Wolstein Chiropractic & Sports Injury Center
Dr. Karen Wolstein, D.C, M.S .
32976 US Hwy 19 N. Plam Harbor, FL. 34684
P: 727-787-6677 F: 727-787-1177

Date of Injury: _____

A. Patient Information

Name: _____ D.O.B: _____
Today's Date: _____ Home/Cell Phone: _____
Address: _____
City: _____ State: _____ Zip Code: _____
E-mail: _____
Sex: Male☐ Female☐ SS#: _____ ☐ Married☐ Widowed☐ Single☐ Divorced
Employer/School: _____ Occupation: _____
Address: _____ Phone: _____
Duties/Activities (bending, squatting, stretching, sitting, lifting, etc) _____
_____
_____.
Emergency Contact: _____ Phone: _____
Primary Care Physician: _____ Phone: _____

Parent or Legal Guardian Informaiton (if applicable)

Mother's Full Name: _____ Father's Full Name: _____
If not the parent/legal guardian, please explain you relationship to patient: _____
_____.

B. Past Medical History

___ Diabetes	___ High Blood Pressure	___ Heart Disease
___ Asthma	___ Bronchitis/Emphysema	___ Seizure History
___ Hypo/Hyper Thyroid	___ Rheumatoid Arthritis	___ Cancer: Type _____
___ Ulcers	___ Hepatitis	___ Heart Attack
___ Blood Clots	___ HIV/AIDS	___ Other: _____

C. Past Surgical History

List any past surgeries you had: _____
_____
_____.

D. Current Medications: List all medications you are taking NOW

Medication	***Doseage***	***Frequency***	***Reason***
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are you allergic to any medications? Yes ___ No ___
If yes, please list: _____
_____

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Patient/Guardian Name(sign): _____
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E. Family History

Has anyone in your family had an adverse reaction to anesthesia? Y _____ N _____
Has anyone in your family had a history of alcoholism? Y _____ N _____
Has anyone in your family had a history of drug addiction? Y _____ N _____

F. Social History

Do you smoke tobacco? Y___ N ___ How much/packs per day? _____ How long/years? _____
Do you drink alcohol? Y ___ N ___ How many drinks per day? _____ How long/years? _____
Do you use illegal drugs? Y ___ N ___
these may interact with medication(s) we prescribe so we must know
Have you had a history of alcohol abuse? Yes ___ No ___ drug abuse? Yes ___ No ___
Has anyone in your family had a history of alcoholism and/or drug abuse? Yes ___ No ___
Has anyone in your family had an adverse reaction to anesthesia? Yes ___ No ___

Do you have any problems related to the following?

Neurological	*Gastrointestinal*	*Respiratory*	*Hematology/Lymphatic*
Tremors	Abdominal Pain	Frequent Cough	Blood Clots
Dizzy Spells	Nausea/Vomiting	Shortness of breath	Easy Bleeder

Cardiovascular	*Musculoskeletal*	*Psychological*	*Genitourinary*
Chest Pain	Joint Pain	Depression	Urine Retention
High B.P.	Muscle Aches	Bi Polar Disorder	Bladder Control Loss
Heart Failure	Fibromyalgia	Schizophrenia	UTI

Other medical conditions not already mentioned: _____
_____
_____

G. Pain Survey

Please check any of the following that pertain to your pain(s)

1. Neck Pain ___
Ache ___ Burning ___ Sharp ___ Tightness ___ Other _____
Does pain travel to left arm? ___ right arm? ___
Do you have pins & needles in your left arm? ___ right arm? ___
Do you have numbness in your left arm? ___ right arm? ___
Do you have previous injuries to your left neck? ___ right neck? ___

2. Upper Back
Ache ___ Burning ___ Sharp ___ Tightness ___ Other _____

3. Mid Back Pain
Ache ___ Burning ___ Sharp ___ Tightness ___ Other _____

4. Low Back Pain
Ache ___ Burning ___ Sharp ___ Tightness ___ Other _____

Does the pain travel to either buttock or leg? left leg / buttock ___ right leg / buttock ___
Do you have pins & needles in your buttock or leg? left leg / buttock ___ right leg / buttock ___
Do you have numbness in you buttock or leg? left leg / buttock ___ right leg / buttock ___
Do you have any previous injuries to your low back? right side ___ left side ___

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J. Pain Survey Continued:

Please check any of the following that pertain to your pain(s)

5. Headaches Yes ___ No ___

Location: Temporal ___ Front of head ___ Back of head ___ All of head ___

Describe headache: Dull ___ Tension/Pressure ___ Sharp ___ Other _____

Frequency of headache: Rarely ___ Sometime ___ Every day ___ Constant ___

6. Do you have any of the following:

Dizziness ___ Change of vision ___ Passing out ___ Nausea/Vomiting ___

Additional symptoms: _____

7. Joint Pains:

Shoulders: right ___/left___ Elbows: right___/left___ Wrists: right ___/left ___ Fingers ___

Hips: right___/left___ Knees: right___/left___ Ankles: right___/left___ Toes ___

8. Jaw Pain: Right or Left:

Popping ___ Clicking ___ Stiff/Tight ___ Spasmodic ___

9. Additional area(s): _____

Ache ___ Burning ___ Sharp ___ Other _____

Describe the pain of eache area: Radiating, Sharp, Dull, Tight, Ache, Spasmodic, etc.)

