



CHIRO SPORTS

Dr. Ronald G. Hernandez, Jr.

Patient Information

Date:

| | | | |
|----------------------------|---|-------------------------|-------------------------------|
| First Name: | MI: | Last Name: | SSN: |
| Birth Date: | Age: | Please Circle One: | Male Female |
| Address: | City: | State: | Zip: |
| Phone- Home: | Cell: | | |
| Work: | | | |
| Marital Status: | Single Married Divorced Separated | Spouse's Name: | |
| How did you hear about us? | Current Patient _____ | Another Physician _____ | |
| Print Advertising | Insurance Carrier | Internet | Yellow Pages Other _____ |
| Email address: | | | |

Employer Information

| | | |
|----------------------------|-----------------|--------------------------|
| Employer: | Employer Phone: | Fax #: |
| Employer Address: | City: | State: |
| Are you currently working? | Yes No | If Not, Last Day Worked: |

Emergency Contact (Closest relative or friend not living with you)

| | | |
|-------------------------|--------------------------|--------|
| Name: | Relationship to patient: | |
| Address: | | |
| Phone- Home: | Work: | Cell: |
| Primary Care Physician: | Location: | Phone: |

Is the patient younger than 18 years old? If so, please complete the following:

Authorization to Treat a Minor

I, the undersigned, hereby attest and warrant that I am the legal guardian of:

 Name of minor patient Child's DOB Child's Social Security Number
 a minor child as described by law. Further I warrant that my authority to act on the child's behalf is by virtue of my
 _____ Being the child's natural parent.
 _____ Having been duly appointed legal guardian by a Court of Competent Jurisdiction (Copy of the order is attached)

And that I hereby give my consent to such medical examinations, diagnostic procedures and treatments as may be deemed necessary by the physician for the evaluation and treatment of the condition for which this minor child has been presented. This consent begins on the date below and remains in effect unless revoked in writing.

Signed in the presence of this witness on _____ 20____

 Printed Name of Parent/Consenting Adult

 Signature of Parent/Consenting Adult

 Date

Name: _____

INSURANCE INFORMATION & FINANCIAL POLICY

I, the undersigned hereby authorize the staff to perform such services as deemed necessary by the physician to diagnose and treat my condition(s). I also certify that I (or my dependent) have (has) insurance coverage with _____ and assign directly to Dr. Ronald G. Hernandez, Jr of ChiroSports, Inc SC all insurance benefits, if any, that would otherwise be payable to me for services rendered by Dr. Ronald G. Hernandez, Jr of ChiroSports, Inc SC.

I understand that I am responsible for all charges whether or not they are paid by my insurance company. I understand that this may include legal and/or consulting fees and/or other expenses incurred by the provider in collection of my account, whether through insurance or from the patient.

I understand that for any balance remaining on my account past 30 days and on second billing cycle, pursuant to Dr. Ronald G. Hernandez, Jr of ChiroSports, Inc SC discretion, will accrue monthly late fees assessed of \$30 each month for up to 3 months, and/or charged in arrears for the initial 3 months. After 90 days' time, I understand my account may be turned over to collections, where I will be liable for additional fees, such as but not limited to, interest and administrative. I hereby authorize the doctor to release all information necessary to secure payment for services rendered. I authorize all parties to accept a copy of this release and assignment in lieu of the original. This shall remain in effect until revoked by Dr. Ronald G. Hernandez, Jr of ChiroSports Inc SC in writing.

I understand a valid credit card is required to secure my appointment time. It is my responsibility to keep the clinic updated on any changes to my card account. I authorize the card to be charged for any insurance balance or balance on my account on the 15th of the month, or for any other fees associated. Credit cards may be charged \$0.01 randomly to assure a valid account.

If an insurance deductible applies, payments will be required as deductible deposits per date of service.

If insurance co-payment applies, then payment is due at time of service.

If non-insurance or out of network, payment is due at time of service.

If the service is not covered under my insurance plan, I understand I am solely responsible for any additional expenses, which may include billing fees.

Appointment changes require 24 hour notice. If less than 24 hours is provided to change my appointment time, there is a cancellation fee of 50 applied to the credit card on file per episode. Office days are observed as Monday through Friday. Cancellations will only be accepted during office days, or by Friday 6pm for Monday appointments.

INITIALS _____

Print

Signature

Date

Name: _____

INSURANCE INFORMATION & FINANCIAL POLICY (cont)

If the patient is not the insured, please provide the following information for both your primary insurance and any secondary insurance you may have. If the patient is the same as the insured, please right "self" in the "Insured's Name" box below.

