Fralicker Chiropractic Clinic, Inc

835 Cesery Blvd.
Jacksonville, FL 32211

Date: _____

Patients Name: _____ Chief Complaint: _____

Address: _____ Home Phone: _____

City, State, Zip: _____ Cell Phone: _____

Social Security #: _____ Email: _____

Date of Birth: _____ May we email you monthly health newsletters? _____

Occupation: _____ Age: _____ Marital Status: M S W D

Employer: _____

Insurance Company: _____ Insurance ID#: _____

Insurance Phone #: _____ Name of the Insured: _____

Are your present symptoms or conditions related to or the result of an auto collision, work-related injury or other personal injury someone else might be responsible for? ___ Yes ___ No

Family Physician: _____ Name of Facility: _____

Person to contact in case of emergency (Name, phone, relation): _____

What operations have you had? _____ When? _____

_____ When? _____

Serious Illness: _____ When? _____

_____ When? _____

What medications or drugs are you taking? Please list all prescribed medications and supplements/vitamins.

Medication name: _____ Mg/dosage_____ Times taken daily _____

Medication name: _____ Mg/dosage_____ Times taken daily _____

Medication name: _____ Mg/dosage_____ Times taken daily _____

Medication name: _____ Mg/dosage_____ Times taken daily _____

Medication name: _____ Mg/dosage_____ Times taken daily _____

If you need more space, please continue list on the back.

What is your goal in our office? _____

How did you hear about us? _____

By signing below, you indicate that all the information above is true and correct.

Patient/Guardian signature: _____ Date: _____

Fralicker Chiropractic Clinic
CASE HISTORY

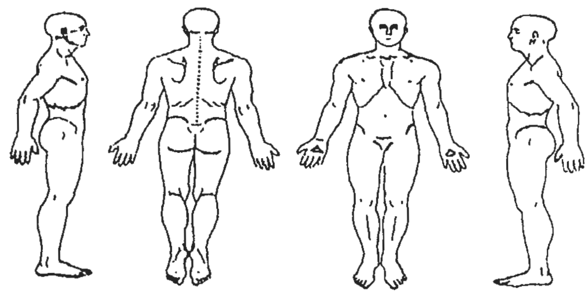
1. Circle the severity (1 = No Pain to 10 = Very Severe Pain) and the Frequency of your pain (% of the day you experience the pai

(Please list your conditions on the lines below and rate them from top to bottom in the order of severity)

Condition	**Severity** Minimal Severe	**Frequency (% of day)** Occasional Constant
____________	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
____________	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
____________	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
____________	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
____________	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
____________	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
____________	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100

Please circle the areas on the right figures where you experience pain.

Indicate the type of pain: Achy, Dull, Sharp, Radiating, Numb, Burning



2. **HOW** and **WHEN** did your symptoms begin? ____

____

3. Has your condition? Improved ___ Gotten Worse ___ Stayed the same since its onset ___

4. Circle the things that make your problems worse:

   Bending - Lying - Walking - Standing - Sitting - Movement - Twisting - Lifting

5. Is there anything you can do to relieve the problems? No ___ Yes ___ Describe: ____________________

   If No, what have you tried that has not helped? ____________________________

6. Have you been treated for this before? No ___ Yes ___ How long ago? ____________________

7. What treatment did you receive? ____

8. Results of previous treatment? Good ___ Poor ___ Comments ____________________________

9. Is this condition interfering with Work ___ Sleep ___ Daily Routine ___ Recreation ___

10. Approximate date of last Chiropractic treatment? ____________________________

11. Approximate date of last MD / DO treatment? ____________________________

12. List any other major injuries you have had other that those that might have been mentioned above: ____________

____

13. To your knowledge, have you had any diseases, major illnesses, or injuries not indicated on this form either in the past or the present? Yes ___ No ___. If yes, Please explain ____________________________

I certify that the above information is accurate to the best of my knowledge.

Patient's Signature ____________________________ Date: ____________________

Guardian's Signature ____________________________ Date: ____________________

FIGURE 17-A

Pain Disability Questionnaire (PDQ)

NAME: _____ DATE: _____

Please read:

This survey asks for your views about how your pain now affects how you function in everyday activities. This information will help you and your doctor know how you feel and how well you are able to do your daily tasks at this time.

Please answer every question by making an "X" along the line to show how much your pain problem has affected you (from having no problems at all to having the most severe problems you can imagine).

BE SURE TO ANSWER *ALL* QUESTIONS.

