

FERNANDINA

CHIROPRACTIC CENTER

463392 East State Road 200

Yulee, FL 32097

Phone: 904-491-1345

E-Fax: 904-513-9206

Email: Fernchiro@gmail.com

Appointment Letter:

Thank you for choosing Fernandina Chiropractic Center. Our chiropractors provide quality care for all ages, including pediatric patients. We understand that chiropractic care is about more than just treating neck pain and back pain – we find and correct the cause of your symptoms. If you've been injured in a car accident or are suffering from a sports injury, our chiropractors can help you get well and stay well. To prepare better for your upcoming appointment please follow these procedures.

- Please complete the following paperwork and try to arrive 15 minutes prior to your appointment time for proper processing.
- **IF YOU ARE UNABLE TO COMPLETE PAPERWORK**, you are required to arrive 30 minutes prior to allow you time to fill out paperwork. If the paperwork is not completed by your scheduled time you will be rescheduled to the next available time.
- Don't forget these following items:
 - Insurance cards
 - Government issued ID
 - List of Medications
 - Previous imaging (disks or reports if you have it)
 - Discharge Summary (if released from hospital recently)
- If Auto Accident
 - Police Report
 - **YOUR** automobile insurance card
 - **YOUR** automobile policy jacket- declaration page (you can call your insurance company to get this)
 - **YOUR** automobile claim number and Medical Adjustor Information
- Copay is due at time of service. We accept cash, check, credit and debit cards.
- If you cancel within 24 hours a \$40 fee is added to your account and you will not be able to reschedule until paid.

We look forward to working with you to deliver the highest quality of chiropractic care!

Thank you,

Fernandina Chiropractic Staff

Patient Registration & Insurance Information

Please present insurance card and photo ID for us to copy.

Date _____ Physician _____

Person Responsible for Bill

Guarantor Name _____
Address _____
City, State, ZIP _____
Home Phone # _____ Work Phone # _____
Relation to Patient _____

Patient Information

I consent to receive email/text relating to my care from your office?

YES: _____
NO: _____

Name _____
Address _____
City, State, ZIP _____
Home Phone # _____ Work Phone # _____
Cell Phone # _____ Carrier: _____ Email _____
Date of Birth _____ Sex _____ Marital Status _____
Race: Unknown African American Asian Caucasian Chinese Filipino Hispanic Japanese
 Native American Native Hawaiian Pacific Islander Other _____
Ethnicity: Hispanic Non-Hispanic Unknown Unrecruited
Primary Language _____ Do you require an Interpreter Yes _____ No _____
Social Security Number _____
(If a minor): Mother's Name _____ Home Phone # _____
Father's Name _____ Home Phone # _____

Emergency Contact Information

Contact Name _____
Relationship to Patient _____
Address _____
City, State, ZIP _____
Home Phone # _____ Work Phone # _____

Primary Insurance Name

Insurance Company _____
Group # _____ Policy # _____
Subscriber Name _____
Patient Relation to Subscriber _____ Date of Birth _____
Social Security Number _____
Employer _____ Work Phone # _____

Secondary Insurance Name

Insurance Company _____
Group # _____ Policy # _____
Subscriber Name _____
Patient Relation to Subscriber _____ Date of Birth _____
Social Security Number _____
Employer _____ Work Phone # _____

Referred by _____

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To whom it may concern:

I, _____, hereby authorize my insurance company,
_____ to release insurance benefit information to
Beckerton Chiropractic PLLC/ dba Fernandina Chiropractic Center LLC.

Print: _____

Sign: _____

Date: _____

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Insurance Assignment and Instruction for Direct Payment

I, _____ hereby instruct and direct my insurance company pursuant to F.S. 627.422 to pay directly to Beckerton Chiropractic PLLC, dba Fernandina Chiropractic Center LLC for professional or medical services by check, draft, or electronic funds transfer (EFT). The payment is not to exceed my indebtedness to the above-named provider.

I hereby assign all rights and benefits that I have under any Group Health Insurance, Automobile Insurance (including PIP, UM and Med Pay benefits), Medicare and Disability benefits. I direct and assign all related policies or reimbursement plans to pay benefits for services and treatments that I have or continued to receive from the above-named provider.

Assignment includes but is not limited to all rights to collect benefits directly from Health or Auto Insurances for those services and treatments that I have received and continue to receive, including all rights to proceed against my insurance company in any action including legal suit if for any reason my insurance company fails to make payments of benefits that are due to the above-named provider. This assignment also includes the right to recover any attorney fees and costs for such action brought by the provider as my assignee.

