FOX
SPINE + SPORTS
MEDICINE

3030 S Dixie Hwy # 4, West Palm Beach, FL 33401, Ph) 561-650-1205 Fx) 561-650-1206, www.drchrisfox.com

# GENERAL PATIENT INTAKE FORM and CHIROPRACTIC CARE AGREEMENT

**Patient Information:**

Today's Date _____
Name _____
I prefer to be called _____

Address _____
_____
_____

Sex ☐ **Male** ☐ **Female**
Occupation _____
Employer _____

Home Phone _____
Cell Phone _____
Work Phone _____
Email _____
Date of Birth _____ Age _____
Height ____'____" Weight _____lbs
Marital Status _____
No. of Children _____
Do you agree to receiving appointment reminders via text message and email? ☐ **Y** ☐ **N**

If minor, name of parent or guardian _____
Who should we contact in case of an emergency? _____
Relation _____ Phone _____
Address _____
Primary Care Physician _____ Phone _____
How did you hear about our office? _____
Were you referred to us by a treating physician? ☐ **YES** ☐ **NO** If so, who? _____
Have you ever been to a chiropractor before? ☐ **YES** ☐ **NO** If so, who? _____

**Insurance Information:**

Dr. Fox is non-participating with ALL insurance plans, EXCEPT statutorily approved Medicare services. If you have Medicare and would like us to submit on your behalf, please give your Medicare and/or Medicare Secondary cards to the front desk. We will give you an Advance Beneficiary Notice of Non-Coverage to read and sign.

**Reason for Visit:**

1. If this visit is due to pain, when did the symptoms begin? ____/____/____
2. Please explain what you are experiencing. _____
_____
3. Is the condition getting worse? ☐ **YES** ☐ **NO** Describe ☐ **Constant** ☐ **Comes & Goes**
4. List activities that aggravate this condition(s) or inhibit this condition(s):_____
_____
_____

5. Have you had this or a similar condition in the past? ☐ **YES** ☐ **NO**
6. Have you been treated by a medical physician or other provider for this condition? ☐ **YES** ☐ **NO**
7. Are you taking any medications? Please include any vitamins or supplements. ☐ **YES** ☐ **NO**

If **yes**, please list:_____

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# HEALTH HISTORY

Please check the box for any of the following which apply to you?

| | | |
|---|---|---|
| ☐ **HEART ATTACK or STROKE** | ☐ **PACEMAKER** | ☐ **MURMUR** |
| ☐ **HEART SURGERY** | ☐ **CONGENITAL HEART DEFECT** | ☐ **MITRAL VALVE COLLAPSE** |
| ☐ **ARTIFICIAL VALVES** | ☐ **ALCOHOL/DRUG ABUSE** | ☐ **VENEREAL DISEASE** |
| ☐ **HEPATITIS** | ☐ **SHINGLES** | ☐ **CANCER** |
| ☐ **FREQUENT NECK PAIN** | ☐ **HIV+/AIDS** | ☐ **EMPHYSEMA** |
| ☐ **ANEMIA** | ☐ **HIGH/LOW BLOOD PRESSURE** | ☐ **PSYCHIATRIC PROBLEMS** |
| ☐ **RHEUMATIC FEVER** | ☐ **SEVERE/FREQ. HEADACHES** | ☐ **KIDNEY PROBLEMS** |
| ☐ **ULCERS/COLONITIS** | ☐ **FAINTING/SEIZURE/EPILEPSY** | ☐ **SINUS PROBLEMS** |
| ☐ **ASTHMA** | ☐ **DIABETES** | ☐ **DIFFICULTY BREATHING** |
| ☐ **TUBERCULOSIS** | ☐ **LOWER BACK PROBLEMS** | ☐ **ARTIFICIAL BONES/JOINTS** |
| ☐ **ARTHRITIS** | | |

Please list **any other** medical conditions that you have or have ever had. _____

Please list any allergies. _____

Please list previous hospitalizations or surgeries and dates. _____

Please list any past motor vehicle accidents or traumas and dates. _____

Is there anything else about your health history or family health history that you feel is important to share?

Do you exercise? ☐ **YES** ☐ **NO**

Are you on a special diet? ☐ **YES** ☐ **NO** Since: _____/_____/_____ Describe:_____

Do you smoke or use tobacco products including e-cigarettes/vape? ☐ **YES** ☐ **NO**

How much? _____ How long? _____

Does your current injury or discomfort relate to any pending litigations, proceedings, or application/approval of disability benefits? **YES** ☐ **NO** If yes, please describe?

_____

_____

***For women**:* Are you pregnant? ☐ **YES** ☐ **NO** How far along? _____ Nursing? ☐ **YES** ☐ **NO**

**Patient or Legal Guardian Signature**_____**Date** _____

*Updated 2020*

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# RECEIPT OF NOTICE OF PRIVACY PRACTICES
# WRITTEN ACKNOWLEDGEMENT FORM

By signing this form, you hereby acknowledge receipt of the **Notice of Privacy Practices**. Our **Notice of Privacy Practices** provides information about how we may use and disclose your protected information. We encourage you to read it in full. **Our Notice of Privacy Practices** is subject to change.

_____ _____ _____
Patient Name (please print) Patient Signature Date

_____ _____ _____
Parent, Guardian, or Patient's legal representative, if applicable. Please print, sign, and date.

List below the name(s) and relationship of people to whom you authorize Fox Spine + Sports Medicine to release your **Protected Health Information** (PHI).

