File #_____ Page 1 of _____

Acknowledgement 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.
I understand I may be contacted by the office staff or doctor for reminders, updates, status inquiries, referral acknowledgment, referrals to other providers, and other general office dealings. By initialing below I understand this may be done via phone, email, text, or Facebook. Privacy supervisor: Kristen Land.

Patient Initials _____

Appointment Cancellation Fee

In order to provide you and our other patients with the best care, we request you respect our guidelines regarding broken and/or cancelled appointments. We do not double book appointments. Therefore, **we require at least 24 business hours notice in order to reschedule your appointment**. (We are closed Thursdays, Saturdays, and Sundays.) This will enable us to offer your cancelled time to other patients needing to get in for treatment. When you cancel your appointment at the last minute, everyone loses - you, the doctor and other patients that would like to have utilized your appointment time.
Our office charges a $50 cash fee for the first broken or missed appointment and the full visit cost thereafter (fees are non-refundable if 24 business hours is not given).
Please be advised, this fee is not covered by your insurance and your exam visit deposit is nonrefundable without 24 business hours notice given. Please realize how important it is to keep your reserved appointment time. Thank you for your consideration of our policies and other patients.

Patient Initials _____

Release of Information

If a referral for imaging or other provider is necessary I allow Land Chiropractic and Sports Clinic to refer me for such consultation or imaging.

Patient Initials _____

If you would like us to send a treatment update to your primary care physician or other physician (or healthcare provider) please complete the following information:
I hereby authorize/request Land Chiropractic and Sports Clinic to release a copy of my patient records or x-rays containing protected health information to the following person(s). This authorization is given pursuant to Florida Statute 456.057 and HIPPA Regulations. I understand that Florida Statute 456.057(12) makes clear that any third party to whom records are disclosed is prohibited from further disclosing any information in the medical record without the express written consent of the patient or patient's legal representative.

Physician/Practice Name_____ Contact Info_____

Please list the name(s) and relation of any person(s) you allow us to release medical information to and initial next to each name. (You may change this authorization by notifying us at any time.)

Name _____ Relation _____ Initial _____

Name _____ Relation _____ Initial _____

By Signing Below you acknowledge all listed above

_____ (signature of patient or guardian) _____ (date)

File # _____ **Patient Information** Page 2 of _____

Land Chiropractic and Sports Clinic
3603 Cardinal Point Drive, Suite 1
Jacksonville, FL 32257
904-338-9995

We do not double book appointments so please ARRIVE 10 MINUTES PRIOR to your scheduled time with this COMPLETED PAPERWORK.

Upon your arrival, please allow us to photocopy your driver's license and insurance card(s).
Please PRINT and COMPLETE THOROUGHLY so we can ensure a thorough examination

Full Name _____ Gender ___M ___F Home Phone _____

Cell Phone _____ Work Phone _____

Email _____

Address _____ City _____ State_____ Zip _____

Birthdate _____ Marital Status ___S ___M ___W Number of Children _____ Employed ___Y___N

Employer _____ Occupation _____ Years on Job _____

Health Insurance ID# _____ Insurance Company _____

Primary Insured _____ Primary Insured DOB _____

Name of Spouse/Parent _____ Spouse/Parent's Occupation _____

How did you find out about our office (so we may thank your referral source): _____

Is your condition due to a traumatic accident? ___ Yes ___ No Date of your accident: _____

Any allergies you may have _____

Please be aware that due to managed care networks and reimbursement policies we can only treat one injury at a time. We must treat all patients by the same overall protocols. We are happy to address other injuries you have but that must be once your current injury is completed.

You will complete an injury specific history form in the office prior to your examination. Please arrive in enough time to complete the form and be seen by the doctor at your scheduled time.

File # _____ **Patient Health History** Page 3 of _____

Read Carefully and accurately answer the questions below concerning your health history. Be sure to list all conditions or symptoms, both past and present. **If the answer is YES or you are unsure, explain in the space provided**

Full Name _____ Age _____ Gender _____ Height _____ Weight _____

Past History

1. List any diseases you have ever been diagnosed with (including childhood), such as diabetes, cancer, blood pressure, cholesterol, heart, lymph node, digestive, hormone, nervous system, etc.
   _____
2. List any physical injuries you have suffered (falls or blows, auto accidents, whiplash, concussion, broken bones, sprains, dislocations, etc. _____
3. List any surgeries you have had (including appendix, tonsils, ear tubes, wisdom teeth, etc)
   _____ date _____
   _____ date _____
   _____ date _____
4. Have you ever been hospitalized for anything other than surgery? __ Yes __ N0 _____
5. List any medication (rX and non rX) you are taking or taking occasionally (including birth control) _____
   _____
6. Females Only: Do you or have you ever had any menstrual problems, if yes, describe?_____
   _____

