Gilbert Chiropractic Clinic *Dr. Ronald K. Gilbert*
2109 60th Street West, Suite B, Bradenton, FL 34209
941.794.3344

PATIENT INFORMATION

Date: _____/_____/_____

Full Name: ___________________________ Gender: ___ M ___ F Age: _____ Birth Date: ___/___/___

Address: ____________________________ City: _____________________ State: ______ Zip: _________

Social Security #: _____-_____-_____ Drivers License #: _________________

Home Phone: (____) ____________ Cell Phone: (____) ___________ Work Phone: (____) ___________

Spouse's Name: ________________ Phone # _______________ Occupation: ______________________

Employer: _________________________ Occupation: ____

E-mail Address: ____

Emergency Contact: ________________________ Phone #: __________________ Relation: ___________

HOW WERE YOU REFERRED TO OUR OFFICE:

____

HEALTH INFORMATION

What is your major complaint: ____

When did this first occur:____

What are any addition symptoms you are having: ____

How often do they occur: ____________________ Have you had these symptoms in the past: ____

If so, when and how long did they last: __________ Does anything aggravate your symptoms: _____
If so what: ____

Does anything help your symptoms: ______________ If so what: _______________________________

Do you have any of the following conditions: (Please circle):

Heart attack	Stroke	Heart Murmur	Venereal Disease
Hepatitis	Alcohol / Drug Abuse	Shingles	Kidney Problems
Frequent Neck Pain	Anemia	Psychiatric Problems	Ulcers
Low Blood Pressure	High Blood Pressure	Cancer	Colitis
Sinus Problems	Severe Headaches	Frequent Headaches	Asthma
Difficulty Breathing	Diabetes	Tuberculosis	Fainting
Epilepsy/Seizures	Arthritis	Low Back Problems	Artificial Bones/Joints

DR NOTES:

Have you been involved in any auto accidents: Yes or No

If so please describe and list dates of all accidents: ______________________________

____

____

Have you had any other serious injury or illnesses: Yes or No

If so please describe: ____

____

Do you take Vitamins: Yes or No Do you exercise: Yes or No If yes how often: ________

Do you smoke: Yes or No

____ Everyday Smoker ____ Someday Smoker ____ Former Smoker ____ Never a Smoker

____ Heavy Smoker ____ Light Smoker

Smoking Start Date: ____/____/____ Smoking End Date: ____/____/____

FOR WOMAN: Is there a chance you could be pregnant: Yes or No Last menstrual cycle: ________

FAMILY HEALTH INFORMATION

Many health problems are the result of hereditary spinal weaknesses; thus total information about your family members will give us a better picture of your total health.

Name: ____________________ Relation: __________ Past/Present Heath Problems: ____________

Name: ____________________ Relation: __________ Past/Present Heath Problems: ____________

Name: ____________________ Relation: __________ Past/Present Heath Problems: ____________

Name: ____________________ Relation: __________ Past/Present Heath Problems: ____________

Do you have health and/or accident insurance? Yes or No

If so, company name: ________________________

Policy Number: ______________________________ Phone number: ____________________

It is our office policy that fees are paid in full at the time services are rendered.

X-ray negatives remain the property of this office, on file where they have been seen if necessary. We reserve the right to bill for missed appointments. We reserve the right to charge 1 and ½ % per month, plus attorney's fees on all overdue accounts. In consideration of others, please refrain from wearing perfumes or heavily scented items when in the clinic. Personal cleanliness is requested and smoking is prohibited. Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the insurance company and /or billing manager. I authorize the staff to perform any necessary services needed during diagnosis and treatment. I authorize the release of any information required to process insurance claims. Please sign below to acknowledge your understanding and agreement to the above policies.

