Elevate Chiropractic, Inc. d/b/a

Destination Health & Wellness

The following information is needed to better serve you. Please complete all questions. If you need help, please ask the receptionist. PLEASE PRINT.

Today's Date _____

Name _____ Date of Birth_____/_____/_____
Address _____
City _____ State _____ Zip _____Social Security Number_____
Home Phone_____ Cell Phone_____
Email Address _____ Work Phone_____
Name of Parent/Spouse_____ Phone Number_____
Emergency Contact _____ Phone Number_____
Marital Status _____ Occupation _____

Reason for the Visit:

- ❑ Pain Symptoms
- ❑ Wellness Visit
- ❑ Auto Accident
- ❑ Work Related Injury
- ❑ Sports Injury
- ❑ Other Injury

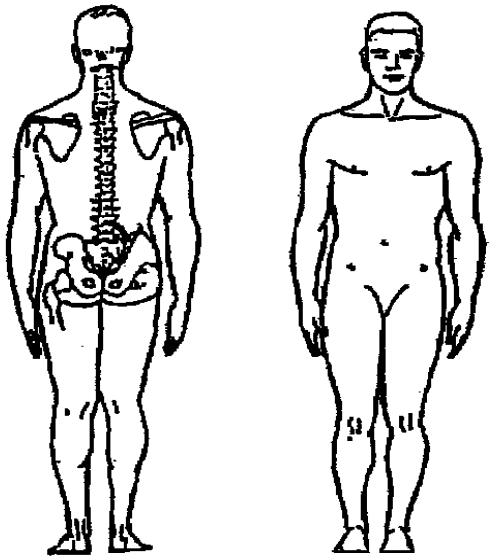
Date of Injury_____

Primary Symptoms: (Check all that apply)

❑Headache	❑Migraines	❑Neck pain	❑Neck stiffness	❑Shoulder pain
❑Arm pain	❑Low back pain	❑Hip pain	❑Leg pain	❑Back pain
❑Soreness	❑Discomfort	❑Numbness	❑Tingling	❑Dizziness
❑Fatigue	❑Weakness	❑Memory loss	❑Hearing loss	❑Depression
❑Elbow pain	❑Knee pain	❑Digestion	❑Sweating	❑Sleep problems
❑Irritability	❑Chest pains	❑Numbness in toes	❑Numbness in fingers	❑Buzzing in ears
❑Shortness of breath	❑Feet cold	❑Hands cold	❑Loss of balance	❑Ringing in ears
❑Pins & needles in arm	❑Pins & needles in leg	❑Fainting	❑Light bothers eyes	❑Upset stomach
❑Loss of smell	❑Loss of taste	❑Constipation	❑Diarrhea	❑Head feels heavy

❑Other_____

If you are in pain, please circle the location of your pain on the diagram.



Please describe the pain:

Severity: ❑Mild ❑Moderate ❑Severe

Frequency: ❑Intermittent ❑Occasional ❑Frequent ❑Constant

Quality: ❑Dull ❑Medium ❑Sharp ❑Stabbing ❑Burning

The pain is worse: (Check all that apply)

❑Morning ❑Midday ❑After work ❑Evenings ❑Nighttime

Past History:

What other conditions have you been treated for?_____
_____
_____
What surgeries or procedures have you had? Dates?_____
_____
_____
List any current allergies: (Be specific) _____
_____
_____
List any current medications or supplements you are currently taking: (Be specific)_____
_____
_____

Medical History: (Check all that apply)

❑Diabetes	❑Arthritis	❑AIDS	❑Sciatica	❑Bursitis	❑Osteoporosis
❑Kidney dis.	❑Gout	❑Ulcers	❑Cancer	❑Stroke	❑High blood pressure
❑COPD	❑Scoliosis	❑Deafness	❑Blindness	❑Disc disorder	❑Low blood pressure
❑Constipation	❑Diarrhea	❑Nausea	❑Vomiting	❑Fainting	❑Heart attack
❑Sweats	❑Chills	❑Eczema	❑Asthma	❑Allergies	❑Varicose veins
❑Prostate	❑Menstrual	❑Bleeding	❑Tonsilitis	❑Earaches	❑Hemorrhoids
❑Neuro muscular disease		❑COVID-19			

❑Other_____

Family History:_____
_____
_____

Social Activities:

❑Smoke cigarettes_____#packs per day ❑Smoke cigars ❑ Former Smoker ❑I don't smoke
❑Drink alcoholic beverages_____#per day or _____# per week ❑I don't drink
❑I have a history of recreational drug use ❑I do not have a history of recreational drug use
❑ I am currently pregnant ❑ There is a possibility that I am currently pregnant ❑I am not pregnant

Habits:

Sleep:	❑Heavy	❑Moderate	❑Light	❑None
Exercise:	❑Heavy	❑Moderate	❑Light	❑None
Appetite:	❑Heavy	❑Moderate	❑Light	❑None
Caffeine:	❑Heavy	❑Moderate	❑Light	❑None

What activities of daily living do you have difficulty performing due to your pain?

