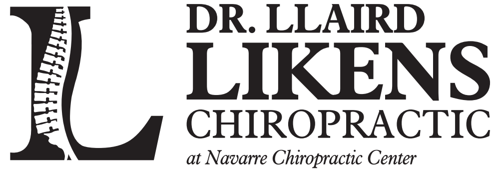

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WELCOME! THANK YOU FOR CHOOSING US TO EVALUATE AND TREAT YOUR CONDITION.

Please fill out the personal information below. If you need assistance, please inform the desk.

How did you hear about us? ______________________________

First Name ____________________ MI ______ Last ____________________

Address ____________________ City ______________ State ______ Zip __________

Home Ph# ______________ Cell Ph# ______________ Work Ph# ______________

Email ____________________ Date of Birth __________ Age ______ SSN XXX-XX- ______

Sex: M or F Marital Status __________ Spouse's Name __________ Spouse's Ph# __________

Employer/School ____________________ Occupation ____________________

Employer Address __________ City __________ State ______ Zip ______ Employer Ph# __________

Emergency Contact ______________ Relationship __________ Emergency Ph# __________

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT

Primary Insurance Company ____________________ Policy Number ______________

Name of Policyholder for your Insurance ______________ Policyholder DOB ______________

Policyholder SSN ____________________ Relationship to Policyholder ______________

IS THIS DUE TO AN AUTOMOBILE ACCIDENT? ☐YES ☐NO IF YES, DATE OF INJURY_____ /_____ /_____

DID YOU GO TO THE HOSPITAL? IF YES, WHERE ______________ DID YOU HAVE ANY X-RAYS? ☐YES ☐NO

AUTO INSURANCE INFORMATION ______________ CLAIM# ______________

ADJUSTER NAME ____________________ PHONE NUMBER ______________ EXT ______

ATTORNEY NAME ____________________ PHONE NUMBER ______________

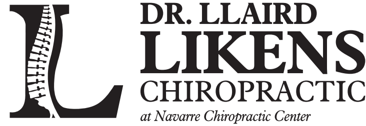
IS THIS DUE TO WORKERS' COMPENSATION? ☐YES ☐NO IF YES, DATE OF INJURY _____ /_____ /_____

Patient Informed Consent

I, ____________________ the undersigned, consent to care at **NAVARRE CHIROPRACTIC CENTER**, I understand that I have the opportunity to discuss with the doctor and/or with other office personnel, the nature and purpose of chiropractic adjustments and progressive wellness. I hereby request and consent to the performance of chiropractic procedures, including various modes of physio therapy, diagnostic x-rays, and any supportive therapies on me (or on the patient above, for whom I am legally responsible) by the doctor of chiropractic and support team at **NAVARRE CHIROPRACTIC CENTER**. I also understand that as is with all healthcare treatments, results are not guaranteed, there Is no promise to cure, and that there are some risks. Risks include, but are not limited to: aggravation and/or temporary increase In symptoms, muscle spasms, fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor's judgment, based upon the facts then known, and Is In my best Interests. I further understand that chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about Its content, and by signing below I agree to the above-named procedures.

Patient Signature ______________________________ Date ______________

Office Employee's Signature ______________________________ Date ______________



FINANCIAL AGREEMENT

Navarre Chiropractic Center
1816 Alpine Dr., Navarre, FL 32566

Please remember that insurance is considered a method of reimbursing the patient for fees put to the doctor and is **NOT A SUBSTITUTE FOR PAYMENT.** Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance.

IN ORDER TO CONTROL YOUR OUTSTANDING BALANCE, IT IS OUR POLICY TO COLLECT CO-PAYS, CO-INSURANCE, AND DEDUCTIBLE AT TIME OF SERVICE.

If this account is assigned to an attorney/outside agency for collection and/or suit, **Navarre Chiropractic Center (Dr, Joshua Pickett, and/or Dr. LLaird Likens)** shall be entitled to reasonable attorney's fees and for cost of collection.

I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim.

____

Patient Signature/Guardian **Date**

____

Print your name or name of person for whom you are legally responsible

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with ______________________________, and hereby assign and convey directly to Navarre Chiropractic Center (Dr. Joshua Pickett and/or Dr. Llaird Likens) all medical benefits and/or Insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical Information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, Insurer, and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions. I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, Including, If necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

____

Patient Signature/Guardian **Date**

____

Print your name or name of person for whom you are legally responsible

Patient Name:______________________________ Date:______________
Chief complaint for today's visit: ______________ Secondary complaint: ______________

How often do you experience the pain? ☐ Constantly ☐ Frequently ☐ Intermittently ☐ Occasionally
Is the reason for your visit today due to an accident or Injury? ☐ YES ☐ NO
Date of onset:______________________________ Cause:______________
Have you had a similar incident in the past? ☐ YES ☐ NO
Is the condition getting progressively worse? ☐ YES ☐ NO Does the pain radiate or travel? ☐ YES ☐ NO
If yes, please identify to where:______________________________

On a scale of 0 to 10, use the key below to rate the severity of your pain.

