Fogarty
Chiropractic Life Clinic

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 th s 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 hea th of your:

Father: ______________________ Mother: ______________________
Spouse: ______________________ Children, give ages: ____________

For Official Use:

Blood Pressure: ______/_____ Pulse: _______ Temp: ______

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

(Revised 07/13/23)

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PERSONAL INJURY

Vital: This form must be filled out completely before claim can be made!

Name: ______________________ Age: ________ Sex: __________

Address: ______________________ City: __________ State: _____ Zip: ______

1. What was the date and time of accident? ______________________
2. What are your symptoms? ______________________
3. Where do you feel pain? ______________________
4. Where were you taken after the accident? ______________________
5. What treatment did you receive? ______________________
6. Name (s) of other doctors consulted since your accident.

   ____

   ____

7. Treatment received? ______________________
8. Are you still receiving care? ______________________
9. Have you injured this area before? __________ If yes, when and how? __________

   ____

10. Are you out of work from your injury? ________ If yes, from what date? __________
11. Is your injury covered by insurance? ________ Have they been notified? __________

    If covered, give name and address of insurance company ______________________

    ____

12. Have you retained an attorney? ________ If yes, his/her name, address, and phone: __________

    ____

Please explain in detail, how and where the accident took place:

____

____

____

____

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Patients signature: ______________________________ Date:____________________

(Revised 07/25/2023)

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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: ______

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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)

Fogarty Chiropractic Life Clinic

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LETTER OF PROTECTION
DIRECTION TO PAY

PATIENT NAME: ______________________________

DATE OF BIRTH: ______________________________

DATE OF INJURY: ______________________________

IMPORTANT: THIS IS A CONTRACT. IF YOU DO NOT UNDERSTAND THIS THEN CONSULT WITH AN ATTORNEY BEFORE SIGNING.

Patient authorizes and directs his/her present and future attorneys related to the above-referenced date of injury ("Attorneys") to honor this agreement. This agreement is made in favor of the above-referenced Medical Provider and shall be termed a "Letter of Protection." The Letter of Protection shall serve to place a continuing lien on any proceeds I recover in any legal action related to the above-referenced date of injury. The Direction to Pay applies to the Patient's Attorneys.

Background: Medical Provider expects to be paid from any proceeds related to the above-referenced date of injury in exchange for providing medical care/treatment. Medical Provider also agrees not to place patient in collections until the resolution of Patient's claims related to the above-referenced date of injury. Patient expects to receive medical care that is reasonable, related to the above referenced accident and medically necessary. Patient has sustained injuries as a result of injuries related to the above-referenced date of injury and does not have the funds to pay for the medical care which he/she needs. Patient is signing this Letter of Protection in order to receive medical care.

Insurance Benefits: In the event that there are disability benefits, medical payment benefits, No-Fault benefits, health and accidental benefits, worker's compensation benefits or any other insurance benefits available to patient besides Bodily Injury and/or Un-insured Motorist (aka Underinsured Motorist) coverage then this Letter of Protection can be used to cover any co-payments and/or deductibles.

OVER

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Protection of Medical Bills: If Patient recovers any money related to the above referenced date of injury, then Patient shall withhold from those funds, sufficient money to pay the outstanding balance of any bill(s) owed to Medical Provider. It is understood that Attorney's fees/costs are first-in-line and that this Letter of Protection does not interfere with Attorney's retainer agreement with Patient. Patient authorizes Medical Provider to provide Attorney with a copy of Patient's medical records, bills, etc. with regard to the above-referenced date of injury.

Patient's Responsibility for Bills: Patient understands that he/she id directly responsible to Medical Provider for services rendered and that payment is not contingent on any settlement, judgment, or verdict related to the above referenced date of injury. Regardless of any settlement, judgment or verdict, Patient is still responsible for paying Medical Provider's outstanding bills so long as they are reasonable and related to the above-referenced date of injury and medically necessary,

Patient's Responsibility Regarding His/hers Attorney (Present and Future). Patient is responsible for informing each and every attorney retained by him/her of the existence of this agreement. Medical Provider has the right to notify Patient's Attorney(s) about the existence of this Letter of Protection. Upon request, Patient shall provide status updates about any claims related to the above-referenced date of injury as well as the contact information fir any new Attorneys. It is also the Patient's responsibility to advise the Medical Provider at least 10 days prior to collecting any funds and to request a bill for any and all outstanding charges. Patient understands that if funds related to the above-referenced date of injury are insufficient to cover the medical bill(s) then Medical Provider has the right to collect the remaining balance.

Disputes: If the patient fails to pay the Medical Provider's full outstanding balance and Medical Provider is the prevailing party in an action to enforce this Letter of Protection then Medical Provider shall have the right to recover all attorney fees and costs including post-judgment proceedings. Binding arbitration is an option if both parties agree in writing.

Direction to Pay: ATTENTION ATTORNEY: THIS IS A DIRECTION TO PAY MY MEDICAL PROVIDER. Patient directs his/her attorneys to pay any outstanding medical bills in connection with the above-referenced date of injury. Patient hereby directs Attorneys to provide a status update in writing within 15 fays of receiving a request from Medical Provider.

Effective Date: This agreement becomes effective when the Patient signs the agreement below.

____

Patient Signature / Parent   Date

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THIRD PARTY BILLING (OTHER LIABILITY)

This is to certify that the below signed is a patient of the Fogarty Chiropractic Life Clinic and is receiving Chiropractic care for injuries because of a slip/trip/fall.

Per your request and/or the request of your attorney, you have asked this clinic to submit the charges for services rendered to a supplemental insurance carrier.

By signing below, you understand that any payment received by your insurance company, if not paid in full will act as a supplemental payment which will be applied to your outstanding balance.

If this clinic is under contract to a group health policy under an HMO/PPO or capitation arrangement, any payment received will not be considered as payment in full, but rather a supplement to your outstanding balance and will be credited to your account as such.

Our clinic will be happy to continue to work with you and your attorney under a Letter of Protection to defer payment until settlement is reached if necessary.

I understand that I remain personally liable for payment of services rendered.

I certify that I have read and understand the above.

_______________________________ _______________________
Patient's Signature Date

____
Print Name

_______________________________ _______________________
Witness Signature Date

____
Print Name

(Revised 02/03/2023)

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