# WATT FAMILY CHIROPRACTIC

2255 N. Wickham Road, Suite 109 Melbourne, FL 32935 Phone: (321)253-8511 Fax: (321)253-8711

Name:_____SSN:____-____-_____Date:_____

Address:_____City:_____ST:_____ ZIP:_____

Home Phone: (____)_____-_____Cell Phone #: (____)_____-_____ Cell Phone Carrier_____

Text Message Appt Reminder: Y___ N___ E-Mail:_____

Marital Status:_____ Date of Birth:_____Height:__'__"Weight:_____ Sex: M___ F___

How did you hear about us? _____

Have you been to a Chiropractor before? __Yes __No Name of Dr. _____

Condition treated for:_____

## What brings you in today?

**Primary Issue:** (Please Describe) _____

_____

_____

How did it start?: _____

_____

_____

What would you rate the Pain / Discomfort right now? (Circle)

(Best) 0 1 2 3 4 5 6 7 8 9 10 (Worst)

What would you rate the Pain / Discomfort at its worst? (Circle)

(Best) 0 1 2 3 4 5 6 7 8 9 10 (Worst)

How frequently does it happen? (Check One)

__Constant __Most of the time __Frequently __Comes and Goes __Rarely

Did it start: (Circle One) __Gradually __All of a sudden __Not sure

How long have you had it?: _____

What makes the pain worse?: (Check All that Apply)

__Everything __Nothing __Bending __Standing __Walking __Sitting __Lifting
__Carrying __Stress __Exercise __Twisting __Coughing/Sneezing __Sleeping
Other: _____

What makes the pain better? (Check All that Apply)

__Nothing __Chiropractic Adjustments __Rest __Ice __Heat __Sitting
__Medications (Prescription or Over the Counter) __Stretching __Exercising
__Standing __Massage __Other: _____

# WATT FAMILY CHIROPRACTIC

2255 N. Wickham Road, Suite 109 Melbourne, FL 32935 Phone: (321)253-8511 Fax: (321)253-8711

What is the quality of the pain? (Check All that Apply) __Sharp __Dull __Achy __Throbbing
__Burning __Tightness __Soreness __Other:_____

Has the pain been getting: (Check One)

__Better __Slowly Better __Worse __Slowly Worse __Staying the same

**Secondary Issue**: (Please Describe)_____
_____
_____

What would you rate the Pain / Discomfort right now? (Circle)

(Best) 0 1 2 3 4 5 6 7 8 9 10 (Worst)

What would you rate the Pain / Discomfort at its worst? (Circle)

(Best) 0 1 2 3 4 5 6 7 8 9 10 (Worst)

How frequently does it happen? (Check One)

__Constant __Most of the time __Frequently __Comes and Goes __Rarely

Did it start: (Check One) __Gradually __All of a sudden __Not sure

How long have you had it?: _____

What makes the pain worse?: (Check All that Apply)

__Everything __Nothing __Bending __Standing __Walking __Sitting __Lifting
__Carrying __Stress __Exercise __Twisting __Coughing/Sneezing __Sleeping
Other: _____

What makes the pain better? (Check All that Apply)

__Nothing __Chiropractic Adjustments __Rest __Ice __Heat __Sitting
__Medications (Prescription or Over the Counter) __Stretching __Exercising
__Standing __Massage __Other: _____

What is the quality of the pain? (Check All that Apply) __Sharp __Dull __Achy __Throbbing
__Burning __Tightness __Soreness __Other:_____

Has the pain been getting: (Check One)

__Better __Slowly Better __Worse __Slowly Worse __Staying the same

Any other issues?: (List)

_____
_____
_____
_____

# WATT FAMILY CHIROPRACTIC

2255 N. Wickham Road, Suite 109 Melbourne, FL 32935 Phone: (321)253-8511 Fax: (321)253-8711

**Personal History:**

What percentage of the time do you eat healthy, well-balanced meals?: (Circle One)