0 = None	1 = Minimal	2 = Very Mild	3 = Mild	4 = Mild to Moderate	5 = Moderate	6 = Moderate to Severe
7 = Mildly severe, Restricts some activity			8 = Severe, Limits most activity		9 = Very severe	10 = Excruciating

As of today, what is your pain on a scale of 0 to 10? ________
What is the **least** intense the symptom has been on a scale of 0 to 10? ________
What is the **most** intense the symptom has been on a scale of 0 to 10? ________

MODIFYING FACTOR

Please check what activities are difficult to perform and/or increase your pain.

- ☐ Sneezing
- ☐ Coughing
- ☐ Exercise
- ☐ Lifting
- ☐ Walking
- ☐ Looking up or down
- ☐ Looking to the side
- ☐ Stooping
- ☐ Sitting
- ☐ Standing
- ☐ Stress
- ☐ Driving
- ☐ Repetition
- ☐ Pulling
- ☐ Pushing
- ☐ Stairs
- ☐ Lyings down
- ☐ Getting into/out of car
- ☐ Getting out of bed

Other:______________________________

Please check what relieves your pain/symptom.

- ☐ Rest
- ☐ Sleep
- ☐ Exercise
- ☐ Hot bath
- ☐ Medications
- ☐ Walking
- ☐ Sitting
- ☐ Ice
- ☐ Heat
- ☐ Looking up or down
- ☐ Looking to the side

Other:______________________________

Please check what treatment have you tried for your pain/symptom.

- ☐ Medication
- ☐ Injections
- ☐ Surgery
- ☐ Physical Therapy
- ☐ Massage Therapy
- ☐ Chiropractic

Other:______________________________
Who have you seen?______________________________

DAILY HABITS

- What type of exercise do you perform on a daily basis? ☐ None ☐ Light ☐ Moderate ☐ Heavy
- What are your activities or hobbies? ______________________________
- What do your daily work habits include? ☐ Sitting ☐ Standing ☐ Computer Work ☐ Labor
  Other______________________________
- Sufficient Rest: ☐ Never ☐ Rarely ☐ Occasionally ☐ Always
- Hours of Sleep: ☐ 6 ☐ 8 ☐ 10 ☐ Less than 6 ☐ More than 10
- Well Balanced Diet: ☐ Never ☐ Rarely ☐ Occasionally ☐ Always
- Do You Smoke? ☐ YES ☐ NO ☐ Occasionally Packs/day ______________
- Do You Drink Caffeinated Beverages? ☐ YES ☐ NO ☐ Occasionally Drinks/day ______________
- Do You Drink Alcoholic Beverages? ☐ YES ☐ NO ☐ Occasionally Drinks/day ______________

MEDICAL HISTORY

SYSTEM	YES	NO	CURRENT	EXPLANATION
• **Constitution:** Sudden weight loss or weight gain	☐	☐	☐	________
• **Eyes:** Change in vision, watering, pain, pressure, cataracts, glaucoma	☐	☐	☐	________
• **Ears:** Change in hearing, buzzing	☐	☐	☐	________
• **Nose:** Bloody nose, sinus congestion	☐	☐	☐	________
• **Throat:** Throat pain, difficulty swallowing, tonsillitis	☐	☐	☐	________
• **Cardiovascular:** Chest pain, palpitations, ankle swelling, heart disease, pacemaker, angioplasty, vascular stent	☐	☐	☐	________
• **Respiratory:** SOB, asthma, bronchitis, cough, emphysema, pneumonia, tuberculosis	☐	☐	☐	________
• **Gastrointestinal:** Abdominal pain, blood in stool, irritable bowel, ulcer	☐	☐	☐	________
• **Genitourinary:** Frequency, pain, blood in urine, sexual dysfunction	☐	☐	☐	________
• **Musculoskeletal:** Joint pain, muscle pain, osteoporosis, herniated disc, difficult movements, arthritis, fractures	☐	☐	☐	________
• **Neurological:** Headache, migraine, numbness, tingling, pinched nerve	☐	☐	☐	________
• **Hematological/Lymphatic:** Swollen glands, bleeding problems, anemia	☐	☐	☐	________
• **Endocrine:** Increased thirst, change in body temp., thyroid problem, diabetes	☐	☐	☐	________
• **Skin:** Rash, itching, burning, unexplained bruising	☐	☐	☐	________
• **Immunological:** Immune disorder, AIDS/HIB, herpes, mononucleosis	☐	☐	☐	________