Family History

7. List any disease or condition common among your family members (ie: inherited conditions or conditions)
   _____

Social History

8. How often do you exercise? _____ What type of exercise? _____
9. How do you spend your spare time (hobbies)? _____
10. Your diet is ___ Balanced ___ Fair ___ Poor ___ Excessive ___ Restricted
11. Do you consume ___ Caffeine ___ Tobacco ___Nicotine ___Recreational Drugs ___Alcohol
12. Describe your work (ie: clerical, factory):_____ Stress Level ___ high ___ medium ___ low

Additional Information

13. Please give any additional information for any response and/or provide information for anything not included in the history above _____
    _____
14. Please list the name of your medical doctor and/or OBGYN _____

Do you currently have, or could you have, any of the following:

Receiving Chemotherapy	Y	N	Diarrhea	Y	N
Receiving Radiation Therapy	Y	N	Pain Moving Bowels	Y	N
Taking Blood Thinners	Y	N	Fever	Y	N
Implanted Devices	Y	N	Recurring Headaches	Y	N
Metal Fragments/Bullets/Shrapnel	Y	N	Slipped/Herniated Disk	Y	N
Nausea and/or Vomiting	Y	N	Work or Auto Accident	Y	N
Blurred or Double Vision	Y	N	Loss of Strength	Y	N
Speech Problems	Y	N	Abnormal Period Discharge	Y	N
Change in Bowel or Bladder Habits	Y	N	Thickening or Lump in Breast	Y	N

Land Chiropractic and Sports Clinic
Insurance Assignment Policy Statement

For all patients selecting INSURANCE ASSIGNMENT (whether in or out of network) as the method of choice to take care of your financial obligation with Land Chiropractic and Sports Clinic:

It is important that you realize in this office we offer the option of INSURANCE ASSIGNEMENT strictly as a courtesy to our patients, and as such, our patients must understand and agree to the following:

1. You must pay all deductibles in full, as well as inform us when your deductible has been met.
2. Payments towards deductibles, co-pays, and/or coinsurances must be paid at the time services are rendered.
3. If your insurance company sends payment to you, it is your responsibility to sign and give the check(s) to this office. You are responsible for all payments that are paid to you for services rendered in this office.
4. You give Land Chiropractic and Sports Clinic authorization to release information to your insurance company concerning your care.
5. We will directly bill your insurance company on your behalf whenever possible.
6. You authorize your insurance company to pay Land Chiropractic and Sports Clinic directly for services rendered.
7. Ultimately, you are responsible for payment and any and all services rendered (covered or non-covered by your insurance company).
8. If coverage benefits are misquoted to our office it is still your responsibility to know your benefits and pay any and all balances due even if such a misquote is received.
9. If a referral is required per your insurance it is your responsibility to let our office know or you will be responsible for any balance due.
10. If you present no insurance, you are unaware of your coverage, or your coverage changes, this office is not responsible to know your current status with your insurance company.

By signing below, you are acknowledging all listed above and accept full responsibility of your balances and payments.

_____ _____

Patient Name Parent/Guardian Name (if applicable)

_____ _____

Patient or Parent/Guardian Signature Date

File # _____ **CREDIT GUARANTEE FOR BALANCES**

Per our office policy and because we do not double book appointments, we require a credit card authorization on file. All payments due are expected to be paid at the time of service. By signing below the patient agrees to have Land Chiropractic and Sports Clinic deduct the funds automatically from his/her credit card at the time of service, for any appointment deposit required, and as indicated below. Any balance due after processing will be automatically charged to your designated card below.

This guarantee will also be used should you cancel without 24 business hours notice, please see our cancellation policy for details.

You may at any time ask for a detailed receipt from our office. We will always keep you current on payments charged or refunds issued if applicable.

Should the patient's form of payment change, it is his/her responsibility to notify the provider of the change so the records may be updated accordingly.

Credit Card: ____ Visa ____ MC ____ Discover

Cardholder Name _____

Card # _____ Exp. Date _____

Billing Address: _____

_____ _____

Signature Date

_____

Printed Name

Land Chiropractic and Sports Clinic, 3603 Cardinal Point Drive, Suite 1, Jacksonville, FL 32257
904-338-9995 (ph)
904-425-4421 (fax)