10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

How often do you drink alcohol? Frequently Occasional Rarely Never

How often do you use tobacco? Frequently Occasional Rarely Never

How often do you use drugs? Frequently Occasional Rarely Never

How often do you Exercise? Frequently Occasional Rarely Never

Describe Type of Exercise: _____

Highest level of education completed: _____

What is your occupation?: _____ For how long?: _____

Females: Is there a possibility you are pregnant? __Yes __No

**Past Medical History:**

What problems have you had in the past? (Check All that Apply)----------

__Allergies __Appendicitis __Arthritis __Asthma __Cancer __COPD __Diabetes
__Disc Issues __Heart Disease __Hernia __HIV/AIDS __High Blood Pressure __Stroke
__Osteoporosis __Thyroid Issues __Whiplash __Other:_____

Have you been in any traumatic auto accidents: (List the year and any injuries reported)_____

_____

Have you broken any bones? (List the bones and the year) _____

_____

What surgical procedures have you had? (List the Procedures and Years Performed)

_____

_____

What Medications are you currently taking?: (List) _____

_____

_____

**Family History:**

How many children do you have?: _____

Please describe your family's health:

Mother: _____ Siblings:_____
Father:_____ Children:_____

# WATT FAMILY CHIROPRACTIC

2255 N. Wickham Road, Suite 109 Melbourne, FL 32935 Phone: (321)253-8511 Fax: (321)253-8711

**Review of Systems:**

Do any of these issues apply to you? (Check) __None

| | | | |
|---|---|---|---|
| Constitutional | __Unexplained weight loss<br>__Loss of appetite<br>__Fever | __Fatigue<br>__Insomnia | __Night sweats<br>__Poor memory |
| Neurological | __Frequent loss of consciousness<br>__Numbness<br>__Changes in sight<br>__Changes in taste<br>__Changes in bladder habits | __Headaches<br>__Weakness<br>__Changes in smell<br>__Changes in speech<br>__Changes in bowel habits | __Seizures<br>__Poor balance<br>__ Changes in hearing |
| Psychiatric | __Depression<br>__Personality Changes | __Anxiety<br>__ADD | __Paranoia<br>__ADHD |
| Visual | __Eye pain<br>__Double vision | __Floaters<br>__Blurry vision | __Crossed eyes |
| Ears, Nose, Throat | __Earaches<br>__Ear fullness<br>__Persistent cough<br>__Toothache | __Ringing in the ears<br>__Sinus issues<br>__Sore throat | __Loss of hearing<br>__Hoarseness<br>__Painful swallowing |
| Respiratory | __Breathlessness<br>__Asthma | __Cough<br>__Allergies | __Chest pain<br>__Cough up fluid |
| Cardiovascular | __High blood pressure<br>__Palpitations<br>__Shortness of breath<br>__Fainting | __Low blood pressure<br>__Rapid heart beat<br>__Varicose veins | __Chest pain<br>__Ankle Swelling<br>__Lightheadedness |
| Genito-urinary | __Painful urination<br>__Lack of bladder control<br>__Irregular pap smear | __Bloody urination<br>__Irregular menses<br>__Genital discharge | __Frequent urination<br>__Menopause |
| Gastrointestinal | __Constipation<br>__Vomiting<br>__Hemorrhoids | __Diarrhea<br>__Indigestion<br>__Unusual stools | __Nausea<br>__Lack of appetite |
| Endocrine | __Diabetes | __Hyperthyroid | __Hypothyroid |
| Skin | __Itching<br>__Changes in moles<br>__Sores won't heal | __Hives<br>__Lumps | __Rashes<br>__Bruises easily |

Do you have problems with any organs?: (Check) __ None

__Brain __Eyes __Ears __Thyroid __Throat __Lungs
__Heart __Pancreas __Liver __Kidneys __Spleen __Stomach
__Bowels __Bladder __Prostate __Uterus __Rectum
__Reproductive Organs

