WELCOME

PATIENT INFORMATION

Date ______________________________

SS/HIC/Patient ID # ______________________________

Patient Name ______________________________
Last Name

____
First Name Middle Initial

Address ______________________________

City ______________________________

State ______________ Zip ______________

E-mail ______________________________

Sex ☐ M ☐ F Age ______________

Birthdate ______________________________

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for ______ years

Occupation ______________________________

Patient Employer/School ______________________________

Employer/School Address ______________________________

____

Employer/School Phone (_____) ______________________________

Spouse's Name ______________________________

Birthdate ______________________________

SS# ______________________________

Spouse's Employer ______________________________

Whom may we thank for referring you? ______________________________

INSURANCE

Who is responsible for this account? ______________________________

Relationship to Patient ______________________________

Insurance Co. ______________________________

Group # ______________________________

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name ______________________________

Birthdate ______________ SS# ______________

Relationship to Patient ______________________________

Insurance Co. ______________________________

Group # ______________________________

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with ______________________________ and assign directly to
Name of Insurance Company(ies)

Dr. ______________________________ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

____
Signature of Patient, Parent, Guardian or Personal Representative

____
Please print name of Patient, Parent, Guardian or Personal Representative

______________ ______________
Date Relationship to Patient

PHONE NUMBERS

Home Phone (______) ______________________________

Cell Phone (______) ______________________________

Best time and place to reach you ______________________________

IN CASE OF EMERGENCY, CONTACT

Name ______________________________

Relationship ______________________________

Home Phone (______) ______________________________

Work Phone (______) ______________________________

ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No

Date ______________________________

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable)

____

PATIENT CONDITION

Reason for Visit ______________________________

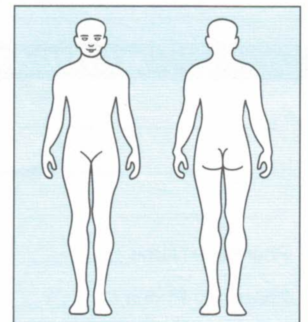
When did your symptoms appear? ______________________________

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) ______________

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other



How often do you have this pain? ______________________________

Is it constant or does it come and go? ______________________________

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

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HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other ____________________

Name and address of other doctor(s) who have treated you for your condition ____________________

Date of Last: Physical Exam__________ Spinal X-Ray__________ Blood Test__________

Spinal Exam__________ Chest X-Ray__________ Urine Test__________

Dental X-Ray__________ MRI, CT-Scan, Bone Scan__________

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
AIDS/HIV	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Alcoholism	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Measles	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Allergy Shots	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Migraine Headaches	☐ Yes	☐ No	Sexually Transmitted Disease	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Fractures	☐ Yes	☐ No	Miscarriage	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Anorexia	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Mononucleosis	☐ Yes	☐ No	Suicide Attempt	☐ Yes	☐ No
Appendicitis	☐ Yes	☐ No	Goiter	☐ Yes	☐ No	Multiple Sclerosis	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Gonorrhea	☐ Yes	☐ No	Mumps	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Gout	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Bleeding Disorders	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Tumors, Growths	☐ Yes	☐ No
Breast Lump	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	Parkinson's Disease	☐ Yes	☐ No	Typhoid Fever	☐ Yes	☐ No
Bronchitis	☐ Yes	☐ No	Hernia	☐ Yes	☐ No	Pinched Nerve	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Bulimia	☐ Yes	☐ No	Herniated Disk	☐ Yes	☐ No	Pneumonia	☐ Yes	☐ No	Vaginal Infections	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Polio	☐ Yes	☐ No	Whooping Cough	☐ Yes	☐ No
Cataracts	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Prostate Problem	☐ Yes	☐ No	Other __________		
Chemical Dependency	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No	Prosthesis	☐ Yes	☐ No	__________		
Chicken Pox	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No			
						Rheumatoid Arthritis	☐ Yes	☐ No			

