Coastal Spine and Rehab Center

13910 Fivay Rd. • #10 • Hudson, Florida 34667 •
Ph 727-862-3509 Fax 727-862-3500

Registration

Patient Information

____ ______________
(First, Middle, Last Name) *(Date of Birth)*

____ ______________
(Address) *(City, State, Zip Code)*

__________________ __________________ __________________
(Home Telephone Number) *(Work Telephone Number)* *(Cell Telephone Number)*

______________________________ ______________________
(E-mail) *(Social Security Number)*

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Sex: ❑ Male ❑ Female

Employment Status: ❑ Employed ❑ Part-time Student ❑ Full-time Student ❑ Other

Contact me for my next appointment by: Email / Text / My Cell Mobile provider is: ____________

Employment Information

______________________ ______________________________
(Occupation) *(Employer)*

____ ______________
(Address) *(City, State, Zip Code)*

Spouse Information

____ ______________
(Name) *(Date of Birth)*

______________________ ______________________________
(Social Security Number) *(Occupation)*

______________________________ ______________________
(Employer) *(Employer Phone Number)*

Responsible Person (If Applicable)

______________________________ __________ ______________
(Name) *(Date of Birth)* *(Relationship to Patient)*

____ ______________
(Address) *(City, State, Zip Code)*

__________________ __________________ __________________
(Phone Number) *(Social Security Number)* *(Occupation)*

______________________________ ______________________
(Employer) *(Employer Phone Number)*

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Relative to Contact in Case of Emergency (Not Living in Home of Patient)

_______________ *(Name)* _______________ *(Phone Number)* _______________ *(Relationship to Patient)*

_______________ *(Address)* _______________ *(City, State, Zip Code)*

Insurance Information

_______________ *(Name)* _______________ *(Date of Birth)* _______________ *(Relationship to Patient)*

_______________ *(Insurance Company)* _______________ *(Group Number)* _______________ *(ID Number)*

_______________ *(Address)* _______________ *(City, State, Zip Code)*

How were you referred to our office?

- ❑ By an Attorney
- ❑ By a Doctor
- ❑ By a Patient
- ❑ Other

Please print the name of your source below.

____

Is your illness or injury related to any of the following?

- ❑ Employment
- ❑ Emergency
- ❑ Accident
- ❑ Auto Accident

If Auto Accident, please print the state where the accident occurred below

____

Pregnancy Release

This is to certify that to the best of my knowledge, I am not pregnant and the above doctor and his/her associates have my permission to perform an X-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: _______________________________

