Boze Family Chiropractic and Wellness Center, LLC
Gabriel Boze, DC
224 Mariner Blvd. Spring Hill, FL 34609 P:352-610-9991 F:352-610-9992
844-SPINE-99

Please Print

Patient Name _____
Date of Birth _____ SSN_____ Gender M/F
Address _____
City/State_____Zip _____

Cellphone_____Cellphone Carrier_____
Home Phone_____ Work Phone_____
Best Number to call during the day? (Please circle one) CELL HOME WORK

Emergency Contact Person_____Phone_____
Relationship to Patient_____

Primary Care Physician/Group_____

Is your visit a result of an accident or injury? YES / NO If yes, Date of Accident:_____
Type of accident/Injury (Please circle) AUTO WORK SPORTS FALL
Do you have an attorney? YES / NO If yes, Name of Attorney _____

Would you like us to do a benefit review of your health insurance? Please be sure to give receptionist a copy of your insurance card and driver's license.

Insurance: Primary
Company Name_____
Policyholder (if different) _____ Policyholder DOB_____
Policyholder Address (if different) _____

Insurance: Secondary
Company Name_____
Policyholder (if different)_____Policyholder DOB_____
Policyholder Address (if different)_____

As a courtesy our office will bill one primary insurance and one secondary insurance per year. I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account of any professional services rendered. I will notify you of any change in my status regarding the above information. I consent to the care including diagnostic procedures, examinations, and treatment that the physician designates and considers to be necessary to treat my condition. I certify that I have read all information on this sheet and have and have answered all questions to the best of my knowledge.

Patient/Guardian Signature _____ Date_____

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HIPAA Compliant Authorization for Release of Patient Information
Pursuant to 45 CFR 164.508

Section I – Patient Information

Name_____
Relationship to patient_____
Street Address_____
City, State & Zip Code_____
Telephone_____
Email address_____

Section II – Authorization for Release of Patient Information

I, or my authorized representative, hereby authorize _____(name of entity holding the requested records) and their respective employees, agents and subcontractors to disclose my Personal Health Information (PHI) and Insurance Record to: Boze Family Chiropractic and Wellness Center, LLC 224 Mariner Blvd Spring Hill, FL 34609, 352-610-9991 or 934 Candlelight Blvd Brooksville, FL 34601, 352-796-2660.

Section III – Specific Information to be Released.

☐ Please release my Medical Record from _____ to _____
Date Date

☐ Please release my entire Medical Record, including patient histories, office notes (excluding psychotherapy notes), test results, radiology studies, films, referrals, consults.

☐ Other _____

Reason for release of information

☐ At the request of the individual
☐ At the request of the Provider

Section IV

I understand that Section 460.413 (1) (m), Florida Statues, and Board of Chiropractic Medicine Rule 64B2-17.006 require chiropractic physicians to retain records and x-rays for at least four years. Therefore, a chiropractic physician receiving a request for a patient's x-rays within that four-year period must retain the x-ray and provide a copy of it in lieu of the original x-ray. I, further understand that Section 456.057 (18), Florida Section 457.057 (16), Florida Statutes, authorizes a health care practitioner or patient records owner furnishing copies of reports or records or making the reports or records available for digital scanning pursuant to this section to charge no more than the actual cost of coping, including reasonable staff time, or the amount specified in administrative rule by the appropriate board, or the department when

there is no board. The Board of Chiropractic Medicine Rule 64B-17.0055, Florida Administrative Code, authorizes chiropractic physicians to charge patients $1.00 per page for the first 25 pages, and 25 cents for each page in excess of 25 pages. The Board of Chiropractic Medicine Rule defines the reasonable costs of reproducing x-rays, and such other special kinds of records as the actual costs. The phrase “actual costs” means the cost of the material and supplies used to duplicate the record, as well as the labor costs and overhead costs associated with such duplication. The Board of Chiropractic Medicine Rule 64B-17.0055, Florida Administrative Code, authorize chiropractic physicians to charge people who are not patients authorized to seek copies of my patient records $1.00 per page. I understand that the HIPPA regulations authorize the practice to charge the cost of labor and hardware onto which the records are electronically copied unless the Board of Chiropractic Medicine sets lower costs. I understand that there is no cost for transmitting the electronic records by email.

This authorization will be in effect for one year from the date signed unless you indicate a shorter period below:
Date or event on which this authorization will expire_____.
If an authorized representative is making this request, please provide your information below and attach certifying documentation of your status as the authorized representative, such as a Power of Attorney or Guardianship papers.