I understand that I am financially responsible for any balance not covered by my insurance company. Ultimately, payment responsibility rests with you the patient.

All self-pay patients are expected to pay for the services in full at the time services are rendered.

I authorize the release of any information pertinent to my case or claim to the above-named provider or any attorney involved in this case. A photocopy of the assignment shall be considered as effective and valid as the original.

Signature of patient (Claimant):

Date:

Witness:

Date:

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Phone: 904-491-1345

E-Fax: 904-513-9206

Email: FERNCHIRO@GMAIL.COM

Address: 463392 East State Road 200
Yulee, Florida 32097

Medical Record Release Form

Fax to: _____

Location: _____

Phone: _____

Fax Number: _____

Today's Date: _____

Patient: _____

Date of Birth: _____

Date of Testing: _____

At the request above patient, please fax medical records regarding the following:

Patient or Guardian: _____ (PRINT)

Patient or Guardian: _____ (SIGNATURE)

Date Sent: _____ Time: _____ Employee Initials _____

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Informed Consent to Care

I hereby request and consent to the performance of Chiropractic adjustments and other procedures performed in office, including various modes of physical therapy and diagnostics x-rays by, any Doctor of Chiropractic or therapist, employed by Beckerton Chiropractic PLLC., dba Fernandina Chiropractic Center LLC.

I have had the opportunity to discuss with the Doctor and/or with the other office personnel the purpose and benefits of the Chiropractic adjustments and other treatments outlined below.

Though Chiropractic adjustments and treatments are usually beneficial and seldom cause any problem, I understand and am informed that there are some risks to treatment. Risks include, but are not limited to, fractures, disc injuries, strokes, dislocations and sprains.

I understand that I may receive ONE or MORE of the following treatments:

- Chiropractic Adjustment/Manipulation
- MLS Laser Therapy
- Acupuncture / Dry Needling / Cupping
- Electric Muscle Stimulation
- Heat/Cold Pack(s)
- Ultrasound
- Traction
- Massage/Therapeutic exercises and stretches

I understand that Chiropractic is not an exact science and that, therefore, reputable practitioners cannot fully guarantee the results. I understand, acknowledge, and affirm that treatments may involve direct bodily contact and touch. I acknowledge that no guarantee or assurance has been made to anyone regarding the chiropractic treatment that I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

For Treatment of Minors only:

I, as a parent/guardian of a minor receiving treatment from above named provider do and hereby agree and understand that I have been advised to remain on the premises during any such treatment and waive any claim I may have resulting in failure to do so. **I consent to treatment of the minor if I am not in the office (initial) _____

Please discuss any questions or concerns with the Doctor or Therapist BEFORE signing this consent.

Signature of patient, parent, guardian, or personal representative:

Date:

Witness Signature:

Date:

Doctor's Signature:

Date:

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Statement of Policies

The following policies are in place for mutual convenience and benefit. Please read them carefully and sign at the bottom to indicate your agreement.

1. You are responsible for the cost of your visit at the time of service. Our office will be in network with most United Health Care plans. If you carry a health insurance plan our office is not in network with, you will be responsible for submitting your visits to insurance, which our office will provide, and the assignment of benefits will be redirected to you, the patient. Our office cannot guarantee reimbursements from the insurance company that will be between you and your insurance provider.
2. Deductibles, co-insurance and co-pays are due at the time of service, payable by cash, check or credit/debit cards. ANY previous balance on your account(s) are expected to be paid at time of service.
3. All new patient exams are \$100, with the adjustment fee being \$40.
4. If you schedule an appointment, and are unable to make it, please call 24 hours in advance. Failure to do so will result in a forfeit of the \$40 appointment fee for new patient and massage appointments. To book your next appointment it will be an additional \$40.
5. Processing disability paperwork, FMLA insurance forms, and any related forms require a \$75.00 fee. This fee is to be prepaid and must coincide with an office visit.
6. Request for medical records is subject to a fee of \$1.00 per page for the first 25 pages and \$0.25 for each additional page after. All requests must be submitted in writing, and please allow 24-48 business hours for these requests. Please plan accordingly.
7. The above-named provider is not responsible for loss or damage to personal valuables.

I acknowledge that I have read and understand the Statement of Policies carefully and agree to abide by them.

