North Ridge
5353 North Federal Hwy Suite 220 Ft. Lauderdale, Florida 33308
Phone 954.491.8127 Fax 954.491.2388

PATIENT INFORMATION

Thank you for choosing our practice for your chiropractic needs. Please complete form in ink. If you have any questions or concerns, do not hesitate to ask for assistance.

(Please Print)

Name_____ S/S _____-_____-_____ Date_____

Address _____ City_____ State_____ Zip _____

Sex (circle) Female Male Date of Birth _____/_____/_____

Home phone # (_____) _____Cell # (_____) _____ Email address: _____@_____

Our office uses texts alerts to remind patients about their future appointments. Please circle your wireless service provider. If you do not have a cell phone, or your wireless provider is not listed please let the receptionist know.

Alltel AT&T Nextel Sprint T-Mobile Verizon Virgin Mobile Metro PCS

I am: (circle one) Single Married Divorced Widowed Separated

Your Employer _____ Occupation_____

Business Address _____ City _____State _____Zip _____

Business Phone # (____) _____

Spouse or Parent's name _____

Person to contact in case of emergency_____ Phone # (_____) _____

Who referred you? _____

INSURANCE INFORMATION

Primary - *(present card to receptionist)*

Insurance _____ Primary Insured Name _____

Policy #/ SS# _____ Date of Birth _____/_____/_____

Secondary - *(present card to receptionist)*

Insurance _____ Primary Insured Name _____

Policy #/ SS# _____ Date of Birth _____/_____/_____

CHIROPRACTIC / ACUPUNTURE TREATMENT CONSENT

I hereby request and consent to the performance of chiropractic adjustments, acupuncture, and other procedures. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic and acupuncture there are some risks to treatment including, but not limited to, fractures, disk injuries, strokes, dislocations, sprains, nerve damage, organ puncture, burning, scarring ,or infection. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of treatment concerning which treatment(s) are in my best interests, based upon the facts as they are then known.

X_____ _____/_____/_____

Signature of Patient (or parent if a minor) Date

AUTHORIZATION/FINANCIAL RESPONSIBILITY

I authorize the chiropractor and acupuncturist to release any information concerning my diagnosis and medical records about any treatment or examination rendered to me or my child during the period of chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay the chiropractor directly for insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered to me or my dependents. I understand that payment for services and/or the applicable co-payment is due at the time of service.

X_____ _____/_____/_____

Signature of Patient (or parent if a minor) Date

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Prior to discussing your current condition please advise us of any pertinent information

Past medical history:

Accidents: **O** Auto **O** Workers Comp **O** other_____ Date(s):_____

Surgeries: _____ Date(s):_____

Other incidences: _____ Date(s):_____

Chiropractic Care **O** yes **O** no Date_____ Results_____

Medical Care **O** yes **O** no Date_____ Results_____

Acupuncture **O** yes **O** no Date_____ Results_____

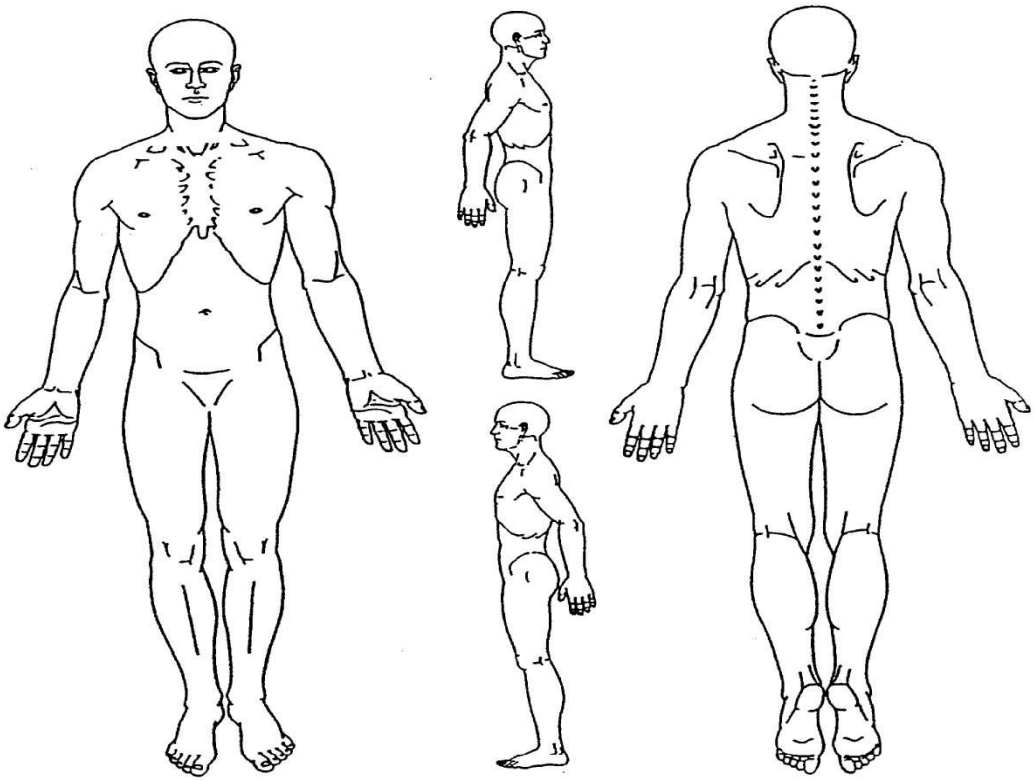
Family history: Family Member Present/Past Health History