Primary Insurance

| | | |
|------------------------------------|-------|-------|
| Insured's Name: | | |
| Insured's Social Security Number: | | |
| Insured's Birth Date: | | |
| Insured's Address: | | |
| Insured's Phone- Home: | Work: | Cell: |
| Insured's Employer: | | |
| Insured's relationship to patient: | | |

Subscriber Information

| | | |
|---------------------------------------|-------|-------|
| Subscriber Name (as appears on card): | | |
| Subscriber ID: | | |
| Subscriber Group Number: | | |
| Subscriber Birth Date: | | |
| Subscriber's Phone- Home: | Work: | Cell: |

CREDIT CARD INFORMATION

Name on Card (PRINT as appears on card):

Card Type: VISA MASTERCARD DISCOVER

Card Number: _____

Expiration: _____

SEC: _____

Billing Zip Code: _____

Authorization Signature: _____

Today's Visit

What is the reason for your visit today?

What treatment have you already received for this condition, if any?

Medications Surgery Physical Therapy Chiropractic Services Acupuncture Massage

Other _____ None

What other doctors, facilities, etc., if any, have you seen for this condition? Please list names and practice locations to the best of your ability.

May we share this information or our treatment procedures with them? YES NO

Which advanced imaging was performed for this ailment? MRI X-Ray CT PET Other None

What were the results?

Please list any/all **prescriptive medications** with dosages.

Please list any/all **allergies** (food, insect, environmental, etc).

Please list any/all nutritional supplements with dosages.

Please answer the following questions to the best of your ability, have you ever or are you currently being treated for any of the following conditions?

If answering "YES," please **check all that apply**:

CARDIOVASCULAR

Pacemaker/Internal Device Bleeding/Clotting Disorder Heart Attack Chest Pain Irregular HR
 Heart Murmur High/Elevated BP Shortness of Breath High/Elevated Cholesterol Anemia

RESPIRATORY

Asthma Bronchitis Emphysema COPD Sleep Apnea Smoker

GI/DIGESTIVE

Crohn's Disease Colitis Acid Reflux/Heart Burn Ulcers Hernia Hemorrhoids
 IBS Hepatitis Celiac Disease Cirrhosis

METABOLIC/ENDOCRINE

Diabetes Thyroid Disorder High/Low Blood Sugar Adrenal/Pituitary/Other Glandular Disorder
 Chronic Fatigue Syndrome Fibromyalgia Obesity/Weight Loss Surgery

BRAIN/NERVOUS SYSTEM

Seizures Migraine Epilepsy Chronic Headaches Stroke or TIA Head Injury Concussion
 Blacked Out/Knocked Out Multiple Sclerosis Parkinsons Disease Restless Leg Syndrome Dizziness
 Visual Disturbances Internal Device

IMMUNE SYSTEM

HIV Positive AIDS Leukemia or Lymphoma

MUSCULOSKELETAL

Arthritis Gout Lupus Herniated Disc TMJ Carpal Tunnel Syndrome Rheumatoid Arthritis
 Other Bone or Joint Disorder

MENTAL/BEHAVIORAL/EMOTIONAL

Depression Anxiety Disorder Attention Deficit Disorder BiPolar Disorder Eating Disorder

SKIN CONDITIONS

Acne Psoriasis Eczema Pre-Cancerous Lesions Herpes Melanoma

GENERAL HEALTH

Currently Pregnant Cancer (Current or Remission) Organs Lost or Missing Smoker
 Consume Alcohol

Please explain all "Yes" answers to the above questions.

Are you currently pregnant? If so, what trimester/weeks? If not, date of last menstrual cycle.

Have you ever been hospitalized? If so, please specify.

Please list all surgical procedures performed and date.

Are there any diseases or ailments that are common to your family? If so, please list who, what condition, and their relation to you.

Do you use any special equipment for participation in sports? If so, please specify.

Other than the reason for this visit, do you experience any chronic ailments/pain? If so, please specify.

If your current condition involves pain, please complete the following section.

1. When did you first notice your complaint/condition? _____
2. Is your condition getting worse? Yes No Unknown
3. Have you had anything like this before? Yes No
4. How often do you have this pain? _____
5. What makes it better? _____
6. What makes it worse? _____
7. Is it better or worse in the morning? _____
8. Please circle the best description of your pain.
 Constant
 On and off, lasting ___ minutes ___ hours ___ days ___ weeks at a time.

For questions 9-11, circle all that apply.

