CHIROPRACTIC CENTER
BISCAYNE

PATIENT INTAKE FORM

TODAY'S DATE _____

PATIENT INFORMATION

Title: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. Sex: ☐ M ☐ F Age: _____ Date of Birth: _____/_____/_____

First Name: _____ Middle Initial: _____ Last Name: _____

Address _____ Apt # _____

City _____ State _____ Zip Code _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

E-mail _____ May we contact you via email: ☐ Yes ☐ No

Have you received chiropractic care in the past? ☐ Yes ☐ No How did you hear about our office? _____

SPOUSE/PARTNER

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced Children: ☐ No ☐ Yes How Many: _____

First Name: _____ Middle Initial: _____ Last Name: _____ Date of Birth: _____/_____/_____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

EMERGENCY CONTACT (if different from above)

Name _____ Relationship _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Patient's Nearest Relative **(if different from above)** _____

Relationship _____ Phone _____

EMPLOYMENT INFORMATION

Occupation: _____

Employer: _____ Office Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

PURPOSE OF THIS APPOINTMENT

Is the condition due to injury or sickness arising out of auto or other accident? ☐ Yes ☐ No Employment? ☐ Yes ☐ No

Explain: _____

Days lost from work? _____ Date symptoms appeared or accident happened ____/____/____

Other doctors seen for this condition _____

PAST, FAMILY, AND SOCIAL HISTORY

Have you been treated for any health conditions by a physician in the past 6 months)? ☐ Yes ☐ No

If yes, when and describe _____

_____

Have you ever had the same or similar condition? ☐ Yes ☐ No

If yes, when and describe _____

_____

MEDICAL HISTORY

What medications or drugs are you taking (past 6 months)? _____

_____

Medical Doctor _____ Date of last physical exam ____/____/_____

What operations have you had? _____ When? ____/____/_____

Serious Illnesses? _____ When? ____/____/_____

Allergies? ☐ No ☐ Yes _____

How often do you exercise? ☐ Always ☐ Often ☐ Occasionally ☐ Rarely ☐ Never

Do you use / consume? ☐ Tobacco ☐ Alcohol ☐ Caffeine How often per day? _____

Has anyone in your family had any of the following problems? ☐ Arthritis ☐ Cholesterol ☐ Heart Problems ☐ Psychiatric Problems ☐ Thyroid ☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Stroke ☐ Other:_____

REVIEW OF SYSTEMS - Have You Ever Had Any Of The Following?

Cardiovascular
☐ Aortic Aneurysm
☐ Chest Pain
☐ Heart Attack
☐ Heart Disease
☐ High Blood Pressure
☐ High Cholesterol
☐ Pace Maker
☐ Poor Circulation
☐ Vascular Disease

Neurological
☐ Balance Problems
☐ Brain Aneurysm
☐ Carpal Tunnel
☐ Head Injury
☐ Numbness
☐ Pinched Nerves
☐ Seizures
☐ Stroke

Hematologic/Lymphatic
☐ Blood Clots
☐ Cancer
☐ Easy Bleeding
☐ Easy Bruising
☐ Fevers/Chills/Sweats
☐ Hepatitis

Musculoskeletal
☐ Arthritis
☐ Broken Bones
☐ Gout
☐ Joint Stiffness
☐ Joints Replaced
☐ Muscle Weakness
☐ Osteoporosis

Psychiatric
☐ Anxiety Disorder
☐ Depression
☐ Unusual Stress

Allergic/Immunologic
☐ Allergy Shots
☐ Cortisone Use
☐ Hives
☐ HIV/AIDS
☐ Immune Disorder

Genitourinary
☐ Blood in Urine
☐ Burning Urination
☐ Frequent Urination
☐ Kidney Disease
☐ Kidney Stones
☐ Lower Side Pain

Eyes
☐ Blurred Vision
☐ Double Vision
☐ Glaucoma

Respiratory
☐ Asthma
☐ Cold/Flu
☐ Cough/Wheezing
☐ Coughing Blood
☐ Emphysema
☐ Shortness of Breath
☐ Sputum
☐ Tuberculosis

Ears/Nose/Throat
☐ Bleeding Gums
☐ Hearing Loss
☐ Nosebleed
☐ Sinus Infection
☐ Sore Throat
☐ Swallowing

Head
☐ Head Injury
☐ Headaches
☐ Migraines
☐ Severe Headaches

Gastrointestinal
☐ Bloody Stools
☐ Bowel Problems
☐ Constipation
☐ Diarrhea
☐ Gallbladder
☐ Liver Problems
☐ Nausea/Vomiting
☐ Ulcers

General
☐ Difficulty Sleeping
☐ Energy Level
☐ Weight Gain
☐ Weight Loss

Skin
☐ Eczema
☐ Psoriasis
☐ Skin Disease/Cancer
☐ Skin Lesions
☐ Skin Ulcers

Females: Are you or could you be pregnant?
☐ Yes ☐ No Due Date: _____

Other problems not elsewhere listed:

PAYMENT/INSURANCE INFORMATION - Payment is expected at time of visit.