_____

_____

_____

10. Does anything lessen your pain? Yes ___ No ___

Please explain: _____

11. Does anything worsen your pain? Yes ___ No ___

Please explain: _____

12. Additional comments: _____

_____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Wolstein Chiropractic & Sports Injury Center, or insurance company, to release information required to process my claims.

Patient/Guardian Name(print): _____

Patient/Guardian Name(sign): _____

Date: _____

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PATIENT/PHYSICIAN AGREEMENT

Failure to follow physician orders:

"Physician Orders" are meant to improve and/or resolve the patient's medcal condition and/or symptoms. The patient is expected to follow orders given. In the event the patient does not follow given orders, the patient may be dischharged from the treating physician care and /or facility, from any injury or illness claim resulting from the patient's failure to follow orders. Not following orders given can include but not limited to missing/postponing appointments or refusal of making scheduled apoointments. I grant consent to Wolstein Chiropractic & Sports Injury Center to use and disclose my potected health information for the purposes of diagnosing or providing treatment and conducting surgical operations. I understand that the diagnosis and treatment of my, by Wolstein Chiropractic & Sports Injury Center, may be conditioned upon my consent, as evidence by my signature on this document.
I have read, understand and agree to the above.

Patient/Guardian Signature: _____ **Date:** _____

Prescription Refills:

Please don't wait until you run out of medicine to call for a refill. In fact, call at least 2 days ahead to protect yourself. Your doctor must review your medical file before remewing a prescription. Please do not call for refills after hours or on weekends when records are unavailable. It can take up to 48 hours after you call before the doctor can review your file and call in prescriptions. The files are reviewed and presscriptions are called to pharmacies at the end of the office hours, after all patients have been seen. By law, doctors cannot order certain narcotics over the phone; a written prescription is required in those cases.
I have read, understand and agree with the above.

Patient/Guardian Signature: _____ **Date:** _____

Medical Records:

Your records are kept in strict confidence as part of our permanent file. We will release copies only if we have your written permission. We prefer to mail copies of records, but are willing to give them to you in person, if hand-carry time is critical. Please give us at least 48 hours notice prior to picking up records as it does take some time to get them together. My protected health information includes demographic information which is collected from me, created or received by my physician and or other health care provider, and my employer. This protected information relates to my past, present, and future physical and mental health ondition(s).
I have read, understand and agree with the above.

Patient/Guardian Signature: _____ **Date:** _____

Statement of finacially responsibility:

I, the undersigned, realize that all medical and surgical charges incurred by me or my dependent(s) are my financial responsibility. All court fees, attorney fees, and other fee(s) necessary to collect theis amount are payable buy me.
I have read, understand, and agree with the above.

Patient/Guardian Signature: _____ **Date:** _____

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NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used/disclosed and how you can get access to this information. Please review this carefully.

At Wolstein Chiropractic & Sports Injury Center, we have always kept your health information secure and confidential. The Health Insurance Portability & Accountability Act that requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice. The law permits us to use or disclose your health information to those involved in your treatment. For example, reviews of your file by a specialist doctor whom we may involve in your care. We may use or dosclose your health information for payment of you services. For example, we may send a report of your progress to your insurance company.We may use or disclose your health information for our normanl healthcare operations. For example, one of our staff will put your personal information into our computer system. We may use your personal information to contact you. For example, we may send you newsletters or other information. We may also want to call and remind you about upcoming appointments with us. If you don't answer we may leave this information on your voicemail or with another person that answers the call. We may release some or all of your health information when required by law. If this practice is sold, your information will become the property of the new owner.

Except as described above, this practice will not use/disclose your health information withour your prior written authorization. You may request in writing that we do not use/disclose your health information as described above. We will let you know if we can fulfill that written request.

You have the right to transfer copies of your health information to another practice. We will mail, fax, or email your files for you. You have the right to receive a copy of your health infromation, with a few exceptions. Please provide us with a written request regarding the information you want to have copied. If necessary, we may charge you a resonable fee for these copies.

You have the right to amend your health information. Please provide a written request to make these changes. If you wish to include a statement in your file, please provide it to us in writing. We may or may not make the changes you request but will include your statement in your personal file. If we agree to amend or change your information, we will neither move nor alter earlier documents, but we will add the new information.

