



12595 SW 137 AVENUE STE 108  
MIAMI, FL 33187  
(305) 388-7577

Patient Account Number

Date

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### PATIENT INFORMATION

First Name	Middle Name	Last Name	Nickname		
Street Address		Apt.	City	State	Zip Code
Home Phone	Cell Phone	E-mail Address	Age	Date of Birth	

Appointment Reminders will be sent via text message 24 Hrs before appointment.

Marital Status				Sex	
Single	Married	Divorced	Widowed	Male	Female

Please provide the **LAST 4 DIGITS** of your Social Security Number for insurance verification purposes  
XXX-XX-\_\_\_\_\_

### EMERGENCY CONTACT

Full Name	Relationship	Phone Number
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### AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I authorize Martinez Chiropractic Center and any member of its staff to call, leave voice mail messages and/or e-mail messages and disclose Protected Health Information (PHI) pertaining to me, including but not limited to medical information, such as test results, procedures results, appointment reminders, or any other PHI related to my treatment to the following numbers:

Home:	Cell:	Work:	Fax:
Email:			

I authorize Martinez Chiropractic Center and any member of its staff to disclose my (PHI), including test results to the following individuals, as well as allow them to make changes or ask questions regarding my appointments on my behalf:

Name:	Relationship:	Phone:
Name:	Relationship:	Phone:
Name:	Relationship:	Phone:

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### NO ACCIDENT FORM

I am seeking care from Martinez Chiropractic Center the treatment is not due to a work related injury, automobile accident, or slip and fall.

### INSURANCE AUTHORIZATION

I hereby authorize payment of benefits due to me from my insurance company and/or attorney to be made directly to Martinez Chiropractic Center.. I further authorize the release of any medical records required by my insurance carrier.. I fully understand that I am financially responsible for any charges covered by this authorization to Martinez Chiropractic Center.. In the event that it becomes necessary to institute litigation over the non-payment of our fees, the cost and legal expenses incurred therein are that of the patient..

### INSURANCE CERTIFICATION

This is to certify that I have presented any and all information regarding my health insurance plan..

The only health insurance policy in effect is:

Name of Insurance Co.:

ID:

Group:

Insured's Name:

Relationship with Insured:

Insured DOB:

My signature certifies that the information I have filled in above is accurate, and that I am not seeking care due to an auto accident, work injury or slip/fall nor do I have an open or pending case.

Patient Name:

Patient Signature: \_\_\_\_\_ Date:

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### RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGMENT FORM

I acknowledge that I have received a copy of Martinez Chiropractic Center's Notice of Patient Privacy Practices..

### INFORMED CONSENT FORM

I hereby request and consent to the performance of chiropractic treatments and other chiropractic /medical procedures, including various forms of physical therapy and diagnostic x-rays by Martinez Chiropractic Center. This consent is extended to other licensed chiropractic Physicians, Chiropractic assistants or licensed Massage Therapists, who now or in the future, are employed by, working with or associated with this office..

I certify that I have had the opportunity to discuss, with the doctor of Chiropractic and/or other office personnel, the nature and purpose of the care that is being provided. I understand that the results are not guaranteed. Further, I have been informed and I understand that, as in the practice of any of the healing arts, in the practice of Chiropractic, there are some risks to treatment including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I also understand that the doctor, who has explained all of these things to me, is not expecting to be able to anticipate and explain all the risks and complications. I will rely on the doctor to exercise appropriate judgment during the course of care, based on the facts known at this time, and in my best interest.

My signature below certifies that I have read, or have had read to me the above consent. I also certify that I have had the opportunity to ask questions and options to care have been explained. By signing this consent form, I agree to the care being provided to me for the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

Patient Name:

Patient Signature: \_\_\_\_\_ Date:

### MASSAGE AND MANUAL THERAPY POLICY

We offer massage and manual therapy in our office as an extra service to our patients. We believe that massage and manual therapy has a value in helping you heal. Our policy is that appointments be pre-scheduled. If you must reschedule or miss an appointment YOU MUST CALL US 24 HOURS IN ADVANCE. If you do not call, there is a \$25.00 charge. The only exception to this is if you have a serious emergency. Thank you for your cooperation.

Patient Name:

Patient Signature: \_\_\_\_\_ Date:

# Patient Health Questionnaire

ChiroCare of Wisconsin, Inc.

