



Name: _____

Address: _____

City: _____

State: _____ Zip: _____

Date of Birth: ____ / ____ / ____ SS#: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

E-mail: _____

Primary Care Physician Information

Name: _____

Street: _____

City: _____

State: _____ Zip: _____

Phone: _____

CONFIDENTIAL PATIENT INFORMATION

This information is confidential. If we do not sincerely believe your problem will resopns favorably, we will not accept your case. We will refer you to disciplines we believe will help you. In order for us to understand your health problems, please complete this form neatly, accurately and completely. Thank you!

Date: _____

Name: _____ SS#: _____ Home Phone: _____

Street: _____ City: _____ Zip Code: _____

Age: _____ Birth Date: _____ Marital Status: S M W D How Many Children: _____

Occupation: _____ Employer: _____

Address: _____ Office Phone: _____

Name of Wife/Husband: _____ Occupation: _____

Employer: _____ Office Phone: _____

Other Nearest Relative: _____ Phone: _____

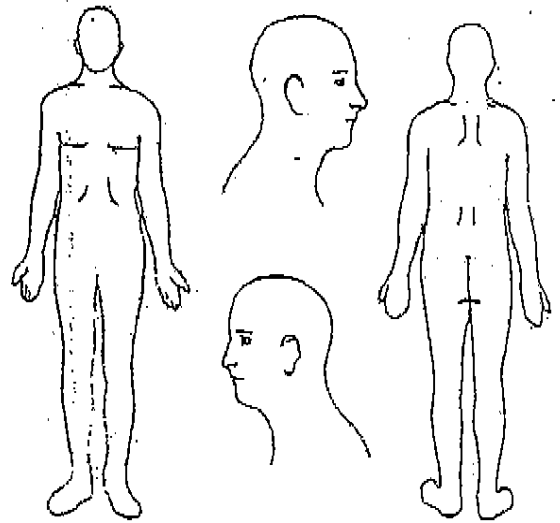
List present complaints, injuries and duration:

Please mark your area of pain on the figures below:

1. _____

2. _____

3. _____



Remarks and details of any accident:

List other doctors consulted for present complaints and injuries:

Name: _____ When Consulted: _____

Diagnosis: _____ Treatment: _____

How long did you see the Doctor? _____ How frequently: _____

Results: _____

Name: _____ When Consulted: _____

Diagnosis: _____ Treatment: _____

How long did you see the Doctor? _____ How frequently: _____

Results: _____

Present Family Doctor: _____ Date of last physical examination: _____

What surgeries have you had?

Type/When/Doctor/Remarks: _____

List former serious accidents and falls: (circle one ~ auto, work, home, leisure, sports, other)

What/When/Symptoms/Treatment/Results: _____

List broken bones:

What/When/Remarks: _____

List Medications and/or diet supplements you take:

What/Frequency/Doctors/Side Effects/Remarks: _____

Environment:

Work ~ Please circle appropriate answer
Seated/Standing ~ Work Bench/Desk/Counter/Other: _____
Job Involves ~ Lifting/Bending/Stooping/Twisting/Carrying/Walking/Standing/Other: _____
Chair ~ Executive/Steno/Bench/Stool/Folding/Other: _____
Shoes ~ High heels/Boots/Other: _____

Leisure:

Sedentary activities? Standing/Seated/Lying? TV/Reading/Card Games/Sewing/Other (Please describe)

Strenuous activities? Exercise ~ Type/Frequency/Length of time? _____

Sports ~ Type/Frequency/Length of time? _____

If you have discontinued sports or strenuous activities, why the change? _____
Exert Yourself ~ Frequently/Occasionally/Rarely/Never? Describe how: _____

Circle Current Conditions ~ Check Former Conditions**Nervous System**

Hot/Cold Spots	Nervousness	Insomnia	Numbness/Tingling
Personality Change	Depression	Fainting	Irritability
Forgetfulness	Paralysis	Tremors	Hiccups
Dizziness	Anxiety	Confusion	Convulsions Tension