____

Patient Name (or guardian if a minor) Date

____

Patient Signature

Patient Name: ______________________________ Date: ____________

Medications:

Surgeries:

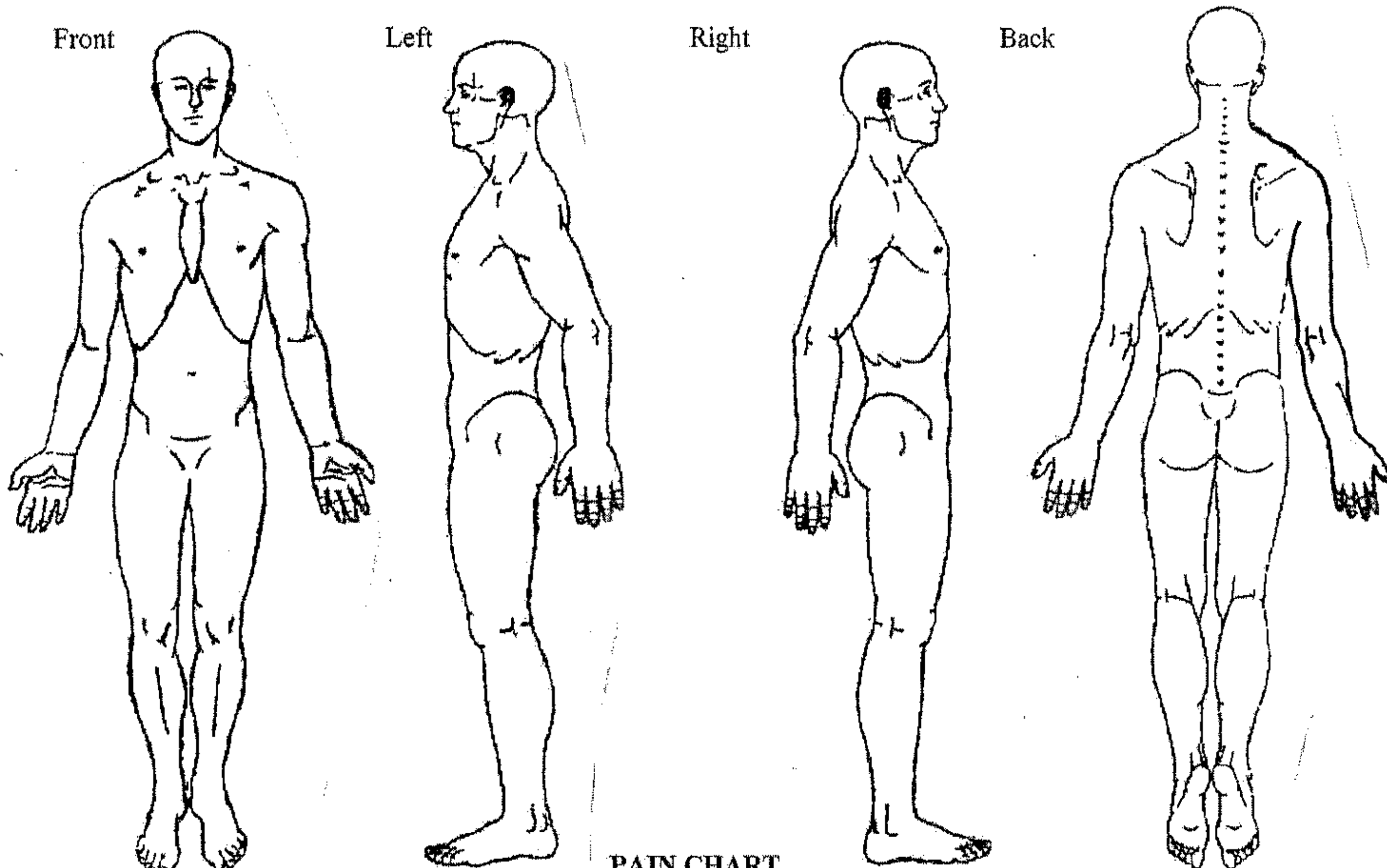
GILBERT CHIROPRACTIC CLINIC
2109 60th Street West, Suite B
Bradenton, FL 34209
PHONE: 941-794-3344
FACSIMILE: 941-794-8057

PAIN SENSATION FORM

PATIENT NAME:____DATE:__________________

MARK THE AREAS OF THE DESCRIBED SENSATION. USE THE APPROPRIATE SYMBOL TO MARK THE AREAS OF PAIN.