❑Sleeping ❑Walking ❑Standing ❑Sitting ❑Running ❑Climbing ❑Bathing ❑Showering
❑Dressing ❑Shoes ❑Toileting ❑Cleaning ❑Self care ❑Family care ❑Child care ❑Home care
❑Driving ❑Gardening ❑Working ❑Lifting ❑Desk work ❑Traveling ❑School ❑Concentrating

Describe how the pain affects these activities of daily living:

_____
_____
_____

❑ Auto Accident OR Slip/Trip and Fall

Date of the accident_____ Time of accident _____AM/PM
You were the: ❑Driver ❑Passenger, front ❑Passenger, rear left ❑Passenger, rear right ❑Pedestrian

Location of accident_____
Were you wearing a seatbelt? ❑ Yes ❑ No
Is there a Police Report? ❑ Yes ❑ No
Were you seen anywhere else? ❑ Yes ❑No
Did you receive aid at the scene? ❑ Yes ❑No
Were you taken to the hospital? ❑ Yes ❑No
Was there any imaging done? ❑ Yes ❑No

Where did you get treatment/imaging?_____
What type of treatment or imaging was rendered? _____
_____

Type of car you were in_____ Year?_____ Type of car that hit yours?_____
Estimated speed of your vehicle?_____ Estimated speed of other vehicle?_____
Other people in the vehicle_____
Name of your insurance carrier:_____
Claim number:_____ Insurance Policy Number:_____

On a scale of 1 (mild) to 10 (severe), how do you feel? Circle one number below.
1 2 3 4 5 6 7 8 9 10

Did you hit? ❑Air Bag ❑Steering Wheel ❑Side Door ❑Windshield ❑Dashboard ❑Other_____
Did the air bags deploy? ❑ Yes ❑ No Did you lose consciousness? ❑ Yes ❑ No

Describe the accident:_____
_____
_____
_____
Which direction you were looking?:_____
Any previous accidents: ❑Yes ❑No If yes, when:_____
Weather conditions: Dark, sunny, wet etc. _____
Do you have an attorney who has advised you in this case: ❑Yes ❑No If yes, Attorney Name and Phone:_____
_____

❑ Work Related Injury

Date of the injury_____ Time of injury _____AM/PM
Job Title:_____ Company:_____ Years on the job_____
Describe your normal work activities:_____
_____

Did you file a report? ❑ Yes ❑ No Were you taken to the hospital? ❑ Yes ❑ No
Describe in detail how the injury happened:_____
_____
_____
_____

OFFICE FINANCIAL POLICIES

GENERAL FINANCIAL POLICY

It is customary to pay for professional services when services are rendered. Elevate Chiropractic, Inc. d/b/a Destination Health & Wellness's policy is that payment be rendered at the time of each visit, unless alternate payment arrangements are made before services are rendered. Elevate Chiropractic, Inc. d/b/a Destination Health & Wellness (Destination Health & Wellness) may make payment plan arrangements on an individual basis. Any such plan or arrangement will be discussed during the patient's report of findings. If the patient is referred to another specialist or discontinues care for any reason, the patient's bill is due and payable in full immediately.

INSURANCE POLICIES AND OUR PRACTICE

All patients are on a cash basis. Destination Health & Wellness does not submit claims to any health insurance companies except for Medicare. The patient may choose to submit receipts to the patient's insurance company or other third-party healthcare programs (excluding Medicare), but payment for such services by insurance companies is neither implied nor agreed to by Destination Health & Wellness. Destination Health & Wellness takes *no responsibility* for non-payment by health insurance companies for services rendered at our clinic. Destination Health & Wellness will not respond to *any* requests from health insurance companies for information on any patient's case. However, upon patient request, Destination Health & Wellness will provide the patient a copy of the patient's records, bills, and x-rays.