Eye, Ear, Nose and Throat

Visual Disturbances	Hearing Loss	Canker Sores	Zig Zag Flashes
Nose Pain	Difficulty Speaking	Eye Strain	Nose Bleeding
Sinus Trouble	Eye Inflammation	Nose Discharge	Hay Fever/allergies
Sore Throat	Chronic Earache	Hoarseness	Ear Noises
Sore Mouth/Gums	Head Colds	Difficulty Breathing through Nose	
Light Sensitivity	Ear Discharge	Dental Problems	

Respiratory

Difficulty Breathing	Asthma	Tuberculosis	Chronic Cough
Allergies	Chest Colds	Coughing Phlegm/Blood	

Cardio-Vascular

Heart Attack	Slow Beating Heart	Poor Circulation	High Blood Pressure
Pain over Heart	Stroke	Low Blood Pressure	Hardening of Arteries
Varicose Veins	Rapid Beating Heart	Swelling of Ankles	

Skin

Skin Disorder	Itching	Boils	Acne
Bruise Easily	Hives or Allergies	Shingles	Dryness

General

Fever	Sweats	Cancer	Thyroid Disorder
Rheumatic Fever	Loss of Weight	Chills	Chronic Fatigue
Weight Trouble	Diabetes		

Gastro-Intestinal

Chronic Nausea	Belching Gas	Diverticulosis	Vomiting
Gastritis/Heartburn	Hemorrhoids	Vomiting Blood	Pain over Stomach
Liver Trouble	Food Allergy	Jaundice	Poor Appetite
Gall Bladder Trouble	Black Stool	Excessive Hunger	Constipation
Excessive Thirst	Diarrhea	Bloody Stool	Ulcers/Stomach Disorder
Colitis	Difficulty Chewing/Swallowing		

Genito-Urinary

Urine Disorder~Frequent/Excessive/Scanty/Painful/Discolored/Blood/Pus	Impotency
Bladder Trouble	Kidney Infections/Stones Bed-Wetting Prostatitis

Female

Periods ~ Painful/Excessive	Hot Flashes	Menopause Symptoms
Irregular/Cramps	Breast Lumps/Congested	Pregnant ~ Yes or No

Musculo-Skeletal

Recurring Headaches	Eye or Sinus Pain	Facial Spasms	Facial/Jaw Pain
Restricted Movement ~ Head/Neck	Neck Pain	Neck Spasms	Poor Posture
Upper Back Pain	Swollen Arm/Hand	Vision Problems	Pain/Stiff Joints
Sore, Aching "Shawl" Muscles	Shoulder/Arm/Hand	Arthritis	Bursitis
Pain Beneath/Under Shoulder Blade	Mid Back Pain	Chest Pain	Rib Cage Pain
Pain Beneath/Below Breast Bone	Hiatal Hernia	Scoliosis	Rheumatism
Restricted Movement ~ Torso	Low Back Pain	Neuritis	Neuralgia
Lumbago	Painful Tailbone	Buttock Pain	Hip Pain
Sciatica	Leg Cramps	Leg Pain ~ Lower/Upper	
Foot/Toe Pain	Sore/Weak Muscles	Walking Problems	
Restricted Movement ~ Leg/Foot	Pain around Collar Bone		
Restricted Movement ~ Shoulder/Arm/Hand			
Swollen/Painful/Stiff Joints ~ Leg/Foot			



Dr. Mike R. Marcell
Chiropractic Physician

Health Record Update:

NAME- _____ DATE- _____

PHONE- _____ EMAIL- _____

Chiropractic:

1. Have there been any recent changes to your health? Yes No
2. Have you had any falls or injuries that may have resulted in broken bones since your last visit? Yes No
3. Have you had a car accident since your last visit? Yes No
4. Have any of your family members or friends been recently involved in a car accident? Yes No
5. Have they been evaluated? Yes No
6. Do you have a friend or family member that you feel would benefit from chiropractic care? Yes No

Nutrition:

1. Do you currently take vitamins, minerals or herbal supplements? Yes No
2. If YES do you notice a difference in your health? Yes No
3. Are you interested in learning more about nutritional supplements? Yes No
4. Are you interested in a nutritionally based weight loss program that teaches you how to shop, cook, eat and exercise? Yes No

Exercise:

1. I currently exercise used to exercise do not exercise
2. Are you interested in starting to exercise? Yes No
3. What is your exercise goal?
 Weight loss Cardiovascular conditioning
 Strength Training Flexibility
4. Do you need a plan or guidance? Yes No
5. Would you be interested in a free consultation with a licensed personal trainer? Yes No



Financial Responsibility Agreement

I, the undersigned, have read and agreed to the following office procedure polices of **Complete Family Chiropractic Health Care**.