Signature: _________________________________ Date: ________________________

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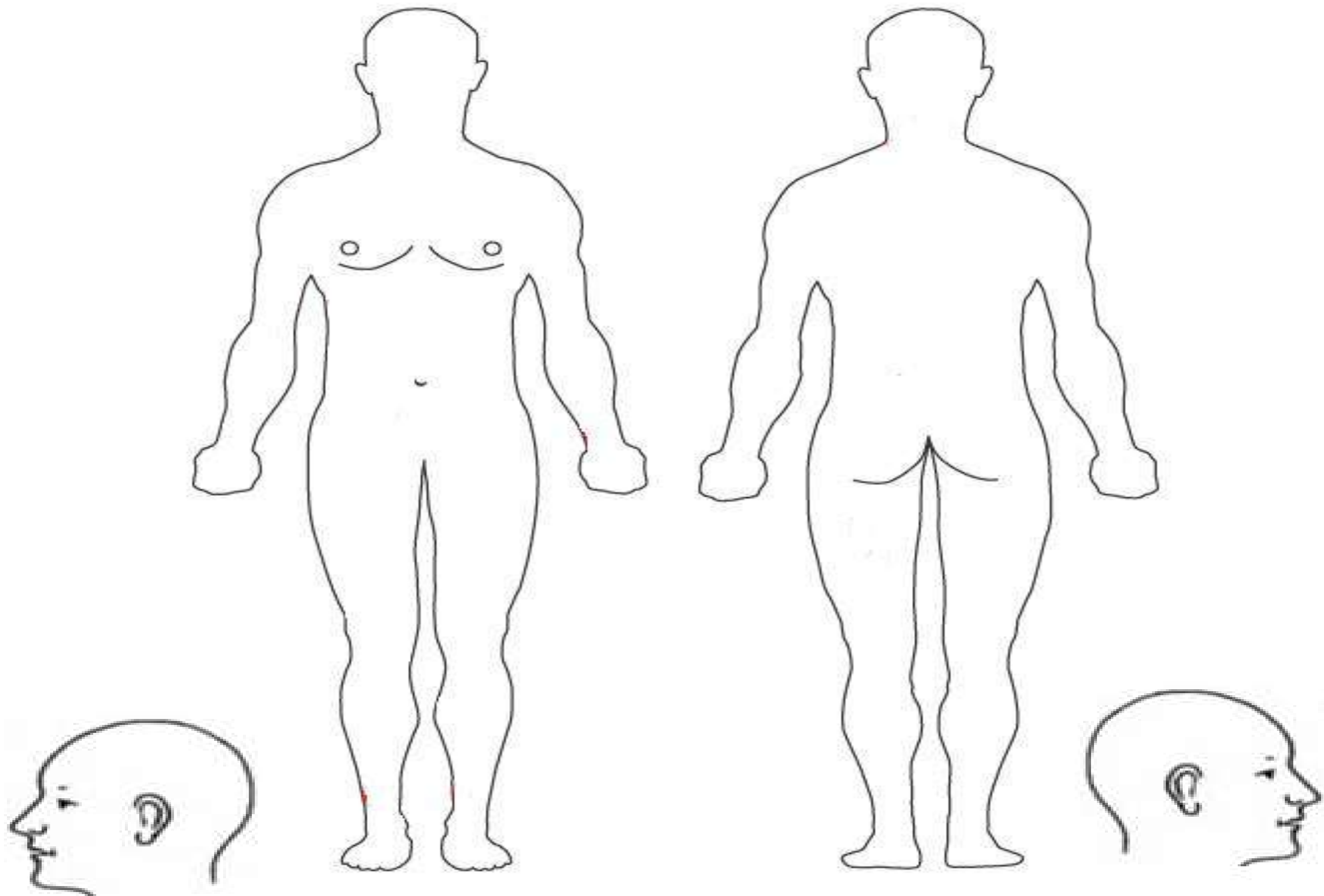
Place an **"X"** on the drawing below on areas causing you pain and a letter describing it.

A- Ache **B**- Burning **S**- Stabbing **N**- Numbness **P**- Pin and Needles



Pain Scale

Please circle the number that best describes your pain

0	1	2	3	4	5	6	7	8	9	10
	None			Little			Medium			

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Medical Family History

Do you have chest pain?	Yes	No
Do you have indigestion?	Yes	No
Do you have headaches for hours or days?	Yes	No
Do you have blurred vision?	Yes	No
Do you have pain in neck, jaw or face?	Yes	No
Do you have vertigo (dizziness)?	Yes	No
Do you have any visual disturbances?	Yes	No
Do you have any ringing in your ears?	Yes	No
Do you pass out easily (faint)?	Yes	No
Do you take birth control pills?	Yes	No
Do you have a history of stroke in your family?	Yes	No

What prescription medication are you taking if any?
( ) High blood pressure medication
( ) Blood thinners
( ) Other____
( ) List allergies or adverse reactions to medications _______________________________________

Have you ever had cancer?	Yes	No
Does your pain ever wake you from a sound sleep?	Yes	No
Have you had any loss of bladder or bowel control?	Yes	No
Have you lost consciousness or had double vision recently?	Yes	No
Are you seeing any other doctor now for any reason?	Yes	No

Note: ____

Are you taking any medications or over-the-counter drugs?	Yes	No

Please indicate type (aspirin, etc.) ____
What was the date of your last menstruation? ____

SOCIAL HISTORY
SMOKER ____YES or ____NO, If Yes, How many packs______________________
ALCOHOL ____YES or ____NO, If Yes, How much__________________________

FAMILY HISTORY
Did you or your mother or father have any of the following:
Put an **S** for self**, M** for mother, **F** for father, and **A** for all

( ) High Blood Pressure	( ) Ulcer or Stomach Problems	( ) HIV Positive
( ) Heart Attack	( ) Stroke	( ) Pacemaker
( ) Emphysema	( ) Arthritis-Rheumatism	( ) Thyroid Disease
( ) Seizures-Convulsions	( ) Mental Illness	( ) Circulation Problems
( ) Asthma	( ) Diabetes	( ) Cancer
( ) Kidney Disease	( ) Osteoporosis	

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ACKNOWLEDGMENT OF RECEIPT OF HIPAA PRIVACY NOTICE

I, ________________________________, have received a copy of this office's Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the health care providers who may be directly and indirectly involved in providing my treatment.

