WELCOME

PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ 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 authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

PHONE NUMBERS

Home Phone (_____) _____

Cell Phone (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Home Phone (_____) _____

Work Phone (_____) _____

ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No

Date _____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable)

_____

PATIENT CONDITION

Reason for Visit _____

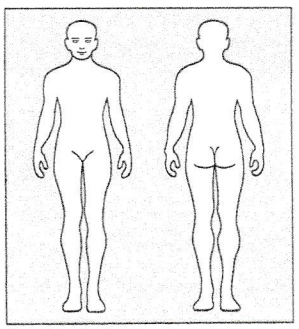
When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other



How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam_____ Spinal X-Ray_____ Blood Test_____

Spinal Exam_____ Chest X-Ray _____ Urine Test_____

Dental X-Ray_____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Alcoholism	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Measles	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Allergy Shots	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Migraine Headaches	☐ Yes ☐ No	Sexually Transmitted Disease	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Fractures	☐ Yes ☐ No	Miscarriage	☐ Yes ☐ No		
Anorexia	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Mononucleosis	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Appendicitis	☐ Yes ☐ No	Goiter	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No	Suicide Attempt	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Gonorrhea	☐ Yes ☐ No	Mumps	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Bleeding Disorders	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Breast Lump	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Parkinson's Disease	☐ Yes ☐ No	Tumors, Growths	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	Hernia	☐ Yes ☐ No	Pinched Nerve	☐ Yes ☐ No	Typhoid Fever	☐ Yes ☐ No
Bulimia	☐ Yes ☐ No	Herniated Disk	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Polio	☐ Yes ☐ No	Vaginal Infections	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Prostate Problem	☐ Yes ☐ No	Whooping Cough	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Prosthesis	☐ Yes ☐ No	Other _____	
Chicken Pox	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No		
				Rheumatoid Arthritis	☐ Yes ☐ No		

EXERCISE

☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY

☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

HABITS

☐ Smoking Packs/Day _____
☐ Alcohol Drinks/Week _____
☐ Coffee/Caffeine Drinks Cups/Day _____
☐ High Stress Level Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date_____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

MEDICATIONS

_____
_____
_____
Pharmacy Name_____
Pharmacy Phone (_____) _____

ALLERGIES

_____
_____
_____
_____
_____

VITAMINS/HERBS/MINERALS

_____
_____
_____
_____
_____

Harmony Healing Center

LINDSAY LEVY, D.C.
Chiropractic Physician

97840 Overseas Highway
Key Largo, FL 33037

Telephone (305) 852-3232
Fax (305) 852-3281

Patient: _____ Date of Birth _____

CONSENT FOR TREATMENT

I, the undersigned, hereby authorize ***Dr. Lindsay Levy / Harmony Healing Center*** and whomever he/ she may designate as his/ her assistant(s) to perform diagnostic test, including but not limited to radiographs and to administer treatment as is necessary.

I, also certify that no guarantee or assurance has been made to the results that may be obtained.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that this office will prepare any necessary report and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse remittance for the conveyance of credit to my account. HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICE RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT.

Patient's Signature_____ **Date** _____ **Witness**_____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize the release of any medical information necessary to process my insurance claim(s) and also certify that all insurance information given to this clinic is correct and complete.

Patient's Signature_____ **Date** _____ **Witness**_____

REQUEST FOR PAYMENTS OF BENEFITS TO PROVIDER OF CARE

I hereby authorize _____ Insurance Company/ Insurance Administrator to pay by check and for it to be mailed directly to: ***Harmony Healing Center, 97840 Overseas Hwy, Key Largo, FL 33037*** the expense benefits allowable and otherwise payable to me under current policy, as payment toward the total charges for professional services rendered. I have agreed to pay, in a current manner, any balance of said applicable charges. I agree that this office be given power of attorney to endorse/ sign my name on any and all drafts for payment of my bill.

Patient's Signature_____ **Date** _____ **Witness**_____

X- RAY/ MEDICAL RECORDS RELEASE

I have requested the release of records of (patient's name) _____which are part of the records at (facility) _____ I hereby request and authorize you, your employees and agents to furnish to the person(s) listed below or anyone designated in writing by them copies of records and reports, including copies of x-rays and photo static copies, abstracts or excerpts of all records and any other information they request relating to any examination, treatment or opinion concerning any condition that I may have had in the past, now have or may have in the future Please forward this to: ***Harmony Healing Center, 97840 Overseas Hwy, Key Largo, FL 33037***

Patient's Signature_____ Date _____ Witness_____

HARMONY HEALING CENTER

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THAT INFORMATION.

Treatment – To provide you with the health care you require, the Practice may use and disclose your PHI to those health care professionals, whether on the Practice's staff or not, so that it may provide, coordinate, plan and manage your health care. For example, a chiropractor treating you for lower back pain may need to know and obtain the results of your latest physician examination or last treatment plan.

Payment – To get paid for services provided to you, the Practice may provide your PHI, directly or through a billing service, to a third party who may be responsible for your care, including insurance companies and health plans. For example, the Practice may need to provide the Medicare program with information about health care services that you received from the Practice so that the Practice can be reimbursed. The Practice may also need to tell your insurance plan about treatment you are going to receive so that it can determine whether or not it will cover the treatment expense.

Advice of Appointment and Services – The Practice may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. The following appointment reminders may be used by the Practice: a) a postcard mailed to you at the address provided by you; and b) telephoning your home and leaving a message on your answering machine or with the individual answering the phone.

Directory/Sign-In Log – The Practice maintains a sign-in log at its reception desk for individuals seeking care and treatment in the office. The sign-in log is located in a position where staff can readily see who is seeking care in the office. This information may be seen by, and is accessible to, others who are seeking care or services in the Practice's offices.

Family/Friends – The Practice may disclose to a family member, other relative, a close personal friend, or any other person identified by you, your PHI directly relevant to such person's involvement with your care or the payment for your care. If you are not present, the Practice will, in the exercise of professional judgment, determine whether the use or disclosure is in your best interests and, if so, disclose only the PHI that is directly relevant to the person's involvement with your care. The Practice may use and disclose PHI to a person who has the authority to represent you in making decisions related to your health care

Workers' Compensation – The Practice may use and disclose PHI if you are involved in a Workers' Compensation claim to an individual or entity that is part of the Workers' Compensation system.

You have the right to: Revoke any Authorization or consent you have given to the Practice, at any time. To request a revocation, you must submit a written request to the Practice's Privacy Officer. For instance, you may request all written communications to you marked "Confidential Protected Health Information." You must make your request in writing. The Practice will accommodate all reasonable requests.

The Practice: Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI. This Notice is in effect as of 04/15/03.

PATIENT ACKNOWLEDGEMENT By subscribing my name below, I acknowledge receipt of a copy of this Notice, and my understanding and my agreement to its terms.

Patient_____

Date: _____