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

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. Health Insurance Information:

Insurance Company: ______________________________________
Insured's Name: ______________________ D.O.B: ________ SS#: ______________
Insured's address (if different from above) ______________________
City: ______________________ State: ________ Zip Code: ______________
Member ID #: ______________________ Group #: ______________
Insurance Address : ______________________________________
City: ______________________ FL: ________ Zip: ______________

C. Do you have secondary insurance?

If yes, please provide name: ______________________________________

D. Is this visit due to any accident and/or injury? Yes ___ No ___

If yes, please explaine: ______________________________________
____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I unde4rstand 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: ______________________________________

E. 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: ______________

F. Past Surgical History

List any past surgeries you had: ____
____
____.

G. 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 _____

H. 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

I. 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: ____
____

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

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

J. 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 ___

5. Headaches Yes ____ ***No*** ___

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

Describe Headache: Dull ___ Tension/Pressure ___ Sharp ___ Other ______________________

Headache Frequency: Rarely ___ Sometimes ___ Every day ___ Constant ___

6. Do you have any of the following:

Dizziness ___ Change of vision ___ Passing our ___ 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:

Popping: right___/left___ Clicking: right___/left___ Stiff/Tight: right___/left___

Spasmodic: right___/left___

9. Additional area(s): ____

Ache: ____ Burning: ____ Sharp: ____ Other: ____

Describe the pain in each area: Radiating, Sharp, Dull, Tight, Ache, Spasmodic, etc.

____

____

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 Chiropactic & Sports Injury Center, or the insurance company, to release information required to process my claim(s).

Patient/Guardian Name(print): ____

Patient/Guardian Name(sign): ____

Date: ____

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

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:** ____________________

PATIENT/PHYSICIAN AGREEMENT CONT

Confidentiality:

The physician will diagnose you illness according to your complaints, symptoms, test results, and medical history. In order to treat the patient appropriately, the patient understands and authorizes the treating physician and/or facility to obtain any and all medical records relating to the patient and to communicate with previous physicians by a method that can assist with the care of the patient.
I have read, understand, and agree with the above.

Patient/Guardian Signature: ______________________________ Date: ____________________

Individual Patient Authorization:

Name the people and/or organization and their relationship to you that you authorize to use and/or disclose your personal health information:

____
____
____

Irrevocable Medical Lein:

I hereby authorize any and all parties, including any insurance company and my attorney (if applicable), to pay directly to Wolstein Chiropractic & Sports Injury Center sums as may be due and owed for medical services rendered to me. Such sums may be withheld from any settlement, judgement, or verdict as may be necessary to adequately protect Wolstein Chiropractic & Sports Injury Center. If applicable, I also authorize my attorney to release any and all information without limitation regarding any legal proceedings, judgements, or settlements that will aide in the recovery of Wolstein Chiropractic & Sports Injury Center upaid sum(s).

I fully understand that I am directly and fully responsible to Wolstein Chiropractic & Sports Injury Center for all medical bills incurred by me, for services rendered, in consideration of awaiting payment. I further understand that such payment is not contingent on any settlement, judgement, or verdict by which I may eventuallu recover said fee(s).

I hereby give my authorization to Wolstein Chiropractic & Sports Injury Centr to record a Uniform Commercial Code Form (UCC-1) to protect this medical lien and to send my unpaid sum to the Tortfeasor. I have read, understand, and agree with the above.

Patient/Guardian Signature: ______________________________ Date: ____________________

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

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.

Patient/Guardian Name(print): ____

Patient/Guardian Name(sign): ____

Date: ____

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

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: ____

OFFICE POLICIES

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

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 $50 fee will be applied to their bill.

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: ______________________________