EXERCISE

☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY

☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

HABITS

☐ Smoking Packs/Day __________
☐ Alcohol Drinks/Week __________
☐ Coffee/Caffeine Drinks Cups/Day __________
☐ High Stress Level Reason __________

Are you pregnant? ☐ Yes ☐ No Due Date__________

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS
Pharmacy Name__________		
Pharmacy Phone (____)__________		

Integrated Chiropractic

Dr. Ryan T. Johnson
2206 Jo-An Drive, STE 1
Sarasota, FL 34231

EXPLANATION OF MEDICARE SERVICES

Dear Medicare Patient,

Welcome to Integrated Chiropractic! We would like to take this opportunity to explain your Medicare benefits as they relate to your chiropractic care.

It is important that you understand Medicare **will consider** payment for **spinal** adjustments only, for neuro-musculo-skeletal conditions only. Medicare **will not provide benefits** for any other chiropractic services required for your care, including: ***physical examination, x-rays, extremity adjustments, and rehabilitation procedures such as heat, ice, soft-tissue therapies, physiotherapies (ultrasound, electric muscle stimulation, cold laser) and other passive and active therapies.***

You will be responsible to pay for all non-covered services at the time of service. You will also be responsible for an annual **$233 deductible** as well as your co-pay. **Medicare will only pay 80% of charges. The other 20% (your co-pay) will be your responsibility after all charges have been processed through Medicare.**

If you have a secondary insurance that covers Chiropractic care, we will submit your charges to the insurance company. Please be sure to provide your insurance card(s).

I fully understand the above paragraphs and agree to pay for all services not covered by Medicare at the Time of Service.

Name of Beneficiary________________________________HICN:____________________

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Integrated Chiropractic for any services furnished to me by that physician. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicare Services and its agents any information needed to determine these benefits or the benefits payable for related services.

____ ____________________

(Patient's Signature) *(Date)*

____ ____________________

(Witness Signature) *(Date)*

Name ______________________ Date: ____________ Age: ________

L or R handed?	Left	Right
Height: ____________		
Weight: ____________		
Any unexplained weight loss?	Yes	No
Has pain been greater the last 4 weeks?	Yes	No
Does pain improve with rest?	Yes	No
Have you had failure to respond to conservative care in the past?	Yes	No
Any prolonged use of corticosteroids?	Yes	No
If yes, which type? ______________________		
Any intravenous drug use?	Yes	No
Any recent / current infection?	Yes	No
If yes, what type: URI, UTI, Sinus, Ear, Other: ______________________		
Immunosuppression condition / medication?	Yes	No
If yes, what type? ______________________		
Any sunburns or open wounds?	Yes	No
If yes, please specify where: ______________________		
Any muscle weakness?	Yes	No
Any bowel problems?	Yes	No
Any urinary problems?	Yes	No
Any history of cardiac problems?	Yes	No
Any history of seizures?	Yes	No
For women, any chance you're pregnant?	Yes	No
Is this your first Chiropractic visit?	Yes	No
If no, when / where was last visit? ______________________		

Integrated Chiropractic

2206 Jo-An Drive STE 1
Sarasota, FL 34231
(941) 487-0266

Dr. Ryan Johnson, D.C.

Informed Consent to Chiropractic Treatment

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named above and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed above or any other office or clinic. I have had an opportunity to discuss with the doctor of chiropractic named above and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic care, there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all the risks and complications, and I wish to rely upon the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. I understand that there are other medical treatments and options available to me at this time including but not limited to medications, injections, or surgeries. I am choosing to receive chiropractic care and acknowledge that I am of sound mind at the time of signing this document.

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

Print Patient's Name ____

Patient (Legal Guardian) Signature ______________________________________

Date ______________

Office Signature ________________________________ Date ______________

2206 Jo-An Drive, STE 1

Sarasota, FL. 34231

941-487-0266

Dear Patient:

Please read, initial, and sign:

We **do not accept** 3rd party health insurances such as Blue Cross, Cigna, or Aetna.