Obtain payment from third-party payers.

Conduct normal health care operations such as quality assessments and accreditation.

____
Patient

____
Signature

____
Date

For Office Use Only

We attempted to obtain written Acknowledgment of receipt of our Notice of Privacy Practices, but Acknowledgment could not be obtained because:

- ☐ **Individual refused to sign**
- ☐ **Communications barriers prohibited obtaining the Acknowledgment**
- ☐ **An emergency situation prevented us from obtaining Acknowledgment**
- ☐ **Other (Please Specify)**

____
____

____
Staff signature **Date**

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Acknowledgement of Services

I, ____________________________, hereby acknowledge that I am receiving (or I am about to receive) health care services at **Coastal Spine and Rehabilitation Center LLC**. I have been advised that the doctor providing the services is willing to wait for payment for these services, provided that there continues to be a reasonable chance that payment will be made either by insurance proceeds **or** out of the settlement of a liability claim.

I understand and agree to pay for my services rendered on a current basis if it is determined that: ***1) there is no insurance company obligated to pay for these services...***
2) the insurance company involved refuses to acknowledge an assignment to the doctor or
make other provisions for the protection of the interest of the doctor...
3) a liability claim exists, but my attorney refuses to agree to protect the interest of the doctor...
4) I have not engaged the services of an attorney...

Also, I understand and agree to pay my bill in full as soon as my Insurance denies my claim**,** my liability claim is settled or within three months of my last treatment, whichever occurs first.

Dated the ___________ day of ________________________, __________
(day of month) (month) (year)

____________________________________ ____________________________________
(patient/insured signature) (witness)

Insurance Assignment

In consideration of services to be rendered, I hereby assign and transfer to **Coastal Spine and Rehabilitation Center** any benefits payable to or for my benefit under hospitalization, sickness or accident insurance, and any other insurance coverage, to include major medical or PIP (Personal Injury Protection) for the payment of such services rendered. I agree to cooperate, aid and assist **Coastal Spine and Rehabilitation Center** in procuring all possible insurance benefits including initiation and fulfillment of all policy provisions such insurance companies may require for payment.
I further assign and transfer to **Coastal Spine and Rehabilitation Center** an interest in any cause of action I may have arising out of injuries directly or indirectly resulting in this period of treatment. This assignment includes insurance benefits occurring to me under uninsured motorist coverage.
If a Medicare patient, I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I request that payment of authorized benefits be made in by behalf.

____________________________________ ____________________________________
(patient/insured signature) (date)

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Financial Responsibility Statement

Insurance is a way for you to receive repayment for fees you have paid to a physician for services rendered. Having insurance is not a substitute for payment even though insurance companies have a fixed allowance or percentage based on your policy with them, **your policy is with your insurance company, not with this office**!

It is your responsibility to provide payment *for* the deductible, co-insurance, and any other balances not paid for by your insurance.

We will assist you in receiving reimbursement in any way possible, but you are ultimately responsible for the payment of your bill.

Primary Insurance ____________________ Effective Date __________________

Address ______________________________ City/State/Zip ___________________

Policy # ____________ Group # __________ Phone # ________________________

Insured _______________________________ Relationship to Insured ___________

Secondary Insurance ___________________ Effective Date __________________

Address ______________________________ City/State/Zip ___________________

Policy # ____________ Group # __________ Phone # ________________________

Insured _______________________________ Relationship to Insured ___________

I authorize the release of all medical records needed to process this clam and that is pertinent to my medical care I assign all medical and/or surgical benefits, including major medical benefits to which I am entitled, to **Coastal Spine and Rehabilitation Center LLC**. This agreement will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

I ASSUME FINANCIAL RESPONSIBILITY FOR ALL CHARGES. I HAVE READ THE ABOVE INFORMATION AND UNDERSTAND IT.

