Fogarty Chiropractic Life Clinic

Kevin Fogarty, D.C., F.I.C.A. (Hon)

Megan Traficante, D.C.

Please fill in below:

Name:______________________________ Date:____________

Address:______________________ Apt:_____ City, State:____________ Zip:_______

Home Phone:______________ Work Phone:______________ Cell Phone:______________

Gender: M___ F___ Date of Birth:______________ Height:__________ Weight:__________

Marital Status: ____________ SS#:______________ Email:______________________

Chief Complaint:____

Mechanism of Injury: ____

____

How long have you had this problem?____

Are you under the care of any other physician? Yes______ No________

If yes, please list the doctors you are seeing and the conditions you are being treated for:

____

____

Please list any medication you are presently taking and the reason for taking it:

____

____

Please list any previous surgeries: ____

____

Please list any accidents, auto accidents, or broken bones in the past:______________________

____

Please list previous imaging: ____

Have you been to a chiropractor before? Yes_________ No ________ Date of last visit:______________

How long were you under care?______________________ Condition treated for:______________________

Name of chiropractor: ____

Your occupation:____

Duties you are required to perform regularly at work or home: ______________________

____

Do you smoke cigarettes? Yes_____ No_______ # of packs per day:______________________

Do you drink coffee? Yes_____ No_______ # of cups per day:______________________

Do you consume alcohol? Yes____ No______ Approximately how much daily? ______________

Do you exercise regularly? Yes____ No_____ What type and how much?______________

Family Health History

Please describe the health of your:

Father: ______________________ Mother: ______________________

Spouse: ______________________ Children, give ages: ______________________

FEMALES: Is there a possibility of you being pregnant? ______________________

Have you EVER had any of the following? Please check:

___ Hay Fever	___ Prostate Problems	___ Heart Disease	___ Venereal Disease	___ Ulcers
___ T.B.	___ Gout	___ Thyroid Trouble	___ Hemorrhoids	___ Epilepsy/Seizures
___ Allergies	___ Pneumonia	___ Cancer	___ Tonsillitis	___ Liver Trouble
___ Polio	___ Pleurisy	___ Gall Bladder Trouble	___ Appendicitis	___ Diabetes
___ Slipped Disc	___ Asthma	___ High Blood Pressure	___ Arthritis	___ Rheumatic Fever
___ Stroke	___ Bowel Trouble	___ Menstrual Problems	___ Hypoglycemia	___ Kidney Trouble

Other: ____

Systems Review

Are you PRESENTLY suffering from any of the following? Please check:

Eyes
- ___ change in vision
- ___ eye pain
- ___watery eyes

Ears
- ___ ear discharge
- ___ impaired hearing
- ___ ear aches
- ___ ringing in ears

Nose
- ___ sinus pains
- ___ nose bleeds

Throat
- ___ blisters in mouth
- ___ problems swallowing
- ___ throat lumps
- ___ sore throat

Cardiovascular
- ___ heart palpitations
- ___ chest pains

Abdominal
- ___ indigestion
- ___ heart burn
- ___ belching
- ___ vomiting
- ___ rectal bleeding
- ___ irritable bowel
- ___ gas
- ___ constipation
- ___ diarrhea
- ___ abdominal pains
- ___ nausea
- ___ change in weight
- ___ swelling

Musculoskeletal
- ___ back pains
- ___ hip pains
- ___ leg pains
- ___ neck pains
- ___ shoulder/arm pains
- ___ other muscle pains
- ___ numbness
- ___ tingling
- ___ joint pains
- ___ swelling of ankles
- ___ swelling of joints

Neurological
- ___ headaches
- ___ balance issues
- ___ fatigue
- ___ weakness

Cognitive
- ___ poor appetite
- ___ poor memory
- ___ insomnia
- ___ inner tension
- ___ nervousness
- ___ personality changes

Pulmonary
- ___ cough
- ___ shortness of breath
- ___ dizziness
- ___ fainting

Urinary
- ___ blood in urine
- ___ frequency of urination
- ___ pain on voiding
- ___ cloudy urine

Skin
- ___ dry skin
- ___ skin discoloration
- ___ itching
- ___ burning
- ___ skin eruptions/rash
- ___ excessive sweating
- ___ bruising

Other *(please list)*

____

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____

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____

Insurance Information

Type of insurance: Regular Medical_____ Medicare____ Medicaid____ Auto_____ Workers Comp_____

Name of Insured: ____ SS# ________________________________

Insured's Date of Birth: ____________________________ Name of Employer: __________________________________

Insurance Company: ____ Phone #: _________________________

Insurance Company Address: ____

Policy # _________________________ Group # ______________________ Claim # ___________________________

I certify to the best of my knowledge, the above information is complete and accurate. I agree to notify this practitioner immediately whenever I have changes in my health condition.