Do you have health insurance: ☐ No ☐ Yes Company _____ Insurance phone number: _____

Person responsible for payment _____ Relationship _____

ID # _____ Cardholders Birth Date ____/____/____ SS # _____-_____-_____

I understand and agree that health and accident policies are an arrangement between an insurance carrier and me. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I hereby acknowledge that I have received and had an opportunity to ask questions concerning the Notice of Privacy Practices. In addition, I have read and agree to all the above Financial Policies and Notices.

Patient's Name (Printed) _____ Signature: _____ Date ____/____/____

Guardian's Signature: _____ Date ____/____/____

CHIROPRACTIC CENTER
BISCAYNE

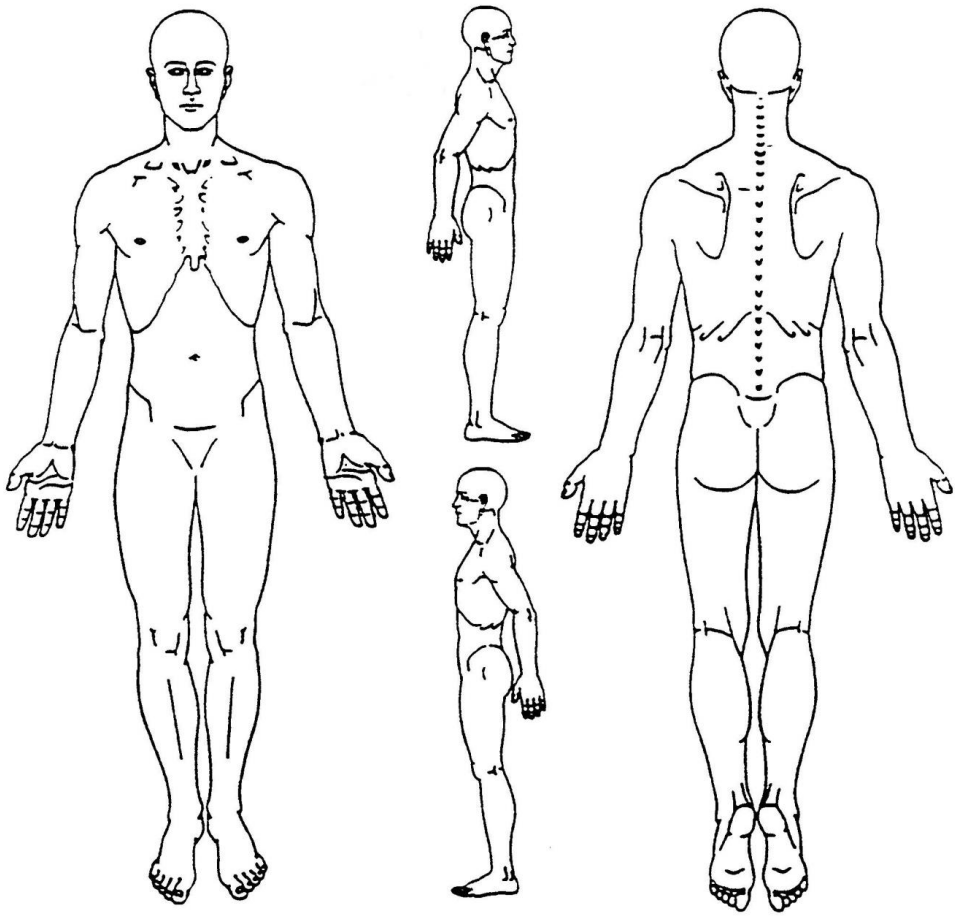
PAIN ASSESSMENT

Name: _____ Date ____/____/____

Please circle in the figures below where you are experiencing pain or discomfort

Next to each area circled, mark the intensity of your pain:

0	**1 2**	**3 4**	**5 6**	**7 8**	**9**
No Pain	Minimal	Tolerable, but hinders Activities	High - 50% of Activities Impaired	Extreme - most activities impaired	Unbearable



