File #__________________

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 request at least 24 hours notice in order to reschedule your appointment**. 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 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)

Patient Information

Land Chiropractic and Sports Clinic
3874 San Jose Park Drive, Suite 5
Jacksonville, FL 32217
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 keep in mind when completing the following section 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.

HISTORY OF COMPLAINT (ONLY ONE injury can be treated at a time)

Please complete specifically and thoroughly.

Body Region ___________________________ Approximate Start Date ____________________

XRay/MRI/etc taken ______ YES ______ NO

If yes, where did you have it and when? ____

How did your injury occur? ____

Does the pain travel to other areas of your body? ______ NO (it is stabilized) ______YES

If Yes, where does it travel (list the start and finish path) ____

What improves it? ___ice ___heat ___rest ___exercise ___sitting ___standing ___other ___________________________

What makes it worse? ___ice ___heat ___rest ___exercise ___sitting ___standing ___other ________________________

Describe your pain ___achy ___burning ___numb ___sharp/stabbing ___pins/needles ___other_____________________

When is your pain the worst? ___morning ___afternoon ___evening ___while sleeping ___constantly ___on and off

List any other doctors or health care professionals consulted for the complaint that bring you to our office:

________________________________ Office Name and Location _______________________________________

________________________________ Office Name and Location _______________________________________

VISUAL ANALOGUE SCALE

	No Pain 0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10 Unbearable Pain**
a)	Right Now:	0	1	2	3	4	5	6	7	8	9	10
b)	Avg Pain:	0	1	2	3	4	5	6	7	8	9	10
c)	At Best:	0	1	2	3	4	5	6	7	8	9	10
d)	At Worst:	0	1	2	3	4	5	6	7	8	9	10

ADDITIONAL INJURIES I WOULD LIKE DR. LAND TO ASSESS – I understand these injuries will be evaluated and treated AFTER my primary complaint/injury is resolved.

1. ____
2. ____

File # ______________________ **Patient Health History**

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:

Condition			Condition		
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

As a courtesy to you we will keep a current credit card on file for payments. 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 or service. Any balance due after insurance processing will be automatically charged to your designated card below.

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

You may ask at any time 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, 3874 San Jose Park Drive, Ste 5, Jacksonville, FL 32217
904-338-9995 (ph)
904-425-4421 (fax)