference to the nervous system. Any interference to the nervous system may or may not cause various different symptoms. Again, our focus is to correct the cause, not the symptom.

Vertebral subluxations come on from physical, chemical, and/or emotional stress or trauma. Through specific chiropractic adjustments, we reduce and/or correct these subluxations. It is also important to note that the sooner we are able to treat your subluxations and the degenerative processes that are involved the faster and more completely your body will heal. It may be necessary to examine an individual each time a new injury occurs and often x-rays are necessary to maintain the utmost safety when dealing with your body. The risks of chiropractic care or massage therapy are minimal when dealing with a licensed professional; however, if you have concerns about these risks, please discuss them with the doctor prior to the examination.

I have read and I accept the terms above and understand them fully. I hereby give consent to Injury & Chiropractic Centers of Florida (DBA ChiroMed Health Spa) to evaluate me to determine my condition and treat me for such conditions. I also understand that I may at anytime discontinue with the exam and/or x-rays or any treatment if I so choose.

PRINT_____

SIGNATURE_____ DATE_____

PARENT OR GUARDIAN SIGNATURE_____

721 7th St. W. Palmetto, FL 34221 Tel:941-479-4999 Fax:941-479-4998
WWW.CHIROMEDHEALTHSPA.COM

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OFFICE POLICIES

1. It is our office policy that any patient and /or insurance company that pays up-front or in advance is entitled to an administrative discount.

2. The fee paid for treatment x-rays is for analysis only. The film itself is the property of this office. Once films are taken, they cannot be released, but may be copied. There may be a fee for copying of the x-rays.

3. If you have any out of pocket responsibility what will be your method of payment?

Cash Check Credit Card/Debit Card Attorney /Letter of Protection.

I understand and agree that health and accident insurance policies are an agreement between the insurance carrier and my self. Furthermore, I understand Injury & Chiropractic Centers of Florida (DBA ChiroMed Health Spa) will prepare any necessary reports, and forms to assist in making collections from my insurance company and that any amount authorized to be paid directly to Injury & Chiropractic Centers of Florida will be credited to my account upon receipt. *However*, I clearly understand and agree that all services rendered to 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 at this office, any outstanding charges for professional services rendered to me will be immediately due and payable. I agree that I will be responsible for all attorney and legal fees if legal action becomes necessary to collect this amount.

Print Patient Name: _____

Patient/Guardian Signature authorizing care: _____ Date: _____

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Injury & Chiropractic Centers of Florida (DBA ChiroMed Health Spa) (hereinafter referred to as the "Practice) to use and disclose protected Health Information (PHI) about me to carry out treatment, payment and helathcare operations (TPO). The Practice's Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy prior to signing this consent. The Practice reserves the right to revise its Notice of Privacy any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to:

Dr. Curtis Reynolds, our Privacy Officer, at the following address:

721 7th Street West, Palmetto, FL 34221

With this consent, the Practice may call my home or other alternate locations and leave a message on voice mail or in person in reference to any items that assist the Practice in carrying out TPO, such as appointment reminders, insurance items, and calls pertaining to my clinical care, including laboratory results among others.

With this consent, the Practice may mail to my home or other alternate locations and any items that assists the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, the Practice may email to my home or other alternate locations any items that assist the Practice in carrying out TPO, such appointment reminder cards and patient statements. I have the right to request that the Practice restrict how it uses or discloses my PHI to carry out TPO. However, the Practice is not required to agree to my requested restrictions. But if it does, it is bound by this agreement.

By signing this form. I am consenting to the Practice's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the Practice has already make disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, the Practice may decline to provide treatment to me.

PRINT_____

SIGNATURE_____ DATE_____

PARENT OR GUARDIAN SIGNATURE_____