Destination Health & Wellness does accept automobile insurance (auto insurance). If during the course of care at Destination Health & Wellness, the patient becomes involved in an accident or slip/trip and fall, the patient MUST notify the front desk BEFORE the patient is seen by the doctor. Auto insurance policies are an arrangement between an insurance carrier and the patient. At the patient's request, Destination Health & Wellness will submit claims to auto insurance companies and will respond to requests from auto insurance companies. However, the patient is personally responsible for payment of all services not covered through auto insurance. Destination Health & Wellness takes no responsibility for non-payment by auto insurance companies for services rendered at our clinic.

CHECK RETURN POLICY

A $35 fee for any returned checks will be charged to the patient's account. Full balance including returned check fee will be due immediately.

COLLECTIONS POLICY

If a balance remains on the patient's account for more than 90 days, the outstanding bill will be transferred to a collections agency. In order to avoid Destination Health & Wellness transferring the outstanding balance to collections, Destination Health & Wellness requires a minimum monthly payment of $20. Once three statements have been mailed and no payment has been received, or monthly payments have been received in an amount less than the minimum $20 per month, the patient's account will be transferred to a collections agency. Before the outstanding bill is transferred to a collections agency, the patient's account will be assessed an additional $20 processing fee. If we have to retain an attorney to collect on overdue amounts, the patient will be responsible for payment of the costs and reasonable attorney's fees incurred by Destination Health & Wellness.

By signing below, it states that you have read and understand the Office Financial Policy and agree to abide by these terms.

I (We) agree to pay for services rendered to the above-mentions patient as the charges are incurred. I understand and agree that insurance policies are an arrangement between an insurance carrier and myself. I understand that I am personally responsible for payment of all services not covered through insurance. I also understand that if I suspend or terminate my treatment and care, any fee for professional services rendered to me will be immediately due and payable.

Patient's (or Guardian's) Signature_____ Date____/____/____

INFORMED CONSENT

We want you to be informed about the care in which you may receive, including risks and benefits. This information is given so that you may be knowledgeable about your choice to consent to chiropractic care.

Risks & Benefits of Chiropractic Care:

Chiropractic treatment involves the science, philosophy, and art of locating and correcting spinal misalignments and as such, is oriented toward improvement of spinal function relative to range of motion, muscular and neurological aspects. There has been no promise, implied or otherwise, of a cure for any symptom, disease, or condition as a result of treatment in this clinic. I understand that the chiropractor will use his hands or a mechanical device upon my body to adjust a joint, which may cause an audible "pop" or "click." It is my intention to rely on the doctor to exercise professional judgment during any procedures, which s/he feels at the time to be in my best interest. Neither the practice of chiropractic nor medicine is an exact science but relies upon information relayed by the patient, information gathered during examination, and the doctor's interpretation thereof, as well as the doctor's judgment and expertise in working with like cases. I understand that in the practice of chiropractic there are some risks to treatment including but not limited to disc injuries, fractures, joint injuries, strokes, dislocations, soreness, dizziness, and sprains. In most cases, chiropractic care offers multiple benefits including the relief of neck pain, headaches, and low back pain.

Alternative Treatments Including Risks and Benefits:

Alternative treatments include, but may not be limited to, massage therapy, physical therapy, medication, or surgery. The risks involved with these alternative treatments should be discussed with practitioners within the relative field. Chiropractic care offers a non-invasive, natural treatment of vertebral misalignments.

Consent to Chiropractic Examination:

I hereby consent to the performance of a chiropractic examination, including physical, neurological, and orthopedic tests. This may include reflexes, range of motion and the taking of a series of postural photos and x-rays.
Possible complications could be exacerbation (irritation) of existing symptoms or muscle strain or stiffness after the assessment.

Consent For X-rays.

I consent to the staff at Destination Health and Wellness taking x-rays.
I understand that the purpose of this is to:

- Reveal pathologies and degeneration.
- Show a history of my spinal stresses.
- Visualize the location of spinal problems.
- Confirm other examination findings.
- Record the structural and functional progress.

I understand and have read (or had read to me) the risks listed above. I acknowledge that the doctor was open with me about the risks of chiropractic and was willing to answer any questions that I have (or may have in the future). I intend for this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature: _____ Date: ____/____/_____
Patient name (Printed)_____

(If patient is a minor, consent must be signed by parent or official guardian)

Parent Guardian or Legal Representative (Print Name): _____

Parent Guardian or Legal Representative Signature: _____ Date: ____/____/_____

Destination Health & Wellness – Notice of Privacy Practices

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Introduction
Destination Health & Wellness is committed to giving you quality care and protecting your private health information (PHI). We are also committed to treating and using PHI about you responsibly. This notice of health information practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information
This notice is effective 9/01/21.

