



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: _____

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

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

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

Other: _____

Systems Review

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

- | | | | | |
|--|---|---|---|--|
| Eyes: | Cardiovascular: | Musculoskeletal: | Cognitive: | Skin: |
| <input type="checkbox"/> change in vision | <input type="checkbox"/> heart palpitations | <input type="checkbox"/> back pains | <input type="checkbox"/> poor appetite | <input type="checkbox"/> dry skin |
| <input type="checkbox"/> eye pain | <input type="checkbox"/> chest pains | <input type="checkbox"/> hip pains | <input type="checkbox"/> poor memory | <input type="checkbox"/> skin discoloration |
| <input type="checkbox"/> watery eyes | Abdominal: | <input type="checkbox"/> leg pains | <input type="checkbox"/> insomnia | <input type="checkbox"/> itching |
| Ears: | <input type="checkbox"/> indigestion | <input type="checkbox"/> neck pains | <input type="checkbox"/> inner tension | <input type="checkbox"/> burning |
| <input type="checkbox"/> ear discharge | <input type="checkbox"/> heart burn | <input type="checkbox"/> shoulder/arm pains | <input type="checkbox"/> nervousness | <input type="checkbox"/> skin eruptions/rash |
| <input type="checkbox"/> impaired hearing | <input type="checkbox"/> belching | <input type="checkbox"/> other muscle pains | <input type="checkbox"/> personality change | <input type="checkbox"/> excessive sweating |
| <input type="checkbox"/> ear aches | <input type="checkbox"/> vomiting | <input type="checkbox"/> numbness | Pulmonary: | <input type="checkbox"/> bruising |
| <input type="checkbox"/> ringing in ears | <input type="checkbox"/> rectal bleeding | <input type="checkbox"/> tingling | <input type="checkbox"/> cough | Other: (Please list) |
| Nose: | <input type="checkbox"/> irritable bowel | <input type="checkbox"/> joint pains | <input type="checkbox"/> shortness of breath | _____ |
| <input type="checkbox"/> sinus pains | <input type="checkbox"/> gas | <input type="checkbox"/> swelling of ankles | <input type="checkbox"/> dizziness | _____ |
| <input type="checkbox"/> nose bleeds | <input type="checkbox"/> constipation | <input type="checkbox"/> swelling of joints | <input type="checkbox"/> fainting | _____ |
| Throat: | <input type="checkbox"/> diarrhea | Neurological: | Urinary: | _____ |
| <input type="checkbox"/> blisters in mouth | <input type="checkbox"/> abdominal pains | <input type="checkbox"/> headaches | <input type="checkbox"/> blood in urine | _____ |
| <input type="checkbox"/> problems swallowing | <input type="checkbox"/> nausea | <input type="checkbox"/> balance issues | <input type="checkbox"/> frequency of urination | _____ |
| <input type="checkbox"/> throat lumps | <input type="checkbox"/> change in weight | <input type="checkbox"/> fatigue | <input type="checkbox"/> pain on voiding | _____ |
| <input type="checkbox"/> sore throat | <input type="checkbox"/> swelling | <input type="checkbox"/> weakness | <input type="checkbox"/> cloudy urine | _____ |

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: _____

Fogarty Chiropractic Life Clinic



LASTING PURPOSE

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: _____ 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: _____
Relationship to you: _____

Date of Birth: ____/____/____
Phone#: ____-____-____

Authorized User #2: _____
Relationship to you: _____

Date of Birth: ____/____/____
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: _____

Fogarty

Chiropractic Life Clinic



LASTING PURPOSE

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

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: _____

Fogarty Chiropractic Life Clinic, 839 Barton Blvd., Rockledge, FL 32955 Ph (321) 636-5200 Fax (321) 639-0418

Revised 12/21/2023



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

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 adjustments 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: _____

(Revised 8/18/2021)

Fogarty Chiropractic Life Clinic
839 Barton Boulevard, Rockledge, Florida 32955

Universal Patient Authorization Form for Full Disclosure of Health Information for Treatment and 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/YY): _____

Address: _____ City: _____ State: _____ Zip: _____

You may use this form to allow your healthcare provider to access and use your health information. Your choice on whether to sign this form will not affect your ability to get medical treatment, payment for medical treatment, or health insurance enrollment or eligibility for benefits.