Patient Name: ___________________________________ Date: _________________________________

Signature: _______________________________________ Relation to patient: ______________________

Fogarty
Chiropractic Life Clinic

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Doctor Patient Relationship

Privacy:

The *Standards for Privacy of Individually Identifiable Health Information* ("Privacy Rule") establishes, for the first time, a set of national standards for the protection of certain health information. The U.S. Department of Health and Human Services issued the Privacy Rule to implement the requirement of the ***Health Insurance Portability and Accountability Act*** of 1996 ("HIPAA") A major goal of the Privacy Rule is to assure that individuals' health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care and to protect the public's health and well being.

You can be assured that our clinic takes your privacy seriously and is in compliance with all HIPPA guidelines. Your health information will not be disclosed without your permission or will your name, address or telephone number be disclosed to any third party. Our privacy policy is posted in the reception area and is available at the front desk upon your request.

Questions

Just as in a good marriage, proper communication is an absolute necessity. We want to help you attain your goal of health. If at any time your response is not satisfactory, we will gladly assist you in choosing a referral doctor for another opinion. Your health is our number one priority.

Acknowledgement:

I have read or have had read to me the above consent. I have had the opportunity to ask questions, about its context and by signing below I agree to the above named procedures. I intend this consent to cover the course of treatment for my present condition and for any future condition(s) for which I seek treatment.

I have read and understand the foregoing.

Date______________ Patient Name: ______________________________

Signature: ______________________________

Name of Guardian/Parental and Relationship to Patient: ______________________
Guardian/ Parental Signature: ______________________________

Date______________ Witness: ______________________________

839 Barton Blvd. • Rockledge, FL 32955 • (321) 636-5200 • Fax (321) 639-0418
www.fogartychiropractic.com

Fogarty Chiropractic Life Clinic

839 Barton Blvd.
Rockledge, FL 32955-3127
Phone (321) 636-5200

Electronic Health Records Intake Form

In compliance with requirements for the government EHR Incentive program

First Name:_______________________ **Last Name:**_______________________

Email address: _______________@_______________

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** _______________

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: ________________________________ Date:____________

For office use only

Height: ________ Weight:__________ Blood Pressure:_____/_____

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Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

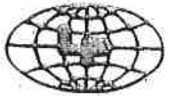
I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: ______________________ Signature: ______________________ Date:

Parent or Guardian: ______________________ Signature: ______________________ Date:

Witness Name: ______________________ Signature: ______________________ Date:

Fogarty Chiropractic Life Clinic



Kevin Fogarty, D.C., F.I.C.A. (Hon)

FINANCIAL RESPONSIBILITY
Lifetime Assignment and Instruction for Direct Payment to Doctor
Private and Group Accident and Health Insurance
Authorization to Release/Request Records

Patient name: ______________________________ SSN: ____________________ Date of Birth: __________

I hereby instruct and direct __________________________ Insurance Company to pay benefits by check made out and mailed to:

FOGARTY CHIROPRACTIC LIFE CLINIC
839 BARTON BLVD.
ROCKLEDGE, FL 32955

The professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional service rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY TO FOGARTY CHIROPRACTIC LIFE CLINIC FOR PAYMENT OF PROFESSIONAL SERVICES RENDERED.** This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. I assign to said clinic all rights patient has under any contract of insurance for collection of same.

This also certifies that the above named individual agrees to pay in full for all professional services rendered at the time they are performed, unless other arrangements are made in advance of the set appointment. The below named guarantor understands a $25.00 returned check fee will be charged along with any appropriate collection or attorney's fee which may accrue upon collection of any outstanding balance.

____
Initials

RECORDS REQUEST

This is to certify that the above named patient authorizes full request of any records pertinent to the health care of same individual from but not inclusive of any insurance carrier, adjustor, attorney, hospital or other health care provider.

This also authorizes Fogarty Chiropractic Life Clinic to release records, upon receipt of the above named patient's signature, or on an emergency basis, to but not inclusive of, any insurance carrier, attorney, health care provider, hospital or immediate family member.

____
Initials

A photocopy of this assignment shall be considered as effective and valid as the original. This document is considered a living document and does not expire.

Privacy: The *Standards for Privacy of Individually Identifiable Health Information* ("Privacy Rule") establishes, for the first time, a set of national standards for the protection of certain health information. The U.S. Department of Health and Human Services issued the Privacy Rule to implement the requirement of the ***Health Insurance Portability and Accountability Act*** of 1996 ("HIPAA") A major goal of the Privacy Rule is to assure that individuals' health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care and to protect the public's health and well being.

