

PATIENT INFORMATION

Today's Date: ___/___/___

Date of Accident: ___/___/___

Patient Last Name: _____ First Name: _____ MI: _____

Social Security Number _____ Birth Date: ___/___/___ Age: _____ Gender: F M

If patient under 18 yrs, legal parents or guardian: _____

Race: African American () Asian () Caucasian () Hispanic () Other _____ Language: English ()
() Spanish Other _____ Marital Status: () Married () Single () Divorced () Widowed

CURRENT ADDRESS

Street _____ City _____ State _____ Zip _____

Home Phone: _____ Cell: _____ Cell carrier: at&t Verizon Sprint

T-Mobile (Other): _____ Email address: _____

Emergency Contact: _____ Contact's Phone #: _____

Emergency Contact is my: (specify relationship) _____

If you are covered under another person's insurance.... Please complete

Patient Relationship to the insured Self Spouse Child Other: _____

Name of Insured: _____

Address of insured: _____

Phone of insured: _____ Sex : _____ Birth date: _____

Auto Accident Insurance: _____ Policy Number: _____

Carrier: _____

Address: _____

City: _____ State: _____ ZIP: _____ Phone: _____

Person to Contact... _____ Claim # _____

Health Insurance Info: _____

Carrier: _____ Ins Co phone: _____

Address: _____

Policy # _____ Group # _____

How did you hear about us? (Circle One) Newspaper Ad, Mailer/Flyer, Website, Workshop/Event, Medical Referral Friend, Family, Yellow Pages, Insurance Co. Other: _____

Signature Touch Chiropractic
2700 S. University Drive Suite 203
Miramar, FL 33025
Phone: (954)367-6716 Fax: (954)391-8711

SLIP AND FALL

Patient Name: _____

Date of Accident: _____ Time of Accident: _____

What was the location and address of the accident? _____

City: _____ State: _____

Was an incident report taken due to this accident? Yes No Incident number: _____

How would you describe the property where this accident occurred? (Commercial property, private property)

Describe in detail how this accident happened: _____

Did you go to the hospital or urgent care? Yes No Name of hospital/urgent care: _____

Taken by ambulance? Yes No

Diagnostic Studies? Yes No If yes: X-ray MRI CT-Scan

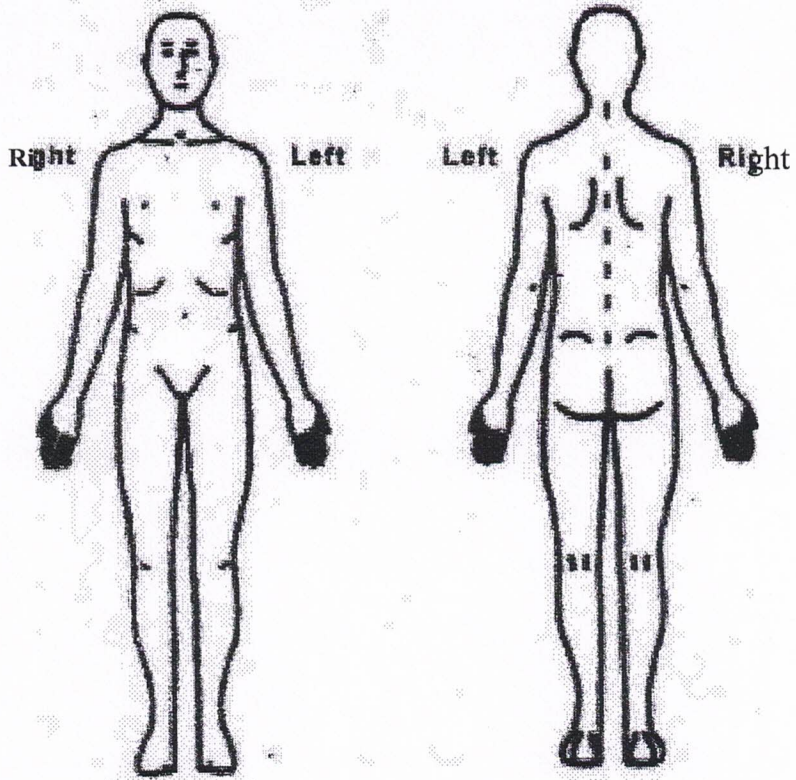
Medications Given? Yes No RX: _____

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

Please check any of the following symptoms you are now experiencing:

On the diagram, circle the area (s) where you feel pain. Put an X on the area that hurts the most

- Headache
- Neck pain
- Neck Stiffness
- Tingling in arms/hands
- Numbness in arms/hands
- Pain in arms/hands
- Shoulder Pain
- Upper/Mid Back Pain
- Lower Back Pain
- Tingling in legs/feet
- Numbness in legs/feet
- Knee Pain
- Pain in legs/feet
- Dizziness
- Nausea
- Buzzing in Ears
- Nervousness
- Loss of Balance
- Chest Pain
- Fatigue
- Rib Pain
- Hip Pain
- Burning muscle pain
- Sharp/shooting pain
- Other: _____



Additional Information Related to the Condition:

Describe your pain: []Burning []Sharp []Dull []Achy []Stiff []Sore []Throbbing []Shooting []Superficial []Deep
 []Electric []Discomfort []Tearing []Spasm []Stabbing []Cramp-like []Piercing []Other (describe): _____

What aggravates your symptoms?

What relieves your symptoms?

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

Medical History:

List any previous accidents (automobile) and date: _____

Illnesses: _____

Previous Surgeries/Hospitalizations: _____

Traumas/Injuries/Accidents: _____

Medication(s): _____

REVIEW OF SYSTEMS

Do you currently have or have had any of the following problems?
 to every item; do not skip any.

Please check an answer "Yes" or "No"

General (constitutional)

Fever Yes No
 Chills Yes No
 Fatigue Yes No
 Unexpected Weight loss Yes No

Eyes

Blurred vision Yes No
 Double vision Yes No
 Vision loss Yes No
 Eye pain Yes No
 Sensitivity to light Yes No

Ear/Nose/Mouth/Throat

Earache Yes No
 Ringing in ears Yes No
 Decreased hearing Yes No
 Nosebleeds Yes No
 Sore throat Yes No
 Difficulty swallowing Yes No
 Wheezing Yes No

Allergic/Immunologic

Hepatitis Yes No
 Tuberculosis Yes No
 HIV exposure Yes No

Gastrointestinal

Nausea Yes No
 Vomiting Yes No
 Change in bowel habits Yes No
 Abdominal Pain Yes No

Psychiatric

Depression Yes No
 Anxiety Yes No
 Memory loss Yes No

Genitourinary

Unusual Discharge Yes No
 Difficult urination Yes No
 Urination blood Yes No
 Urination frequency Yes No
 Pelvic pain Yes No
 STD Yes No

Musculoskeletal

Back pain Yes No
 Neck pain Yes No
 Shoulder pain Yes No
 Wrist/hand pain Yes No
 Torticollis/stiff neck Yes No
 Hip/knee pain Yes No
 Arthritis Yes No

Skin and/or breast

Rash Yes No
 Itching Yes No
 Suspicious lesions Yes No
 Skin infections Yes No

Neurologic

Weakness Yes No
 Poor balance Yes No
 Difficulty walking Yes No
 Difficulty writing Yes No

Endocrine

Cold intolerance Yes No
 Heat intolerance Yes No
 Excessive thirst Yes No
 Excessive earing Yes No
 Excessive urination Yes No

Hematologic/Lymphatic

Abnormal bruising Yes No
 Abnormal bleeding Yes No
 Enlarged lymph nodes. Yes No

Family/Social History:

Members of my family (parents, brothers/sisters, grandparents, aunts/uncles) suffer with the following:

Check all that apply

- | | | |
|---|--|---|
| <input type="checkbox"/> Stroke | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Spine Problems |
| <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Alcohol dependence |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Aneurysm |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Migraines | <input type="checkbox"/> Mental disorders |

Do you smoke? Yes No *if yes, number of packs per day:* _____

Do you drink alcohol? Never Socially Occasionally Frequently Regularly

Please indicate any other healthcare providers who the Patient has seen for the condition or symptoms:

Name	Type of Licensure	Date of Last Visit
_____	_____	____/____/____
_____	_____	____/____/____

Have you missed work or school due to your injuries? Yes No *if so, How many days?* _____

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

Signature Touch Chiropractic
2700 S. University Drive, Suite 203
Miramar, FL 33025
Phone: (954)367-6716 Fax: (954)391-8711

Medical Records Release Form

I hereby authorize and any of its appointed assistants to obtain the following information from the healthcare record of:

Patient Name _____ Date of Birth _____

Street Address _____ City _____ State _____

Zip code _____ Phone Number _____

This information is to be received by:

Signature Touch Chiropractic
2700 S. University Drive, Suite 203
Miramar, FL 33025
Phone: 954-367-6716 Fax: 954-391-8711

Information to be disclosed:

- Office notes for date(s) of service _____
- X-ray reports of _____ for date(s) of service _____
- MRI reports of _____ for date(s) of service _____
- CD (s) containing images of above marked studies – PLEASE MAIL TO ADDRESS LISTED ABOVE
- Photographs or other images
- Complete healthcare record
- Other (please describe) _____

Special instructions: _____

*****PLEASE FAX ALL REPORTS TO**

I understand that this authorization is valid for 12 months after the date signed, unless cancelled by me in writing. This authorization must be dated subsequent to the period for which the information is requested.

I have read and understand the above statements and do expressly and voluntarily consent to disclosure of the above information to those persons or agencies named above. I hereby release Palmer Chiropractic care and any of its appointed assistants from all legal responsibility or liability that may arise from the release of these healthcare records.

Signature of patient/guardian

Date

Signature Touch Chiropractic
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Informed Consent for Chiropractic Care

Patient's Name: _____

Please read carefully before signing.

General. I, the below-signed patient/individuals, have read this document and Care Plan in their entirety and understand the potential benefits and risks of the Care which you are recommending. I understand that there may be other forms of care which I may wish or need to seek provided by other health care practitioners. I also understand that there may be significant risks of not seeking any care for my condition.

I understand that while the Care Plan lists you as the "Rendering Provider," at any moment, other associates or staff in your office with appropriate scopes of practice and training may need to provide the Recommended Care based on factors which are not necessarily within anyone's ability to predict. You have made it clear that every health care practitioner who is licensed under state law may have different scopes of practice relating to diagnoses and treatment and that the licenses of the primary Rendering Provider are listed below.

I do not expect you to be able to anticipate and explain all risks and complications, or forms of treatment, and I wish to rely on you to exercise judgment within your scope of practice during the course of the Care Plan which you feel at the time based upon the facts known. I understand that in rare cases, underlying physical-defects, deformities or pathologies may render me susceptible to injury. It is my responsibility to make known before and throughout the Care whether I am suffering from any latent, pathological defects, illnesses, or deformities-that would otherwise not come to your attention, as well as any pathological defects, illnesses, or deformities I may be experiencing.

Possible Risks of the Care: Alternatives

Chiropractic manipulation / adjustment, as with any healthcare procedure, I understand that there are certain complications, which may arise during chiropractic manipulation, and that those complications include: fractures, disc injuries, dislocations, muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I understand that fractures are rare occurrences and generally result from some underlying weakness of the bone. I also understand that stroke and other complications are also generally described as "rare."

X-Rays. I have been advised that x-rays can be hazardous to an unborn child. To the best of my knowledge, I am not pregnant.

Other Potential Alternatives. I understand that other treatment options for my condition may include: Self-administered, over-the-counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; hospitalization with traction; and surgery.

Contraindications to Manipulation / Adjustment. I understand that you will not give me an adjustment/ manipulation, x-rays, modalities, or therapies if you feel that such are contraindicated. In the event that the Care does not include such procedures, I have discussed all contraindications with you and fully understand them.

Definitions. "You" and "office" refer to any provider who renders care to me at the Location above. "Care" includes all care outlined in my Care Plan as well as any other care I receive from you in the future, including care related to other conditions.

Patient's Consent. I have thoroughly discussed and reviewed my recommended Care with you, as well as your examination, diagnoses, and thoughts regarding my condition, and also all of the information in this Informed Consent. I have had ample opportunity to explore other potential forms of care, have asked you all of the questions that have, and have no additional questions. I voluntarily and knowingly elect to receive the recommended Care.

