New Member Packet

PATIENT NAME: _____

APPOINTMENT SCHEDULED FOR:_____

Attached you will find the necessary forms to **COMPLETE** and **BRING WITH YOU** on your scheduled appointment date. As a courtesy to our Practice Members, we do verify health insurance benefits; so bring both a photo ID and benefit card with you to your first appointment. In the event that you do have eligible chiropractic benefits we will inform you of what they are, but keep in mind this is not a guarantee of coverage.

In the event that you are not able to keep your new appointment time, we require a minimum of a 24-hour notice of schedule changes. We are a very busy practice, and have set aside special times for our new member appointments. Please call our office as soon as possible so that we may give that appointment to someone on our waiting list. At that time we will gladly reschedule your appointment.

Thank you for your cooperation. If you have any further questions please contact our office.

Sincerely,

Dr. Omar-Shay Clark & Staff

Contact Information:

2378 Surfside Blvd. Suite A133 Cape Coral, FL 33991

Phone: (239) 205-3700

www.efchealth.com

Confidential Member Information - Health Review

Name: _____ Birth Date: _____-_____-_____ Age: _____ ☐ M ☐ F

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

E-mail: _____ Cell Phone Provider: _____

Phone: (Home) _____ (Cell) _____ (Office) _____

☐ Check this box if you would like to receive SMS (text) reminders for your scheduled appointments.

Marital Status: ☐ Single ☐ Married SSN#: _____ Drivers License #: _____

Employer: _____ Occupation: _____ Years on Job: _____

Spouse's Name:_____ Spouse's Employer: _____

Previous Chiropractic Care? ☐ Yes ☐ No When: _____ Where: _____

Who may we thank for referring you & your family to our office: _____

Number of Children and Ages: _____

HISTORY OF COMPLAINT

Please identify the condition(s) that brought you to this office: Primarily: _____

Secondarily: _____ Third: _____ Fourth: _____

On a scale of 0 to 10 with 10 being the worst pain and zero being no pain, rate your above complaints: (circle)

Primary or chief complaint is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 ____
Second complaint is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 ____
Third complaint is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 ____
Forth complaint is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 ____

If completing online fill in your answer on the corresponding line.

When did the problem(s) begin? _____ When is the problem at its worst? ☐ AM ☐ PM ☐ mid-day ☐ late PM

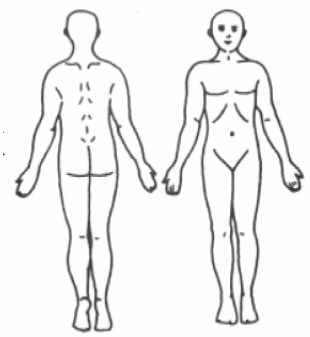
How long does it last? ☐ constant **OR** ☐ on & off during the day **OR** ☐ It comes & goes throughout the week

How did the injury happen? _____

Condition(s) ever been treated by anyone in past? ☐ Yes ☐ No If yes, when: _____ by whom? _____

How long were you under care? _____ What were the results? _____

*PLEASE MARK the areas on the Diagram with the following letters to describe your symptoms:
R=**R**adiating **B**=**B**urning **D**=**D**ull **A**=**A**ching **N**=**N**umbness **S**=**S**harp/**S**tabbing **T**=**T**ingling



What relieves your symptoms? _____

What makes them feel worse? _____

List Restricted Activity	Current Activity Level	Usual Activity Level
_____	_____	_____
_____	_____	_____

Is your problem the result of ANY type of accident? ☐ Yes ☐ No

Confidential Member Information - Health Review

Identify any other injury(s) to your spine, minor or major, that the doctor should know about:_____

PAST HISTORY

Have you suffered with any of this or a similar problem in the past? ❑ No ❑ Yes If yes how many times? _____
When was the last episode? _____ How did the injury happen?_____

Other forms of treatment tried: ☐ No ☐ Yes If yes, please state what type of treatment: _____,
and who provided it: _____ **How long ago?** _____What were the results.

☐ Favorable ☐ Unfavorable→ please explain. _____

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body: _____

If you have ever been diagnosed with any of the following conditions, please indicate with a **P** for in the **Past**, **C** for **Currently** have and **N** for **Never** have had:

___ Broken Bone ___Dislocations ___ Tumors ___Rheumatoid Arthritis ___ Fracture ___Disability ___Cancer

___ Heart Attack ___Osteo Arthritis ___ Diabetes ___Cerebral Vascular ___ Other serious conditions: _____

PLEASE identify ALL PAST & any CURRENT conditions you feel may be contributing to your present problem:

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
SURGERIES →			
CHILDHOOD DISEASES →			
ADULT DISEASES →			

SOCIAL HISTORY

How often?

