STANGER HEALTHCARE
601 NORTH CONGRESS AVE SUITE 417 DELRAY BEACH, FLORIDA 33445
PHONE: (561) 498-4300 EMAIL:DR.JEFFREYSTANGER@STANGERHEALTH.COM FAX: (561) 498-4539

Welcome to our practice! We look forward to partnering with you on your journey to health!

PATIENT INFORMATION & CONDITION FORM

Patient Name: _____ Today's Date: ____/____/____

How did you hear about us? _____

Social Security Number: _____ Birth Date: ____/____/____ Age: ____ Gender: F M

CURRENT ADDRESS: _____

City _____ State _____ Zip _____

Home Phone: (____)_____ Cell Phone: (____)_____

Email Address: _____

Primary Care Physician Information: _____ Phone: _____

Marital Status: ☐ Married ☐ Separated ☐ Widowed ☐ Single ☐ Minor ☐ Divorced ☐ Partnered

Occupation _____ Employer _____

Work Address _____ Work Phone (____) _____

Student at _____ ☐ FULL-TIME ☐ PART-TIME

Name of Spouse _____ Spouse's Date of Birth ____/____/____

Spouse's Occupation _____ Spouse's Employer _____

Spouse's Work Address _____ Work Phone (____) _____

Spouse is a student at _____ ☐ FULL-TIME ☐ PART-TIME

IN CASE OF EMERGENCY, CONTACT

Name: _____ Relationship: _____ Phone: (____) _____

Who may we thank for referring you? _____

What brings you today? _____

MEDICAL HISTORY: Please check ALL that apply.

Is your condition or injury due to an accident or work-related cause? ☐ YES ☐ NO

Did the condition or injury result from *automobile* accident? ☐ YES ☐ NO

Did it result from a *work-related* accident or cause? ☐ YES ☐ NO (briefly describe): _____

_____

If the condition did not result from an automobile accident or relate to your work, where did the accident occur? _____

Approximately, when did your injury or condition occur? _____/_____/_____

Describe your condition, symptoms, or the purpose of this appointment: _____

_____

AREAS OF PAIN

Draw a line from each type of pain/symptom that you are experiencing, to the corresponding area of the body.

Achy Sharp

Burning Shooting

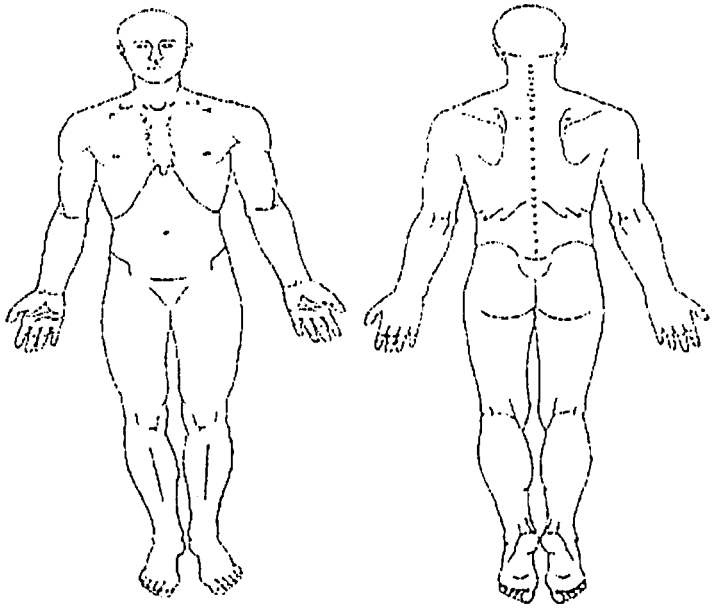
Cramping

Stiffness

Electrical Shock

Numbness

Radiating



Stabbing Dull

Swelling

Throbbing

Tingling

INJURY HISTORY

Please list and briefly describe all significant injuries that you have experienced: (ie. falls, car accidents, sports injuries, etc)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Health Goals

Please list your top 4 long term lifestyle and health goals in order of priority.