You have the right to receive a copy of this notice at any time upon request.

If we change any details of this notice, we will notify you in writing.

You may file a complaint with the Department of Health and Human Services at 200 Independence Avenue SW, Room 509F, Washington, D.C. 20201. You will not be retaliated against for filing a complaint.

Acknowledgement: I have read, understand, and agree with the above Notice of Privacy Practice.

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Patient/Guardian Name(sign): _____

Date: _____

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AUTHORIZATION TO RELEASE RECORDS:

ATTENTION MEDICAL RECORDS DEPARTMENT

Physician: _____

Medical Facility: _____

Phone: _____

Fax: _____

Please release all records, radiology/diagnostic reports and any results pertaining to any and all treatment rendered to the following patient.

Patient Name: _____

DOB: _____ /_____ /_____

Social Security Number: _____ - _____ - _____

Thank You,

Patient/Guardian Name(print): _____

Patient/Guardian Name(sign): _____

Date: _____

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OFFICE POLICIES

Insurer and Patient please read the following in its entirety carefully!

The following is an explanation of our clinic policies. We believe that a clear definition will allow us both to concentrate on the most important issues: REGAINING AND MAINTING YOUR HEALTH.

Appointments & Scheduling:

In order to better serve our patients we ask that you call if you are unable to make your appointment or if you will be late. Your appointment time is reserved for you. If you fail to notify our office, it leaves a time slot open that could be used to help another patient. If you are scheduled for a massage and are more than 5 minutes late, you may ot be able to get your massage. This will depend on the scheduling of other patients. Please try to arrive earlier than your scheduled time. To schedule, cancel, or change appointments, you must call the office at: 727-787-6677.

If you are unable to keep you appointment, please call. Late arrival may necessitate rescheduling your appointment or missing out on therapies. If a patient fails to keep an appointment and does not call within 24 hours to cancel, a $25 fee will be applied to their bill.

Patient Payment Policy:

We fee the patient's health needs are paramount. The following payment policy is an attempt to allow you, the patient, to receive the care you need with the least amount of difficulty. Balances must be kept under $100 on a weekly basis. **Payment is due at the time of service.**

Cell Phone Policy:

We ask that while in the office you refrain from using your cell phone. If a call is important and you "must" take it, please understand that the doctor will bypass you for the next ready patient, so that we don't delay others. You will then be the next patient to be seen by the doctor. We also ask that you wait to place your scheduled appointment in your phone until you are away from the reception desk. This will allow others to check out and this will comply with HIPPA standards.

Health Insurance Policy:

Today most insurance policies do cover chiropractic care but may not cover all treatments offered in our office. We will be happy to file your primary insurance claim and do everything we can to ensure that you receive proper reimbursement. We cannot take responsibility for what your health insurance will or will not cover. If your policy has a deductible, then we suggest you pay this amount at the onset of your care. Payments for services are neither implied nor agreed to by our office. *Our office takes no responsibility for non-payment by insurance companies for services rendered.*

I agree that my account with Wolstein Chiropractic & Sports Injury Center is my responsibility. I agree to standby any balance that has gone unpaid over 60 days. If I default on my account, I agree to pay all costs of collections, including collection agency fees and /or reasonable attorney's fees. Furthermore, I understand that these prodedures and fees are subject to change without prior notice. I understand and agree to the conditions of this policy.

Patient/Guardian Name(print): _____

Patient/Guardian Name(sign): _____

Date: _____

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It is our policy to retain a payment method prior to all CASH massage visits.
If you are unable to keep your appointment, please call. Late arrival may necessitate rescheduling and missing out on therapies. If a patient does not call to cancel and does not show for an appointment, 100% of the service will be charged to the payment method on file. If you give a same day cancellation, you will be charged 50% of the service. If you cancel with 24 hours of service, no charge will be given to on file payment method.

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We ask that while in the office you refrain from using your cell phone. If a call is important and you "must" take it, please understand that the doctor will bypass you for the next ready patient, so that we don't delay others. You will then be the next patient to be seen by the doctor. We also ask that you wait to place your scheduled appointment in your phone until you are away from the reception desk. This will allow others to check out and this will comply with HIPPA standards.

Groupon Massage Policy:

You may cancel your appointment up to 24 hours preceeding your scheduled time. Same day cancellations and no shows will not be rescheduled and you will have to get a refund from Groupon.

I agree that my account with Wolstein Chiropractic & Sports Injury Center is my responsibility. I agree to stand by any balance that has gone unpaid over 30 days. If I default on my account, I agree to pay all costs of collections, including collection agency fees and /or reasonable attorney's fees. Furthermore, I understand that these prodedures and fees are subject to change without prior notice. I understand and agree to the conditions of this policy.

Patient/Guardian Name(print): _____
Patient/Guardian Name(sign): _____
Date: _____