1. **Smoking:** ❑cigars ❑ pipe ❑ cigarettes → ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
2. **Alcoholic Beverage:** consumption occurs → ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
3. **Recreational Drug use:** ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
4. **Hobbies -Recreational Activities- Exercise Regime:** How does your present problem affect the following:

FAMILY HISTORY

1. Does anyone in your family suffer with the same condition(s)? ❑ No ❑ Yes
If yes whom:❑ grandmother ❑ grandfather ❑ mother ❑ father ❑ sister ❑ brother ❑ son(s) ❑ daughter(s)
Have they ever been treated for their condition? ❑ No ❑ Yes ❑ I don't know

2. Any other hereditary conditions the doctor should be aware of. ❑ No ❑Yes: _____

I hereby authorize payment to be made directly to Omar-Shay Clark D.C. or Experience Family Chiropractic, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Experience Family Chiropractic for any and all services I receive at this office.

_____ ____ - ____ - ____
Patient or Authorized Person's Signature Date Completed

Confidential Member Information – Activities of Life

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITIES:	EFFECT:			
Carrying Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	❑ Unable to Perform
Sit to Stand	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Climbing Stairs	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Pet Care	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Extended Computer Use	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Household Chores	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Lifting Children	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Reading/Concentration	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Bathing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dressing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Shaving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sexual Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sleep	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Yard work	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Washing/Bathing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sweeping/Vacuuming	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dishes	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Laundry	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Yard work	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Garbage	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Climbing Steps	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Lifting Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dressing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sleep	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Concentration (Reading)	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sexual Activity	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform

Other: _____ ☐ **No Effect** ☐ **Painful (can do)** ☐ **Painful (limits)** ☐ **Unable to Perform**

Patient signature: _____ Today's Date: ___/___/____

Confidential Member Information – Activities of Life

Please mark P for in the Past, C for Currently have and N for Never

___ Headache	___ Pregnant (Now)	___ Dizziness	___ Prostate Problems	___ Ulcers
___ Neck Pain	___ Frequent Colds/Flu	___ Loss of Balance	___ Impotence/Sexual Dysfun.	___ Heartburn
___ Jaw Pain, TMJ	___ Seizures/Epilepsy	___ Fainting	___ Digestive Problems	___ Heart Problem
___ Shoulder Pain	___ Tremors	___ Double Vision	___ Colon Trouble	___ High BP
___ Upper Back Pain	___ Chest Pain	___ Blurred Vision	___ Diarrhea/Constipation	___ Low BP
___ Mid Back Pain	___ Pain w/Cough/Sneeze	___ Ringing in Ears	___ Menopausal Problems	___ Asthma
___ Low Back Pain	___ Foot or Knee Problems	___ Hearing Loss	___ Menstrual Problem	___ Difficulty Breathing
___ Hip Pain	___ Sinus/Drainage Problem	___ Depression	___ PMS	___ Lung Problems
___ Back Curvature	___ Swollen/Painful Joints	___ Irritable	___ Bed Wetting	___ Kidney Trouble
___ Scoliosis	___ Skin Problems	___ Mood Changes	___ Learning Disabilty	___ Gall Bladder Trouble
___ Numb/Tingling arms, hands, fingers		___ ADD/ADHD	___ Eating Disorder	___ Liver Trouble
___ Numb/Tingling legs, feet, toes		___ Allergies	___ Trouble Sleeping	___ Hepatitis (A,B,C)

Are you currently taking any medications[prescription or non-prescription]? ❑ No ❑ Yes

Please list: _____

_____

QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name_____ Date _____

Please read carefully:

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:

Headache Neck Low Back

No pain _____ **worst possible pain**

0 1 (2) 3 4 (5) 6 7 (8) 9 10

---

1 – What is your pain RIGHT NOW?

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

2 – What is your TYPICAL or AVERAGE pain?

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

OTHER COMMENTS:

_____

_____

Examiner

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

Informed Consent

We encourage and support a **shared decision making process** between us regarding your health needs. As a part of that process you have a right to be informed about the condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether or not to undergo such care with full knowledge of the known risks. This information is intended to make you better informed in order that you can knowledgably give or withhold your consent.

Chiropractic is based on the science which concerns itself with the relationship between structures (primarily the spine) and function (primarily of the nervous system) and how this relationship can affect the restoration and preservation of health.

Adjustments are made by chiropractors in order to correct or reduce spinal and extremity joint subluxations. **Vertebral subluxation** is a disturbance to the nervous system and is a condition where one or more vertebra in the spine is misaligned and/or does not move properly causing interference and/or irritation to the nervous system. The primary goal in chiropractic care is the removal and/or reduction of nerve interference caused by vertebral subluxation.

A chiropractic examination will be performed which may include spinal and physical examination, orthopedic and neurological testing, palpation, specialized instrumentation, radiological examination (x-rays), and laboratory testing.

As your healthcare provider, we are legally responsible for your chiropractic records. We must maintain records of your x-rays in our files. At your request, we will provide you with a copy of the x-ray files.

Please Note: If x-rays are necessary, they are utilized in this office to help locate and analyze vertebral subluxations. These x-rays are not used to investigate for medical pathology. The doctors of Experience Family Chiropractic do not diagnose or treat medical conditions; however, if any abnormalities are found, we will bring it to your attention so that you can seek proper medical advice.

