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: Work:			Cell:	
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:

<u>Authorization to Treat a Minor</u>

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

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Name: ______________________

INSURANCE INFORMATION & FINANCIAL POLICY (1/3)

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.
INITIALS____________

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.
INITIALS____________

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.
INITIALS____________

I understand a valid credit card (not HSA) 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.
INITIALS____________

24 Hour Cancellation policy: 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 occurrence.
INITIALS______________

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

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

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

Balances are due in full by last office day of the month.

____
Print

__________________________________ ________________
Signature **Date**

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Name: ______________________

INSURANCE INFORMATION & FINANCIAL POLICY (cont. 2/3)

Valid Personal Information: I understand it is my responsibility to contact the office if any of my personal information changes, such as but not limited to: name, address, phone, email, credit card.
INITIALS____________

Billing Cycle: Monthly billing cycles close on the last office day of the month. All balance statements are sent out first week of every month. Balances are due in full by last office day of the month, before late fee of 30 will apply. Credit card (check or cash payment arrangements available) will be on file and billed by the 15th of each month.
INITIALS____________

Cancellation Policy: The cancellation policy requires a valid credit card (not HSA) be on file to secure the appointment time. Any changes are required to have a 24 hour notice. There is a 50 fee to cancel or change appointment time per occurrence.
INITIALS____________

Non-Covered Services: If the service is not covered under my insurance plan, I understand I am solely responsible for any and all expenses, which may include billing and/or administrative fees. All balances are required to be paid in full by end of billing month.
INITIALS____________

Insurance Denials: For any insurance submissions that are denied in any way, I understand I am solely responsible for the balance due. All balances are required to be paid in full by end of billing month.
INITIALS____________

Insurance Disputes/Denials: For insurance disputes/denials, Dr. Ronald G. Hernandez, Jr of ChiroSports, Inc. SC reserves the right to refrain from participation. It is the clinic's policy to refrain from participation. I understand I am still financially responsible for the balance, even if the clinic does not participate.
INITIALS____________

Letters/Paperwork: I understand that any number of letters or paperwork required by any person or company that are deemed by the clinic to be excessive may incur a fee for the production and authentication thereof, prior to being provided.
INITIALS____________

Outstanding balance/delinquent accounts: For outstanding balance/delinquent accounts, any related family members or account relation between patients may jeopardize services to other related accounts, and/or cause suspension of services until all accounts are settled.
INITIALS____________

____
Print

___________________________________ __________________
Signature **Date**

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Name: ____________________

INSURANCE INFORMATION & FINANCIAL POLICY (cont. 3/3)

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:

REQUIRED CREDIT CARD INFORMATION

If HSA card is provided, a NON-HSA card will be required to secure the account

Name on Card (PRINT as appears on card):

______________________________ ______________________________

Card Type:

VISA MASTERCARD DISCOVER HSA VISA MASTERCARD DISCOVER HSA

Card Number:

______________________________ ______________________________

Expiration: ____________________ ____________________

SEC: ____________ ____________

Billing Zip Code: ________________ ________________

Authorization Signature: ____

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Name: ______________________

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

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Name: ______________________

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 __Other_________________

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/year.

____

____

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.

____

____

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Name: ______________________

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

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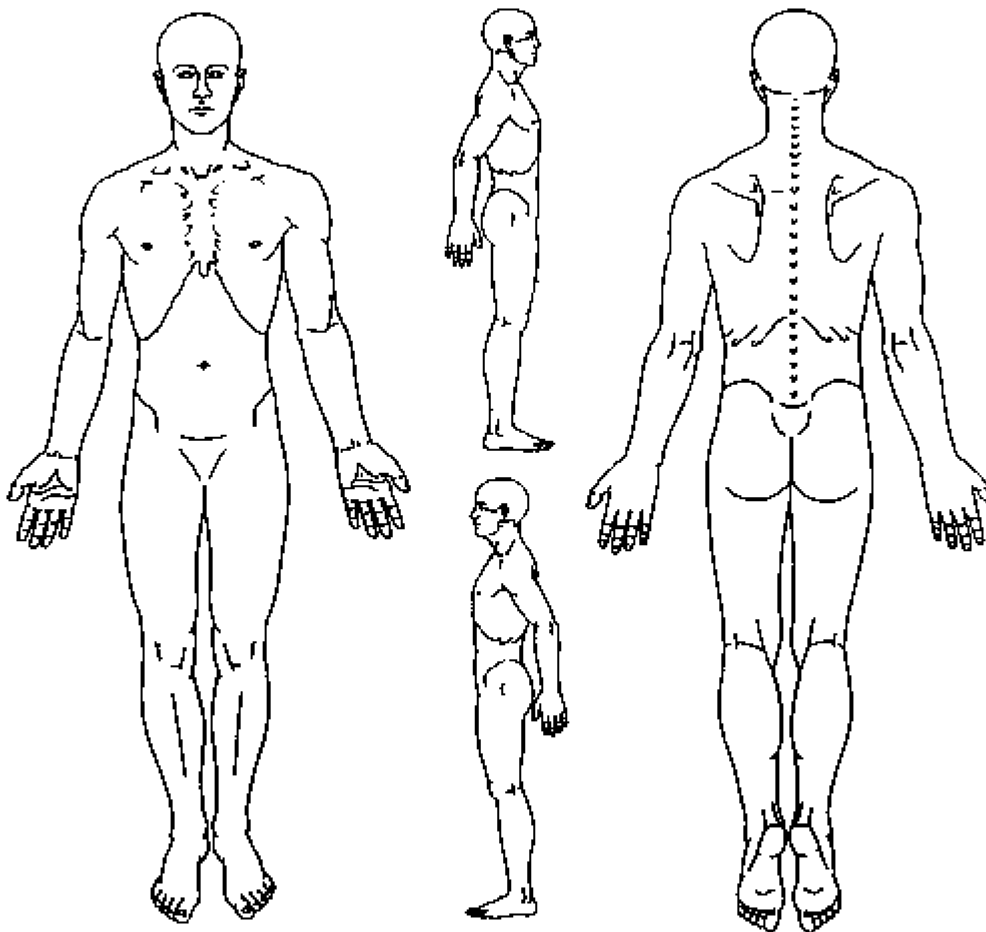
Name: ______________________

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, or 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.

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Name: ______________________

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 and their representatives, including any other providers, students, interns, or residents.

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

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Name: ______________________

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 herby give my full consent to treatment.

______________________________ ____________________________ _______________

Printed Name **Signature** **Date**

WITNESS:

______________________________ ____________________________ _______________

Printed Name **Signature** **Date**

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Name: ______________________

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 the physician and respective company, as listed in the financial policy, 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.
- 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 the physician and respective company 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**

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