= = NUMBNESS X X BURNING /// STABBING *** PINS & NEEDLES))) ACHING



PAIN CHART

Using the scale below, please indicate the degree of pain. One being mild discomfort and ten being extreme pain

__________	1	2	3	4	5	6	7	8	9	10
__________	1	2	3	4	5	6	7	8	9	10
__________	1	2	3	4	5	6	7	8	9	10

Please mark any of the following symptoms that appeared as a result of the accident/injury.

___Headache	___Elbow Pain L/R	___Numbness of________________
___Neck Pain	___Wrist/Hand Pain L/R	___Tingling of________________
___Mid Back Pain	___Hip Pain L/R	___Sleep Difficulties
___Low Back Pain	___Knee Pain L/R	___Jaw Pain L/R
___Shoulder Pain	___Ankle/Foot Pain L/R	___Other

Gilbert Chiropractic Clinic
Ronald K. Gilbert, D.C.

Bournemouth Questionnaire for **Low Back Pain:** The following scales have been designed to find out about your Low Back pain and how it is affecting you. Please answer ALL the scales by circling ONE number on EACH scale that best describes how you feel:

1. Over the past week, on average how would you rate your **Low Back pain**?
(No pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst pain possible)

2. Over the past week, how much has your **Low Back pain** interfered with your daily activities (housework, washing, dressing, lifting, reading, driving)?
(No interference) 0 1 2 3 4 5 6 7 8 9 10 (Unable to carry out activities)
Please Describe:
____
____

3. Over the past week, how much has your **Low Back pain** interfered with your ability to take part in recreational, social, and family activities?
(No interference) 0 1 2 3 4 5 6 7 8 9 10 (Unable to carry out activities)
Please Describe:
____
____

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?
(Not at all anxious) 0 1 2 3 4 5 6 7 8 9 10 (Extremely anxious)

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?
(Not at all depressed) 0 1 2 3 4 5 6 7 8 9 10 (Extremely depressed)

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your **Low Back**?
(Made it no worse) 0 1 2 3 4 5 6 7 8 9 10 (Made it much worse If worse)
Which activities?
____

7. Over the past week, how much have you been able to control (reduce/help) your **Low Back pain** on your own?
(Completely control it) 0 1 2 3 4 5 6 7 8 9 10 (No control whatsoever)

What have you done? ____

Patient Name: ______________________ Date: ______________________

Gilbert Chiropractic Clinic
Ronald K. Gilbert, D.C.

Bournemouth Questionnaire for **Neck Pain**: The following scales have been designed to find out about your Neck and how it is affecting you. Please answer ALL the scales by circling ONE number on EACH scale that best describes how you feel:

1. Over the past week, on average how would you rate your **Neck pain**?
(No pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst pain possible)

2. Over the past week, how much has your **Neck pain** interfered with your daily activities (housework, washing, dressing, lifting, reading, driving)?
(No interference) 0 1 2 3 4 5 6 7 8 9 10 (Unable to carry out activities)
Please Describe:

____

____

3. Over the past week, how much has your **Neck pain** interfered with your ability to take part in recreational, social, and family activities?
(No interference) 0 1 2 3 4 5 6 7 8 9 10 (Unable to carry out activities)
Please Describe:

____

____

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?
(Not at all anxious) 0 1 2 3 4 5 6 7 8 9 10 (Extremely anxious)

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?
(Not at all depressed) 0 1 2 3 4 5 6 7 8 9 10 (Extremely depressed)

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) you **Neck**?
(Made it no worse) 0 1 2 3 4 5 6 7 8 9 10 (Made it much worse If worse)
Which activities?

____

7. Over the past week, how much have you been able to control (reduce/help) your **Neck Pain** on your own?
(Completely control it) 0 1 2 3 4 5 6 7 8 9 10 (No control whatsoever)

What have you done? ____

Patient Name: ______________________ Date: ______________________

Gilbert Chiropractic Clinic
Request To Limit The Protected Information

PLEASE LIST ANY PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(Such as a family member, relative, or close friend that is directly related to that person's involvement with your care or the payment for services.)