You can be assured that our clinic takes your privacy seriously and is in compliance with all HIPPA guidelines. Your health information will not be disclosed without your permission or will your name, address or telephone number be disclosed to any third party.

I have read and understand the foregoing. I have also received a copy of the HIPPA privacy statement and Fogarty Chiropractic Life Clinic's Fee Sheet.

Date____________ Patient/Policyholder______________________________

Date____________ Witness______________________________

Fogarty Chiropractic Life Clinic
839 Barton Blvd.
Rockledge, Florida 32955
(321) 636-5200

UNIVERSAL PATIENT AUTHORIZATION FORM FOR FULL DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT & QUALITY OF CARE

******PLEASE READ THE ENTIRE FORM, BOTH PAGES, BEFORE SIGNING BELOW******

Patient (name and information of person whose health information is being disclosed):

Name (First Middle Last): ______________________________

Date of Birth (mm/dd/yyyy): ______________

Address: ______________________ City: ______________ State: ________ Zip: ________

You may use this form to allow your healthcare provider to see and obtain access to your health information. Your choice on whether to sign this form will not affect your ability to get medical care or health insurance coverage and cannot be used as the basis for denial of health services.

By signing this form, I voluntarily authorize and give my permission and allow disclosure:

OF WHAT: ALL MY HEALTH INFORMATION including any information about sensitive conditions (if any) [See page 2 for details]

FROM WHOM: ALL information sources [See page 2 for details]

TO WHOM: Specific person(s) or organization(s) permitted to receive my information (must be a healthcare provider):

Person/Organization Name: Fogarty Chiropractic Life Clinic Phone: (321) 636-5200

Address: 839 Barton Blvd., Rockledge, FL 32955 Fax: (321) 639-0418

PURPOSE: To provide me with medical treatment and related services, and to evaluate and improve patient safety and the quality of medical care provided to all patients.

EFFECTIVE PERIOD: This authorization/permission form will remain in effect until the day I withdraw my permission.

WITHDRAWING MY PERMISSION: I can withdraw my permission at any time by giving written notice to the person or organization named above in "To Whom."

In addition:

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- I understand that there are some circumstances in which this information may be redisclosed to other persons [See page 2 for details].
- **I understand that refusing to sign this form does not stop disclosure of my health information that is otherwise permitted by law without my specific authorization or permission.**
- **I have read both pages of this form and agree to the disclosures above from the types of sources listed.**

X ______________________________ ______________________
Signature of Patient or Patient's Legal Representative Date Signed (mm/dd/yyyy)

____
Print Name of Legal Representative (if applicable)

Check one to describe the relationship of Legal Representative to Patient (if applicable):

- ☐ Parent of minor
- ☐ Guardian
- ☐ Other personal representative (explain: ______________________)

NOTE: This form is invalid if modified. You are entitled to get a copy of this form after you sign it.

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MEDICAID EXPLANATION SHEET

In order to better understand how Medicaid works, our clinic has prepared this explanation for you. Please read it over carefully, as it will probably save you some misunderstanding. If you still have any questions after reading this sheet, please feel free to ask us.

MEDICAID PAPERWORK

On your first visit, one of our staff will ask to see your Medicaid card. This gives us the basic information that we need in order to process your Medicaid.

Also on this first visit you will be asked to sign an "Assignment of Benefits" sheet from our clinic. This gives us permission to bill Medicaid directly for payment. Without this you would be required to pay the entire bill in full at the time the services are rendered.

WHEN YOU START CHIROPRACTIC CARE

When you first start care in our clinic you may need to have both a spinal examination and spinal x-rays. These services are needed in order to determine the exact nature of your problem and to document the need for additional care. In most instances, our clinic can provide any x-ray services required for your care on the premises.

THE ADJUSTMENT VISITS

Medicaid allows twenty-four adjustment visits per calendar year, providing that you keep your schedule of care. This means that if the recommended schedule of visits is not followed, the twenty-four adjustment visits could be reduced by Medicaid. We will inform you prior to your falling outside of the twenty-four visit guideline Medicaid has set up for reasonable and necessary treatment. However, this is not a guarantee of benefits and you should remain aware of your own enrollment status within the Medicaid program. If Medicaid denies payment, it becomes your responsibility to provide payment for the denied service.

We hope this information will help avoid any confusion so that your care here will be both helpful and healthful. Our clinic will do its utmost to keep you informed of any changes it becomes aware of within the Medicaid system. If you feel the Medicaid system is unjust, please write to your Congress person and air your views to them, as they are the ones who can change Medicaid's policy with your feedback.

I, ______________________________ have read the above information and understand that there may be some services rendered in this office which Medicaid may not pay for. I understand I will be responsible for any services Medicaid does not pay for.

Signed: ______________________________ Dated: ___________________________

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