(Examples: Pain free living as I age, able to golf, surf, weight lift, exercise, achieve/maintain ideal body weight, stop using pain meds, sleep more/pain free, decrease/manage stress, improve nutrition, play with grandchildren)

1. _____
2. _____
3. _____
4. _____

OTHER:

SURGERY HISTORY

Have you had any surgeries or procedures? Yes / No If yes, please list year and all surgeries:

Procedure:_____ Date:_____

Procedure:_____ Date:_____

Procedure:_____ Date:_____

Procedure:_____ Date:_____

Procedure:_____ Date:_____

SOCIAL HISTORY

Which of these activities do you engage in and how often?

	Occasionally	Often	Never
Exercise	☐	☐	☐
Drink Water	☐	☐	☐
Caffeine	☐	☐	☐
Drink Alcohol	☐	☐	☐
Smoke Cigarette	☐	☐	☐

FAMILY HISTORY

Do you have any family members that have or are currently experiencing any of the following conditions:

☐ Arthritis ☐ High cholesterol ☐ High Blood Pressure

☐ Cancer ☐ Heart Problems ☐ Thyroid Problems

☐ Stroke ☐ Mental Illness ☐ Neurological Disease

☐ Diabetes

MEDICATION & SUPPLEMENTS

List current medications/ supplements Prescribed?

_____ Yes / No

_____ Yes / No

_____ Yes / No

_____ Yes / No

_____ Yes / No

_____ Yes / No

ALLERGIES (to food/medications)

Food:

☐ Dairy/Lactose ☐ Soy ☐ Peanuts

☐ Gluten/Wheat ☐ Corn ☐ Sulfites

☐ Shellfish ☐ MSG ☐ Others:_____

_____

Medication: Reaction:

_____ _____

_____ _____

_____ _____

Certified Natural Wellness Coach

Please check all that apply:

Are you interested in losing weight? ☐

Would you like to be provided with more information about our special weight loss program ☐

Patient Privacy

It is the policy of the Clinic to maintain the privacy and security of all individually identifiable health information for all patients. The Clinic provides notice to all Clinic patients who arrive for appointments, informing them of their right to privacy of their protected health information (PHI). This policy describes procedures implemented by the Clinic to ensure the privacy of PHI. The Clinic obtains acknowledgment of receipt of such notice.

Procedures

1. A designated privacy officer is appointed from within the Clinic to oversee the policies and procedures to ensure that patient's rights to privacy are fulfilled.

2. All patients arriving for care receive a Notice of Patient's Privacy Rights and the Clinic's Receipt of Notice of Privacy Practices Written Acknowledgment Form. All patients are asked to sign the acknowledgment of receipt form.

3. The Clinic website contains the privacy notice, privacy practices, and the acknowledgment response.

4. The Clinic obtains written acknowledgment from the patient or legal guardian prior to engaging in treatment, payment, or health care operations.

5. Patients may request an accounting of certain non-routine disclosures of their PHI. The request may be a time period not longer than six (6) years and may not include dates prior to April 14, 2011, as stated in the request for an accounting of certain disclosures for non-treatment, payment, or health care operations (TPO) purposes.

6. The Clinic obtains written authorization for use or disclosure of PHI in connection with research and marketing.

    a. When appropriate, the Clinic uses a combined informed consent authorization form, especially as it relates to patients participating in research studies.

7. The Clinic discloses only the minimum PHI to requesting entities and insurance companies in order to accomplish the intended purpose.

8. As a covered entity, the Clinic fully complies with the Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA).

9. The Clinic provides the patient, in the Notice of Privacy Practices, a clear, written explanation of how the covered entity may use PHI.

10. Patients are provided access to their medical records and receive copies upon completing a Request to Inspect and Copy PHI. If the Clinic is unable to provide copies based upon the HIPAA guidelines, written notice, in the form of the Patient Denial Letter, is provided to the patient.

11. Patients are given the opportunity to request a correction or amendment to their PHI by completing the Request for Correction/Amendment of Protected Health Information. Any allowed amendments must be in a written amendment; no changes are made directly to the medical record. The Clinic must inform patients that a written request for a correction or amendment is required, and that the patient is required to provide a reason to support the requested change. The amendment is accepted or denied in a provider's written response, on a Disposition of Amendment Request.