1. Payment is expected in full as services are rendered unless prior financial arrangements have been made.
2. The patient is responsible for any portion of an insurance claim which is not paid by their insurance company.
3. Patients involved in legal suits are responsible for any portion not paid by their insurance company. In the event of a legal settlement, all medical bills to **Complete Family Chiropractic Health Care** shall be paid out of settlement funds and before disbursement of settlement funds.
4. Any outstanding balances of thirty (30) days of age or greater are automatically presented to a collections attorney. A 30% fee is assessed to each account and the patient is responsible for all attorney fees and court fees.
5. Payment plans are available and will be privately discussed between the doctor and patient upon the patient's request.

Financial Responsibility Statement

I understand and agree that insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, against the Doctor's recommendations, my account balance will be immediately due and payable.

Signature

Date



Acknowledgement of Receipt of Notice of Privacy Practices
You may refuse to sign this acknowledgement

The undersigned acknowledges receipt of a copy of the currently effective notice of Privacy Practices for **Complete Family Chiropractic** this _____ day of _____, 20____

A copy of this signed, dated acknowledgement shall be effective as the original.

 Printed Name

 Signature

If you are the legal representative of the patient, please print the patients' name(s) and describe your authority: _____

Thank you and if you have any questions about this form, please contact our Privacy Officer.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representative's) signature on this acknowledgement.

- It was an emergency treatment.
- I could not communicate with the patient.
- The patient refused to sign.
- The patient was unable to sign because _____
- Other (please describe) _____
- Signature of Privacy Officer _____



Dr. Mike R. Marcell
Chiropractic Physician

Personal Injury Agreement

I have been involved in an injury which may involve litigation. I understand that this may create the need for documentation, correspondence, planning, etc., which is greater than for non-litigation related claims. I hereby agree that **Michael R. Marcell, D.C. and Complete Family Chiropractic Health Care** shall have the right not to bill my health insurance, Medicare, HMO, PPO or other, even if they are contracted providers on that plan. I do, therefore waive all rights to use such health insurance, Medicare, etc and agree that all providers for **Complete Family Chiropractic Health Care** may charge their usual and customary fees for all services provided and may place such charges under a **Letter of Protection**. I further affirm that I have been afforded the opportunity to review the fee schedule for **Complete Family Chiropractic Health Care** and agree in advance that such fees are reasonable for the services provided.

In addition, I agree that I, or anyone on my behalf, will not submit my bills to my health insurance without the permission of **Complete Family Chiropractic Health Care**. I understand and agree that I am ultimately responsible for the full payment of any bills incurred as a result of my treatment with **Complete Family Chiropractic Health Care** after payment by personal injury protection insurance or other liability insurance. I understand that payment of any balance may be postponed until the time of settlement upon issue of an acceptable **Letter of Protection** by my attorney to **Complete Family Chiropractic Health Care**. I also understand that if this **Letter of Protection** is not honored, not executed or signed, or if I change my attorney that I will be responsible for the balance in full.

I do also, hereby, waive all rights to attorney/client privilege and authorize **Michael R. Marcell, D.C. and Complete Family Chiropractic Health Care** to obtain any and all information from my attorney that they, in their sole discretion, deem necessary.

I understand and agree to the above.

Signature

Date

Complete Family Chiropractic
1244 South Pinellas Avenue
Tarpon Springs, Fl 34689
Phone (727)937-2086
Fax (727)939-2554

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____ SSN: _____

Information Requested From:

Name: _____

Address: _____

Phone: _____

Recipient Of Information:

Self Other

Address: _____

Phone: _____

Information To Be Disclosed:

- Admission Form
- Physician Dictated records
- Physician Orders
- Physician Progress Notes
- ER Documentation
- X-Ray Reports
- Laboratory Reports
- Operative Documentation
- X-Ray Films
- Entire Medical Record

Purpose Of Disclosure:

Continuing care with another physician or hospital Personal Copy Other

Authorization:

I understand that:

This authorization will remain in effect for 30 days.
I may revoke this authorization at any time in writing, but if I do it will not affect any actions taken prior to receiving the revocation.
I may refuse to sign this authorization and that it is strictly voluntary
My treatment, payment, enrollment of eligibility for benefits may not be conditioned on signing this authorization
If the requestor or receiver is not health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed
I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy, fee if I ask for it.
I will receive a copy of this form.