_____ _____
Name(s) Relationship(s)

## OFFICE POLICIES

**The following are FOX Spine + Sports Medicine's office policies. Please read carefully and be sure to ask any questions you might have before signing the document.**

**Appointment Scheduling and Cancellation Policy.** At FOX Spine + Sports Medicine, we understand that unanticipated events happen occasionally in everyone's life. Business meetings, project deadlines, flight delays, car problems, and illness are just a few reasons why one might consider canceling an appointment. In our desire to be effective and fair to all of our patients and staff **24 hour advance notice is required when canceling an appointment otherwise the full fee for the missed appointment will be charged to your account.** This allows the opportunity for someone else to utilize our services during that appointment time.

**Office Visits.** We understand that the undersigned and/or the Patient may come to the office with family, friends or others. The Patient (or, if a minor, the undersigned) acknowledges that the Patient (or undersigned) is solely responsible for children or those in their care. This is an office; we are busy with patients. Please be careful and aware of your surroundings.

**Telephone Messages.** We do not leave detailed messages on voicemails or answering machines, unless you consent to the same in writing.

**Patient or Legal Guardian Signature**_____**Date** _____

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# CHIROPRACTIC INFORMED CONSENT

The undersigned Patient (which includes the parent/guardian) understands and acknowledges that the Patient is only receiving chiropractic care from FOX Spine + Sports Medicine, its doctors and staff, (jointly, "FOX Spine + Sports Medicine").

The Doctors are "chiropractic physician" as defined in Florida Statute 460.403(5)(2008). Chiropractic physicians examine, analyze, and diagnose the human living body and its diseases by use of (a) any physical, chemical, electrical or thermal methods, (b) x-ray for diagnosing, (c) blood tests, and (d) other chiropractic methods.

Before you, the Patient, receive chiropractic care, it is important that you read this Consent and understand the nature and risks of chiropractic medicine. The "practice of chiropractic medicine" (or chiropractic care) involves the adjustment, manipulation, and treatment of your body in which vertebral subluxations and other malpositioned articulations and structures may be interfering with the normal generation, transmission, and expression of nerve impulse between the brain, organs, and tissue cells, thereby causing disease. Chiropractic adjustments, manipulations, and treatments are intended to restore the normal flow of nerve impulse which produces normal function and consequent health.

The undersigned Patient understands and acknowledges that there are risks associated with the practice of chiropractic medicine and chiropractic care including but not limited to ataxia, bruising, thermal injuries, dislocations/subluxations, dizziness, "drop attacks," fracture(s), mobility disruption, paralysis, quadriplegia, spinal injury, stroke/disruption of blood flow to brain, vision problems, and death.

The Patient is encouraged to ask questions! Although we are not affiliated with and cannot confirm the content of internet sites, resources such as WebMD, Chiro.org, AmerChiro.org, and others may be helpful. The Patient is specifically instructed to consult a medical doctor before receiving (and during/after) chiropractic medicine.

I the undersigned, understand the risks and limitations associated with the practice of chiropractic medicine, including the use of chiropractic care, evaluation, diagnosis, adjustments, manipulations, and treatments by FOX Spine + Sports Medicine. Having read this form and having asked and having had answered any questions I might have about my condition and treatments, and as a result having fully understood the services to be provided by FOX Spine + Sports Medicine and what I should expect from my treatment, including the risks associated therewith. I hereby give my informed consent to receive chiropractic medicine from FOX Spine + Sports Medicine.

**Patient or Legal Guardian Signature**_____**Date** _____

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# THIS PAGE APPLIES TO MEDICARE BENEFICIARIES ONLY

## PATIENT AGREEMENT TO PAY FOR CHIROPRACTIC SERVICES AND ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize FOX Spine + Sports Medicine, to furnish my insurance carrier **all** information concerning my treatment and/or illness. I also authorize benefits under this claim to be made payable directly to FOX Spine + Sports Medicine. I understand that I am responsible financially to FOX Spine + Sports Medicine for charges not covered by my insurance company, I, the patient or the guardian of the patient, will be responsible in full in payment.

I also understand that all co-payments and / or deductibles are to be paid at the time services are rendered. I agree to assist FOX Spine + Sports Medicine in any collection efforts to receive payment from my insurance company providing the office with any information that may be necessary for the physicians to receive payment.

I understand that by signing this agreement I agree to make all payments to FOX Spine + Sports Medicine that I am responsible for, and that if the insurance denies a claim for any reason that I am responsible ultimately for payment in full to the physicians.

**By not signing this agreement, services may be denied.**

**Patient or Legal Guardian Signature**_____**Date** _____

I hereby authorize FOX Spine + Sports Medicine to apply for benefits on my behalf for covered services rendered by him/her or by his/her order. I request that payment from my insurance company be made directly to FOX Spine + Sports Medicine (or to the party who accepts the assignment). I certify that the information I have reported with regard to my insurance coverage is correct. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

**Patient or Legal Guardian Signature**_____**Date** _____

I authorize the release of any medical information necessary to process this claim. I also authorize FOX Spine + Sports Medicine to release any of my information, inclusive of information I provided to it or information relating to my treatment or medical condition to any third party presenting FOX Spine + Sports Medicine with a medical release form purportedly signed by me. I understand that FOX Spine + Sports Medicine will not independently verify the authority granted by any release presented to it. I permit a copy of any authorization to be used in the place of the original. This authorization is given with full knowledge that such disclosure may contain information of a confidential nature and may result in a denial of insurance coverage for services rendered by said FOX Spine + Sports Medicine.

**Patient or Legal Guardian Signature**_____**Date** _____