AUTHORIZED REPRESNETATIVE

By signing this form, I am confirming that it accurately reflects my wishes. In addition, I have kept a copy of this form for my records.

_____ _____

Signature of Member or Authorized Representative Date

Name_____

Relationship to patient_____

Please send records to **Boze Family Chiropractic and Wellness Center, LLC**
 224 Mariner Blvd Spring Hill, FL 34609 P:352-610-9991 F:352-340-4753

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Insurance Assignment and Instructions for Direct Payment

I_____ hereby instruct and direct my insurance company pursuant
(Print patient name)
to F.S. 627.422 to pay by check or draft made out to and mailed to the ***Boze Family Chiropractic and Wellness Center*** for professional or medical services and any reimbursements otherwise payable to me under my current insurance policy as payment toward total charges for professional services rendered by them. The payment is not to exceed my indebtedness to any of the medical providers practicing within this facility.

I hereby assign all rights and benefits that I have under any Group Health, HMO plan, Individual Health, PIP, Disability, or any other Health, Medical, Policy or Reimbursement plan that may pay patient benefits for service or treatment that I have received or will receive from the medical providers within this facility.

If my current policy prohibits direct payment to the Doctors, then I hereby instruct and direct you to make the check payable to me and mail it to the office indicated above.

This assignment includes but is not limited to all rights to collect benefits directly from my insurance company or HMO for those services and treatments that I have received and all rights to proceed against my insurance company or HMO in any action including legal suit if for any reason my insurance company or HMO fails to make payments for benefits that are due to the providers within this facility. This assignment also includes the right to recover any attorney fees and costs for such action brought by the provider as my assignee.

I also agree that the providers within this facility be given Power of Attorney to endorse/sign my name on any and all checks for the payment of services provided by them.

I understand that I am financially responsible for any balance not covered by my insurance company. All self-pay patients are expected to pay for all services in full at the time services are rendered. Ultimately, payment responsibility rests with the patient.

I also authorize the release of any information pertinent to my case or claim to the medical providers within this facility or any attorney involved in this case. A photocopy of this assignment shall be considered effective and valid as the original.

I hereby authorize the medical providers within this facility to file any informal complaints that are necessary to the Insurance Commissioner's Office, agency, or court they deem appropriate on my behalf.

_____ _____
Signature of Patient (Claimant) Date

_____ _____
Signature of Witness (if minor) Date

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Informed Consent

Please read the entire document prior to signing. It is important that you understand the information presented in this document. Please feel free to ask any questions if anything is unclear.

The Chiropractic Adjustment

Chiropractic manipulative therapy is a procedure where the doctor may us his/her hands or a mechanical instrument to move the joints in the body. This may cause an audible 'pop' like what is experienced when you 'crack your knuckles'. You may even feel a sense of movement during this adjustment.

Analysis/Examination/Treatment

As a part of the analysis, examination and treatment, you are consenting to the following procedures: palpation, vital signs, orthopedic and neurological testing, muscle strength testing, range of motion testing, spinal manipulation therapy, extra-spinal manipulation therapy, physical therapy modalities, manual therapy and nutritional counseling. Acupuncture is not considered in this informed consent.

The material risks inherent in chiropractic manipulation

As with ANY healthcare procedure there are certain complications which may arise during chiropractic manipulation and therapy These complications include but are not limited to: fractures, dislocations, muscle/ligament strain, costo-vertebral (rib) strains and separations and burns. Some type of manipulations of the neck have been associated with injuries to the arteries in the neck which may have led to complications including stroke. It is common to feel stiffness or soreness following treatment for the first few days. It is your responsibility to inform the doctor of any disease or illness that you may have so that the doctor can determine if there are any contradictions to chiropractic care.

Probability of those risk occurring

Fractures are rare occurrences and generally result from underlying weakness of the bones and soft tissue. Stroke and vascular injury to the neck has been the ongoing subject of medical debate. Research on this topic is inconclusive as to a specific incident of this complication occurring. If there is a causal relationship at all, it is extremely rare and remote. Unfortunately, there is no absolute clinical screening test used to recognize patients who may be at risk for arterial stroke. The doctor will put all patients through a thorough exam to isolate any underlying risk or contraindications to care.

Alternatives to care

Other treatment options for your condition may include self-administered over the counter drugs, rest, pharmaceutical drugs prescribed by appropriate health care providers, surgery, and hospitalization. Please consult with the appropriate providers should you choose any of the care outside our facility.