_____ _____

_____ _____

_____ _____

Current Condition:



Key: Use Numbers below to indicate location of pain on model above (circle if large area involved)

1 = Primary Complaint
2 = Secondary Complaint
3 = Tertiary Complaint

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Primary Complaint: _____

Pain Scale: 0 1 2 3 4 5 6 7 8 9 10

O aching **O** burning **O** deep **O** cramping **O** dull **O** sharp **O** severe **O** shooting

O stabbing **O** throbbing **O** pins/needles **O** constant **O** comes/goes **O** mild **O** moderate

Duration: Symptoms first appeared:_____

Symptoms: **O** constant **O** intermittent **O** insidious **O** gradual

O slowly progressing **O** sudden _____

Pain: Made worse **O** cough/sneeze/straining **O** sitting **O** walking **O** twisting

O standing **O** bending **O** physical activity **O** inspiration **O** lifting

Improves **O** OTC meds **O** standing **O** physical activity **O** heat **O** ice
O pressure **O** rest **O** walking **O** sitting **O** massage **O** manipulation

Secondary Complaint: _____

Pain Scale: 0 1 2 3 4 5 6 7 8 9 10

O aching **O** burning **O** deep **O** cramping **O** dull **O** sharp **O** severe **O** shooting

O stabbing **O** throbbing **O** pins/needles **O** constant **O** comes/goes **O** mild **O** moderate

Duration: Symptoms first appeared:_____

Symptoms: **O** constant **O** intermittent **O** insidious **O** gradual

O slowly progressing **O** sudden _____

Pain: Made worse **O** cough/sneeze/straining **O** sitting **O** walking **O** twisting

O standing **O** bending **O** physical activity **O** inspiration **O** lifting

Improves **O** OTC meds **O** standing **O** physical activity **O** heat **O** ice
O pressure **O** rest **O** walking **O** sitting **O** massage **O** manipulation

Tertiary Complaint: _____

Pain Scale: 0 1 2 3 4 5 6 7 8 9 10

O aching **O** burning **O** deep **O** cramping **O** dull **O** sharp **O** severe **O** shooting

O stabbing **O** throbbing **O** pins/needles **O** constant **O** comes/goes **O** mild **O** moderate

Duration: Symptoms first appeared:_____

Symptoms: **O** constant **O** intermittent **O** insidious **O** gradual

O slowly progressing **O** sudden _____

Pain: Made worse **O** cough/sneeze/straining **O** sitting **O** walking **O** twisting

O standing **O** bending **O** physical activity **O** inspiration **O** lifting

Improves **O** OTC meds **O** standing **O** physical activity **O** heat **O** ice
O pressure **O** rest **O** walking **O** sitting **O** massage **O** manipulation

I attest that all the above information is correct

Patient Signature: _____ Date: _____

North Ridge
5353 North Federal Hwy Suite 220 Ft. Lauderdale, Florida 33308
Phone (954) 491-8127 Website www.mynorthridgechiro.com

Assignment of Benefit / Policy Rights

Patient

The undersigned patient hereby assigns the benefits of insurance under the automobile insurance or other insurance with (Insurance Company) _____ to North Ridge Chiropractic, for services rendered to the undersigned patient and covered by Personal Injury Protection (P.I.P.) coverage or other insurance coverage under (Insured's Name) _____ in accordance with Florida Statue 627736 (5). The undersigned agrees to pay any applicable deductible or co-payment not covered by the P.I.P. or other insurance coverage. I have read the information herein and it is true to the best of my knowledge and belief.

This assignment includes, but is not limited to, all rights to collect benefits directly from patient's insurance company for services patient has received and all rights to proceed against Patient's insurance company in any action including legal suit if for any reason patient's insurance company fails to make payments of benefits to which patient is due. The assignment also includes any right to recover attorney's fee and costs for such action brought by the provider as patient's assignee. Additionally, upon forwarding payment for any medical services and/or supplies, I direct my applicable personal injury protection and/or medical payments insurance carrier to provide my medical provider with a copy of an updated PIP payout sheet.

I agree that North Ridge Chiropractic may select an attorney it wishes and understand and agree that the attorney selected by North Ridge Chiropractic may be different than the attorney handling my personal injury/ bodily injury claim or case.

As part of this agreement of benefits which becomes binding upon my insurance carrier upon its receipt of said assignment, I hereby instruct my insurance carrier that in the event the subject medical benefit (s) is disputed for any reason, including medical reasonableness, customary and/or necessity, that the amount if benefits claimed by North Ridge Chiropractic, is to be held in abeyance and not disbursed until the resolution of any legal proceedings brought by said provider. As part of this assignment of benefits, the patient further instructs his/her insurance carrier to notify the provider immediately of any dispute as to payment so that they may exercise its legal rights.