Understanding Your Health Information
Each time you visit our office, a record of your visit is made. Typically, this record contains symptoms, examination and test results, diagnosis, treatment, and a plan for future care.

This information serves as a basis for planning your treatment, means of communication among the many health professionals who contribute to your care, legal document describing care you received, means by which you or a third-party payer can verify that services billed were provided, a tool in educating health professionals, a source of data for medical research, a source of data for our planning and marketing, and a tool with which we can assess and continually work to improve the care we render and the outcome we achieve.

Understanding what is in your record and how PHI is used helps you to ensure its accuracy, better understand who, when, and why others may access your PHI, and helps you make more informed decisions when authorizing disclosures to others.

Your Health Information Rights
Although your health record is the physical property of Destination Health & Wellness, the information belongs to you. You have the right to obtain a paper copy of this notice of information practices upon request, inspect and copy your health record as provided for by federal law (a reasonable fee may be charged to cover the cost of copying), amend your health record as provided by federal law, obtain an accounting of disclosures of your PHI as provided by federal law, request communication of your PHI by alternative means or at alternative locations, at your request, request a restriction on certain uses and disclosures of your PHI as provided for by federal law, and revoke your authorization to use or disclose PHI except to the extent that action has already been taken.

Our Responsibilities
Destination Health & Wellness provides patients with this written notice as to our legal duties and privacy practices regarding the information we collect and maintain. Destination Health & Wellness agrees to abide by the terms of this notice and to accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations. Destination Health & Wellness reserves the right to change the clinic practices and to make new provisions effective for all PHI the clinic maintains. Should our information practices change, we will mail the revised notice to the address you have supplied. Your responsibility is to notify us of all address and insurance changes. Destination Health & Wellness will not use or disclose your PHI without your authorization, except as described in this notice. We will also discontinue to use or disclose your PHI after we have received a written revocation of the authorization according to the procedures included in the authorization.

Disclosures for Treatment, Payment, and Health Operations
Destination Health & Wellness is committed to maintaining the privacy of your PHI. Below are examples of how your PHI may be disclosed:

Referral: Destination Health & Wellness may disclose your PHI to another provider if the disclosure is necessary in order to refer you to the provider.
Payment: We may disclose your PHI to a third party such as an insurance carrier, Medicare, an HMO, a PPO, or collections agency in order to obtain payment for services provided to you.
Personal Injury: We may disclose your PHI to an attorney in order to obtain payment for services provided to you.
Operations: We may use your PHI to conduct internal quality assessment and improvement activities and for business management and general administrative activities.
Business Associates: There are some services provided in our organization through contacts with associates. Examples include, but are not limited to, physician services in the emergency department, radiology, and certain lab tests, referrals to other physicians, and others who may provide work in our office. We may need to disclose your PHI to our business associates so they may perform the job we have asked of them.
Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.
Research: We may disclose PHI to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.
Law Enforcement: We may disclose PHI for law enforcement purposes as required by law or in response to a valid subpoena.

Change of Ownership: In the event that Destination Health & Wellness is sold or merged with another organization, your health/record(s) will become property of the new owner.
Workers Compensation: We may disclose PHI to the extent authorized by and to the extent necessary to comply with laws relating to workers' compensation or other established programs by law.
Public Health: As required by law, we may disclose your PHI to public health or legal authorities charged with law relating to workers' compensation or other programs. Your provider is required by law to report communicable diseases and certain conditions to the Center for Disease Control in Atlanta, GA. Your PHI will be protected by our office and the CDC or health center.

For more information or to report a problem
You may file a complaint with our practice's Privacy Officer, Jennifer Carrau at 407-831-3833, or with the Department of Health and Human Services. There will be no retaliation for filing a complaint.