12. Anyone who feels the confidentiality of a patient's PHI has been violated may must submit a Patient Complaint Form to the privacy officer. Complaints are kept confidential and no repercussion may occur due to the report. Complaints are logged by the privacy officer.

13. Sanctions are imposed upon employees who violate the privacy of a patient's PHI; sanctions could be disciplinary action, up to and including termination of employment.

14. All employees of the Clinic receive initial and ongoing training on how to prevent misuse of PHI and how to obtain authorization for its use.

15. The Clinic secures a signed release form whenever a patient requests files be sent to another provider or vice versa.

16. The Clinic releases no PHI to employers or financial institutions without explicit authorization from the patient or legal guardian.

17. Electronic, physical, and logistical safeguards are implemented to secure the confidentiality of PHI of all patients.

18. The patient may submit a written Request for Limitations and Restrictions of Protected Health Information.

19. The clinic does not sell or distribute the patient's information for any reason.

Patient's Parent/Guardian (minors)_____ Date_____

DISCLOSURE & CONSENT FOR CHIROPRACITIC ADJUSTMENTS AND CARE

Congratulations for choosing chiropractic and natural healthcare, the safest and most natural health care program in the world. This painless, natural and effective approach to healthcare has been providing healing for people all over the world for over 100 years.

By signing this document I acknowledge that I have discussed or have had the opportunity to discuss all of the possible risks associated with chiropractic treatment. I understand that the doctor of chiropractic listed below will not give an adjustment if they are aware that such care may be contra-indicated. I do not expect the doctor of chiropractic named below and / or any other office or clinic staff to be able to anticipate all risks and complications and I wish to allow them to exercise their best judgment during the course of my chiropractic adjustments and treatments. I understand that the at all times the doctor of chiropractic named below and / or any other office or clinic staff assigned to provide care will be acting in my best interest based on the known facts and information I provide. As such I request and consent to the performance of chiropractic adjustments and other chiropractic treatments as recommended by the doctor(s) named below.

Patient/Parent Signature_____ Date _____

Witness Signature _____ Date_____

Name /Address of Clinic:

STANGER HEALTHCARE CENTERS 601 NORTH CONGRESS AVE SUITE 417 DELRAY BEACH , FL 33445 SHCC

AUTHORIZATION CARE

I authorize and agree to allow the doctor and/or physical therapist to work with my spine through the use spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration of normal biomechanical and neurological function.

I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges.

The Doctor and/or physical therapist will not be held responsible for any health conditions or diagnoses which are preexisting, given by another health care practitioner, or are not related to the spinal structural conditions diagnosed at this clinic. I also clearly understand that if I do not follow the doctors and/or physical therapist specific recommendations at this clinic that I will not receive the full benefit from these programs, and that if I terminate my care prematurely that all fees incurred will be due and payable at that time. I authorize the assignment of all insurance benefits be directed to the doctor and/or physical therapist for all services rendered.

_____ _____ _____

Patient's Name Printed Patient's signature Date

_____ _____ _____

Guardian/Spouse's Name Guardian/Spouse's Signature Date authorizing care for minor authorizing care for minor

HEALTHCARE AUTHORIZATION FORM

THE FOLLOWING AUTHORIZES SHCC TO USE AND/OR DISCLOSE PROTECTED HEALTH CARE INFORMATION IN ACCORDANCE WITH THE FOLLOWING SPECIFIC AUTHORIZATIONS: By signing the following you are giving SHCC permission to use and disclose your protected health information in accordance with the directives listed below.

USE OF CONTACT INFORMATION

I give permission to SHCC to use my name, address, phone numbers and clinical records to contact me with birthday cards, holiday related cards, health related e-mails messages and information about treatment alternatives or other health related information as well as any advertisements, newsletters or patient of the week/month postings.

Patient Signature_____ Date_____

INSURANCE INFORMATION

Name of Insurance Co. _____ Policy#_____

Address_____ Phone # _____

Insured's Name_____ Insured's SS# _____

Relationship to Insured _____ Birthdate _____/_____/_____

Employer_____

Who should receive charges on your account?