Risk of not treating

Remaining untreated may allow the formations of adhesions and reduce mobility which may increase your pain and further reduce mobility. Over time, this may complicate treatment making it more difficult and less effective the longer it is postponed.

CONSENT TO TREAT (MINOR)

I hereby request and authorize Boze Family Chiropractic to perform diagnostic tests and render care as seen fit to my minor son/daughter _____. This authorization extends to all other doctors and staff members employed by Boze Family Chiropractic. As of this date, I have the legal right to select and authorize health care services for the patient indicated on this form. If my authority to select and authorize this care should revoked or modified in any way, I will immediately notify this office.

Sign below ONLY after you have READ all of this form and understand it fully.

I have read or had read to me the above explanation of the treatments provided. I have discussed with **Boze Family Chiropractic** any concerns and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment as well as the risks of not treating and have decided that it is in my best interest to undergo treatment that is recommended.

_____ _____

Print Patient Name Patient Signature

_____ _____

Relationship to Patient Date

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ACKOWLEDGEMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for 6 years.

By checking the lines below, I authorize being contacted for practice reminders

By Email _____;
At Email Address_____
By Text Message _____; At Cellphone Number_____
Cellphone Provider _____(Verizon, AT&T, ECT.)

_____ _____
Patient Name (Please Print) Date

Minor Release/Consent

_____
Name of Parent, Guardian or Child's Legal Representative

_____
Signature of Patient, Parent Guardian, or Child's Legal Representative

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR 6 YEARS. List below the names and relationships of people to whom you authorize the Practice to release medical records to or correspond.

_____ _____

_____ _____

Cancellation / No-Show Policy

Our office policy in regard to missed appointments is as follows:

- We must have a 24-hour notice of cancelled appointments.
- If you do not cancel your appointment within 24 hours of your scheduled appointment, there will be a $100 no-show fee.
- This fee (for personal injury patients) will be charged to the attorney handling your case; however, you the patient are ultimately responsible for your bill.
- If you do not have an attorney, you the patient are responsible for the bill.
- Exceptions may be made at our discretion due to emergency situation.

Patient Printed Name _____

Patient Signature _____

Date Signed _____

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Informed Consent

Laser therapy is a safe, non-invasive, FDA cleared modality for the treatment of pain and the temporary increase of microcirculation. Increased microcirculation can provide relief for many acute and chronic conditions. Laser therapy utilizes visible and invisible laser radiation; therefore, appropriate eye protection is required at all times during treatment.

Effects of your treatment will continue for up to 18 hours. Individuals respond uniquely to treatment; you may see immediate results after the first treatment or depending on the severity of your condition you may require several treatments before you begin to feel results.

Increased soreness may occur after your first laser session. This is a normal healing phenomenon known as retracing. Mild bruising may occur from the soft tissue manual therapy element of your treatment program.

You are required to complete the Patient Intake Form prior to treatment to ensure that laser therapy is a viable option for you.

☐ I understand the above and consent to treatment

☐ I understand that failing to complete any part of my treatment program will reduce my chances of success.

_____ _____

Print Patient Name Date

_____ _____

Patient Signature Physician Signature

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Patient Intake Form

Are you a candidate for laser therapy?

Laser therapy is an FDA cleared modality for the treatment of pain and inflammation and the temporary increase of microcirculation. Increased microcirculation can provide relief for many acute and chronic conditions. This form is a tool to help your clinician determine if you are a candidate for laser therapy. If you answer yes to any of these questions you will need to discuss details of your condition with your clinician.

Please check YES or NO to the questions below

YES ☐ NO ☐ Do you have a pacemaker or any other implanted devices?

YES ☐ NO ☐ Are you pregnant?

YES ☐ NO ☐ Are you currently being treated for, or have a past history of cancer?

YES ☐ NO ☐ Are you taking medications that may increase your sensitivity to light?

YES ☐ NO ☐ Have you had a steroid injection in the last 7 days?

_____ _____

Printed Patient Name Date

_____

Patient Signature

*The ultimate decision to recommend treatment lies with your health care provider. Speak with your health care provider if you have further questions about therapy treatment.

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Notice of Privacy Practice

The Health Insurance Portability and Accountability Act (HIPAA) provide safeguards to protect your privacy.

Implementation of HIPAA requirements officially began on April 14, 20003. This form is a "friendly" version. A more complete text is posted in the office and is available upon request.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPPA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care.

Additional information is available from the U.S. Department of Health and Human Services www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documentation or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, email, US mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you have changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payors in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods, or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete, or modify any of these provisions to better serve the needs of the both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.