Dr. Leone's Chiropractic Accident & Injury Center
Dr. Angela Leone

7003 NW 11 PL Suite 5
Gainesville, Florida 32606
Office: 352-374-0909

CONFIDENTIAL PATIENT INFORMATION

Please complete this questionnaire. Your answers will help us determine if chiropractic can help you.
If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case.
Thank You

Date:__________________ How did you hear about us?____

Name:____ Social Security#:________________________________

Address:____ City:____________________State:______Zip:___________

Home Phone:____________________Work#/extension:__________________ Cellphone#:______________________

Age:_________ Birthdate:_____________________ Email Address:____

Marital Status: Married Separated Widowed Divorced Spouse/Partner Name:______________________________
Emergency Contact Name if different:______________________ Contact #____________________________

Occupation:___________________________________ Employer:_______________________________________

HEALTH INFORMATION Have you had previous chiropractic care?_______________

What is your major complaint?____

Other complaints:____

How long have you had this condition?_______________ Have you had this or similar condition in the past?________

What activities aggravate your condition?____

____

Is this condition getting progressively worse? Yes_____ No______ Constant______ Comes &Goes______

Is this condition interfering with your: Work_______ Sleep_______ Daily Routine_______ Other__________

Date of Last Physical Examination:____________________________

Right or Left Handed_______________

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Print Name ______________________________________ *Date:*___________________

Insurance Information Is your condition due to a car accident? Yes__ No__ IF yes, accident date:_______________

We can file car insurance on your behalf up to four years after your accident if you have benefits left.

Do you have insurance? Yes___ No___

Claim# AUTO/ or Health Policy letters & #:_____________________________

If Federal Insurance, list enrollment code_____________

Name of Insurance Company:___________________ Name of policy holder/ date of birth of policy holder if not self: _________________________ ___/___/___ relationship to self_______________________

Is this policy through an employer? Yes____ No____ If yes, list employer_____________________________

IF Auto;Medical Adjuster name:_____________________ IF Auto;Medical Adjuster#/Extension_______________________

PATIENT'S AFFIRMATION OR RECEIPT OF

PATIENT'S STATEMENT OF PRIVACY RIGHTS

ACKNOWLEDGEMENT FORM

I have received this office's Statement of Privacy Rights, provided on my behalf and in accordance with law, and have read and understand my rights to privacy and security of Personal Health Information, as a patient of this practice.

Affirmed,

*Birth Date*____

*Signature*____

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CURRENT PHYSICIANS ______ Name ______ ______ Date ______

NAME OF FAMILY DOCTOR:______________________ DATE LAST SEEN:______________

ADDRESS:______________________ PHONE#:______________

NAME OF OTHER PHYSICIANS: ______________________ DATE LAST SEEN:______________

ADDRESS:______________________ PHONE NUMBER:______________

WHAT IS YOUR MAJOR COMPLAINT: ______________________________________

____

PLEASE CIRCLE THE FOLLOWING YOU HAVE

IN YOUR ARMS DO YOU HAVE:	NUMBNESS	TINGLING	CRAMPMING	PAIN
IN YOUR LEGS DO YOU HAVE:	NUMBNESS	TINGLING	CRAMPMING	PAIN

1. **WHAT ACTIVITIES ARE YOU HAVING DIFFICULTIES WITH BECAUSE OF THIS CONDITION? (CHECK ALL THAT APPLY)**

☐ WALKING ☐ WORK ☐ STANDING ☐ SLEEPING ☐ SITTING ☐ BENDING ☐ OTHER______________

WHEN IS THE PAIN THE WORST? ☐ MORNING ☐ AFTERNOON ☐ NIGHT ☐ ALWAYS ☐ TURNING YOUR HEAD
OTHER______________________________________

PLEASE DESCRIBE PAIN: ______________________________________

2. **HAVE YOU SEEN A CHIROPRACTOR BEFORE?** ☐ YES ☐ NO IF YES, PLEASE PROVIDE THE FOLLOWING:
NAME OF DOCTOR______________________ DATE LAST SEEN:______________
ADDRESS:______________________ PHONE#______________

3. **DO YOU HAVE ANY FEARS OR CONCERNS ABOUT CHIROPRACTIC CARE?** ☐ YES ☐ NO IF YES
LIST:______________________________________

4. **MEDICAL HISTORY** DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING? (CIRCLE YES OR NO AND THEN PLEASE EXPLAIN):

YES	NO	ASTHMA______	YES	NO	KIDNEY TROUBLE______
YES	NO	LIVER TROUBLE______	YES	NO	NERVOUS BREAKDOWN______
YES	NO	TURBERCULOSIS______	YES	NO	STOMACH TROUBLE______
YES	NO	COLITIS______	YES	NO	INTESTINAL ULCERS______
YES	NO	BLACKOUTS______	YES	NO	HEART TROUBLE______
YES	NO	DIZZY SPELLS______	YES	NO	STROKE______
YES	NO	BACK TROUBLE______	YES	NO	CURRENTLY PREGNANT______
YES	NO	NECK PAIN______	YES	NO	RECENT WEIGHT LOSS OR WEIGHT GAIN______
YES	NO	HEADACHES______	YES	NO	FAINTING______
YES	NO	DIABETES______	YES	NO	CONVULSIONS______
YES	NO	TROUBLE w/HEARING______	YES	NO	ABNORMAL BLEEDING______
YES	NO	TROUBLE w/VISION______	YES	NO	ANEMIA______
YES	NO	ARTHRITIS______	YES	NO	SKIN RASHES OR CANCER______
YES	NO	THYROID (GOITER)______	YES	NO	HIGH BLOOD PRESSURE______
YES	NO	CIRCULATION______	YES	NO	CANCER______