___Patient ___Spouse ___Parent / Guardian ___Workers Comp

___Auto Insurance ___Medicare ___Personal Health Insurance

I clearly understand that all insurance coverage, whether accident, work related, or general coverage is an arrangement between my insurance carrier and myself. If this office chooses to bill any services to my insurance carrier that they are performing these services are strictly as a convenience to me. The Doctors office will provide any necessary reports or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny my claims and that I am ultimately responsible for any unpaid balances. Any monies received will be credited to my account. I understand there could be some services that my insurance company does not cover, if this is the case are you willing to pay for these services: [ ] YES [ ] NO

Patient's Signature_____ Date_____

Guardian or Spouse's Signature Authorizing Care_____ Date_____

I hereby authorize Integrated Wellness to administer care as deemed necessary to my child, a minor under the age of 18 years old.

INFORMED CONSENT TO MEDICAL CARE

A patient coming to our facility gives our Healthcare Providers permission and authority to provide medical and alternative health care for them after examination, assessment and any diagnostic testing deemed necessary. The clinical procedures and/or therapies performed are designed to benefit and aid in the healing of your body. Seldom do these therapies or care cause any adverse or unwanted effects. On rare occasion, underlying physical abnormalities or other pathologies may render the patient susceptible for complications or injury. The Healthcare Provider will not perform specific procedures or therapies if he/she feels that the therapy or procedure may be contraindicated with said abnormalities or pathologies. It is the responsibility of the patient to inform the Healthcare Provider of any latent pathological abnormalities, illnesses, or deformities which they may have. This office does not perform breast, pelvic, prostate, rectal, or full skin evaluations. These examinations should be performed by your primary care provider, gynecologist and/or dermatologist to assess for cancers, or other illnesses and conditions. The patient assumes all responsibility/liability for adverse events related to or resulting from non-disclosure of past medical history, illnesses, medications, allergies or other conditions.

I agree to settle any claim or dispute I may have against, or with any of these persons or entities, whether related to the prescribed care or otherwise, and will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

I have read, understand and agree to the above consent form.

Patient's Signature _____ Date _____

Patient's Parent/Guardian (minors)_____ Date_____

RADIOGRAPH CONSENT

I hereby give my consent to allow SHCC STANGER HEALTHCARE and its representatives, as deemed necessary by the examining Healthcare Provider to take radiographs of my spine and/or extremities.

I also hereby declare that to my knowledge that I am not pregnant _____ (Initial)

Patient's Signature _____ Date _____

STANGER HealthCare

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Print Name of Patient: _____ Date of Birth: _____

I. My Authorization:

I authorize the following using or disclosing party: *Stanger Healthcare Center* to obtain, request or disclose the following health information:

☐ - All of my health information including imaging and any health information relating to the following treatment, condition and/ or date range:

_____

II. My Rights:

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Signature of Patient: _____ Date: _____

If the patient is a minor or unable to sign, please complete the following:

☐ - Patient is a minor: _____ years of age

☐ - Patient is unable to sign because: _____

STANGER HealthCare

ASSIGNMENT OF INSURANCE BENEFITS, RELEASE, & DEMAND *Insurer and Patient Please Read the Following in its Entirety Carefully!*