Name (print)

Signature

Date

Witness (print)

Signature

Date

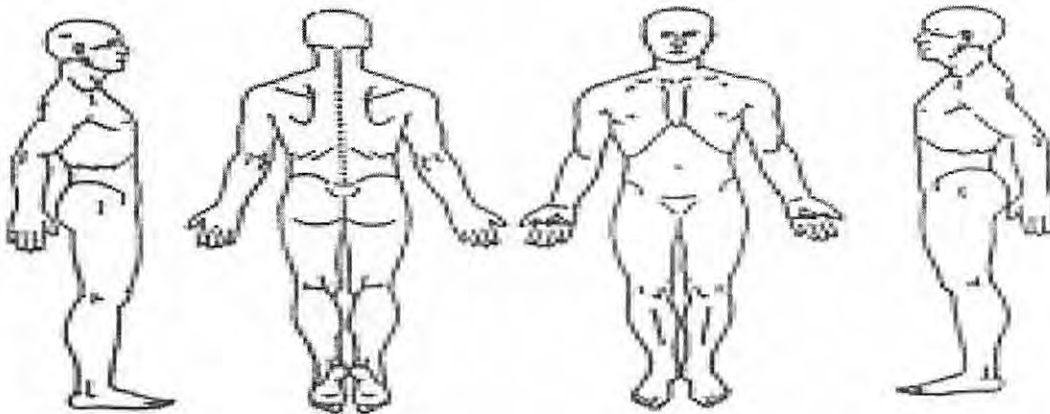
Name: _____

FERNANDINA

CHIROPRACTIC CENTER

Patient Intake Form

Please mark the area of pain:



Where is the pain located/ what side? _____

How/ When do you think the pain started? _____

My pain is located on the **RIGHT** **MIDDLE** **LEFT** **BOTH SIDES**

Have you ever had problem in the past? Please circle. **YES** **NO**

Explain your pain. Please circle. **Getting Worse** **Staying the Same** **Getting Better**

How would you describe the type of pain? Please circle.

- Sharp** **Numbness** **Dull** **Tingling**
- Diffuse** **Achy** **Burning** **Sharp with motion**
- Stiff** **Shooting** **Stabbing** **Electric like**
- Sore** **Other:** _____

Fill in your pain scale 0-10 (10 being most severe): ____ (1-3 mild) (4-7 Moderate) (8-10 Severe)

How often do you experience this pain? Please circle. **Constantly** **Frequently** **Intermittent** **Occasionally**

Does your pain radiate? **YES** **NO** If so, where? _____

Do you have Numbness? **YES** **NO** If so, where? _____

When is the pain worse? Please circle. **Morning** **Afternoon** **Evening** **Night** **Consistent**

When is pain better? Please circle. **Morning** **Afternoon** **Evening** **Night** **Consistent**

What makes the pain worse? **SITTING** **STANDING** **MOVEMENT** **SLEEPING** **WALKING** Other _____

What makes pain better? _____

Headaches **YES** **NO** If so, where? _____

Does this problem interfere with work or daily routine activities? Please circle. **YES** **NO**

Who else have you seen for the following issue? Please circle.

- Chiropractor** **Primary Care** **ER physician** **Orthopedist**
- Physical Therapist** **Massage Therapist** **None** **Other:** _____

Medications (Please attach list if available):

Medication or Vitamin Name:	Dosage:	Reason For Taking:
1.		
2.		
3.		
4.		
5.		

Drug Allergies (please also list reaction):

Past Surgical History:

Medical History (Please circle what condition applies to you):

AIDS/HIV	Coronary Artery Disease	Hepatitis	Obesity	Spinal Stenosis
Alcoholism	Crohn's disease	High Cholesterol	Osteoarthritis	Spondyloarthropathy
Anemia	Degenerative Joint Disease	Hypertension	Osteoporosis	Thyroid Disease
Angina (Chest Pain)	Depression	Inflammatory Bowel Disease	Parkinson's Disease	Valvular Disease
Arthritis	Diabetes	Rheumatoid Arthritis	Peptic Ulcer	
A Fib	Drug abuse	Kidney Disease	PVD	Other: _____
Enlarged Prostate	DVT (Blood Clot)	Liver Disease	Renal Disease	
Cancer:	Fibromyalgia	Lyme Disease	Scolliosis	
CVA (Stroke)	Gallbladder Disease	Migraines	Seizure Disorder	
Congestive Heart Failure	Gerd	Multiple Sclerosis	Sleep Apnea	
COPD	Gout	Myocardial Infarction	SLE- Lupus	

Family History (Please select which applies):

	Father	Mother	Sibling	Grandparent
Arthritis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Colitis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Diabetes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Epilepsy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Heart Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hypertension	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Kidney Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Osteoporosis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Psoriasis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Stroke	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Thyroid Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Review of Symptoms

Please CIRCLE current symptoms that apply.