NAME______________________________ RELATIONSHIP____________________
NAME______________________________ RELATIONSHIP____________________
NAME______________________________ RELATIONSHIP____________________
NAME______________________________ RELATIONSHIP____________________

__ I AUTHORIZE CONTACT FROM THIS OFFICE TO CONFIRM MY APPOINTMENTS OR TREATMENT AND BILLING INFORMATION VIA:

__ I AUTHORIZE INFORMATION ABOUT MY HEALTH BE CONVEYED VIA:

__ I APPROVE BEING CONTACTED ABOUT SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS OR NEW HEALTH INFO ON BEHALF OF THIS OFFICE VIA:

__ CELL PHONE __ HOME PHONE __ WORK PHONE __ E-Mail __ Direct Mail

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent,

______________________________ ________
Print Patient Name Date

____
Signature of Patient or Personal Representative

---------------OFFICE USE ONLY---------------

I attempted to obtain the patient's or representatives signature on this Acknowledgement but was unable to because:

___ It was emergency Treatment ___ I could not communicate with the patient ___ The patient refused to sign
___ The patient was unable to sign because:_______________________________________
____
____

______________________________ ________
Signature of Compliance Officer Date

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Gilbert Chiropractic Clinic

HIPAA OMNIBUS RULE

<u>Patient Acknowledgement of Receipt of Notice of Privacy Practices</u>

Print Patient Name: ______________________________

I acknowledge that I have been provided a copy of the currently effective Notice of Privacy. A copy of this signed, dated document shall be as effective as the original.

DATE:____________

____
Signature of Patient or Personal Representative

____
Signature of Witness / Office Representative

You may refuse to sign the acknowledgement & authorization. In refusing, this practice will not be allowed to process your insurance claims.

I acknowledge that I declined the Notice of Privacy Practices provided:

DATE:____________

____
Signature of Patient or Personal Representative

____
Signature of Witness / Office Representative

****

Office Use Only: I attempted to obtain written authorization of receipt of Notice of Privacy Practices, but acknowledgement could not be obtained because: ___ Individual refused to sign ___ Communication barrier ___ Emergency situation occurred with patient ___ Other (explain):____
____

____
Signature of Office Representative

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GILBERT CHIROPRACTIC CLINIC
2109 60th Street West, Suite B
Bradenton, FL 34209
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FACSIMILE: 941-794-8057

Consent for Chiropractic Care

I hereby consent to the performance of chiropractic care and other chiropractic/medical procedures, including but not limited to various forms of physical therapy and x-rays by Dr. Ronald Gilbert, D.C. at the office of Gilbert Chiropractic Clinic. This consent is extended to other licensed chiropractic physician, chiropractic assistants or licensed massage therapist, who now or in the future, are employed by, working with or associated with Gilbert Chiropractic.

I certify that I have had the opportunity to discuss, with the doctor of chiropractic and/or other office personal, the nature and purpose of the care that is being provided. I understand that the results are not guaranteed. Further, I have been informed and I understand that, as in the practice of any of the healing arts, in the practice of chiropractic, there are some risks to treatment including, but not limited to, fractures disc injuries, strokes, dislocations and sprains. I also understand that the doctor who has explained all of these things with me, is not expected to be able to anticipate and explain all risks and complications. I will rely on the doctor to exercise appropriate judgment during the course of care, based on the facts know at this time, and in my best interest.

My signature below certifies that I have read, or have had read to me the above consent. I also certify that I have had the opportunity to ask questions and discuss options to care been explained. By signing this consent form, I agree to the care being provided to me for the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

PATIENT NAME (Print) DATE

PATIENTS SIGNATURE

WITNESS NAME DATE

WITNESS SIGNATURE

GILBERT CHIROPRACTIC CLINIC
2109 60th Street West, Suite B
Bradenton, FL 34209
PHONE: 941-794-3344
FACSIMILE: 941-794-8057

AUTHORIZATION FOR MEDICAL RECORDS

DATE: ______________________

PATIENT NAME: ___________________________
DATE OF BIRTH: ___________________________

To Whom It May Concern:

Pursuant to all appropriate statutes and rules please accept this as our written request to obtain medical records, reports, and any diagnostic reports in your possession regarding the above-referenced patient at your earliest convenience. Accordingly, please forward same to the above-listed address.