Patient: _______________________________ _______________________________
(If patient is a minor a parent's signature is required) (responsible party)

_________________________________ _________________________________
(witness) (date)

AUTHORIZATION TO OBTAIN PIP BENEFITS PAYOUT INFORMATION

Name of Insurer:
PIP Policy Number:
Name of Insured:
Date of Accident:

I, ___________________________, hereby authorize and direct _____________________ to send to **Coastal Spine & Rehabilitation Center LLC** an accounting of payouts made under all claims submitted for payment under the above referenced policy relating to the automobile accident occurring on the above referenced date as those payouts occur.

____ ______________________________
(Signature of Insured) (Date Signed)

Address of Insured:
____
____
____
____

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Informed Consent for Chiropractic Care

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. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (the spine) and function (the nervous system) as that relationship may affect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system s called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. A Chiropractic adjustment is the specific application of forces to correct and/or reduce the vertebral Subluxation. Our Chiropractic methods are very specific and usually done by hand, however they may be performed by handheld instruments also. In addition, ancillary procedures such as physiotherapy and/or rehabilitation procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept Chiropractic care on this basis.

Print Name___________________________Signature______________________________

Date ___________________________________

Consent to Evaluate and Adjust a Minor Child

I, ____________________________________ being the parent or legal guardian of
Signature of Parent/Guardian
____________________________________ have read and fully understand the above
Informed name of minor or child
Consent and hereby grant permission for my child to receive Chiropractic care.

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Personal Injury / Auto Accident Patient Information

Date of Loss: ______________

Patient: ______________________________________Insured: __________________________

Home Address: ____

____

D.O.B. ______________

Auto Insurance Information

Claim #:____

Insurance Co: _______________________________Policy #: __________________________

Ins. Phone #: _______________________________

Claim Address: _______________________________

____

Adjuster Name: _______________________________Adjuster Phone #: __________________

Auto Coverage Information

PIP Coverage: _______________________________Deductible: ________________________

Med Pay / UM: _______________________________Bodily Injury: ______________________

In File Copy of

Ins. Card Front: ____ Back: ____ Driver's Lic. ____ Accident Report: ____

Prior Medical Records: ____ If None: ____ L.O.P. ____

Attorney Information

Office: ____

Attorney: _______________________________________

Address: ____

Phone: ____Fax: ____________________________

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OFFICE OF INSURA[illegible] REGULATION
Bureau of Property & Casualty Forms and Rates

Standard Disclosure and Acknowledgement Form
Personal Injury Protection - Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

1. The services or treatment set forth below were **actually rendered.** This means that those services have **already been provided.**

   Initial examination, diagnostic testing, prescription for further testing and initial physiotherapy's were provided.

2. I have the right and the **duty to confirm** that the services have already been provided.
3. I was **not solicited** by any person to seek any services from the medical provider of the services described above.
4. The medical provider has **explained** the services to me for which payment is being claimed.
5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to $500.

Insured Person (patient receiving treatment or services) or Guardian of Insured Person:

Name *(PRINT or TYPE)*	Signature	Date

The undersigned licensed medical professional or medical director, if applicable, affirms the statement numbered 1 above and also:

A. I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.

B. The treatment or services rendered were explained to the insured person, or his or her guardian, **sufficiently** for that person to sign this form with informed consent.

C. The accompanying statement or bill is **properly completed** in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to **truthfully, accurately**, and in a **substantially complete** manner.

D. The coding of procedures on the accompanying statement or bill is proper. This means that **no service has been upcoded, unbundled**, or constitutes an invalid **or not medically necessary diagnostic test** as defined by Section 627.732(14) and (15), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Licensed Medical Professional Rendering Treatment/Services or Medical Director, if applicable *(Signature by his/ her own hand):*

Pablo M. Rivera, DC		
Name *(PRINT or TYPE)*	Signature	Date

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of Claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234(1)(b), Florida Statutes.

Note: The **original** of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may **not** be electronically furnished. Failure to furnish this form may result in non-payment of the claim.