The chiropractic adjustment is the application of a precise movement and/or force into the spine in order to reduce or correct vertebral subluxation(s). There are a number of different methods or techniques by which the chiropractic adjustment is delivered. Some may require the use of an instrument, by hand, or other specialized equipment. In addition, physiotherapy or rehabilitative procedures may be included in the management protocol. Among other things, chiropractic care may reduce pain, increase mobility and improve quality of life.

In addition to the benefits of chiropractic care and treatment, one should also be aware of the existence of some risks and limitations of this care. The risks are seldom high enough to contraindicate care and all health care procedures have some risk associated with them.

Risks associated with some chiropractic treatment may include soreness, musculoskeletal sprain/strain, and fracture. Risks associated with physiotherapy may include the preceding as well as allergic reaction and muscle and/or joint pain. In addition there are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment.

I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Experience Family Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. Having this knowledge, I knowingly authorize chiropractic care with Experience Family Chiropractic by any means, method, and or techniques, the doctor deems necessary at any time throughout the entire clinical course of my care.

_____ _____/_____/_____ ☐ *Witness Initials*

Patient or Authorized person's Signature Date

Parental Consent for Minor Patient:

Patient Name: _____ Patient age: _____ DOB: _____

Printed name of person legally authorized to sign for

Patient: _____

Signature: _____

Relationship to Patient: _____

In addition, by signing below, I give permission for the above named minor patient to be managed by the doctor even when I am not present to observe such care.

Printed name of person legally authorized to sign for

Patient: _____

Signature: _____

Relationship to Patient: _____

REGARDING: Non-Pregnancy Verification

FEMALES ONLY → please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.

☐ The first day of my last menstrual cycle was on ___-___-___ Date

☐ I hereby notify all concerned that I neither suspect nor know positively at this time that I may be pregnant. I release this clinic from any and all damages arising from any and all procedures of diagnostic X-rays or care nature with reference to the possibility of pregnancy.

_____ _____/_____/_____ ☐ *Witness Initials*

Patient or Authorized person's Signature Date

Experience Family Chiropractic Notice of Privacy Practice

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **P**ersonal **H**ealth **I**nformation. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as **dictated by our office policy,** we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled **'HIPAA'** on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

PERMITTED DISCLOSURES:

1. Treatment purposes- discussion with other health care providers involved in your care
2. Inadvertent disclosures- open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes- to process a claim or aid in investigation
5. Emergency- in the event of a medical emergency we may notify a family member
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement – to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons –discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders -**we may call your home or cell phone and leave messages** regarding a missed appointment or to apprize you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice
3. To request mailings to an address different than residence
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). **X-rays** are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call Jazmin Clark at (239) 205 – 3700. If she is unavailable, you may make an appointment with our front desk coordinator to see her within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights

200 Independence Ave. SW

Room 509F HHH Building

Washington DC 20201 *Patient initials:* _____

EXPERIENCE FAMILY CHIROPRACTIC'S NOTICE REGARDING YOUR RIGHT TO PRIVACY continued….

I have received a copy of Experience Family Chiropractic's Patient Privacy Notice. I understand my rights as well as the practices duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this 'Notice of Privacy Practice" at any time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept at the front desk area. At this time, I do not have any questions regarding my rights or any of the information I have received.

_____ _____ _____

Patient's Name DOB HR#

_____ _____

Patient signature Date

_____ _____

Witness Date

INSURANCE VERIFICATION FORM

Member Name: _____ Date of Birth:____/____/_____

Social Security Number: _____ Marital Status: _____

Insurance Company(Primary): _____ (Secondary) _____

Name of Insured:*(if different)*_____ Date of Birth:____/____/_____

Insured Social Security Number:*(if different)* _____

Do you have a HSA / FSA? (Health/Flexible Savings Account) ☐ YES ☐ NO

Release of Authorization/Assignment of Benefits

I authorize and request payment of insurance benefits directly to Omar-Shay Clark D.C. or Experience Family Chiropractic. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the patient. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by this assignment.

SIGNED_____ DATE_____

For Office Use Only ☐ Calendar Year ☐ Physical Year Spoke with: _____

Ref #: _____ Effective Date of Ins: _____Date Verified: _____

Chiropractic Benefits: (Out-of-Network)

Deductible: _____ Amt Met: _____ Out of Pocket Max: _____ Amt Met:_____

Co-Pay: _____ Co-Ins: _____ Visits Covered: _____ Visits Used: _____

Notes(PT):_____

Referral: **YES / NO** Pre Authorization: **YES / NO** _____

Chiropractic Benefits: (In-Network)

Deductible: _____ Amt Met: _____ Out of Pocket Max: _____ Amt Met:_____

Co-Pay: _____ Co-Ins: _____ Visits Covered: _____ Visits Used: _____

Notes(PT):_____

Referral: **YES / NO** Pre Authorization: **YES / NO** _____