I acknowledge, and hereby consent to such, that the protected health information released may contain alcohol, drug abuse, psychiatric, HIV results or AIDS information. I also acknowledge I have read the above and authorize the disclosure of the protected health information as stated.

Patient/Guardian
Signature: _____

Date: _____

Patient/Guardian
Printed Name: _____

Date: _____



OFFICE OF INSURANCE REGULATION
Bureau of Property & Casualty Forms and Rates

Standard Disclosure and Acknowledgement Form
Personal Injury Protection - Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

1. The services or treatment set forth below were **actually rendered**. This means that those services have already been provided.

2. I have the right and the duty to **confirm** that the services have already been provided.
3. I was **not solicited** by any person to seek any services from the medical provider of the services described above.
4. The medical provider has **explained** the services to me for which payment is being claimed.
5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to \$500.

Insured Person (patient receiving treatment or services) or Guardian of Insured Person:

Name (PRINT or TYPE)

Signature

Date

The undersigned licensed medical professional or medical director, if applicable, affirms the statement numbered 1 above and also:

- A. I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.
- B. The treatment or services rendered were explained to the insured person, or his or her guardian, **sufficiently** for that person to sign this form with informed consent.
- C. The accompanying statement or bill is **properly completed** in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to **truthfully, accurately, and in a substantially complete manner**.
- D. The coding of procedures on the accompanying statement or bill is proper. This means that **no service has been upcoded, unbundled, or constitutes an invalid or not medically necessary diagnostic test** as defined by Section 627.732(14) and (15), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Licensed Medical Professional Rendering Treatment/Services or Medical Director, if applicable (Signature by his/ her own hand):

Name (PRINT or TYPE)

Signature

Date

Any person who files an application for a license or certificate with the Department of Banking and Finance shall be deemed to have accepted the terms and conditions of the license or certificate. This includes the requirement that the licensee or certificate holder shall maintain a current and valid license or certificate at all times.

Note: This form is not to be used for any purpose other than that for which it was designed. It is not to be electronically transmitted. It is not to be used for any purpose other than that for which it was designed.



Dr. Mike R. Marcell
Chiropractic Physician

Dr. Anna Batten-Lange
Chiropractic Physician

Assignment of Benefits

ASSIGNMENT OF BENEFITS, AUTHORIZATION TO PROVIDE MEDICAL PROVIDER WITH INFORMATION REGARDING INSURANCE COVERAGE AND AUTHORIZATION TO RESERVE BENEFITS IN EVENT DISPUTE ARISES REGARDING PAYMENT

By way of original or a copy hereof, I the undersigned patient, do hereby irrevocably assign to Complete Family Chiropractic Health Care all rights and personal injury protection and/or medical payments benefits under any policy of motor vehicle insurance providing coverage to me as a result of my motor vehicle accident. Said benefits are being assigned to Complete Family Chiropractic Health Care for services and/or supplies rendered to me which were necessitated by my motor vehicle accident.

I also hereby authorize and direct my applicable personal injury protection and/or medical payments insurance carrier to make any and all checks out to Complete Family Chiropractic Health Care only as a result of said services and to forward same to Complete Family Chiropractic Health Care's place of business. Additionally, I direct my applicable personal injury protection and/or medical payments insurance carrier to provide my medical provider with a pre-authorization and/or verification of the amount of PIP/medical payment coverage available to me under my insurance policy. Lastly, in the even a dispute arises with regards to payment of any services rendered at Complete Family Chiropractic Health Care to me as a result of my motor vehicle accident, I hereby direct my applicable personal injury protection and/or medical payments insurance carrier to reserve an amount of personal injury protection and/or medical payment benefits sufficient to cover the disputed amount and that said reserve shall not be utilized until such time the dispute is resolved between Complete Family Chiropractic Health Care and my applicable personal injury protection and/or medical payments insurance carrier.

Patient's Signature

Date

Printed Name