Delray Spinal Care Center

Achieving Better Health naturally!

JUDITH ZEPHIRIN, DC

Patient Demographic

Patient Information

Patient First Name: _____Last: _____ MI:_____

Address:_____

_____

Home Phone #: _____ Cell Phone #: _____

Date of Birth: _____ Age: _____ Female ___ Male ___

Status: ___Minor ___Single ___Married ___Divorced ___Widowed ___Separate

Insurance Information

Insurance Co. Name: _____Phone Number: _____

Insurance Co. Address:_____

_____

Date of Injury_____Date of Initial Visit: _____

Policy Number:_____Claim Number: _____

Insured's Name: _____Relation to Insured: _____

Adjuster's Name : _____Adjuster Phone Number: _____

Attorney Information

Attorney Name: _____
Phone Number: _____Fax Number: _____
Attorney Address:_____
_____
BI limit: _____

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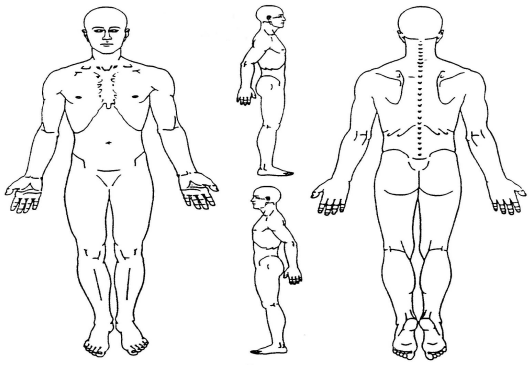
Please take a moment to fill out this form to the best of your ability

Reason for visit: _____

Are your symptoms a result of: □ Motor Vehicle Accident ___□Work related Accident □____

Other_____

Mark in X on the affected area using the picture below.



Describe your symptoms in order of severity, with worse symptom being #1:

_____ _____

On average rating from 0-10, how much pain are you experiencing? 0 = no pain and 10 = the worst pain imaginable?

Please circle: 0 1 2 3 4 5 6 7 8 9 10

How are your symptoms changing? □ Getting better___□ Not changing__Getting worse___

Activities of Daily Living

Please circle if you have pain or difficulty performing the following:

Bending Carrying Groceries Change Posn–Sit-Stand Climb Stairs Driving Extended Computer Use Household Chores Kneeling

Lift Children Reading (Concentration) Self Care–Bathing

Self Care–Dressing Sexual Activities Sleep Static Sitting Static Standing Walking Yard Work

Other_____

Thank you for taking the time to share this information with us. Although no one enjoys such detailed paperwork, we believe it is a valuable exchange between the patient and physician. We hope you will find your encounter, in our office, is taken personally and seriously. We believe that next to one's spiritual and family life, health is the first wealth and if you "ignore your health, it will go away!"

– Dr. Judith Zephirin
Chiropractic Physician

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Accident Report Form

Patient Name:	Date:

Date of Accident: ____ /____ /_____ Time of Accident: _____

Where were you seated? _____

Make/Model of vehicle you were occupying: _____

Location where the accident occurred: _____

Approximately how fast were you traveling when the accident occurred? _____ MPH

Make/Model of other vehicle(s) involved: _____

In your own words, briefly describe the accident: _____

_____

_____

At the time of the accident, which way were you facing? Forward? Turned? _____

Were you surprised by the accident? Yes / No

Were you rendered unconscious? Yes /No

Were you wearing a seat belt? Yes / No

Were the police notified Yes /No

Did the airbags deploy? Yes /No

Was a report filed? Yes /No

With whom? _____

How did you feel immediately following the accident? _____

Is the pain _____Getting better? _____No improvement? _____ Getting worse?

Did you go to the hospital? Yes / No Where? _____ How? _____

Were any of the following performed? _____ X-rays _____ CT MRI

Were you prescribed medication? Yes / No What was prescribed? _____

Have you seen another doctor for this injury? Yes /No Whom? _____

Have you been able to work since the accident/ Yes /No Why or why not_____

What could you do before the accident that you are unable to do now? _____

Do you have an attorney? Yes /No Who? _____

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ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS
AS WELL AS AN
APPOINTMENT AND/OR DESIGNATION AS AN ERISA/PPACA REPRESENTATIVE AND A BENEFICIARY

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay: Delray Spinal Care Center, 3185 S. Federal Hwy, Delray Beach, Fl 33483, as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Health Care Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided.

I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Health Care Provider for any and all medical/healthcare services, supplies, tests, and/or medications that *have been* or *will be* rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under.

I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same.

I hereby assign directly to Health Care Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA plan, PPACA plan, or insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Health Care Provider can act on my/our behalf, as my/our representative, ERISA representative, or PPACA representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals to obtain benefits and/or payments that are due to either Health Care Provider, myself, and/or my family members as a result of services rendered by Health Care Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan or insurer. I hereby also declare that Health Care Provider is my/our beneficiary regarding my/our health plan as contemplated by ERISA and PPACA, and that Health Care Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment and/or designation will remain in effect unless revoked in writing. A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

Signed this _____ day of _____ 20 ____.

_____
(Please print patient name)

X_____
(Patient signature)

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PATIENT FINANCIAL AGREEMENT
PLEASE READ THOROUGHLY AND SIGN BELOW

The purpose of this form is to let you know how our office works in the handling of your insurance claims. We do this to eliminate any questions or misunderstandings that could arise and later affect your ability to use your policies as they were intended.