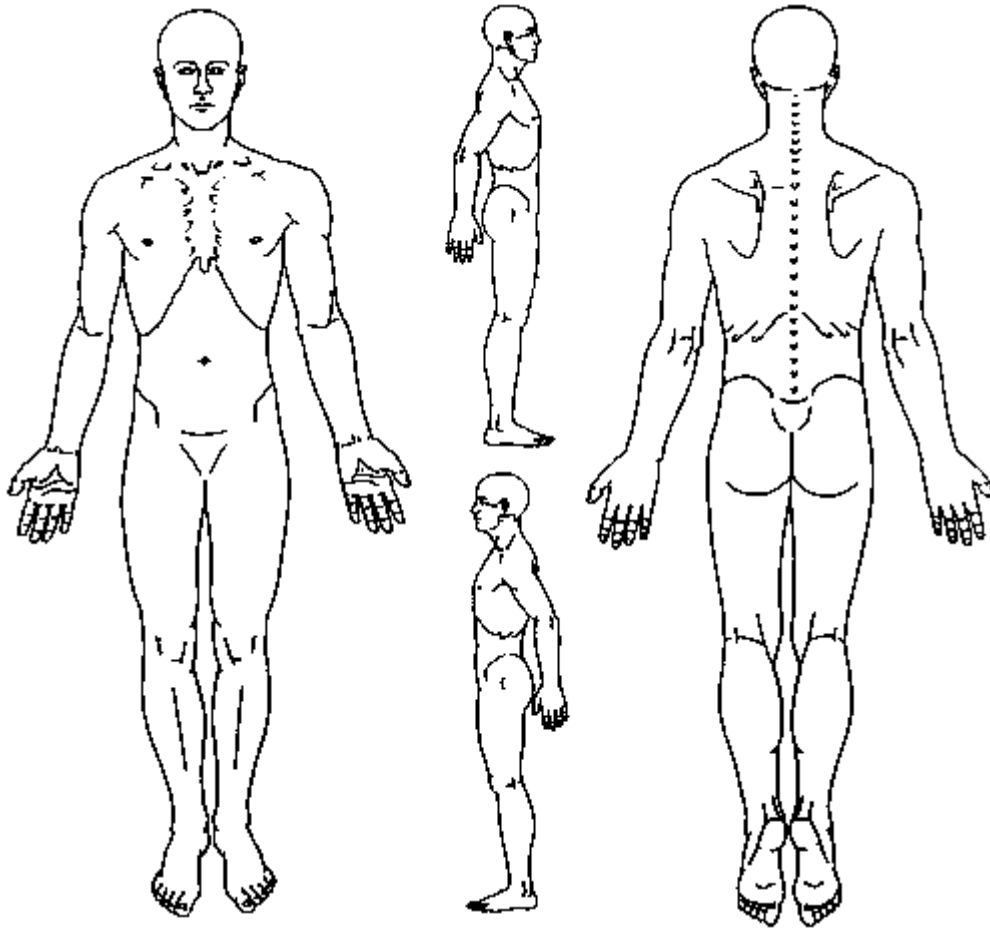
9. Describe how it feels: Numb Aching Pins and Needles
 Throbbing Cramping Stiffness Burning Stabbing Dull Sharp
10. Does it interfere with: Work Sleep Recreation Daily Routine
11. Activities that are painful to perform: Sitting Standing Walking Bending Lying Down
12. Please rate your pain on the scale below. 0= No Pain and 10= Severe Pain

| | | |
|----------------------|----------------------|----------------------|
| 1 2 3 4 5 6 7 8 9 10 | 1 2 3 4 5 6 7 8 9 10 | 1 2 3 4 5 6 7 8 9 10 |
| Pain currently | Pain at its worst | Pain typically |

Name: _____

13. Please mark the area(s) of injury or discomfort as shown in the example below.

N= Numbness P= Pins and needles A= Aching B= Burning S= Stabbing



Lifestyle Questions

How many days/week do you do formal exercise (weight lifting, running, yoga, etc.)? _____

What is the main activity you do in regards to the above exercise? _____

How many times/week do you engage in aerobic sports like basketball, tennis, biking, etc? _____

Does your occupation require mostly: Sitting Standing Light Labor Heavy Labor

In your own opinion, how is your diet? Terrible Poor Average Excellent

How many 8 ounce glasses of plain water do you drink/day? _____

How many caffeinated beverages (coffee, tea, and cola) do you drink/day? _____

Do you consider yourself to be under a great deal of stress? Yes No

Do you smoke cigarettes? Yes No

Do you smoke cigars, tobacco, a pipe? Yes No If so, how often? _____

How many alcoholic beverages do you drink/week? _____

Do you use any recreational drugs? Yes No

Do you practice safe sex, if at all? Yes No

Are you currently pregnant? Yes No Due Date: _____

Please return this packet to the receptionist along with a copy of your insurance card(s), credit card, and driver's license so that we may make a copy of them.

