Fogarty
Chiropractic Life Clinic

LASTING PURPOSE

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

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 doctor (s) 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: _____

For Official Use:

Blood Pressure: _____/_____ Pulse: _____ Temp: _____

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

Females: Is there a possibility of being pregnant? **YES:** _____ **NO:**_____

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 change

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)
_____
_____
_____
_____
_____
_____
_____

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 #: _____
Policy #: _____ Group # _____ Claim #: _____

Emergency Contact:

Name: _____ Phone # _____

Relationship to patient: _____

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: _____

(Revised 07/13/23)

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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: _____ Date of Birth: _____

I hereby instruct and direct my Insurance Company of record to pay benefits by check or electronic payment.

Fogarty Chiropractic Life Clinic
839 Barton Blvd.
Rockledge, Florida 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 preformed, unless other arrangements are made in advance of the set appointment. The below named guarantor understands a $50.00 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 authorized full request of any records pertinent to the health care of same individual from but not inclusive and any insurance carrier, adjustor, attorney, hospital, or other health care provider.

This also authorizes Fogarty Chiropractic Life Clinic to release records, upon receipts 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.

HIPAA

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

I received a copy of the HIPAA Policy

_____
Initials

CONFIDENTIAL COMMUNICATIONS

Use this section to **AUTHORIZE** others who may contact Fogarty Chiropractic Life Clinic to obtain PHI and to communicate with our practice regarding the patient above. For example: Spouse, children, parent, friends, etc.

Authorized User #1: _____ Date of Birth: _____/_____/_____
Relationship to you: _____ Phone#: _____-_____-_____

Authorized User #2: _____ Date of Birth: _____/_____/_____
Relationship to you: _____ Phone#: _____-_____-_____

Select one of the following options

_____ **I AUTHORIZE** Fogarty Chiropractic Life Clinic to leave detailed messages on my answering device.

_____ **I DO NOT AUTHORIZE** Fogarty Chiropractic Life Clinic to leave detailed messages on my answering device.

NO SURPRISES PAYMENT OPTIONS

Fogarty Chiropractic Life Clinic knows how important your health and wellness care are. And it is our top priority to ensure that each patient gets the care they need. We want to make sure that and your family get the best quality of care regardless of insurance high deductible plans, copays, and non-covered services so there are "no surprises".

You have the right to receive a "Good Faith Estimate" explaining how much your medical care will cost. Under the law, health care providers need to give patients who don't have insurance or who are not using insurance an estimate of the bill for medical items and services.

- You have the right to a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescriptions drugs, equipment, and hospital fees.
- Make sure your health care provider gives you a Good Faith Estimate in writing at least 1 business day before your medical service or item. You can also ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service.
- If you receive a bill that is at least $400.00 more than your Good Faith Estimate, you can dispute the bill.
- Make sure to save a copy or picture of your Good Faith Estimate. For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises.

Due to the increased frequency of high deductible insurance plans and out of network policies we offer a discount care program we refer to as our HMA Plan
(Healthcare Made Affordable). This allows us to legally treat our patients at a discounted rate regardless of insurance provider. Ask for more information on your first visit. I received a copy of the Fee Explanation sheet & No Surprise Act. _____
Initials

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

Date: _____ Patient Signature: _____

(Revised 02/3/2023)

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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 prescribed, 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. Please feel free to communicate any discomfort or concern with the doctor.

We may need to conduct diagnostic procedures such as spinal radiographic imaging or to recommend MRI's if indicated. It is important that you inform us if there is any possibility of pregnancy.
Chiropractic care centrally involves what is known as the chiropractic adjustment. 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 joints, and improving neurological functioning and overall well-being.

Treatment recommendations may include the use of modalities including but not limited to: intersegmental traction, cold laser therapy, massage therapy, trigger point therapy or ice as part of your care

Decompression therapy. Spinal decompression is a non-invasive and non-surgical therapy which addresses the intervertebral discs. I understand that spinal decompression treatment is designed to alleviate certain symptoms through a conservative approach with hopes to avoid a more invasive procedure.

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.

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: _____