Insurances we accept are Medicare Part B, PIP (Auto), VA (Veterans) and Meritain (Sarasota Memorial.)

New patient Consultation, Review of History, Examination, and a Report of Findings (with a detailed treatment plan) is $140.

Returning patients are considered a new patient after 3 years of no appointments. After a year of no appointments, or with a new issue, a re-examination is required.

A routine office visit can vary from $32 - $100 (estimated) depending on what services (and/or products) are rendered, as required by your treatment plan.

Our office policy regarding cancellations and rescheduled appointments is as follows:

1. For cancelled appointments, without a prior 24-hour notice, there will be a $60.00 charge to the patient's personal account for chiropractic services, and or nutritional appointments. We understand emergencies can occur and will address those on an as needed basis.
   Initial ________

2. As per OSHA regulations, as well as for the safety of our patients, no returns are allowed on any nutritional supplements purchased from this office.
   Initial ________

Notice

I understand that I am responsible for payment of my account at the time services are rendered, and that I am financially responsible for all charges whether or not paid by insurance. If Integrated Chiropractic INC. is forced to take any action for collection of a balance owed, either by lawsuit or by other means, I agree to pay all collection costs, including attorney's fee(s) and an interest charge of 1.5 % per month (18% annually) on the amount owed until paid.

Print Name: ______________________________________

Signature: ______________________________________ Date: ______________

ACKNOWLEDGEMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or decline the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

By checking the lines below I authorize being contacted for practice reminders by:

Email: ________________________@__________.com
Phone Calls (_______) _________-_____________
Text message (_______) _________-_____________ same
Cell Phone Carrier: sends text reminder day before your scheduled appointment

Please circle: AT&T Boost Mobil Cricket Metro PCS Nextel Sprint
T-Mobil US Cellular Verizon Virgin Mobile Other:______________

________ By initialing, I authorize being contacted for birthday greetings, or promotions by Integrated Chiropractic.
________ By initialing, I authorize Dr. Johnson to personally discuss with me products that may benefit my health or condition

____________________________________ ____________________________________
Patient Name (Print Please) Name of Parent, Guardian or Legal representative

____________________________________ ______________________
Signature of Patient/Parent/Guardian/representative Date

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS

List below the names and relationship of people to whom you authorize the Practice to release PHI

__________________________ __________________________

__________________________ __________________________

__________________________ __________________________

__________________________ __________________________

Health and Wellness Analysis

Do you any have children? ❑Yes ❑No If yes, please list ages ____________________

Please list all food cravings: ____

____

Do you eat organic foods: ❑Yes ❑No

- If yes, what percent of total food intake is organic? ____________________________

Do you avoid certain foods? ❑Yes ❑No

- If so, please list which: ____

Do you eat the recommended 7-13 servings of fruits/vegetables daily? ❑Yes ❑No

Do you have any food allergies? ❑Yes ❑No

- If yes, please list with severity (Scale 1-10) ______________________________________

____

How many bowel movements do you have per day? ________

- If not daily, how many per week? ________________

Please circle/list any other digestive issues you frequently experience:

Gas Bloating Belching Acid reflux ______________________________

On Average:

- What time do you go to bed? ____
- How many hours of sleep do you get per night? _________________________________

Do you sleep through the night? ❑Yes ❑No

- If awakened, what is the time/reason? ______________________________________

Rate your energy level: (1=low, 10=high)

1 2 3 4 5 6 7 8 9 10

Would you like to experience weight gain or weight loss? ❑Yes ❑No

- If yes, how many pounds? ______________

On average, how often do you exercise? ______________________________________

On a scale from 1-10 (1=low, 10=high), how would you rate your willingness to be coached and make changes to your currently lifestyle to address your health challenges?

1 2 3 4 5 6 7 8 9 10