Name Date

7. **HEIGHT**______________**WEIGHT**______________

8. **ARE YOU PRESENTLY TAKING ANY MEDICATION?** YES NO
IF YES PLEASE LIST (IF YOU HAVE A LIST WE WOULD BE HAPPY TO PHOTOCOPY IT FOR YOU)______________

9. **ALLERGIES TO MEDICATION(S), FOOD(S) ETC?** YES NO (IF YES PLEASE EXPLAIN):______________

10. **SOCIAL HISTORY:**
   a. DO YOU SMOKE TOBACCO? YES NO FREQUENCY?______ PACKS A_____DAY_____WEEK ____MONTH
   b. DO YOU DRINK ACOHOL? YES NO FREQUENCY?______DRINKS A_____DAY_____WEEK____MONTH
   c. DO YOU TAKE RECREATIONAL DRUGS? YES NO TYPE:______________
   d. WHAT IS YOUR OCCUPATION? ______________

11. **FAMILY HISTORY:**

	Grandparent	Father	Mother	Siblings	Children
CANCER					
ARTHRITIS					
HEART DISEASE					
DIABETES					
KIDNEY DISEASE					
HIGH BLOOD PRESSURE					
Stroke					

12. **SURGICAL HISTORY:**

OPERATIONS	APPROXIMATE DATE	SURGEON	HOSPITAL

13. PLEASE LIST PRIOR TRAMAS, INCLUDING CAR ACCIDENTS, WORK INJURIES, FALSS, ETC.

TRAUMAS	APPROXIATE DATE	TYPE OF TREATMENT

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EMAIL APPOINTMENT REMINDER/ Cancellation policy

I provide consent to receive email notifications including appointment reminders, and office practice updates which may be in newsletter form (less than six per year). **Please initial** the items below stating that you understand how you will see our medical practice name as it relates to your visits.

_____ I understand that all emails sent to me will be from **GAINESVILLE MEDSPA.**

_____ I understand that all receipts, billings & medical records will read **GAINESVILLE MEDSPA.**

____ I understand that all insurance correspondence will show **GAINESVILLE MEDSPA.**

Chiropractic/ Manuel Therapy Soft Tissue Mobilization / Massage / Acupuncture

Appointment Cancellation Policy

A 24-hour notice is required to change or cancel an appointment. Should 24-hour notice not be provided, your credit card will be billed $25.00 for a missed appointment fee.

__________ (Initial)

Manuel therapy soft tissue mobilization, massage and acupuncture *appointments are held* with a **Visa or MasterCard** credit card – no debit cards. No other credit cards or checks are accepted.

__________ (Initial)

This fee is not payable by insurance. I authorize my **Visa or MasterCard** to be billed, in the event that I do not provide 24-hour Notice of Cancellation, in the amount of $25.00.

__________ (Initial)

______________________________ Signature

______________________________ Date

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MY CURRENT INSURANCE COVERAGE AND ANY FUTURE CHANGES

I understand that it is my responsibility to Dr. Leone, DC, and/or assigns (referred to as "Practice") with my most current insurance information. I also understand that if my insurance coverage changes that I must immediately inform the Practice. Failure to do so may result in a significantly higher patient responsibility.

I also understand that if the Practice does not participate with my current or future medical coverage I will be personally responsible for all charges incurred by myself

ASSIGNMENT OF BENEFITS

I authorize my insurer to make payments directly to my doctor. A copy or fax of this authorization may be used in place of the original and shall apply to all bills submitted by Angela Leone, DC and or their assigns.

FINANCIAL OBLIGATIONS & POLICIES

I understand and agree that all professional services rendered shall be charged directly to me and that I am personally responsible for payment. I understand and agree that the Practice will prepare forms to help me obtain benefits from my insurer but that I will be personally liable for my doctor bills unless my doctor notifies me in writing to the contrary.

I agree to make payment in full on all bills within 30 days of services rendered. I understand that any payment, which is 30 days, or more delinquent will be subject to late fees of $20, plus after such date interest at a rate 1.5% per month (or the highest percentage allowed by law) on the unpaid balance. If my doctor does not initially charge any late fees and/or interest I agree to pay all collection agency, credit bureau and/or attorney's fees and costs incurred in any attempt to collect the amount due. I agree to pay all attorney fees and cost incurred by my doctor in any attempt to collect the amount due. I understand that a $2.00 per month statement postage and handling fee will be charged to all unpaid balances.