# WATT FAMILY CHIROPRACTIC

2255 N. Wickham Road, Suite 109 - Melbourne, FL 32935 - (321)253-8511 - Fax (321)253-8711

## Electronic Health Records Intake Form

*In compliance with requirements for the government EHR incentive program*

**First Name**:_____ **Last Name**:_____

**Email address:** _____@_____

**Preferred method of communication for patient reminders** (Circle one): Email / Phone / Mail

**DOB:** __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

**Smoking Status (Circle one):** Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked
Date started smoking: ____/____/_____

*CMS requires providers to report both race and ethnicity*

**Race (Circle one):** American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / Other / I Decline to Answer

**Ethnicity (Circle one):** Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

**Are you currently taking any medications?** (Please include regularly used over the counter medications)

| Medication Name | | Dosage and Frequency (i.e. 5mg once a day, etc.) | |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Do you have any medication allergies?**

| Medication Name | Reaction | Onset Date | Additional Comments |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: _____ Date:_____

***For office use only***

Height: _____ Weight:_____ Blood Pressure:_____ /_____ Pulse:_____

# WATT FAMILY CHIROPRACTIC

Dr. Britaney Watt Dr. Bradley Watt

## INSURANCE INFORMATION NOTICE

* * * **Please read this over carefully** * * *

Our clinic supplies this information only as a general guide to assist you in understanding how our insurance may work and what our policies concerning insurance are. This information in no way supersedes your written policy you have between you and your insurance company.

### Insurance Assignment

In our clinic most patients with insurance choose to be on assignment. This means that we bill your insurance company directly for the services we have rendered to you. This does not excuse any patient from responsibility for the deductible, co-payment, or any unpaid portion of their bill.

### Deductible

A "deductible" is the initial portion of your care that your policy requires you pay your doctor before your insurance will start to pay for your care. Each policy has a different deductible which is usually stated in your insurance handbook. You will need to pay the standard fees to our clinic until you have met your yearly deductible, unless you can show proof that your deductible has been met prior to your receiving care with us.

### Co-Payment

Most insurance companies pay for a large percentage of your health care, usually 80%. However, this percentage can vary depending on your individual policy. A co-payment is that portion of your bill that the insurance company does not pay for. In the case where the insurance company pays 80%, your co-payment is the remaining 20%. Your co-payment is entirely your responsibility and will be paid at the time services are rendered unless prior arrangements are made with the doctor.

### Itemized Billing

In accordance with Florida State Statutes, all bills submitted by this clinic are in an itemized form. This means that on each visit to our clinic there may be charges for two, three, or more services that are sent into your insurance company. For an explanation of our itemized billing and charges, please consult our standard fee sheet.

2255 N. Wickham Road, #109 - Melbourne, FL 32935 - (321)253-8511 - Fax (321)253-8711

# WATT FAMILY CHIROPRACTIC

Dr. Britaney Watt Dr. Bradley Watt

Secondary Insurance

If you have a secondary insurance aside from your regular primary insurance, our clinic may process this insurance also. Before processing, we would need to review your secondary to determine the policy benefits. Processing your secondary will probably not eliminate your deductible and may not affect your need to make a co-payment. If an overpayment occurs, you will be reimbursed.

Limitations on Certain Policies

Unfortunately, certain insurance companies have policies, which limit Chiropractic care. If limitations do exist, the patient is responsible for all care rendered beyond the limitation.

If you have any additional questions concerning insurance, please ask one of our staff for assistance.

I have read and understand the forgoing.

| _____ | _____ | _____ |
|---|---|---|
| Date | Signature/Guarantor or Policyholder | Print Name |

2255 N. Wickham Road, #109 - Melbourne, FL 32935 - (321)253-8511 - Fax (321)253-8711

Doctor-Patient Relationship in Chiropractic

Chiropractic:

It is important to be an aware and an informed patient. We have found that an honest, open understanding of chiropractic care is helpful in order to bring about your potential for maximum health.

Your body has a potential to function at 100%. Our goal in chiropractic is to achieve better communication between the brain and the rest of the body through a fully functioning nervous system thus allowing the body the potential to function at 100%. We achieve this through chiropractic adjustments which correct spinal nerve interference called vertebral subluxations. When a vertebral subluxation is present in the spine, the body is unable to function at 100% thus sickness and disease occurs.