HIPPA Declaration

The Practice:

- (a) 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
- (b) Under the Privacy Rule, may be required by State law to grant greater access or maintain greater restrictions on the use or release of your PHI than that which is provided for under federal law
- (c) Is required to abide by the terms of the Privacy Notice
- (d) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your PHI that it maintains
- (e) Will distribute any revised Privacy Notice to you prior to implementation
- (f) Will not retaliate against you for filing a complain

EFFECTIVE DATE

This Notice is in effect as of 7/26/04

PATIENT ACKNOWLEDGEMENT

By subscribing my name below, I acknowledge receipt of this notice, and my understanding and my agreement to its terms.

PATIENT

DATE

By initialing below, I agree to share this information with ChiroSports, Inc SC, Athletic Republic, and their representatives, including any other providers.

Initials: _____

FOR PRACTICE USE ONLY

Practice Documentation of Good Faith Effort to Obtain Acknowledgment
Patient's acknowledgment of this notice could not be obtained because:

- Patient refused to sign
- Communication barrier prohibited obtaining acknowledgment
- Emergency circumstances
- Other

Details:

Signature of Practice

Date

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a “click” or “pop”, such as the noise made when a knuckle is “cracked”, and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound, dry hydrotherapy, acupuncture, or photolight/infrared light therapy may also be used.

Possible risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves, or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness, soreness, or discomfort after or within the first few days of treatment. The ancillary procedures could produce skin irritation, burns, bruises, minor complications, or possible discomfort.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as “rare”, about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered “rare”.

Other treatment options which could be considered may include the following:

- *Over the counter analgesics.* The risks of these medications include irritation to stomach, liver, and kidneys as well as other side effects in a significant number of cases.
- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risk of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue, and other degenerative changes. These changes can further reduce skeletal mobility and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make further rehabilitation more difficult.

Unusual risks: I have had the following unusual risks of my case explained to me.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment and hereby give my full consent to treatment.

| | | |
|---------------------|------------------|-------------|
| | | |
| Printed Name | Signature | Date |

WITNESS:

| | | |
|---------------------|------------------|-------------|
| | | |
| Printed Name | Signature | Date |

Affirmation

By signing this form, you certify the following:

1. I have read this entire application or it has been read to me.
2. I understand all that has been presented to me within this application.
3. No one can change any part of this application or waive the requirement that I answer all questions completely and accurately.
4. I understand that if I intentionally omit or provide false information on or in relation to this application, I assume any and all responsibility for the negative consequences of such acts. Upon any omission or fraud, I agree to hold harmless ChiroSports, Inc SC, Synergy Diagnostic and Therapy, LLC, and Synergy Fitness and Sports, Inc, for any injuries caused by my misrepresentations. I further acknowledge that by omitting or providing false information I may be putting myself and others in danger, of which I accept full and total responsibility. In the event that it is determined that I have intentionally omitted or provided false information I understand that I will be denied further treatment and that legal recourse may be undertaken to rectify the situation.
- 5. All of the answers provided within this application are, to the best of my knowledge and belief, true and complete.**

Initials: _____

Statement of Understanding

I understand and agree that:

- All the information provided in this application will be used by the physician to determine screening qualifications of the individual for modality services, evaluation for diagnosis, and/or course of medical and/or therapeutic treatment.
- I recognize there may not be an examination performed, but a standard pre-participation screening to determine eligibility for a therapeutic modality. I recognize, in the event of a screening, no in-depth testing, x-rays, lab work, or cardiac testing will be performed. A screening will consist of no examination by the physician, unless decided so by the physician, or elected so by the individual, or advised by the Synergy representative.
- In the event of an emergency, I agree to emergency medical procedures as deemed necessary by the responder. I agree to waive responsibility and hold harmless ChiroSports, Inc SC, Synergy Diagnostic and Therapy, LLC, and Synergy Fitness and Sports, Inc, for any actions taken to stabilize my condition in an emergency situation.
- Upon request, I am entitled to one copy of this entire application at no charge. I agree that the photographic copy shall be as valid as the original. A copy of this agreement shall have the same force and effect as the original. I also authorize electronic transmission of the information contained herein.

Initials: _____

I have read the insurance & financial policy, and agree to the terms set herein.

Printed Name

Signature

Date

I have read the Affirmation and Statement of Understanding and agree to the terms set herein.

Printed Name

Signature

Date