Constitutional:

- Chills
- Fatigue
- Malaise
- Night Sweats
- Weakness
- Weight Loss
- HEENT**
- Blurred vision
- Double vision
- Dysphasia
- Ear Drainage
- Facial Pain
- Headache
- Hearing loss
- Hoarseness
- Nasal congestion
- ringing in ears
- Vertigo
- Vision loss

Cardiovascular

- Chest Pain
- Cyanosis
- Heart Murmur
- Irregular Heartbeat
- Leg Swelling
- Syncope (fainting)
- Gastrointestinal**
- Abdominal Pain
- Constipation
- Diarrhea
- Heartburn
- Jaundice
- Loss of appetite
- Nausea
- Vomiting
- Genitourinary**
- Dysuria
- Frequent urination
- Blood in urine
- Urge incontinence
- Urinary incontinence

Skin/ Integumentary

- Contact allergy
- Itchy skin
- Rash
- Skin infection
- Skin lesion
- Neurological**
- Difficulty walking
- Dizziness
- Poor coordination
- Memory loss
- Muscle weakness
- Paresthesia
- Seizures
- Tremors
- Immunological**
- Asthma
- Bee sting allergies
- Contact dermatitis
- Seasonal allergies
- Food allergies
- Environmental allergies

Metabolic / Endocrine

- Cold intolerant
- Heat intolerant
- Hair loss
- Psychiatric**
- Anxiety
- Depression
- Insomnia
- Respiratory**
- Painful breathing
- Cough
- Shortness of breath
- Recent infections
- Known TB exposure
- Wheezing
- Hematologic**
- Bleeding
- Bruising
- FEMALES ONLY:**
- Pregnant? YES NO
- WEEKS: _____

Office staff only past this point:

Height: _____

Weight: _____

BP: _____/_____

BOURNEMOUTH QUESTIONNAIRE

PRINT NAME: _____ DATE: _____

First, consider the location of your main complaint. Is it low back pain, neck pain, shoulder pain? Tell me the one location that is your main complaint: _____

Please circle ONE number for each question related to your MAIN complaint.

1. Over the past week, on average, how would you rate your complaint?

No Pain Worst pain possible
0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your complaint interfered with your daily activities (housework, washing, dressing, lifting, reading, driving)?

No Interference Unable to carry out activity
0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your complaint interfered with your ability to take part in recreational, social, and family activities?

No Interference Unable to carry out activity
0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious Extremely anxious
0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed Extremely depressed
0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your complaint?

Has made it no worse Has made it much worse
0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your back pain on your own?

Completely control it No control whatsoever
0 1 2 3 4 5 6 7 8 9 10

Is there is a second region that you want to have evaluated? Please turn this form over or ask the receptionist for the additional Bournemouth Questionnaire.

BOURNEMOUTH QUESTIONNAIRE

PRINT NAME: _____ DATE: _____

Now, consider where your **SECONDARY** complaint/location. Is it low back pain, neck pain, shoulder pain?
Tell me the one area that is your secondary complaint: _____

Please circle **ONE** number for each question related to your **SECONDARY** complaint:

1. Over the past week, on average, how would you rate your complaint?

No Pain Worst pain possible
0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your complaint interfered with your daily activities (housework, washing, dressing, lifting, reading, driving)?

No Interference Unable to carry out activity
0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your complaint interfered with your ability to take part in recreational, social, and family activities?

No Interference Unable to carry out activity
0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious Extremely anxious
0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed Extremely depressed
0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your complaint?

Has made it no worse Has made it much worse
0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your back pain on your own?

Completely control it No control whatsoever
0 1 2 3 4 5 6 7 8 9 10

Neck Index

Form N1-100

DOB:

rev 3/27/2003

Patient Name _____ Date _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

- Ⓐ I have no pain at the moment.
- ① The pain is very mild at the moment.
- ② The pain comes and goes and is moderate.
- ③ The pain is fairly severe at the moment.
- ④ The pain is very severe at the moment.
- Ⓑ The pain is the worst imaginable at the moment.