Patient Account Number

Patient Name

Date

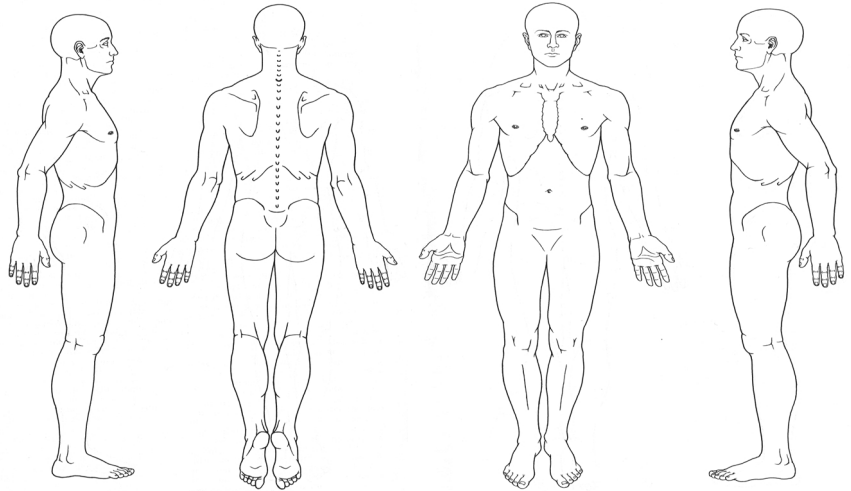
1. When did your symptoms start: \_\_\_\_\_

Describe your symptoms and how they began:

Did your condition start due to a fall, injury or after lifting a heavy object? Yes No Other

2. How often do you experience your symptoms? Indicate where you have pain or other symptoms

- ① Constantly (76-100% of the day)
- ② Frequently (51-75% of the day)
- ③ Occasionally (26-50% of the day)
- ④ Intermittently (0-25% of the day)



3. What describes the nature of your symptoms?

- ① Sharp
- ② Dull ache
- ③ Numb
- ④ Shooting
- ⑤ Burning
- ⑥ Tingling

4. How are your symptoms changing?

- ① Getting Better
- ② Not Changing
- ③ Getting Worse

5. How bad are your symptoms at their:

- None
- a. worst: ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
- b. best: ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
- Unbearable

6. How do your symptoms affect your ability to perform daily activities?

- ① No complaints
- ② Mild, forgotten with activity
- ③ Moderate, interferes with activity
- ④ Limiting, prevents full activity
- ⑤ Intense, preoccupied with seeking relief
- ⑥ Severe, no activity possible

7. What activities make your symptoms worse:

8. What activities make your symptoms better:

9. Who have you seen for your symptoms?

- ① No One
- ② Other Chiropractor
- ③ Medical Doctor
- ④ Physical Therapist
- ⑤ Other

a. When and what treatment?

b. What tests have you had for your symptoms and when were they performed?

- ① Xrays date: \_\_\_\_\_
- ② MRI date: \_\_\_\_\_
- ③ CT Scan date: \_\_\_\_\_
- ④ Other date: \_\_\_\_\_

10. Have you had similar symptoms in the past?

- ① Yes
- ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

- ① This Office
- ② Other Chiropractor
- ③ Medical Doctor
- ④ Physical Therapist
- ⑤ Other

11. What is your occupation?

- ① Professional/Executive
- ② White Collar/Secretarial
- ③ Tradesperson
- ④ Laborer
- ⑤ Homemaker
- ⑥ FT Student
- ⑦ Retired
- ⑧ Other

a. If you are not retired, a homemaker, or a student, what is your current work status?

- ① Full-time
- ② Part-time
- ③ Self-employed
- ④ Unemployed
- ⑤ Off work
- ⑥ Other

12. What do you hope to get from your visit/treatment (select all that apply):

- ① Reduce symptoms
- ② Resume/increase activity
- ③ Explanation of condition/treatment
- ④ Learn how to take care of this on my own
- ⑤ How to prevent this from occurring again
- ⑥

Patient Signature

Date

# Patient Health Questionnaire - page 2

ChiroCare of Wisconsin, Inc.

Patient Account Number

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

What type of regular exercise do you perform?      ① None      ② Light      ③ Moderate      ④ Strenuous

What is your height and weight?      Height 

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      Weight 

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 lbs.  

FeetInches

For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.