When a chiropractic adjustment is provided by the chiropractor, the body is able to approach its potential to express optimum health. This is because of better communication through the nervous system by the reduction and correction of the vertebral subluxation and its related components. Rather than treat the resulting disease or your symptoms, chiropractors correct the subluxation and the resulting nerve interference, which is the number one cause of why the body functions at less than 100%. Instead of masking the symptoms with medications, chiropractors look for the cause and correct the cause of your symptoms.

Analysis:

You will undergo a chiropractic examination for the detection of vertebral subluxations and their related components. During the examination the chiropractor will evaluate how the spine moves and what it feels like. Based upon the results of the examination findings, X-rays of the spine may be performed. These X-rays will tell the doctor how far the vertebra is misaligned and in what direction. The X-rays will also help determine the most efficient chiropractic technique to effectively adjust and correct the spinal subluxations.

Diagnosis:

Only a chiropractor can determine if your case is a chiropractic case. Medical doctors diagnose disease, chiropractors diagnose vertebral subluxations. Your diagnosis in this clinic will reflect spinal nerve interference which is caused by vertebral subluxations. Our doctors will work with any other health care provider for your benefit. Inversely, you should expect all other health care providers to work together with your chiropractor for your benefit. This team approach to your health care will benefit you, the patient, the best.

Chiropractic Adjustments:

The patient, in coming to the chiropractor, gives the chiropractor permission and authority to adjust the patient for spinal subluxations. In rare cases, physical defects, deformities or pathology may render the patient susceptible to injury. The chiropractor, of course, will not provide chiropractic adjustments if he is aware of any such conditions. If the patient is aware of any latent pathological defects, illness or deformities which would not otherwise come to the attention of the chiropractor, it is their responsibility to notify the chiropractor. The patient

should not look to the chiropractor for in-depth diagnostic procedures. The chiropractor provides a specialized health service in the detection and correction of the vertebral subluxation and its related components. Any risks regarding chiropractic treatment will be explained upon request.

Results:

No doctor can promise a cure or guarantee results. The purpose of chiropractic care is to promote natural health through the release of maximum nerve energy. Since there are so many variables, it is difficult to predict the time schedule or efficiency of chiropractic procedures. Sometimes the response is phenomenal. In most cases there is a more gradual but quite satisfactory response. In some it is only partial or not at all. Regardless of the disease, the chiropractor is not offering to heal, treat or cure it.

A major premise in chiropractic is that the body is a self healing organism and by removing the vertebral subluxation, hence the nerve interference, it can function as close to 100% as possible. However, you must remember that there is no process that does not take time, this includes the healing process. The longer the problem has been in the body the longer the healing process will take. The chiropractor's goal is to allow the body to express health at its optimum without nerve interference. This goal is accomplished through the chiropractic adjustment by the correction of the vertebral subluxation.

Privacy:

The ***Standards for Privacy of Individual Identifiable Health Information*** (Privacy Rule) establishes, for the first time, a set of national standards for the protection of certain health information. The U.S. Department of Health and Human Services issued the Privacy Rule to implement the requirement of the ***Health Insurance Portability and Accountability*** Act of 1996 (HIPAA). A major goal of the Privacy Rule is to assure that individuals' health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care and to protect the public's health and well being.

You can be assured that our clinic takes your privacy seriously and is in compliance with all HIPPA guidelines. Your health information will not be disclosed without your permission or will your name, address or telephone number be disclosed to any third party. Our privacy policy is posted in the reception area and is available at the front desk upon your request.

Questions

Just as in a good marriage, proper communication is an absolute necessity. We want to help you attain your goal of health. If at any time your response is not satisfactory, we will gladly assist you in choosing a referral doctor for another option. Your health is our number one priority.

Acknowledgement:

I have read and understand the foregoing.