Sleeping

- Ⓐ I have no trouble sleeping.
- ① My sleep is slightly disturbed (less than 1 hour sleepless).
- ② My sleep is mildly disturbed (1-2 hours sleepless).
- ③ My sleep is moderately disturbed (2-3 hours sleepless).
- ④ My sleep is greatly disturbed (3-5 hours sleepless).
- Ⓑ My sleep is completely disturbed (5-7 hours sleepless).

Reading

- Ⓐ I can read as much as I want with no neck pain.
- ① I can read as much as I want with slight neck pain.
- ② I can read as much as I want with moderate neck pain.
- ③ I cannot read as much as I want because of moderate neck pain.
- ④ I can hardly read at all because of severe neck pain.
- Ⓑ I cannot read at all because of neck pain.

Concentration

- Ⓐ I can concentrate fully when I want with no difficulty.
- ① I can concentrate fully when I want with slight difficulty.
- ② I have a fair degree of difficulty concentrating when I want.
- ③ I have a lot of difficulty concentrating when I want.
- ④ I have a great deal of difficulty concentrating when I want.
- Ⓑ I cannot concentrate at all.

Work

- Ⓐ I can do as much work as I want.
- ① I can only do my usual work but no more.
- ② I can only do most of my usual work but no more.
- ③ I cannot do my usual work.
- ④ I can hardly do any work at all.
- Ⓑ I cannot do any work at all.

Personal Care

- Ⓐ I can look after myself normally without causing extra pain.
- ① I can look after myself normally but it causes extra pain.
- ② It is painful to look after myself and I am slow and careful.
- ③ I need some help but I manage most of my personal care.
- ④ I need help every day in most aspects of self care.
- Ⓑ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

- Ⓐ I can lift heavy weights without extra pain.
- ① I can lift heavy weights but it causes extra pain.
- ② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- ③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ④ I can only lift very light weights.
- Ⓑ I cannot lift or carry anything at all.

Driving

- Ⓐ I can drive my car without any neck pain.
- ① I can drive my car as long as I want with slight neck pain.
- ② I can drive my car as long as I want with moderate neck pain.
- ③ I cannot drive my car as long as I want because of moderate neck pain.
- ④ I can hardly drive at all because of severe neck pain.
- Ⓑ I cannot drive my car at all because of neck pain.

Recreation

- Ⓐ I am able to engage in all my recreation activities without neck pain.
- ① I am able to engage in all my usual recreation activities with some neck pain.
- ② I am able to engage in most but not all my usual recreation activities because of neck pain.
- ③ I am only able to engage in a few of my usual recreation activities because of neck pain.
- ④ I can hardly do any recreation activities because of neck pain.
- Ⓑ I cannot do any recreation activities at all.

Headaches

- Ⓐ I have no headaches at all.
- ① I have slight headaches which come infrequently.
- ② I have moderate headaches which come infrequently.
- ③ I have moderate headaches which come frequently.
- ④ I have severe headaches which come frequently.
- Ⓑ I have headaches almost all the time.

11 Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Neck
Index
Score

Back Index

Form B1100

rev 3/27/2003

Patient Name _____ Date _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

- Ⓐ The pain comes and goes and is very mild.
- Ⓛ The pain is mild and does not vary much.
- Ⓜ The pain comes and goes and is moderate.
- Ⓨ The pain is moderate and does not vary much.
- Ⓔ The pain comes and goes and is very severe.
- Ⓘ The pain is very severe and does not vary much.

Sleeping

- Ⓐ I get no pain in bed.
- Ⓛ I get pain in bed but it does not prevent me from sleeping well.
- Ⓜ Because of pain my normal sleep is reduced by less than 25%.
- Ⓨ Because of pain my normal sleep is reduced by less than 50%.
- Ⓔ Because of pain my normal sleep is reduced by less than 75%.
- Ⓘ Pain prevents me from sleeping at all.

Sitting

- Ⓐ I can sit in any chair as long as I like.
- Ⓛ I can only sit in my favorite chair as long as I like.
- Ⓜ Pain prevents me from sitting more than 1 hour.
- Ⓨ Pain prevents me from sitting more than 1/2 hour.
- Ⓔ Pain prevents me from sitting more than 10 minutes.
- Ⓘ I avoid sitting because it increases pain immediately.

Standing

- Ⓐ I can stand as long as I want without pain.
- Ⓛ I have some pain while standing but it does not increase with time.
- Ⓜ I cannot stand for longer than 1 hour without increasing pain.
- Ⓨ I cannot stand for longer than 1/2 hour without increasing pain.
- Ⓔ I cannot stand for longer than 10 minutes without increasing pain.
- Ⓘ I avoid standing because it increases pain immediately.