_____ _____
Patient's Signature Date

Provider

The undersigned hereby accepts assignment of the insurance benefits for the services rendered to (patient's name) _____ and to be paid directly to North Ridge Chiropractic, under (Insured's name) _____ Personal Injury Protection (PIP) or other insurance coverage with (Insurance company) _____ and in accordance with 627.736 (5). I understand that any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement containing any false, incomplete or misleading information is guilty of a felony of the third degree. I have read the information herein and it is true to the best of my knowledge and belief.

_____ _____
Witness Date

Informed Consent for Chiropractic and Massage Treatment

A patient, in coming to the Doctor of Chiropractic, gives the Doctor Permission and authority to care for the patient in accordance with the Chiropractic tests, diagnosis, and analysis. Chiropractic treatment consists of manipulations of joints and soft tissue, using the hand and/or a mechanical instrument. You may feel joint movement, and may hear joint clicks or other noises. Some patients will feel some stiffness and soreness following the first few days of treatment. These are normal findings and are not a cause for concern. In rare cases, underlying physical defects, deformities, or pathologies may render the patient susceptible to injury. The Doctor, of course, will not give a chiropractic adjustment, recommend neuromuscular re-education, or give health care if he/she is aware that such care may be contra-indicated. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are certain risks which may arise during the examination and treatment. Those complications include: stroke or stroke-like conditions, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy, pathological fracture, cervical disc protrusions, cervical dislocations, costovertebral strains, rib fractures, costochondral separations, compression of the cauda equine. I do not expect the doctor to be able to anticipate and explain all 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 interest. The risks of massage therapy and neuromuscular re-education are bruising, local tenderness, and the release of toxins in the body.

I have read or have read to me the above explanation of the nature and purpose of chiropractic adjustments, pulsed electro-magnetic therapy, other alternatives/procedures for care, neuromuscular re-education, manual therapy, massage therapy, and possible risks. I have also had the opportunity to ask questions about its content and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby request and consent to the performance of chiropractic procedures, pulsed electro-magnetic therapy, diagnostic x-rays if warranted, neuromuscular re-education, manual therapy, and massage therapy on me or on the patient named below, for whom I am legally responsible, by the doctor of chiropractic named below and/or licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or servicing as backup for the doctor of chiropractic named below and by the licensed massage therapist listed below including those working at the clinic or office listed below or any other office or clinic. I intend this form to cover the entire course of treatment for my present condition and or any future condition(s) for which I seek treatment.

****

To be completed by patient:

_____
Print Patient Name

_____
Signature

_____
Date

If patient is a minor to be completed by legal guardian, legally responsible adult:

_____
Print Patient Name

_____
Signature

_____
Date

****

North Ridge Chiropractic
5353 North Federal Hwy.
Suite 220
Ft. Lauderdale, Fl. 33334
954-491-8127

Fax 954-491-2388

Name of Doctor(s)/LMT treating this patient:
Dr. Kim Etheredge, DC Dr. Charles Palminteri, DC

Janine Phillip, LMT
Gustavo Medosky, LMT
Julie Hall, LMT
Ricardo Chaves,LMT
Michael Huppert, LMT
Melissa Rodriquez, LMT
Glaucia Pimenta, LMT

_____
Witnessed by

_____
Date

North Ridge
5353 N. Federal Hwy Suite 220, Ft. Lauderdale, Florida 33334
(954) 491-8127

Consent for Use or Disclosure of Health Information

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.
There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose you health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You may have the right to review that notice before you sign this consent form (act 164.520). We reserve the right to change our privacy practices as described in the notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices

Your Right to Limit Uses or Disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your Right to Revoke Your Authorization

You may revoke your consent to us at anytime; however, your revocation must be in writing. We will not be able to honor your revocation request if we already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health if they decide to contest any of your claims.
I have read your consent policy and agree to its terms. I am acknowledging that I have received a copy of this notice.

_____ _____
Printed Name Witness

_____ _____
Signature Date

_____
Date

North Ridge Integrative Health
5353 N Federal Hwy
Suite 220
Fort Lauderdale, FL 33308

Cancelation and No-Show Policy

Patients at North Ridge Integrative Health,

Effective January 1, 2015 we will implement a “No Show” policy which will affect all patients who do not keep their scheduled appointment or who cancel an appointment with less than a 12-hour notice.

Please be advised that a $25 fee will be charged for all “NO SHOWS” who fail to call 12 hours in advance. This policy applies to “SAME DAY CANCELS” as well.

We greatly appreciate your understanding and patience on this matter. This is to better serve our patients in a timely and efficient manner.

Acknowledgement

I have read and understand the above.

Name:_____

Signature:_____ Date:_____

A. Notifier:

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** _____ below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** _____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** _____ listed above.

  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.** _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.** _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**.

☐ **OPTION 3.** I don't want the **D.** _____ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date: