RIVERA FAMILY R.F.C.C. CHIROPRACTIC CENTER

DR. OMAR M. RIVERA, D.C.
DR. ALICIA A. RIVERA, D.C.
www.riverachiro.com

821 Debary Avenue
Deltona, Florida 32725
Tel: 386-860-5448
Fax: 386-668-3665

900 W. 25th Street
Sanford, Florida 32771
Tel: 407-878-5848
Fax: 407-878-5850

3950 US Hwy 17-92, Ste 1000
Casselberry, Florida 32707
Tel: 407-767-4878
Fax: 407-767-4880

Date: _____

Date of Birth: ___/___/____ Sex: ____M ____F

Name: _____

Address: _____

City: _____ State:_____ Zip Code:_____

Email Address: _____

Social Security Number: _____ Marital Status: ___S ___M

Home Phone: (____) ____-_____ Work Phone: (____) ____-_____

Cellular Phone: (____) ____-_____

Occupation: _____ Employer: _____

Work Address: _____

Auto Accident: YES (__) NO (__) Slip & Fall YES (__) NO (__)

Date of Accident: ___/___/____

Chief Complaints / Injuries: _____

History of Present Illness / Accident: _____

_____

_____

Were you wearing a seat belt? YES (__) NO (__) Were you Hospitalized? YES (__) NO (__)

If yes, what Hospital? _____

Have you been involved in any previous accidents? YES (__) NO (__)

If yes, please explain: _____

_____

Primary Insurance Company Name: _____

Name of Insured: _____ Policy #: _____

Birth Date of Insured: ___/___/____ Deductible: _____

Relationship to Insured: Self (__) Spouse (__) Child (__)

Responsible Party: Parent (__) Guardian (__)

Auto Insurance Company Name: _____

Policy Holder: _____ Policy #: _____

Auto Insurance Phone Number: (____) ____-_____ Claim #: _____

Attorney Name: _____ Firm: _____

Attorney Phone Number (____) ____-_____

Have you lost time from work? YES (__) NO (__)

If yes, are you still off work? YES (__) NO (__)

Is injury work related? YES (__) NO (__) Date of injury ___/___/____

If yes, did you report it to your employer? YES (__) NO (__)

Which supervisor did you report injury to? _____

Employer Name: _____

Employer Address: _____

Employer Phone: _____

SIGNATURE ON FILE:

- I authorize use of this form on all my insurance submissions
- I authorize release of information to all my Insurance Companies
- I authorize my doctor to act as my agent in helping me obtain payment from my Insurance Companies
- I permit a copy of this authorization to be used in place of the original

Name (please print): _____

Signature: _____ Date: ___/___/____

Health History

(Confidential)

Patient Name _____ Today's Date _____

Age _____ Birthdate _____ Date of last physical examination _____

What is your reason for visit? _____

Symptoms

Check (✓) symptoms you currently have or have had in the past year.

GENERAL

- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:

- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders

GENITO-URINARY

- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL

- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR

- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT

- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision - Flashes
- ☐ Vision - Halos

SKIN

- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

MEN only

- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN only

- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period _____

Date of last Pap Smear _____

Have you had a mammogram? _____

Are you pregnant? _____

Number of children _____

Conditions

Check (✓) symptoms you currently have or have had in the past year.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease

Medications

List medications you are currently taking.

_____

_____

_____

_____

Pharmacy Name _____ Phone _____

Allergies

_____

_____

_____

_____

_____

Family History

Fill in health information about your family

Relation	Age	State of Health	Age at Death	Cause of Death	Check (✓) if, your blood relatives had any of the following: Disease	Relationship to you
Father					Arthritis, Gout	
Mother					Asthma, Hay Fever	
Brothers					Cancer	
					Chemical Dependency	
					Diabetes	
					Heart Disease, Strokes	
Sisters					High Blood Pressure	
					Kidney Disease	
					Tuberculosis	
					Other	

Hospitalizations

Year	Hospital	Reason for Hospitalization and outcome

Have you ever had a blood transfusion? ☐ Yes ☐ No

If yes, please give approximate dates _____

Serious Illness/Injuries	Date	Outcome

Pregnancies

Year of Birth	Sex of Birth	Complications if any

Health Habits

Check (✓) which substances you use and describe how much you use.

	Caffeine	
	Tobacco	
	Drugs	
	Other	

Occupational

Check (✓) if your work excess you to the following:

	Stress		Hazardous Subsances
	Heavy Lifting		Other

Occupation

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ Signature

_____ Date

_____ Reviewed By

_____ Date

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ASSIGNMENT OF BENEFITS

RIVERA FAMILY CHIROPRACTIC CENTER
3950 US Hwy 17-92, Ste 1000
Casselberry, FL 32707
Phone: (407) 767-4878

Date_____
Patient_____
ID#:_____
Group#:_____

I, _____, understand that services rendered to me by
Patient Name
Rivera Family Chiropractic Center, are my financial responsibility and that the Provider will bill my insurance company_____, as a courtesy. I authorize my insurance
Insurance Company Name
company to pay my benefits directly to **Rivera Family Chiropractic Center** and I understand that I will be fully responsible for any outstanding balance on my account.
I have been given the opportunity to pay my estimated deductible and co-insurance at the time of service. I have chosen to assign the benefits, knowing that the claim must be paid within all state or federal prompt payment guidelines. I will provide all relevant and accurate information to facilitate the prompt payment of the claim by _____.
Insurance Company Name
I authorize the provider to release any information necessary to adjudicate the claim, and understand that there may be associated costs for providing information above and beyond what is necessary for the adjudication of a clean claim.
I also understand that should my insurance company send payment to me, I will forward the payment to **Rivera Family Chiropractic Center** within 48 hours. I agree that if I fail to send the payment to the Provider and they are forced to proceed with the collections process; I will be responsible for any cost incurred by the office to retrieve their monies.
I authorize the provider to initiate a complaint to the insurance commissioner for any reason on my behalf and I personally will be active in the resolution of claims delay or unjustified reductions or denials.

Signature of Policyholder_____

Patient /Guardian:_____

Printed Name_____

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Name: _____ Date: _____/_____/20_____

Activities that are affected by my current health problems:

0 = No Affects
1 = I am aware of my problem when I do this activity (Mild)
2 = I don't want to do this activity because of my problem (Moderate)
3 = I can't do this activity at all (Severe)

Basic

_____ Bending
_____ Climbing Stairs
_____ Falling Asleep
_____ Kneeling
_____ Lifting
_____ Looking Over Shoulder
_____ Lying Down
_____ Rising Out of Chair
_____ Sitting
_____ Standing
_____ Staying Asleep
_____ Walking

Daily Living

_____ Caring for Infirm Family Member
_____ Child Care

_____ Computer Use (Extended time)
_____ Computer Use (Short time)
_____ Concentrating
_____ Driving
_____ Housework
_____ Lifting Children
_____ Lifting/Carrying Groceries
_____ Pet Care
_____ Reading
_____ Sexual Activity
_____ Yard Work

Occupational Duties

_____ Computer Work
_____ Desk Work
_____ Driving (at work)
_____ Lifting (at work)
_____ Using the Telephone

Personal Care

_____ Bathing
_____ Dressing
_____ Hair Care
_____ Shaving

Recreational Activities

_____ Cycling
_____ Drawing
_____ Exercise
_____ Golf
_____ Needle Work
_____ Piano
_____ Running
_____ Softball
_____ Swimming
_____ Tennis

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Request
Medical Records/X-Rays Reports

Date / Fecha: _____

Patient's Name / Nombre: _____

D.O.B/Fecha de Nacimiento: _____

Social Security / Seguro Social: _____

Please be advised, that I am under the care of **Rivera Family Chiropractic Center L.L.C.** I am requesting all my medical records and x-rays to be transferred to their office as soon as possible, **via fax 407-767-4880.** This is the medical authorization release form duly executed by me.

_____

Patient's Signature / Firma del Paciente

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Consent of Non-Pregnancy

Date: _____

Patient's Name: _____

Date of Last Menstrual Period: _____

This is to confirm that I am not pregnant.

_____
Patient's Signature

_____
Parent / Guardian

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ACKNOWLEDGMENT 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 declined 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.

_____ _____

Patient Name (please print) Date

_____

Parent, Guardian or Patient's legal representative

_____

Signature

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

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provide the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

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CONSENT OF DISCLOSURE

(For the Usage and/or Disclosure of Protected Health Information)

I hereby give consent to Rivera Family Chiropractic Center L.L.C. and all health care providers furnishing care within Rivera Family Chiropractic Center's facilities to use and disclose my Protected Health Information for the purposes of Treatment, Payment and Health care Operations.

You may cancel this consent at any time. You cancellation must be in writing, signed by you or on your behalf, and delivered to the address at the bottom of this form. This may be delivered in person or by mail, but it will be only effective when we actually receive it. Your cancellation will not be effective to the extent that others or we have acted in reliance upon this consent.

You have the right to request restriction on the usage and disclosure of your protected health information for the purposes of Treatment, Payment or Health care Operations. We are not required to grant your request, however, if we do so, the restriction will be obligatory to us.

Our Posted Privacy Policy provides more detailed information about the usage and disclosure of your Protected Health Information. You have the right to review our Posted Privacy Policy before you sign this consent.

We reserve the right to amend the terms of our Posted Privacy Policy. You may obtain a copy of the current policy from our front desk.

Print Name of the Patient: _____

Signature: _____
Date: _____
If you are signing as the patient's Representative:
Print your Name: _____
Relationship: _____

CANCELLATION

I HEREBY VOID THE CONSENT GIVEN ABOVE.
Print Name of the Patient: _____

Signature of Patient: _____
Date: _____
If you are signing as the patient's Representative:
Print your Name: _____
Relationship: _____

Address for cancellation: Your cancellation will be effective, upon receipt, at the following address:

☐ 900 W. 25th Street
Sanford, Florida 32771

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Deltona, Florida 32725

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INFORMED CONSENT TO CHIROPRACTIC TREATMENT

Name: _____ Date: _____

The Nature of Chiropractic Treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop:, such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, neuron-muscular massage, electric muscle stimulation, therapeutic ultrasound or day hydrotherapy may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic adjustment. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irrigatlon, burns or minor complications.

Probability of Risks Occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one In twenty million and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered· "rare".

Other Treatment Options Which Could Be Considered May Include The Following:

- Over-the-counter analgesics. The risks of these medications include irritation to stomach, liver and kidneys, and other side effects In a significant number of cases.
- Medical car, typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- Hospitalizations in conjunction with medical care add the risks of exposure to virulent communicable disease in a significant number of cases.
- Surgery in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of Remaining Untreated: Delay treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual Risks: I have had the following unusual risks of my case explained to me:

_____

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.

_____ _____

Printed Name Signature