



Brevard Chiropractic & Injury Center

Confidential Patient Health Record

Date	I.D. No
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PERSONAL HISTORY

Name: _____ Birth Date: _____ Age: _____
 Address: _____ Sex: ___M___F
 City: _____ State: _____ Driver's License Number: _____
 Zip Code: _____ Social Security #: _____
 Circle One: Married Single Widowed
 Home Phone: _____ Separated Divorced
 Cell Phone: _____ Do you prefer calls at ___Home ___Work
 Work Phone: _____ ___Cell ___Any
 Employer: _____
 Type of Work: _____ Name of Spouse/Parent: _____
 Spouse/Parent's Social Security #: _____
 Spouse/Parent's Employer: _____ Type of Work _____
 Spouse/Parent's Work Phone: _____ Cell: _____

IN CASE OF EMERGENCY, CONTACT:

Name: _____ Relationship _____
 Home Phone: _____ Work Phone: _____

 Email Address: _____

*Your email will NOT be shared with any 3rd parties, and is used for occasional office announcements, promotions and registration on brevardchiro.com

How did you hear about us? (Circle All That Apply)

BCIC Website Myspace Yellow Pages Talking PhoneBook Billboard
 Direct Mail Drive By TV Radio Magnet Road Signs
 Newspaper _____ Internet Search Engine _____
 Other _____

Were you referred to our office? ___Yes ___No

If Yes, By whom? _____ Phone Number _____

Whom is your Primary Care Physician: _____

Phone Number: _____

Informed Consent to Chiropractic Adjustments and Care

I have been informed that it is not uncommon for patients to have some increased discomfort after an adjustment. If that happens, I will apply ice to the area and rest it. If I am concerned about the discomfort or develop any new symptoms, I can call the office and speak to the staff. If I am out of town or unable to contact the doctor, I can present myself to the emergency room.

If any test were performed outside of this office (laboratory or other diagnostic procedures) I understand the doctor will notify me of the results at my next scheduled appointment or when the reports are available.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various methods of physical therapy and if necessary, diagnostic x-rays, on me by the doctor of chiropractic in this office and or anyone working in this clinic authorized by the doctor of chiropractic.

I further understand and have been informed that, as in all health care, in the practice of chiropractic there are some very slight risks to treatment, including, but not limited to muscle strains and sprains. I do not expect the doctor to be able to anticipate and explain all the risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time based upon the facts then known, is in my best interests.

I have read the above consent, and by signing below, I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition for which I seek treatment.

Patient

Date

Parent or Guardian

Date

Witness

Date

Brevard Chiropractic & Injury Center
Timothy Bortz, D.C.
3826 Murrell Road
Rockledge, FL. 32955
(321) 631-1100



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PATIENT INSURANCE INFORMATION

Who is responsible for this account? _____

Relationship to Patient: _____

Primary Medical Insurance Company: _____

Name and Date of Birth of Insured: _____

Phone Number of Insurance Company: _____

Member ID #: _____

Group # _____

Secondary Medical Insurance Company: _____

Name and Date of Birth of Insured: _____

Phone Number of Insurance Company: _____

Member ID#: _____

Group #: _____

Reason for today's visit _____

Is this condition due to an accident? Yes No Date of Accident: _____

Type of Accident Auto Work Home Other _____

To whom have you made a report of your accident?

Auto Insurance Employer Worker Compensation Other

Do you have an attorney? Yes No If So, Name and Number _____

Auto Insurance PIP Information

Name of Insurance Company: _____

Name of Insured: _____

Claim#: _____

Name of Adjuster and Phone Number: _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. Timothy Bortz all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature

Relationship

Date

Notice of Privacy Practices

Brevard Chiropractic & Injury Center

Please review this notice carefully; this paperwork describes certain rights regarding how your Personal Health Information (PHI) may be used and disclosed, and how you can get access to your information.

Please contact our office manager/privacy official if you have any questions about this Notice of Privacy Practices.

This office may from time to time use and disclose your PHI in order to perform treatment, payment or healthcare operations, and for other purposes required by law. This Notice will explain your rights to access and amend your PHI and covers any individually identifiable health information about you relating to your past, present or future physical health care services.

This office is required by law to abide by the terms of this Notice of Privacy Practices. The notice may be changed from time to time, but we will inform you of any changes upon request.

1. Uses and Disclosures of Personal Health Information (PHI).

This office may, with or without your consent, use or disclose PHI for treatment, payment, or health care operations as set forth under HIPAA guidelines. There are, however, exceptions when certain uses and disclosures will require authorization from you.

This office may:

Use or disclose PHI to carry out treatment, payment or healthcare operations. Disclose PHI for treatment activities of another healthcare provider.

Disclose PHI to another covered entity or healthcare provider for payment activities of the entity that receives the information.