Past	Present	Past	Present	Past	Present
<input type="checkbox"/>	<input type="checkbox"/> Headaches	<input type="checkbox"/>	<input type="checkbox"/> High/Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/> Diabetes
<input type="checkbox"/>	<input type="checkbox"/> Neck Pain	<input type="checkbox"/>	<input type="checkbox"/> Heart Attack	<input type="checkbox"/>	<input type="checkbox"/> Excessive Thirst
<input type="checkbox"/>	<input type="checkbox"/> Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Chest Pains	<input type="checkbox"/>	<input type="checkbox"/> Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/> Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Stroke	<input type="checkbox"/>	<input type="checkbox"/> Smoking/Use Tobacco Products
<input type="checkbox"/>	<input type="checkbox"/> Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Angina	<input type="checkbox"/>	<input type="checkbox"/> Drug/Alcohol Dependence
<input type="checkbox"/>	<input type="checkbox"/> Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/> Allergies
<input type="checkbox"/>	<input type="checkbox"/> Elbow/Upper Arm Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Disorders	<input type="checkbox"/>	<input type="checkbox"/> Depression
<input type="checkbox"/>	<input type="checkbox"/> Wrist Pain	<input type="checkbox"/>	<input type="checkbox"/> Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/> Systemic Lupus
<input type="checkbox"/>	<input type="checkbox"/> Hand Pain	<input type="checkbox"/>	<input type="checkbox"/> Painful Urination	<input type="checkbox"/>	<input type="checkbox"/> Epilepsy
<input type="checkbox"/>	<input type="checkbox"/> Hip/Upper Leg Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Bladder Control	<input type="checkbox"/>	<input type="checkbox"/> Dermatitis/Eczema/Rash
<input type="checkbox"/>	<input type="checkbox"/> Knee/Lower Leg Pain	<input type="checkbox"/>	<input type="checkbox"/> Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/> Ankle/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/> Abnormal Weight Gain/Loss		
<input type="checkbox"/>	<input type="checkbox"/> Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/> Poor/Excessive Appetite		
<input type="checkbox"/>	<input type="checkbox"/> Joint Swelling/Stiffness	<input type="checkbox"/>	<input type="checkbox"/> Abdominal Pain		
<input type="checkbox"/>	<input type="checkbox"/> Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Heartburn		
<input type="checkbox"/>	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Constipation/Diarrhea/Vomiting		
<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/> Liver/Gall Bladder Disorder		
<input type="checkbox"/>	<input type="checkbox"/> General Fatigue	<input type="checkbox"/>	<input type="checkbox"/> Cancer		
<input type="checkbox"/>	<input type="checkbox"/> Inbalance	<input type="checkbox"/>	<input type="checkbox"/> Tumor		
<input type="checkbox"/>	<input type="checkbox"/> Visual Disturbances	<input type="checkbox"/>	<input type="checkbox"/> Asthma		
<input type="checkbox"/>	<input type="checkbox"/> Dizziness	<input type="checkbox"/>	<input type="checkbox"/> Chronic Sinusitis		

**Females Only**  

<input type="checkbox"/>	<input type="checkbox"/> Birth Control Pills
<input type="checkbox"/>	<input type="checkbox"/> Menstrual Irregularity/Cramps
<input type="checkbox"/>	<input type="checkbox"/> Pregnancy
<input type="checkbox"/>	<input type="checkbox"/> Last Menstual Cycle

**Children**    None    # of Children  
**Other Health Problems/Issues**  

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

Indicate if an immediate family member has had any of the following:

☐ Rheumatoid Arthritis    ☐ Heart Problems    ☐ Diabetes    ☐ Cancer    ☐ Lupus    ☐ \_\_\_\_\_

List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking:


List all the surgical procedures you have had and times you have been hospitalized:


Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Additional Comments


Doctors Signature \_\_\_\_\_ Date \_\_\_\_\_

**A. Notifier: Martinez Chiropractic Center - 12595 SW 137 Ave. Suite 108 Miami, FL 33186**

**B. Patient Name:**

**C. Identification Number:**

## Advance Beneficiary Notice of Non-coverage (ABN)

**NOTE:** If Medicare doesn't pay for **D. See Box D.** below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D. See Box D.** below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
Examinations X-Rays Physical Therapy and Massages Maintenance Care (S8990)	These services are NOT covered by Medicare	\$50.00 \$25.00 (each) \$10.00-\$90.00 \$50.00

### WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D. See Box D.** listed above.

**Note:** If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

### G. OPTIONS: Check only one box. We cannot choose a box for you.

- ☐ **OPTION 1.** I want the **D. See Box D.** listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.
- ☐ **OPTION 2.** I want the **D. See Box D.** listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.
- ☐ **OPTION 3.** I don't want the **D. See Box D.** listed above. I understand with this choice I am **not** responsible for payment, and I cannot appeal to see if Medicare would pay.

### H. Additional Information:

I understand that Medicare does not cover treatment on the same day as my evaluation. I acknowledge that I will be responsible for the cost of the evaluation should I choose to receive treatment on the same day. If I contact my insurance regarding this, I understand I am not entitled to reimbursement and understand that once the service is rendered, I will not be refunded by my insurance nor Martinez Chiropractic Center.

**This notice gives our opinion, not an official Medicare decision.** If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

**I. Signature:**

**J. Date:**

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