Patient's Signature _____

CHIROPRACTIC INFORMED CONSENT

"Chiropractic physician" as defined in Florida Statute 460.403(5)(2008). Chiropractic physicians examine, analyze, and diagnose the human living body and its disease by use of (a) any physical, chemical, electrical or thermal methods, (b) x-ray for diagnosing, (c) blood tests and (d) other chiropractic methods. *See* Florida Statute 460.403(3)(b)

Before you, the Patient, receive chiropractic care, it is important that you read this Consent and understand the nature and risks of chiropractic medicine. The "practice of chiropractic medicine" (or chiropractic care) involves the adjustment, manipulation and treatment of your body in which vertebral subluxations and other malpositioned articulations and structures may be interfering with the normal generation, transmission and expression of nerve impulse between the brain, organs and tissue cells, thereby causing disease. *See* Fla. Stat. 460.403(9)(a). Chiropractic adjustments, manipulations, and treatments are intended to restore the normal flow of nerve impulse which produces normal function and consequent health. *See* Fla. Stat. 460.403(9)(a)

The undersigned Patient understands and acknowledges that there are risks associated with the practice of chiropractic medicine and chiropractic care including, but not limited to ataxia, bruising, thermal injuries, dislocations/subluxations, dizziness, fracture(s), mobility disruption, paralysis, spinal injury, stroke, vision disturbances and others. The most common side effect following chiropractic manipulation/adjustment is an ache or stiffness at the site of the adjustment.

I, also hereby give authorization for **consent of treatment** to **Biscayne Chiropractic Center** and whomever they may designate as their assistants to perform and administer therapy and treatment as they deem necessary.

I, the undersigned Patient, understand the risks and limitations associated with the practice of chiropractic medicine, including the use of chiropractic care, evaluation, diagnosis, adjustments, manipulations, physical therapy and therapeutic modalities such as heat, ice, ultrasound, stimulation, traction, muscle stimulation and others treatments by Biscayne Chiropractic Center. All of my questions have been answered in detail and I fully understand and certify that no guarantee or assurances have been made to the results or outcome from treatment that may or will be rendered.

COVID-19 LIABILITY RELEASE WAIVER

I acknowledge the contagious nature of the **Coronavirus/COVID-19** and that the CDC and many other public health authorities still recommend practicing social distancing. I further acknowledge that Biscayne Chiropractic Center, Inc has put in place preventative measures to reduce the spread of the **Coronavirus/COVID-19**. I further acknowledge that Biscayne Chiropractic Center, Inc cannot guarantee that I will not become infected with the Coronavirus/Covid-19. I understand that the risk of becoming exposed to and/or infected by the **Coronavirus/COVID-19** may result from the actions, omissions, or negligence of myself and others, including, but not limited to, staff, and other clients and their families. I voluntarily seek services provided by Biscayne Chiropractic Center, Inc and acknowledge that I am increasing my risk to exposure to the **Coronavirus/COVID-19.** I acknowledge that I must comply with all set procedures to reduce the spread while attending my appointment.

I hereby release and agree to hold Biscayne Chiropractic Center, Inc harmless from, and waive on behalf of myself, my heirs, and any personal representatives any and all causes of action, claims, demands, damages, costs, expenses and compensation for damage or loss to myself and/or property that may be caused by any act, or failure to act of the office, or that may otherwise arise in any way in connection with any services received from Biscayne Chiropractic Center, Inc. I understand that this release discharges Biscayne Chiropractic Center, Inc from any liability or claim that I, my heirs, or any personal representatives may have against the office with respect to any bodily injury, illness, death, medical treatment, or property damage that may arise from, or in connection to, any services received from Biscayne Chiropractic Center, Inc. This liability waiver and release extends to all owners, partners, and employees. **My signature at the bottom of this form acknowledges the above and I understand that this liability release waiver will be placed in my file and will be active for all future visits to the office.**

PAYMENT PLANS/WELLNESS PLANS/MEMBERSHIPS/PACKAGES

Biscayne Chiropractic Center, Inc believes in the value of chiropractic care for you and your family toward the goal of achieving total health care and wellness. Therefore, we have created a pricing structure that is flexible enough to allow you to get the chiropractic care you need, no matter what your budget. Our chiropractic office participates in most insurance programs. We also accept auto accident and workers compensation cases that result in back pain, headaches or other symptoms which can be addressed with chiropractic care. For patients who have little or no chiropractic insurance coverage, flexible chiropractor payment plans can be arranged.