DO YOU HAVE A PACEMAKER? ☐YES ☐NO
ARE YOU PREGNANT? ☐YES ☐NO
DO YOU THINK YOU MAY BE PREGNANT ☐YES ☐NO
ARE YOU BREASTFEEDING ☐YES ☐NO

APPROX. HEIGHT ________________

APPROX. WEIGHT ________________

• Please list past surgeries and dates ________________________________
____

• Please list any accident history ________________________________
____

• Please list any current medications. ________________________________
____

• Please list any vitamins or supplements.________________________________
• Please list any known drug allergies. ________________________________

Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Separated ☐ Widowed
Number of Pregnancies _________

Have you ever seen a Chiropractor before? ________________________________
If so, who and when?________________________________

For what symptoms were you seen?________________________________
Did you have any X-Rays taken? ☐YES ☐NO If yes, where/when?________________________________

Primary care Physician: ________________________________ Phone:________________

Patient history was obtained from? ☐Patient ☐Parent/Guardian

Secretary of the Department of Health and Human Services investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures: Will be made only with your consent, authorization, or opportunity to object unless required by law.

You may revoke the authorization: at any time, in writing, except to the extent that your physician or physician's practice has taken an action in reliance on the use of disclosure indicated in the authorization.

Your Rights:
Following is a statement of your rights with respect to your protected health information.

You have the right to Inspect and copy your protected health information: Under federal law, however, you may not inspect or copy the following records, psychotherapy notes, information complied in reasonable anticipations of, or use in, a civil, criminal, or administrative action or proceeding and health information that is subject to the law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the ·purpose of treatment, payment, or healthcare options. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.
Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health Information, your protected health information will not be restricted. You then have the right to use another Calcareous Professional.

You have the right to request to receive confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e electronically.

You have the right to have your physician amend your protected health Information. If we deny your request, for amendment, you will have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.
Complaints: You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact with your complaint. **We will not retaliate against you for filing a complaint.**
This notice was published and became effective on/before **June 1, 2003.**
We are required by law to maintain the privacy of and provide Individuals with this notice of our legal duties and privacy practices with respect to protected health Information. If you have any objection to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main telephone number.

PERSONS WHOM HAVE MY CONSENT FOR ACCESS TO MY MEDICAL RECORDS:

________________________________ Relationship ________________

________________________________ Relationship ________________

________________________________ Relationship ________________

Printed Patient Name: ________________________ Date ________________

Patient Signature: ________________________________

Witnessed By: ________________________________

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HIPAA Notice of Privacy Practices

This notice describes how medical information about you may be used and discloses how you can get access to this Information. Please read and review carefully.

This notice of privacy practices describes how we may disclose your protected health information (PHI), to carry out treatment, payment, or healthcare operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected Health Information” is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental condition and related healthcare services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION:
Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing healthcare services to you, to pay your healthcare bills, to support the operation of the physician’s practice any other use required by law.

TREATMENT:
We will use and disclose your protected health information to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party. For example, we would disclose your protected health information to a physician to whom you have referred, to ensure that the physician has the necessary information to diagnose or treat you.

PAYMENT:
Your protected health information will be used, as needed, to obtain payment for your healthcare coverage.

HEALTHCARE OPTIONS:
We may use or disclose as needed, your protected health information in order to support the business activities of your physician’s practice. These activities include, but are not limited to quality assessment activities, employee review activities, training of chiropractic assistants, licensing and conducting or arranging for other business activities. In addition, we may use a sign in sheet at registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers’ Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of HIPAA.

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CONSENT FOR TEXT/EMAIL CORRESPONDENCE

At Navarre Chiropractic Center we offer text messaging and email services for our patients. We may disclose patient health information (PHI) to third parties that perform services for this practice in accordance with HIPAA. Text messages are not encrypted and thus are not secure. Should your contact information change please Inform the staff at NCC. At any point that you wish to stop receiving text or email correspondence, please inform our office or reply to opt out.

Please make a selection and sign below to indicate that you agree to allow us to use this method of communication. I, ______________________________

☐ do not wish to receive text or email correspondence from Navarre Chiropractic Center, including but not limited to, appointment reminders and birthday messages.

☐ wish to receive text message correspondence from Navarre Chiropractic Center, including but not limited to, appointment reminders and birthday messages.

Service Provider ______________________________
Phone Number______________________________

☐ wish to receive email correspondence from Navarre Chiropractic Center, Including but not limited to, appointment reminders and birthday messages.

Email Address______________________________

Printed Patient Name: ______________________ Date ______________

Patient Signature:______________________________

Witnessed By:______________________________