I, the undersigned patient/insured knowingly, voluntarily and intentionally assign the rights and benefits of my automobile insurance, also known as Personal Injury Protection (hereafter PIP) and Medical Payments policy of insurance to the above health care providers (Stanger Healthcare Center). I understand it is the intention of the provider to accept this assignment of benefits in lieu of demanding payment at the time the services are rendered and that this document will allow the provider to file suite against an insurance company for payment of the insurance benefits. I understand the provider may file a lawsuit against my insurer for payment and if the provider's bills are paid or applied to a deductible I agree this will serve as a benefit to me and I authorize and request such litigation. This assignment of benefits includes the cost of transportation, medications, supplies, overdue interest and any potential claim common law or statutory bad faith/unfair claims handling. If the insurer disputes the validity of this assignment of benefits then the insurer is instructed to notify the provider in writing within five days of receipt of this document. Failure to inform the provider shall result in a waiver by the insurer to contest the validity of this document. The undersigned directs the insurer to pay the healthcare provider directly without reductions & without including the patient's name on the check. To the extent the PIP insurer contends there is a material misrepresentation on the application for insurance resulting in the policy of insurance is declared voided, rescinded or canceled, I, as the named insured under said policy of insurance, hereby assign the right to receive the premiums paid for my PIP insurance to this provider and to file suit for recovery of the premiums. The insurer is directed to issue such a refund check payable to this provider only. The insured and the provider hereby contests and 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 protect, at the risk of the insurer, and the deposit shall not be deemed a waiver or agreement by the provider to accept a reduced amount as payment in full. The insurer is hereby placed on notice that this provider reserves the right to seek the full amount of the bills submitted. If the insurer schedules a defense examination or examination under oath (hereinafter "EUO") the insurer is hereby INSRTUCTED to send a copy of said notification to this provider. The provider or the provider's attorney is expressly authorized to appear at any EUO or IME set by the insurer. The assignment applies to both past and future medical expenses and is valid even if undated. A photocopy of this assignment is to be considered as valid as the original. I agree to pay any applicable deductible, copayments, for services rendered after the policy of insurance exhausts and for any other services unrelated to the automobile accident.

Release of Information: I hereby authorize this provider to: furnish an insurer, an insurer's intermediary, the patient's other medical providers, and the patient's attorney via mail, fax, or email, with any and all information that may be contained in the medical records; to obtain insurance coverage in writing and telephonically from the insurer; request from any insurer all explanation of benefits (EOBs) for all providers and non-redacted PIP payout sheets; obtain any written and verbal statements the patient or anyone else provided to the insurer, obtain copies of the entire claim file and all medical records, including but not limited to, documents, reports, scans, notes, bills, opinions, X-rays, IMEs and MRIs, from any other medical provider or any insurer. The provider is permitted to produce my medical records to its attorney in connection with any pending lawsuits. I permit a copy of this authorization to be used in place of original. Regulations pertaining to Medicare benefits also apply.

Demand: Demand is hereby made for the insurer to pay all bills within 30 days without reductions and to mail the latest non-redacted PIP payout sheet and the insurance coverage declaration sheet to the above provider within 15 days. The insurer is directed to pay the bills in the order they are received. However, if a bill from this provider and a claim from anyone else is received by the insurer on the same day the insurer is directed to not apply this provider's bill to the deductible. If a bill from this provider and claim from anyone else is received by the insurer on the same day then the insurer is directed to pay this provider first before the policy is exhausted. In the event the provider's medical bills are disputed or reduced by the insurer for any reason, or amount, the insurer is to: set aside the entire amount disputed or reduced; escrow the full amount at issue, and not pay the disputed amount to anyone or any entity, including myself, until the dispute is resolved by Court. Do not exhaust this policy. The insurer is instructed to inform, in writing, the provider of any dispute.

Certification: I certify that: I have read and agree to the above; I have not been solicited or promised in exchange for receiving health care; I have not received any promises or guarantees from anyone as to the results that may be obtained by any treatment or service; and I agree the provider's prices for medical services, treatment and supplies are reasonable, usual and customary. Caution: Please read before signing. Please ask to view a copy of our charges. If you do not completely understand this document please ask us to explain it to you. If you sign below we will assume you understand and agree to the above. Patient's Name_____ Patient's

Signature_____ (Please Print) (If patient is a minor, signature of parent/guardian)

Statement of Financial Hardship

Date:____/____/_____

This is to confirm that I, _____, have a current
(Print Patients name)
financial hardship. My current hardship prevents me from being able to afford the Usual and Customary Charges associated with the Medical Treatment and/or Testing that will be rendered by Stanger HealthCare Center Inc.

I am therefore requesting that Stanger HealthCare Center Inc. reduce the Usual and Customary charges associated with the Medical Treatment and/or Testing provided to me. I understand that the reduction of charges is being done as a special courtesy. I understand that this is applicable for services that began on ____/____/_____ and shall only apply to services through ____/____/_____.

_____ _____

Patients Signature **Date**

_____

Witness Signature