Disclose PHI to another covered entity for healthcare operations activities of the entity that receives the information, if each entity either has or had a relationship with the individual who is the subject for the PHI being requested if it is for a covered purpose or for the purpose of health care fraud and abuse, detection or compliance. We may disclose PHI about an individual to another covered entity that participates in an organization healthcare arrangement of which we are also a part.

Your Chiropractor, our office staff and others outside of our office who are involved in your health care treatment and services may use and disclose your PHI. Your PHI may also be used and disclosed to pay your healthcare bills and to support the operation of this practice.

The following are some of the ways we may use or disclose your PHI:

Treatment – We may use and disclose your PHI to provide health care and other service to you and to coordinate your care and services with third parties (for which we will obtain an authorization from you). We may also disclose PHI to other physicians who may be treating you or who may in the immediate future treat you. Additionally, we may disclose your PHI from time-to-time to another specialist or laboratory who, at our request, may provide your diagnosis or treatment to us to help in your treatment.

Payment – We may use or disclose your PHI to obtain payment for your health care services. This may include determining your eligibility of coverage for insurance benefits, reviewing necessary medical services, and undertaking utilization review activities for services you may need to receive.

Healthcare Operations – We may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when your Chiropractor is ready to see you. We may use or disclose your PHI to contact you to remind you of your appointment. All information used or disclosed by this office will be necessary for the purpose required. We may, but are not required to ask, you to sign a consent before we use or disclose your PHI.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object:

Public Health – We may disclose your PHI for public health activities and purpose to a public health authority that is permitted by law to collect or receive the information. The disclosures will be made for the purpose of controlling disease, injury or disability.

Abuse or Neglect – We may disclose your PHI to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your PHI if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information.

Legal Proceeding – We may disclose PHI in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal to the extent such disclosure is expressly authorized, in certain conditions in response to a subpoena.

Worker’s Compensation – We may disclose your PHI as authorized to comply with worker’s compensation laws and other similar legally-established programs.

Required Uses and Disclosures – Under the law, we must make disclosures to you and when required by the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164500 et. seq.

2. YOUR RIGHTS

This office abides by the rights given to you by the United States Government with regards to your PHI.

The following is an overview of your rights and how to exercise them:

You have the right to inspect and obtain a copy of your PHI – You may inspect and obtain a copy (for a minimum fee) of your PHI that is contained in a designated record set for as long as we maintain your PHI. A “designated record set” contains medical and billing records and any other records that we use for making decisions about your care.

You have the right to request a restriction or authorization of your PHI – You may ask us not to disclose all or any part of your PHI for the purpose of treatment, payment or health care operations. You may request that any part of your PHI not be disclosed to family members or friends who may be involved in your case 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. *We are not required to agree to a restriction that you may request. If we believe it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. If we do agree to the requested restriction, we will not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment. You may request a restriction by doing so in writing and providing the detailed request to our Privacy Official.

You may also request that your PHI be released, in your absence, to the following individual(s):

please print name

_____	Relationship_____
_____	Relationship_____
_____	Relationship_____

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. This request must be disclosed with our Privacy Official.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI.

You have the right to obtain a paper copy of this notice from us, upon request.

3. Complaints

You may direct your complaints to us or to the Secretary of Health and Human Services if you believe we have violated privacy rights. You may file a complaint with us by notifying our Privacy Official of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Official by phone at (321) 631-1100 for further information about the complaint process.

Office Policies and Privacy Statement

The nature of our practice is to give our patients the utmost in care and service. Please excuse delays. We will give you the same careful attention as soon as possible.

Our office is committed to providing you with the best *Chiropractic and Rehabilitative* service possible. Your chiropractic care is a form of rehabilitation and therefore will take place over time. For this reason you will be scheduled for a number of visits to be determined by your chiropractor after he or she has examined you.

It is important for you to follow the recommended care plan for best results. This includes frequency and duration of visits to help you achieve your maximum potential. Our goal is to provide a professional and beneficial experience to the patients to whom we render services. We look forward to helping you attain your personal goals and return to a normal, pain free life as soon as possible.

This office may, from time to time, use and disclose your Personal Health Information (PHI), in order to perform treatment, payment or health care operations, and for other purposes required by law. This notice is available for you to read and will explain your rights to access and amend your PHI and cover any individual identifiable health information about you relating to your past, present or future physical and mental health or conditions and related health care services.

We want to make your visits to Brevard Chiropractic & Injury Center as productive and pleasant as possible. Our office is very busy, while we are aware that unforeseen circumstances can sometimes occur, if for some reason you must cancel or reschedule an appointment, ***please call as soon as possible so that we can reschedule you.***

Repeated missed appointments will disrupt your progress. Our office is very busy, with a high demand for appointments; please give us as much notice as possible so that we may use your appointment space for someone else. ***Patients who show a repeated pattern of no-shows will be charged \$20 for their missed appointments.***

As a courtesy to our patients we do file insurance claims for you to your primary insurance company. Our office staff will verify your insurance coverage and let you know your financial responsibility as soon as possible. Health insurance contracts are agreements between patients, their employers and the insurance company.