Thank you for your courtesies and cooperation in this matter.

____
PATIENT NAME (print)

____
PATIENT SIGNATURE

____
DATE

Gilbert Chiropractic Clinic
HIPAA OMNIBUS RULE

Authorization for Disclosure of Health Information

Patient Name: ______________________________ Date of Birth: __________

Address: ______________________________ Phone: ______________

City: ____________ State: ______ Zip: ______ Member I.D.# __________

I authorize the release of the following protected health information:

□ Office Notes /Name of Physician______________________________

□ Radiology Reports □ Laboratory Reports Date(s): ____________________

□ Other: ______________________________ □ Paper Copy □ Electronic Copy

The purpose for this request to release medical information is:
□ Medical Care / Treatment □ Insurance □ Other (specify)______________
Send my medical information to: Name: ____________________________
Address: ________________ City: ____________ State: ____ Zip: ______

I understand that:

- By signing this form, I am authorizing the use or disclosure of protected health information as indicated above.
- I may refuse to sign this authorization, which will not affect my treatment or payment for health care.
- I may revoke this authorization at any time by submitting a request in writing to the office Compliance Officer. Revoking this authorization will not affect any action taken prior to receipt of your written request.
- If the receiving party is not subject to medical records privacy laws, the information may be re-disclosed by the recipient and may no longer be protected by federal or state law. This office shall not be held liable for any consequences resulting from re-disclosure
- If the information to be released contains any information about HIV/AIDS an additional HIPAA release of medical information for will be requested.
- Alcohol or substance abuse, mental health or psychiatry notes may have additional compliance requirements that must be met before the information can be released. A copy of this signed form will be provided to me.
- The Office may charge an administrative fee to cover the cost of labor, copying, and postage. The physician's office will inform me of any charges and arrange for payment.

This Authorization expires on __ / / __ or if date not completed / one year after signed.

______________________________ __________
Patient / Representative Signature Date

______________________________ / ____________________
Print Name and Relationship to patient if minor or unable to sign

[Retain this form in the patient's medical record and provide a copy to the patient]

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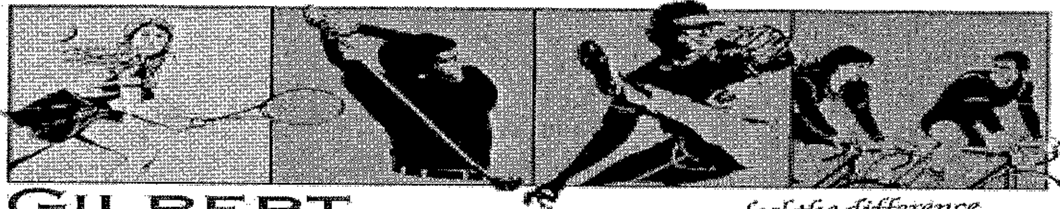

Dear Patient,

We strive to provide excellent chiropractic care to you, your family and all of our patients. In order to do so effectively and efficiently, we have developed an appointment system that sets asides ample time for each patient.

"No-shows" and late cancellations inconvenience those individuals who need access to chiropractic care in a timely manner. In an effort to reduce the number of such occurrences, we have implemented a Chiropractic Appointment Cancellation Policy and it is effective immediately.

Our policy is as follows:

1. We request you give our office a 24- hour notice in the event you need to reschedule your appointment. Our phone number is 941-794-3344.

2. If you miss an appointment and do not contact us with at least a 24 hour prior notice, we will consider this a missed appointment and a $50.00 no-show fee with be assessed to you. This applies to late cancellations and "no-shows."

3. If you are late for an appointment, you will be seen as soon as possible, though the wait time may be longer than normal.

This fee will be billed to you directly and is not covered by your insurance. This balance must be paid prior to your next appointment. If you don't have a scheduled appointment, the balance is expected in a timely fashion and if not, will be subject to collections.

I have read and understand the Chiropractic Appointment Cancellation Policy and agree to the terms of this policy.

Patient Name: ______________________________ **Date:** ______________________

Patient Signature: ______________________________