Name of Parent/ Guardian/ Authorized Representative: _____

Signature: _____ Date of Signature: ____/____/____

NOTICE OF OUR PRIVACY PRACTICES

As required by the Privacy Regulations created as a result of the Health Insurance portability and Accountability Act of 1996 (HIPAA)

This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your individually identifiable health information.

PLEASE REVIEW THIS NOTICE CAREFULLY

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and your treatment and the services we provide for you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at this time.

We realize that these laws are complicated, but We must provide you with the following important information:

- How we may use and disclose your IIHI
- Your privacy rights in your IIHI
- Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Signature Touch Chiropractic
Mildred Morency DC / Matthew Holmes DC
2700 S. University Drive, Suite 203
Miramar, FL 33025
info@signaturetouchchiropractic.com
Phone: (954)391-8711 Fax: (954)367-6716

C. WE MAY USE AND DISCLOSURE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your IIHI.

1. **Treatment.** Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. Any of the people who work for our practice — including, but not limited to, our doctors and nurses, or indirectly with any provider we refer you to — may use or disclose your IIHI in order to treat you, or to assist others in your treatment. Additionally, we may need to disclose your IIHI to others who may assist in your care, such as your spouse, children, or parents.
2. **Payment.** Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment and health Status to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members or insurance companies. Also, we may use your IIHI to bill you directly for services and items.
3. **Health Care Operations.** Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you receive from us, or to conduct cost-management and business planning activities for our practice.

4. **Appointment Reminders.** Our practice may use and disclose your IIHI to contact you or a family member who answers the phone (or to leave a recorded message) to remind you of an upcoming appointment.
5. **Treatment Options.** Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.
6. **Health-Related Benefits and Services.** Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.
7. **Release of Information to Family/Friends.** Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to our office for care. In this example, the babysitter may have access to this child's medical information.
8. **Disclosures Required by Law.** Our practice will use and disclose your IIHI when we are required to do so by federal, state, or local law.

D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. **Public Health Risks.** Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of
 - Maintaining vital records, such as births and deaths
 - Reporting child abuse or neglect
 - Preventing or controlling disease, injury or disability
 - Notifying a person regarding potential exposure to a communicable disease
 - Notifying a person regarding a potential risk for spreading or contracting a disease or condition
 - Reporting reactions to drugs or problems with products or devices
 - Notifying individuals if a product or device they may be using has been recalled
 - Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
 - Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.
2. **Health Oversight Activities.** Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.
3. **Lawsuits and Similar Proceedings.** Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. In general, we will require that the party that requests your records provide a records release form, signed by you within the last 3 months.
4. **Law Enforcement.** We may release IIHI if asked to do so by a law enforcement official:
 - Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
 - Concerning a death, we believe has resulted from criminal conduct
 - Regarding criminal conduct at our offices
 - In response to a warrant, summons, court order, subpoena or similar legal process
 - To identify/locate a suspect, material witness, fugitive or missing person
 - In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identify or location of the perpetrator)
5. **Deceased Patients.** Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

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6. **Organs and Tissue Donation.** Our practice may release your IIHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

7. **Research.** Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IIHI for research purposes except when (a) our use or disclosure was approved by an Institutional Review Board or a Privacy Board; (b) we obtain the oral or written agreement of a research that (i) the information being sought is necessary for the research study; (ii) the use or disclosure of your IIHI is being used only for the research and (iii) the researcher will not remove any of your IIHI from our practice; or (c) the IIHI sought by the research only relates to decedents and the researcher agrees either orally or in writing that the use or disclosure is necessary for the research, and if we request it, to provide us with proof of death prior to access to the IIHI of the decedents.

8. **Serious Threats to Health or Safety.** Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

9. **Military.** Our practice may disclose your IIHI if you are a member of the US. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. **National Security.** Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

11. **Inmates.** Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

12. **Workers' Compensation.** Our practice may release your IIHI for worker's compensation and similar programs.

Name of Parent/ Guardian/ Authorized Representative: _____

Signature: _____ Date of Signature: ____/____/____