MEDICAL RECORDS

I understand my original medical records will remain with the Practice as part of my permanent medical record for duration not less than that prescribed by law. I agree that if copies of my records are desired I will provide a written request, minimum of 72 hours advance notice and the prepayment of $1.00 per page.

WELCOMES AND REFERRALS

In an effort to make patients welcome and show our appreciation to patients for their referrals we do post a welcome and thank you board in our reception area. Unless I inform you to the contrary in writing I give the practice my full cooperation and allow them to use my name in this type of acknowledgment.

Print Name of Patient________________ ____Patient Signature____________________ ____Date________________

GUARANTEE (MUST BE COMPLETED FOR ALL UNDERAGE PATIENTS)

The undersigned guarantor(s) guarantee(s) payment of all obligations owed by patient to the doctor.

____________________	____________________	____________________	____________________
Print Name of Guarantor	Relationship	Signature of Guarantor	Date

FORM REQUEST POLICY

There is a $20 charge for forms to be filled out by our office.

Examples (not limited to):

- completed pip mileage forms
- school or work excuse/absence requests

Your required prepayment of $20.00 is non-refundable, non-reimbursable through insurance.

Completed forms are available two days post prepayment, for your pick up located at the office in the white mailbox.

Signature: ______________________________ Date: ________________

Printed name: ______________________________

Circle preferred payment method: credit / cash

Received on: ____/____/______

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Informed Consent for Treatment

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, to include, but not limited to, various modes of physical therapy, diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or associated with, or serving as back-up for the chiropractor named below. I have had an opportunity to discuss with the doctor of chiropractic named below the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that as the practice of medicine, in the practice of chiropractic there are more risks to treatment including, but not limited to, fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then know, is in my best interest. Alternative treatments may include medication, surgery, or physical therapy procedures. As with any of those alternative procedures there are risks. If no treatment is sought, my condition could get worse, remain the same, or improve.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about it's content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition. Any new condition other than that I am being treated for will be explained to me and a new consent will be signed.

____

Patient's Signature Date:

____

Doctor's Signature Date:

To be completed by patient's representative if patient is a minor or is physically or mentally incapacitated.

____

Name of Patient

____

Signature of Patient's Representative Date

__________________________ __________

Relationship to Patient____________________

INSURANCE VERIFICATION FORM

PATIENT NAME: ______________________________

Insured's Name (if different from above)____________________

TYPE OF COVERAGE:

____ Deductible? ☐_____ Amount met? ☐________

____ Co-Payment? ☐_____ VA Federal BS { 104/105 = 30 $
Enrollment Codes { 111/112 = 35 $

****This insurance information was obtained by my insurance company but does not guarantee payment of charges incurred by my and/or my minor child at our office. I understand that all charges are my responsibility whether or not I have insurance coverage by the carrier. Any charges that are not payable by the insurance company are my responsibility. Balance due is an approximation only due to insurance contract. You may be billed if there is a difference in the insurance allowed amount. I authorize the release of my and/or minor child's medical information to the insurance carrier if requested by them.

______________________________________ ____________________
(patient's signature and/or guardian if a minor) (date) (employee initial)

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AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION

TO RELEASE MOTOR VEHICLE CLAIMS INFORMATION, PIP INFORMATION, MEDICAL, PSYCHIATRIC, DRUG USE, ALCOHOL ABUSE, HIV TESTING, ARC, OR AIDS INFORMATION* IN THE RECORDS OF THE PATIENT NAMED BELOW.

I hereby authorize my provider(s)________________________________ to release my personal health information not already excepted by HIPPA or related statutes, or other information as noted below to the part of **GAINESVILLE MEDSPA, PA, 7003 NW 11th Place, Suite 5, Gainesville, Florida 32605** for the purpose of medical treatment for a period commencing on the date below and ending in five (5) years from that date. Release is executed to my current and future healthcare providers.

Review of____

____.

I reserve the right to cancel this authorization by notification in writing except to the extent that action has been taken in reliance on this authorization.

Alcohol and drug abuse information, if present has been disclosed from records whose confidentiality is protected by federal law. Federal regulations 42 CPR Part II prohibits making any further disclosure of it without the specific written consent of the undersigned, or as otherwise permitted by such regulations. HIV testing, ARC, and/or AIDS related diagnosis is further prohibited from further disclosure by state regulations without the specific written consent from the patient.

Affirmed by the patient,

PRINTED NAME____

SIGNATURE ____

DATE ________________________

SOCAL SECURITY NUMBER _______________-__________-__________

*Any of the categories above may be deleted my marking through. Please email records to: leoneINJURY@gmail.com or forward by postal mail to our office, see address above.

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PAIN ASSESSMENT

Aggravated by:	
☐ Coughing	☐ Reaching
☐ Sneezing	☐ Lifting
☐ Straining	☐ Bending
☐ Neck Movement	☐ Sitting
☐ Standing	☐ Walking
	☐ Other

Name ______________________________ Date __________

Extreme Pain

10
9
8
7
6
5
4
3
2
1
0

No Pain

____

____

____