Insurance

Most health insurance plans are accepted at our chiropractic office. We accept auto accident insurance, workers compensation, personal injury cases that have resulted in back pain, neck pain, headaches, or other related pain conditions. We also accept most health insurance plans, including Medicare. Because there are so many insurance plans out there, and because coverage for chiropractic care varies widely, please call us to find out if your plan covers care in our office. Before you start a chiropractic care plan, our staff would be happy to verify your benefits and explain them to you at no charge.

No Insurance

Our goal at Biscayne Chiropractic Center, Inc is to allow everyone to experience the benefits of chiropractic care and adjustments. For patients who have little or no chiropractic insurance coverage, we can work with you to arrange a flexible payment program that fits your budget. If you have no insurance or if your insurance does not have any chiropractic benefits, there are still ways for you to receive the pain relief and chiropractic care that you need. Many patients choose to pay directly for their visits with the chiropractor, especially as they discover that chiropractic care is actually extremely cost-effective and affordable. For these patients, chiropractic care is often cheaper and more effective than alternative pain treatments such as pain medications or invasive surgery.

Family Plans

Our focus at Biscayne Chiropractic Center, Inc is to actively help you and your family in taking responsibility for your total health, wellness, and disease management. Our chiropractor will assist and guide you as you take the time to care for some of the most important people in your world: you and your family. In an effort to make living the wellness lifestyle as easy and affordable as possible, we can create a customized family chiropractic plan that is specific to you and your family.

Health on a Budget with Chiropractic Care

At Biscayne Chiropractic Center, Inc, we are convinced that chiropractic care will help you stay healthy and pain-free, using only a small amount of your time and money. Our chiropractic health professionals will help you care for your most important asset - your health. We truly believe the prevention is the best cure, and regular chiropractic care will be far less time consuming and expensive than trying to recover from pain or an injury after it's happened. If you feel you do not have enough time or money to take care of yourself, please contact us-we can help! The last thing we want is for you to come to our chiropractic center in crisis. So please, we would like to encourage you to take your health very seriously. As the old saying goes, if you don't have your health, you don't have anything. Unfortunately, too many people don't discover how true that statement is until it is too late.

- **GROUPON:** If I have purchased a Groupon, I agree not to purchase a Groupon in the future for any service even if I received the Groupon price in office. All Groupon packages must be used within **two months** of initial treatment. **Groupons are for new patients only. We Will Ask You To Cancel The Voucher.**
- **APPOINTMENTS CANCELLATION POLICY:** For all massage appointments: There is a **24 hour cancellation policy**. A **$39 cancellation fee** will apply if cancelled **within 24 hours or same day.** If you do not show for your appointment or cancel within an hour of your massage, you will be charged the full amount of your scheduled massage session (including membership appointments - pay or reduce by one).
- **MEMBERSHIP POLICY:** If I join any membership program offered by Biscayne Chiropractic Center, Inc, I consent that my credit/debit card will be charged monthly on the date that I join and will continue until I send a cancellation email. All Memberships have a six month commitment. **I UNDERSTAND THAT** if my credit card does not go through on the pre-arranged date (denied for any reason), I give permission to Biscayne Chiropractic Center to continue to submit the charge. If my card is unable to be charged, I understand that all of my rollover massages are forfeited.
- **CANCELING MASSAGE MEMBERSHIPS:** If I cancel my membership. I understand that in the event that I have more than two rollover massages, only two will rollover and must be used within two months of my cancellation date. All additional massages will be forfeited. I must cancel my membership prior to the renewal date (by email) and I must maintain my membership to use any of my rollover massages.
- **PAUSING MASSAGE MEMBERSHIPS:** If I choose to pause my membership, all outstanding massages are also paused. To resume a membership massage, I must un-pause my membership.
- **MASSAGE AND CHIROPRACTIC PACKAGES: If I purchase a m**assage or chiropractic package (now or in the future), I understand that it is not refundable or shareable and must be used within six months of purchase.

By signing below, I understand my information will be saved to file for future transactions, including but not limited to deposits, membership purchases billed in time, or any transaction(s) for goods or services on a prearranged, recurring billing schedule.

I also agree to abide by all the terms above and policies set forth by Biscayne Chiropractic Center and this will also **act as authorization to charge my card on file for any fees due, services rendered or payments due for me or my children or spouse**. I understand the above and I am aware that Biscayne Chiropractic Center offers reduced fees (time of service discounts). These fees cannot be combined with any insurance.

_____	_____	_____/_____/_____
Patient's Printed Name	Signature of Patient	Date