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

OF WHAT: All my health information including any information about sensitive conditions (if any) [See page two for details]

FROM WHOM: ALL information sources [See page two 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 Boulevard, Rockledge, Florida 32955 Fax: (321) 639-0418

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

Effective Period: This authorization/permission form will remain in effect until my death or the day I withdraw my permission.

Revoking My Permission: I can revoke my permission at any time by giving written notice to the person or organization named above in the "To Whom" portion of this form.

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 re-disclosed 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 specific authorization or permission.
- I have read all pages of this form and agree to the disclosure above from the types of sources listed.

Signature of Patient or Patient's Legal Representative

Date _____
(MM/DD/YY)

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): _____

"Universal Patient Authorization for Full Disclosure of Health Information for Treatment & Quality of Care"

Laws and regulations require that some sources of personal information have a signed authorization or permission form before releasing it. Also, some laws require specific authorization for the release of information about certain conditions and from educational sources.

"Of What": Includes ALL YOUR HEALTH INFORMATION, INCLUDING:

1. All records and other information regarding your health history, treatment, hospitalization, tests, and outpatient care. This information may relate to sensitive health conditions (if any), including but not limited to:
 - a. Drug, alcohol, or substance abuse
 - b. Psychological, psychiatric or other mental impairment(s) or developmental disabilities (excludes "psychotherapy notes" as defined in HIPAA at 45 CFR 164.501)
 - c. Sickle cell anemia
 - d. Birth control and family planning
 - e. Records which may indicate the presence of a communicable disease or noncommunicable disease; and tests for or records of HIV/AIDS or sexually transmitted diseases or tuberculosis
 - f. Genetic (inherited) diseases or tests
2. Copies of educational tests or evaluations, including Individualized Educational Programs, assessments, psychological and speech evaluations, immunizations, recorded health information (such as height, weight), and information about injuries or treatment.
3. Information created before or after the date of this form.

"From Whom" Includes: All information sources including but not limited to medical and clinical sources (hospitals, clinics, labs, pharmacies, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, Veterans Affairs health care facilities, state registries and other state programs, all educational sources that may have some of my health information (schools, records administrators, counselors, etc.), social workers, rehabilitation counselors, insurance companies, health plans, health maintenance organizations, employers, pharmacy benefit managers, worker's compensation programs, state Medicaid, Medicare and any other governmental program.

"To Whom": For those health care providers listed in the "TO WHOM" section, your permission would also include physicians, other health care providers (such as nurses) and medical staff who are involved in your medical care at that organization's facility or that person's office, and health care providers who are covering or on call for the specified person or organization, and staff members or agents (such as business associates or qualified services organizations) who carry out activities and purpose(s) permitted by this form for that organization or person that you specified. Disclosure may be of health information in paper or oral form or may be through electronic interchange.

"Purpose": Your signature on this form does NOT allow health insurers to have access to your health information for the purpose of deciding to give you health insurance or pay your bills. You can make that choice in a separate form that health insurers use.

"Revocation": You have the right to revoke this authorization and withdraw your permission at any time regarding any future uses by giving written notice. This authorization is automatically revoked when you die. You should understand that organizations that had your permission to access your health information may copy or include your information in their own records. These organizations, in many circumstances, are not required to return any information that they were provided nor are they required to remove it from their own records.

"Re-disclosure of Information": Any health information about you may be re-disclosed to others only to the extent permitted by state and federal laws and regulations. You understand that once your information is disclosed, it may be subject to lawful re-disclosure, in accordance with applicable state and federal law, and in some cases, may no longer be protected by federal privacy law.

Limitations of this Form: If you want your health information shared for purposes other than for treating you or you want only a portion of your health information shared, you need to use Form Florida AHCA FC4200-005 (Universal Patient Authorization Form For Limited Disclosure of Health Information), instead of this form. Also, this form cannot be used for disclosure of psychotherapy notes. This form does not obligate your health care provider or other person/organization listed in the "From Whom" or "To Whom" section to seek out the information you specified in the "Of What" section from other sources. Also, this form does not change current obligations and rules about who pays for copies of records.