Insurance Benefits and Coverage:
As a courtesy to you, we will file and submit your insurance claim(s) for treatments rendered at this office. Please remember that your insurance coverage is a contract between you and your insurance company. We are not a party to that contract. If you ever have any questions regarding your coverage and or benefits please contact your insurance company. Ultimately you are responsible for all costs incurred during treatment. If your insurance does not accept assignment of benefits in other words, if they pay you rather than us, payment must then be made in full at the time of service. In such instances we will submit the claim on your behalf. Depending on your specific coverage, you may be asked to pay either your deductible, copay, per visit fee, or monthly fee based on your plan.

Payment of Services, Copayment, Deductible and Coinsurance:
Although we do accept assignment of benefits, we require payment of any copayments, due at the time of service. We accept Cash, Credit/Debit card and personal Check. If you have any deductible or coinsurance amount to be met, you will be billed once your insurance has processed and paid their portion of the claim.

Uninsured Patients and Non-Covered Benefits:
Full payment is due at the time of service. We accept Cash, Credit/Debit card and personal Check. In some instances a payment plan may be made for some patients on a case by case basis. While we try to accommodate all of our patients we do maintain strict guideline regarding payment plans.

Balance and Statement:
You will receive a statement once a month if you have a balance owing. Failure to pay a balance by the third billing statement will result in your account being turned over to the collection process if you have made a payment agreement and fail to make two consecutive monthly payment, your account will be turned over to the collection process. ***Please note there is a fee of $25 plus balance owed for all returned checks.***

I have read this financial policy, understand it and agree to its terms.

_____

Signature of patient or parent if patient is a minor Date

NOTICE OF PRIVACY PRACTICES

We may use and disclose your PHI (private health information) in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We may also disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute.

We may use or disclose your PHI for workers compensation and similar programs.

We may use a sign-in sheet at the front desk and we may call you in to see the doctor by name.

We may contact you by mail or phone, at your residence, to remind you of appointments or to provide information about treatment alternatives. Unless you instruct us otherwise, we may mail you a postcard reminding you to make an appointment and we may leave a message for you on any answering device or with any person who answers the phone at your residence.

You can make a reasonable request for us to use alternative methods of communicating with you in a confidential manner. These requests must be submitted in writing in a clear and concise fashion. We are not required to agree to your request. However, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when information is necessary to treat you.

Rights that you have:

You have the right to request restrictions on some of the uses or disclosures described above. Except as stated, we are not required to agree to such restrictions.

You have the right to inspect and obtain copies of your medical Information. (A fee for the costs of copying, mailing, labor and supplies associated with your request will be charged.)

You have the right to request amendments to your medical information. Such requests must be in writing, and must state the reason for the requested amendment. We will notify you as to whether we agree or disagree with the requested amendment. If we disagree with any requested amendment, we will further notify you of your rights.

You have the right to request an accounting of any disclosure we make of your medical information except for disclosures we make to you, to carry out treatment, payment or healthcare operations, as requested by your written authorization, as permitted or required under 45 CFR 164.502, for emergency or notification purposes, for national security or Intelligence purposes as permitted by law, or to correctional facilities or law enforcement officials as permitted by law.

You have the right to receive a paper copy of this notice. To obtain a paper copy of this notice, please contact our office manager.

You have the right to file a complaint if you believe your privacy rights have been violated. You may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing and addressed to 1091 Pemberton Hill Rd ste 201 Office of Civil Rights, Apex, NC 27502. You will not be penalized for filing a complaint.

This privacy policy is subject to change as circumstances dictate. Any changes will be effective upon the release of a revised privacy policy, which will be made available to patients upon request.

Please sign and date below, acknowledging that you have read this policy and that you consent to the terms of our privacy policy as stated in this notice.

Signature of Patient or Legal Guardian:_____ Date:_____

Print Name of Patient or Legal Guardian:_____ Date:_____

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Informed Consent for Chiropractic Treatment

TO THE PATIENT: *You have a right to be informed about your condition, the recommended chiropractic treatment, and the potential risks involved with the recommended treatment. This information will assist you in making an informed decision whether or not to have the treatment. This information is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or refuse to give your consent to treatment.*

I request and consent to chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays. The chiropractic treatment may be performed by the Doctor of Chiropractic named below and/or other licensed Doctors of Chiropractic working at this clinic or office. Chiropractic treatment may also be performed by a Doctor of Chiropractic who is serving as a backup for the Doctor of Chiropractic named below

I have had the opportunity to discuss with the Doctor of Chiropractic named below, my diagnosis, the nature and purpose of my chiropractic treatment, the risks and benefits of my chiropractic treatment, alternatives to my chiropractic treatment, and the risks and benefits of alternative treatment, including no treatment at all.

I understand that, there are some risks to chiropractic treatment including, but not limited to: Broken bones, increased symptoms and pain, Dislocations , No improvement of symptoms or pain, Sprains/strains, Infection (acupuncture), Burns or frostbite (physical therapy), Punctured lung (acupuncture), Worsening/aggravation of spinal conditions.

In rare cases there have been reported complications of vertebral artery dissection (stroke) when a patient receives a cervical adjustment. The complications reported can include temporary minor dizziness, nausea, paralysis, vision loss, locked in syndrome (complete paralysis of voluntary muscles in all parts of the body except for those that control eye movement), and death.

I do not expect the doctor to be able to anticipate and explain all risks and complications. I also understand that no guarantees or promises have been made to me concerning the results expected from the treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions. All of my questions have been answered to my satisfaction. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my current condition.

To be completed by the patient:

_____
Patient name

_____
Signature of patient

_____
Date signed

To be completed by doctor or staff:

_____
Name

_____
Signature

_____
Date signed