1. Does your pain interfere with your normal work inside and outside the home?
   ]_____]_____]_____]_____]_____]
   Work normally — Unable to work at all
2. Does your pain interfere with personal care (such as washing, dressing, etc.)?
   ]_____]_____]_____]_____]_____]
   Take care of myself completely — Need help with all my personal care
3. Does your pain interfere with your traveling?
   ]_____]_____]_____]_____]_____]
   Travel anywhere I like — Only travel to see doctors
4. Does your pain affect your ability to sit or stand?
   ]_____]_____]_____]_____]_____]
   No problems — Cannot sit/stand at all
5. Does your pain affect your ability to lift overhead, grasp objects, or reach for things?
   ]_____]_____]_____]_____]_____]
   No problems — Cannot do at all
6. Does your pain affect your ability to lift objects off the floor, bend, stoop, or squat?
   ]_____]_____]_____]_____]_____]
   No problems — Cannot do at all
7. Does your pain affect your ability to walk or run?
   ]_____]_____]_____]_____]_____]
   No problems — Cannot walk/run at all
8. Has your income declined since your pain began?
   ]_____]_____]_____]_____]_____]
   No decline — Lost all income
9. Do you have to take pain medication every day to control your pain?
   ]_____]_____]_____]_____]_____]
   No medication needed — On pain medication throughout the day
10. Does your pain force you to see doctors much more often than before your pain began?
    ]_____]_____]_____]_____]_____]
    Never see doctors — See doctors weekly
11. Does your pain interfere with your ability to see the people who are important to you as much as you would like?
    ]_____]_____]_____]_____]_____]
    No problem — Never see them
12. Does your pain interfere with recreational activities and hobbies that are important to you?
    ]_____]_____]_____]_____]_____]
    Normal activity — No recreation/hobbies at all
13. Do you need the help of your family and friends to complete everyday tasks (including both work outside the home and housework) because of your pain?
    ]_____]_____]_____]_____]_____]
    Never need help — Need help all the time
14. Do you now feel more depressed, tense, or anxious than before your pain began?
    ]_____]_____]_____]_____]_____]
    No depression/tension — Severe depression/tension
15. Are there emotional problems caused by your pain that interfere with your family, social, or work activities?
    ]_____]_____]_____]_____]_____]
    No problems — Severe problems

Reproduced with Permission from: Anagnostis C, Gatchel RJ Mayer TG. The Pain Disability Questionaire. Spine 2004, 29:2290-2302.

ASSIGNMENT OF BENEFITS, AUTHORIZATION TO SETTLE CLAIM AND DIRECTION TO PAY MEDICAL PROVIDER DIRECTLY

By my signature below, for good and valuable consideration (including but not limited to the extension of credit to me), I hereby assign, transfer and convey to **Fralicker Chiropractic Clinic Inc** (hereinafter "the Provider") all of my rights, title and interest in and to medical expense reimbursement in whatever form, including but not limited to any automobile liability medical expense payments or other health benefits indemnification and/or agreement otherwise payable to me. This payment shall not exceed my indebtedness to the above named assignee and I acknowledge that I will timely pay any indebtedness owed by me to the assignee that is not otherwise satisfied by the above-mentioned assigned proceeds. I also acknowledge that any medical expenses not covered under my insurance policy will be my responsibility.

I further authorize the Provider to negotiate, collect and settle any claim with any insurance carrier or other third party payor with regard to these services, which authorization shall include authority to:
(1) request and receive from any insurer or any other party any and all documentation and records that I am empowered to request regarding this claim, including, without limitation, a statement of coverage, policy declarations page and insurance policy pursuant to Section 627.4137. In addition, the provider has the authority to request and receive any Independent Medical Examination Reports, notices sent to me regarding appointments for Independent Medical Examinations and Examinations Under Oath (including proof of mail), Records Review Reports, coverage denial letters, Explanations of Benefits, and Benefit Payment Sheets or Logs (P.I.P. Payout Sheets), without regard as to whether such documentation has already been provided to me and,
(2) to endorse in my name any check issued for payment where benefits were assigned. By way of this assignment and notice, I further instruct you, the insurer, to furnish to Provider copies of all future notices affecting Provider's interest in this claim, including, without limitation, any notices of requested medical examinations or statements.

The Provider hereby objects to any reductions or partial payments. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by the provider shall be done so under protest, at the risk of the insurer, and the deposit *shall not* be deemed a waiver, *accord, satisfaction*, discharge, settlement or agreement by the provider to accept a reduced amount as payment in full.

I further direct my insurer to direct all payments for services rendered by the Provider directly to Provider at the billing address contained on Provider's medical bills.

THIS IS A DIRECT AND IRREVOCABLE ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER MY POLICY OF INSURANCE.

A photocopy of this form shall be considered as effective and valid as the original.

I have read the foregoing and understand and agree to each of the above provisions:

_____ _____

Patient/Guardian signature Date

Fralicker Chiropractic Clinic, Inc.