Walking

- Ⓐ I have no pain while walking.
- Ⓛ I have some pain while walking but it doesn't increase with distance.
- Ⓜ I cannot walk more than 1 mile without increasing pain.
- Ⓨ I cannot walk more than 1/2 mile without increasing pain.
- Ⓔ I cannot walk more than 1/4 mile without increasing pain.
- Ⓘ I cannot walk at all without increasing pain.

Personal Care

- Ⓐ I do not have to change my way of washing or dressing in order to avoid pain.
- Ⓛ I do not normally change my way of washing or dressing even though it causes some pain.
- Ⓜ Washing and dressing increases the pain but I manage not to change my way of doing it.
- Ⓨ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- Ⓔ Because of the pain I am unable to do some washing and dressing without help.
- Ⓘ Because of the pain I am unable to do any washing and dressing without help.

Lifting

- Ⓐ I can lift heavy weights without extra pain.
- Ⓛ I can lift heavy weights but it causes extra pain.
- Ⓜ Pain prevents me from lifting heavy weights off the floor.
- Ⓨ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- Ⓔ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- Ⓘ I can only lift very light weights.

Traveling

- Ⓐ I get no pain while traveling.
- Ⓛ I get some pain while traveling but none of my usual forms of travel make it worse.
- Ⓜ I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
- Ⓨ I get extra pain while traveling which causes me to seek alternate forms of travel.
- Ⓔ Pain restricts all forms of travel except that done while lying down.
- Ⓘ Pain restricts all forms of travel.

Social Life

- Ⓐ My social life is normal and gives me no extra pain.
- Ⓛ My social life is normal but increases the degree of pain.
- Ⓜ Pain has no significant effect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
- Ⓨ Pain has restricted my social life and I do not go out very often.
- Ⓔ Pain has restricted my social life to my home.
- Ⓘ I have hardly any social life because of the pain.

Changing degree of pain

- Ⓐ My pain is rapidly getting better.
- Ⓛ My pain fluctuates but overall is definitely getting better.
- Ⓜ My pain seems to be getting better but improvement is slow.
- Ⓨ My pain is neither getting better or worse.
- Ⓔ My pain is gradually worsening.
- Ⓘ My pain is rapidly worsening.

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Yulee, Florida 32097

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. THIS NOTICE TAKES EFFECT ON YOUR FIRST DATE OF TREATMENT AND REMAINS IN EFFECT UNTIL WE REPLACE IT, PLEASE REVIEW IT CAREFULLY.

1) OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal, and we are committed to protecting it. We create a record of the care and services you receive at our office. We need this record to provide you with quality care and comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe the rights and certain duties we have regarding the use and disclosure of medical information.

2) OUR LEGAL DUTY

LAW REQUIRES US TO:

- I. Keep your medical information private.
- II. Give you this notice describing our legal duties, privacy practices, and your right regarding your medical information.
- III. Follow the terms of the notice.

WE HAVE THE RIGHT TO:

- I. Change our privacy practice and the terms of this notice at any time, provided the changes are all permitted by law.
- II. Make the changes in our privacy practice and new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

NOTICE OF CHANGE TO PRIVACY PRACTICES:

- I. Before we make any important change in our new privacy practices, we will change this notice and make the new notice available upon request.

3) USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your written authorization. Any specific written authorization you provide may be revoked any time by writing to us at the address provided at the top of this notice.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technician, medical students, or other people who are taking care of you. We may also share medical information about you to other health care providers to assist them in treating you.

FOR PAYMENT: We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

Initial: _____

FERNANDINA

CHIROPRACTIC CENTER

Phone: 904-491-1345
 E-fax: 1-904-513-9206
 email:fernchiro@gmail.com

463392 East State Road 200
 Yulee, Florida 32097

Release of Medical Information

I, _____ give permission for my protected health information to be disclosed for the purposes of communicating results, findings, care decisions and billing inquires to the family members and others listed below.

FAMILY/FRIENDS:

Name :	Relation to Patient:	Release information: YES NO
Name:	Relation to Patient:	Release Information: YES NO

Primary Care Provider:

Name:	Phone: _____	Address: _____ _____ _____
	Fax: _____	
	Email: _____	

Attorney (if applicable):

Name: _____	Phone: _____	Address: _____ _____
Case Manager: _____	Email: _____	

*If the requestor/receiver of information is not a healthcare provider, the released information may no longer be protected from disclosure.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patients Signature: _____

Date: _____