

PATIENT INFORMATION

Date _____ Social Security No. _____ Spouse's Name _____
Name _____ Name of Parent if Minor _____
Address _____ Parent's Phone _____
City _____ State _____ Zip _____ Who is Responsible for Patient's Bill?
Home Phone _____ Number Children _____ Self Spouse Workers Comp Medicare Auto Insurance
Driver's License _____ Personal Health Insurance Medicaid Other _____
Birth Date _____ Age _____ Sex M F Method of Payment for Initial Visit Cash Check Visa MasterCard
 Single Married Divorce Separated Widow Referred By _____

BUSINESS INFORMATION

INSURANCE INFORMATION

Business/Employer _____ Name of Insurance Company _____
Type of Work _____ Phone _____ Policy _____
Work Phone _____ Name Policy is Under _____

REASON FOR VISIT AND HISTORY

Purpose for this appointment _____
Other Doctors seen for this condition _____
When did this condition begin? _____ Is it Job related Auto related Home accident
Drug you now take Nerve pills Pain killers Muscle relaxers Blood pressure pills Insulin
 Other/Over-The-Counter _____ Women only, are you pregnant? Yes No
Major surgery/Operations Appendectomy Tonsillectomy Gall Bladder Hernia Spinal Hysterectomy
 Broken bones Other _____

ACCIDENT HISTORY

Accident or falling history such as auto, work, sport related, jolts or trauma, etc. which could have had an impact upon the spine are of high significance to determine health history. Fill out completely.

Within the past year? When? _____
Describe event _____
Over a year ago? When? _____
Describe event _____
Childhood? When? _____
Describe event _____
Hospitalizations (other than above) _____
Previous Chiropractic Care No Yes When? Where? _____
Do you purchase any of the following? Bottled water Yes No Vitamins Yes No Health food products like organic? Yes No
Are you a member of a gym or health club? Yes No
Signed _____ Date _____ Witness _____
Parents signature if patient is under 18 _____

**Check any of the following that gives you
difficulty presently or recently.**

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Headaches 784 | <input type="checkbox"/> Fainting 780.2 | <input type="checkbox"/> Shortness of breath . . . 786.09 | <input type="checkbox"/> Numbness in legs/feet 782 |
| <input type="checkbox"/> Shooting head pains 784 | <input type="checkbox"/> Loss of balance 781.2 | <input type="checkbox"/> Mid-back pain 724.1 | <input type="checkbox"/> Constipation 564 |
| <input type="checkbox"/> Sinus trouble 473.9 | <input type="checkbox"/> Ringing in ears 388.3 | <input type="checkbox"/> Heart attacks 41 0.9 | <input type="checkbox"/> Kidney trouble 593.9 |
| <input type="checkbox"/> Loss of smell 781.1 | <input type="checkbox"/> Blurred vision 368 | <input type="checkbox"/> Low blood pressure 458.9 | <input type="checkbox"/> Menstrual cramps/pain . . 625.3 |
| <input type="checkbox"/> Allergies 995.3 | <input type="checkbox"/> Lights bother eyes 368.1 3 | <input type="checkbox"/> High blood pressure 401.9 | <input type="checkbox"/> Menstrual irregularity . . . 626.4 |
| <input type="checkbox"/> Hay fever 477.8 | <input type="checkbox"/> Neck pain 723.1 | <input type="checkbox"/> Anemia 285.9 | <input type="checkbox"/> Diabetes 250 |
| <input type="checkbox"/> Asthma 493.9 | <input type="checkbox"/> Muscle spasms in neck . . . 781 | <input type="checkbox"/> Stomach trouble 789 | <input type="checkbox"/> Sleeping problems 780.5 |
| <input type="checkbox"/> Loss of taste 781.1 | <input type="checkbox"/> Grinding in neck 719.68 | <input type="checkbox"/> Nerves / nervousness . . . 799.2 | <input type="checkbox"/> Painful joints 719.4 |
| <input type="checkbox"/> Inflammation of throat 462 | <input type="checkbox"/> Shoulder/arm tightness . . 728.85 | <input type="checkbox"/> Inner tension 799.2 | <input type="checkbox"/> Swollen joints 719 |
| <input type="checkbox"/> Thyroid trouble 246.9 | <input type="checkbox"/> Shoulder/arm pain 719.4 | <input type="checkbox"/> Irritability 799.2 | <input type="checkbox"/> Pins & needles in legs 782 |
| <input type="checkbox"/> Twitching in face 361.9 | <input type="checkbox"/> Pins & needles in arms . . . 782 | <input type="checkbox"/> Gall bladder trouble 575.9 | <input type="checkbox"/> Swollen ankles 782.3 |
| <input type="checkbox"/> Loss of memory | <input type="checkbox"/> Pins & needles in hands . . . 782 | <input type="checkbox"/> Indigestion 536.8 | <input type="checkbox"/> Cold feet 782 |
| <input type="checkbox"/> Fatigue 780.7 | <input type="checkbox"/> Cold hands 782 | <input type="checkbox"/> Intestinal gas 787.3 | <input type="checkbox"/> Pain in legs/feet 719.46 |
| <input type="checkbox"/> Depression 31 1.0 | <input type="checkbox"/> Numbness in arms/hands . . 782 | <input type="checkbox"/> Low back pain 724.2 | <input type="checkbox"/> Hip pain 719.45 |
| <input type="checkbox"/> Dizziness 780.4 | <input type="checkbox"/> Tonsillitis 784 | <input type="checkbox"/> Hernia 550.1 | <input type="checkbox"/> Facial pain 784 |
| <input type="checkbox"/> Spinal curvature 737.43 | <input type="checkbox"/> Prostate trouble 601.4 | <input type="checkbox"/> Stroke 436 | <input type="checkbox"/> Jaw pain 525.9 |
| <input type="checkbox"/> Chest pain 786.5 | <input type="checkbox"/> Bed wetting 788.3 | <input type="checkbox"/> Arthritis 716.96 | <input type="checkbox"/> Ulcers 534.9 |
| <input type="checkbox"/> Ear ache | <input type="checkbox"/> Cancer | <input type="checkbox"/> Facial twitch 781 | |