As a courtesy to our patients we will provide a copy of your medical records at a cost according to Florida Statutes and per written request. Additionally, should you or your insurance company require forms or information, this office reserves the right to charge for time spent in preparation of those forms or requested medical information.

It is your responsibility to make sure your insurance company is paying this office. Although this office may bill your insurance carrier for services rendered, all charges for services rendered are the patients' responsibility.

We will notify you as soon as we know of any difficulties we are having collecting monies from your insurance carrier. Should difficulties arise, you may need to contact your insurance company. If our office determines that your insurance carrier will reimburse you directly and not pay our office, you will be required to pay in full for all services at the time they are rendered. Our office makes every attempt to correspond with insurance carriers to assist them in correctly paying your claims.

All patients who have insurance, no matter the type it is, are required to pay co-payments, deductibles and/or percentages required each visit. If our office is a non-participating provider with the insurance company you have, we will gladly file those claims for you but you will be responsible for payment at the time service is rendered.

If you are a Medicaid enrollee, your eligibility status must be verified each month. If your eligibility is terminated, you become responsible for services rendered.

If you have been injured on the job, you must have authorization for care from the Worker's Compensation Insurance Company before an appointment or treatment can be rendered by our office. Your employer will assist you in securing that information.

X-RAY/MEDICAL RELEASE/INSURANCE INFORMATION:

I hereby authorize that all medical records, x-rays and any other pertinent medical information be released to Brevard Chiropractic & Injury Center. Also to disclose all insurance coverage for treatment provided herein.

Patient Signature

Social Security #

PAYMENT OF BILLS:

1. We will require you to honor the financial agreements you make with our office. If you find that you cannot fulfill the agreement you have made with us, please advise our financial department immediately so new arrangements can be made.
2. Any insurance checks sent to your home should be brought or sent to our office within three (3) days with Explanation of Benefits (stub/statement) to indicate which services were paid.

**Our office will submit your insurance claims for you as a courtesy. However, your insurance is an agreement between you and your carrier, not between your insurance company and this office.

Patients without insurance are expected to pay in full at the time services are rendered, unless other arrangements have been made with our financial department.

Patient Signature

Date

Witness

Date

Brevard Chiropractic & Injury Center
Timothy Bortz, D.C.
3826 Murrell Road
Rockledge, FL. 32955
(321) 631-1100

Patient Consent, Authorization & Acknowledgment of Notice of Privacy
Practices for Brevard Chiropractic & Injury Center

I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures that may be required to fully evaluate my condition. I understand that I am under the care and supervision of the treating chiropractic physician and any treatment performed in this office and shall be by his or her order and under his or her supervision.

If the attending chiropractic physician is required to submit documentation, including patient histories, office notes or patient questionnaires to the contracted insurance company for review for medical payment, I authorize required information to be released.

I hereby attest that I have read the appropriate sections of the above document and fully understand all aspects of these office policies as they apply to myself and my method of payment for services rendered. I also attest that if I did not understand a section above, that I did ask for clarification from the office staff concerning the section in question.

I also attest that I have read the Notice of Privacy Practices for Brevard Chiropractic & Injury Center that was given to me and I understand that this Privacy statement is required by HIPAA, a governmental standard that all offices must now have.

Patient Signature

Date

Patient Printed Name

Witness

Date

Brevard Chiropractic & Injury Center
Timothy Bortz, D.C.
3826 Murrell Road
Rockledge, FL. 32955
(321) 631-1100

PERSONAL MEDICAL HISTORY

Name: _____

Date: _____

Past and Present Medical History:

Please check all that apply and describe.

Past	Present	
-------------	----------------	--

- | | | |
|--------------------------|--------------------------|-----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Mental Illness _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Gout _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Hypertension _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Attack _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney Disease _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Allergy _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Spinal Disorder _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Migraines _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | HIV/AIDS _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Pregnancy _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Other: _____ |

Please check any of the following that apply and describe.

- | | |
|--|--|
| <input type="checkbox"/> Major hospitalization or operations | <input type="checkbox"/> Past auto accidents |
| <input type="checkbox"/> Past work accidents | <input type="checkbox"/> Major illnesses |

Details: _____

Previous Chiropractic Care: None Doctor's Name and approximate date of last visit: _____

Do you suffer from any other condition other than the one you are consulting with us today? _____

List all prescription, over-the-counter medications and nutritional/herbal supplements you are taking. _____

Patient/Guardian Signature _____ Date _____

Patient/Guardian Printed Name _____