Date _____ Signature _____

Witness _____

# WATT FAMILY CHIROPRACTIC LLC

Dr. Britaney Watt Dr. Bradley Watt

## CASH ASSIGNMENT

## FINANCIAL RESPONSIBILITY AGREEMENT

Patient Name _____ SS# _____ Birth Date_____

Billing Address_____

---

Home Phone _____ Work Phone _____ Cell Phone_____

**This is to certify that the above named individual or guarantor agrees to pay in full for all professional services rendered at the time they are performed, unless other arrangements are made in advance of the set appointment**. The guarantor understands a $25.00 returned check fee will be charged along with any appropriate collection or attorney's fee which may accrue upon collection of any outstanding balance.

A photocopy of this assignment shall be considered as effective and valid as the original.

*Privacy: The Standards for privacy of Individually Identifiable Health Information "Privacy Rule" establishes, for the first time, a set of National Standard for the Protection of Certain Health Information. The U.S. Department of Health and Human Services issued the Privacy Rule to implement the requirement of the Health Insurance Portability and Accountability Act of 1996 "HIPAA". A major goal of the Privacy Rule is to assure that individual's health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care and to protect the public's health and well being.*

*You can be assured that our clinic takes your privacy seriously and is in compliance with all HIPPA guidelines. Your health information will not be disclosed without your permission or will your name, address or telephone number be disclosed to any third party.*

I have read and understand the foregoing.

_____ _____ _____

Date Signature/Guarantor or Policyholder Print Name

2255 N. Wickham Road, #109 - Melbourne, FL 32935 - (321)253-8511 - Fax (321)253-8711

# WATT FAMILY CHIROPRACTIC

Dr. Britaney Watt Dr. Bradley Watt

## Assignment and Instruction for Direct Payment to Doctor Private and Group Accident and Health Insurance

Patient name: _____ SSN: _____ Birth date: _____

I hereby instruct and direct _____ Insurance Company to pay benefits by check made out and mailed to:

WATT FAMILY CHIROPRACTIC
2330 N. WICKHAM RD. SUITE 5
MELBOURNE, FL 32935
Or

If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows:

c/o WATT FAMILY CHIROPRACTIC, 2330 N. WICKHAM RD. SUITE 5, MELBOURNE, FL 32935

the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional service rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY TO WATT FAMILY CHIROPRACTIC FOR PAYMENT OF PROFESSIONAL SERVICES RENDERED. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. I assign to said clinic all rights patient has under any contract of insurance for collection of same.

This is to certify that the above named patient authorizes the request of any records pertinent to the health care of same individual from but not inclusive of any insurance carrier, adjustor, attorney, or other health care provider.

This also authorizes this facility to release records, upon receipt of the above named patient's signature, or on an emergency basis, to, but not inclusive of, any insurance carrier, attorney, health care provider, hospital, or immediate family member.

This also certifies that the above named individual agrees to pay in full for all professional services rendered at the time they are performed, unless other arrangements are made in advance of the set appointment. The below named guarantor understands a $10.00 returned check fee will be charged along with any appropriate collection or attorney's fee which may accrue upon collection of any outstanding balance.

A photocopy of this assignment shall be considered as effective and valid as the original.

Privacy: The *Standard5 for Privacy of Individually Identifiable Health Information* ("Privacy Rule") establishes, for the first time, a set of national standards for the protection of certain health information. The U.S. Department of Health and Human Services issued the Privacy Rule to implement the requirement of the *Health Insurance Portability and Accountability Act* of 1996 ("HIPAA") A major goal of the Privacy Rule is to assure that individuals' health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care and to protect the public's health and well being.

You can be assured that our clinic takes your privacy seriously and is in compliance with all HIPP A guidelines. Your health information will not be disclosed without your permission or will your name, address or telephone number be disclosed to any third party.

I have read and understand the foregoing.

Primary Subscriber Name _____ Date of Birth _____

| _____ | _____ | _____ | _____ |
|---|---|---|---|
| Date | Policyholder/Guarantor | Print Name | SS#. |