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be use to attain it. This will prevent any confusion or disappointment.

Adjustment: The adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: The state of optimal physical, mental and social well being, not merely the absence of disease or infirmity.

Vertebral subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer diagnose or treat any disease. We only offer to diagnose either vertebral subluxations or neuro-musculoskeletal conditions. However, if during the course of a chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. However, we may use other procedures to help your body hold the adjustments.

X-Rays: It is understood and agreed the amount paid to Ribley Chiropractic for x-ray(s), is for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office.

CONSENT TO CARE

I do hereby authorize the doctors of Ribley Chiropractic to administer such care that is necessary for my particular case. This care may include consultation, examination, adjustments, or any other procedure which is advisable, and necessary for my health care. I further understand that a fee for services rendered will be charged and that I am responsible for this fee whether results are obtained or not. I also understand any sum of money paid under assignment by any insurance shall be credited to my account, and I shall be personally liable for any and all of the unpaid balance to the Ribley Chiropractic.

I, _____, have read, understand and hereby request chiropractic care on the above agreement.

Date _____ Signature _____

Signature of parent or guardian if minor _____

Ribley Chiropractic
8525 W. Hillsborough Ave.
Tampa, FL 33615

Phone: (813) 886-8824
Fax: (813) 888-5581

**ACKNOWLEDGMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to object to the use of my health insurance for directory purposes
- The right to request restrictions as to how my health insurance may be used or disclosed to carry out treatment, payment, or health care operations

Print Name of Patient _____ Date _____

Signature of Patient _____

Patient's Name _____

Patients SS# _____ Date of Birth _____

THE PATIENT IDENTIFIED ABOVE AUTHORIZES RIBLEY CHIROPRACTIC TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

- I give permission to Ribley Chiropractic to use my address, phone number, e-mail address, and clinical records to contact me with birthday cards, holiday related cards and information about treatment alternatives or other health related information.
- If Ribley Chiropractic contacts me by phone, I give them permission to leave a phone message on my answering machine or voice mail.
- I give Ribley Chiropractic permission to treat me in a semi-private room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with doctor at any time in private, the doctor will provide a room for these conversations.
- By signing this form you are giving Ribley Chiropractic permission to use and disclose your protected health information in accordance with the directives listed above.

EXPIRATION

The Authorization shall expire on the following date: _____

RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of Atlanta Natural Health Clinic. The written notice must contain the following information: Your name, Social Security Number, and date of birth; a clear statement of your intent to revoke this AUTHORIZATION; the date of your request; and your signature. The revocation is not effective until it is received by the Privacy Official.

This AUTHORIZATION is requested by Ribley Chiropractic for its own use/disclosure of PHI. (Minimum necessary standards apply.)

You have the right to refuse to sign this AUTHORIZATION. If you refuse to sign this AUTHORIZATION, Ribley Chiropractic will not refuse to provide treatment.

You have the right to inspect or copy the PHI to be used/disclosed.

A COPY OF THE SIGNED AUTHORIZATION WILL BE PROVIDED TO YOU

Print Name of Patient _____

Signature of Patient _____

Date _____

Signature of Personal Representative _____

Description of Representative's Authority To Act for Patient _____

AUTHORIZATION AND ASSIGNMENT

To Ribley Chiropractic,

In consideration of your undertaking to care for me, I agree to the following:

AUTHORIZATION TO RELEASE INFORMATION

You are hereby authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by, and I hereby release you of any consequence thereof.

AUTHORIZATION TO PAY DIRECTLY TO DOCTOR

I authorize the direct payment to you of any sum I now or hereafter owe you, by my attorney out of the proceeds of any settlement of my case, and/or by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.

AUTHORIZATION OF CAUSE OF ACTION

In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent data below) and authorize you to prosecute said action either in my name or in your name as you see fit and further authorize you to compromise, settle or otherwise receive and claim as you see fit. However, it is understood that until a reasonable effort has been made to collect the sums due from the insurance company or companies contractually obligated, you will refrain from collecting the amounts owed, directly or from me. I understand that whatever amounts you do not collect from insurance company proceeds, whether it be all or part of what is due, I personally owe and agree to pay you.

Signed _____ Witness _____ Date _____

PERTINENT DATA

Date of Injury _____

INSURANCE COMPANIES BELIEVED TO BE INVOLVED

Your insurance company

Companies of person responsible for injuries

Companies _____

Companies _____

Names and addresses of attorney

Attorney _____