835 Cesery Boulevard
Jacksonville, FL 32211

Phone: (904) 754-1444

Dear Patient:

In an effort to provide you with flexible payment arrangements, we have expanded our payment policy.

PAYMENT ARRANGEMENTS ARE REQUESTED AT THE TIME OF YOUR VISIT
We now offer the following payment options:

___ Payment by cash

___ Payment by check

___ Payment by credit card

___ Automatic monthly billing to your Visa or MasterCard

___ Guarantee any amount not covered by insurance with Visa or MasterCard.

Please make your choice, sign below and return to office manager before treatment.

Our office is a fully approved and accredited user of the *Visa and MasterCard Health Care Program* which will enable you to use your Visa and MasterCard to automatically cover amounts not paid by your insurance. You may also choose a comfortable amount to be automatically billed to your Visa or MasterCard on a monthly basis.

If none of the above apply, please see the office manager. Thank you.

_____
Print your name here and sign below

*x*_____
*Date:*_____

Fralicker Chiropractic Clinic
835 Cesery Blvd.
Jacksonville, FL 32211

Protecting Your Health Information

New Regulation Passed

The new regulations are part of the Health Insurance Portability and Accountability Act or HIPPA does three primary things:

1. It helps standardize and simplify the way healthcare organizations exchange health care data.
2. It provides consumers with additional protections for getting and maintaining health insurance coverage; although, it does not guarantee coverage.
3. It creates new security rules to ensure the safety and privacy of individual and medical records.

Our Pledge Regarding Medical Information

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our office. We need this record to provide you with quality care and to comply with certain legal requirements. In addition, we have a policy in effect that makes e very attempt to maintain the confidentiality of all patients' information.

Disclosure of Medical Information

In addition to disclosing your medical information for treatment, payment, and health care operations, we may disclose medical information for the following purposes: for a court order, subpoena, discovery request, or other lawful process. We may disclose medical information to appropriate authorities if we reasonably believe that you are a victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose health information when authorized and necessary to comply with laws relating to worker's compensation, auto accidents, personal injury or other similar issues.

If someone calls or comes by, they will be given general about your care and/or appointments unless otherwise specified and noted in your file.

We will also be publicly noting your name in our newsletter and/or picture in our lobby unless otherwise specified. Also upon becoming a patient, we will be entering your name into our database and you will receive our monthly newsletter. If you do not wish to receive our newsletters, please contact our office and advise the receptionist of such. This list will not be sold to any outside agencies.

Your Rights

You have the right to look at or get copies of your medical records and to receive a list of all the times we shared your medical information for purposes other than treatment, payment and health care operations.

Open Adjusting Concept

Because of the open adjusting concept in this office, it is possible for doctor/patient discussions to be overheard by other patients. Most discussions will involve spinal health, but may also include anything concerning the primary health care of that patient.

Notification by Mail or Phone

Patients may be contacted by mail or phone unless written notification is requested that contact be only in person.

Complaints

If you feel that your rights have been violated, contact the Office Manager or the U.S. Department of Health and Human Services.

Fralicker Chiropractic Clinic
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Terms of Acceptance

The goal of our office is to enable patients to gain control of their health. To attain this we believe communication is the key. There are often topics that are hard to understand and we hope this document will clarify those issues for you.

Please read the below and if you have any question please feel free to ask one of our staff members.

Informed Consent:

A patient, in coming to the chiropractic physician, 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 problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures whatever he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic physician provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by a physician at Fralicker Chiropractic Clinic, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Communications:

In the event that we would need to communicate your healthcare information, to who may be do so?

Spouse: _____

Children: _____

Others: _____

May we leave messages on any answering device, i.e. home answering machines or voicemails? Yes [ ] No [ ]

I, _____, have read and fully understand the above statements.

Acknowledgement

I have been given the opportunity to view the notice of privacy practices (HIPPA) and have been provided an opportunity to discuss my right to privacy.

Print Name: _____

Signature: _____ Date: _____

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

_____

Signature

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

Fralicker Chiropractic Clinic, Inc
835 Cesery Blvd
Jacksonville, FL 32211
Ph. (904)745-1444
Fax (904)743-0805

Records Release Form

I hereby authorize and direct you to release to:

Fralicker Chiropractic Clinic, Inc.

The complete medical records (including all E.R. records and all radiology reports) and X-rays in your possession concerning my illness and/or treatment during the period from _____ to _____.

Emergency Room YES NO

(Patient is to complete the section below)

Print Name: _____

Address: _____

Date of Birth: _____ Social Security: _____

I understand that this records release is effective for one year from the date indicated below.

Signature: _____ Date: _____

Witness: _____

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as a cervical arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. This occurs in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name:_____ Signature:_____ Date:_____

Witness Name:_____ Signature:_____ Date:_____