Office for Civil Rights
U.S. Dept. of Health & Human Services
200 Independence Ave. SW
Room 509 F, HHH Building
Washington, DC 20201

Additional Information

Please check all that apply:

___ **The patient under the age of 18**
(Please complete the Medical Treatment Authorization and Consent Form)

___ **The patient has x-rays, MRIs, or other records the patient would like to be released to Destination Health & Wellness.**
(Please complete an Authorization to Release Records Form)

___ **The patient has retained an attorney for an auto accident or slip/trip and fall.**
(Please complete Attorney Information & Auto Accident Questionnaire Form)

___ **The patient will need a doctor's excuse for ___ work ___ school.**
___ Once ___ Every Visit ___ Only Upon Request From Patient
(You will receive a doctor's excuse at the time of check-out)

___ **The patient will need someone else to have access to their health records in this office other than the parents or authorized guardian.**
(Please complete a HIPPA Release Form)

- I acknowledge that I may request a copy of Destination Health & Wellness's Notice of Privacy Practices Policy. I consent to the use and disclosure of my protected health information as specified in Destination Health & Wellness's Notice of Privacy Practices Policy.
- I understand that in the event I miss an appointment I give consent to Destination Health & Wellness to send me a postcard regarding that appointment. I understand that I can request in writing an alternate form of communication.
- I understand that my records (including x-rays) are the property of Destination Health & Wellness, and if at any time, I request a copy of my records, there will be an additional charge for copying (including x-rays).
- By supplying my home phone number, mobile number, email address, and any other personal contact information, I authorize my heath care provider to employ a third-party automated outreach and messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balances due, lab results, or other communications. I also authorize my health care provider to disclose to third-parties, who may intercept these messages, limited (PHI) regarding my healthcare events.

Patient Signature: _____ **Date:** ____/____/____

Patient Information Release Form
(HIPAA Release Form)

Patient Name ________________________________ Date of Birth: ______/______/_______

Privacy regulations require us to have a release signed by our patients so we may speak with family members, friends, and other relatives regarding your treatment, appointments, and/or financial information. Each person you wish to have information released to must be listed individually by name including a spouse or significant other.
Pease print your contact's name, your relationship with the contact, and phone number for each person you are authorizing us to release information. Also, please select what information each person is authorized to receive.

Release of Information:

[ ] I authorize the release of information to:

[ ] Name: _________________________ **Relation:** ________________ **Phone number**: ___________________
[ ] Treatment information
[ ] Financial information/account balances [ ] All information
[ ] Appointment information

[ ] Name: _________________________ **Relation:** ________________ **Phone number**: ___________________
[ ] Treatment information
[ ] Financial information/account balances [ ] All information
[ ] Appointment information

[ ] Name: _________________________ **Relation:** ________________ **Phone number**: ___________________
[ ] Treatment information
[ ] Financial information/account balances [ ] All information
[ ] Appointment information

[ ] Name: _________________________ **Relation:** ________________ **Phone number**: ___________________
[ ] Treatment information
[ ] Financial information/account balances [ ] All information
[ ] Appointment information

[ ] Name: _________________________ **Relation:** ________________ **Phone number**: ___________________
[ ] Treatment information
[ ] Financial information/account balances [ ] All information
[ ] Appointment information

[ ] DO NOT RELEASE MY INFORMATION TO ANYONE

Patient signature: ____ **Date:** __________________

Patient name: ____

PHOTOGRAPHY & VIDEO RELEASE

Check Appropriate Box: □ For an adult □ For a minor under the age of 18

I, the undersigned, hereby give my consent to Destination Health & Wellness and/or Destination Health and Wellness (DHW), and to those acting on its behalf with DHW's permission and authority, to record my image, likeness and/or voice on video, audio, photographic, digital, electronic or any other medium and to use my name in connection with these recordings; and to use, reproduce, exhibit and/or distribute these recordings in whole or in part in the following manner (please choose one of the following three options – Release for Full Use, Release for Limited Forms of Use, or Opt Out):

□ Release for Full Use
I release the use of any and all media (including but not limited to print publications, videos, internet, DHW website, social media, success story wall, referral board, and any other electronic or other media presently in existence or invented in the future) without payment or any other consideration, for any purpose that DHW, and those acting pursuant to its authority, deem appropriate, including promotional, advertising, and any commercial or non-commercial use.

□ Release for Limited Forms of Use
I release the use of media in the following forms (check all that apply) without payment or any other consideration, for any purpose that DHW, and those acting pursuant to its authority, deem appropriate, including promotional, advertising, and any commercial or non-commercial use:

□ Success story board
□ Referral board
□ Social media
□ Printed publications
□ DHW website

Notwithstanding which option above is chosen, I understand that my image may be edited, copied, exhibited, published or distributed and waive the right to inspect or approve the finished product wherein my likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of my image or recording.

There is no time limit on the validity of this release nor is there any geographic limitation on where these materials may be distributed.

I hereby release DHW and those acting pursuant to its authority from and against any and all claims, demands, actions, causes of actions, suits, costs, expenses, liabilities, and damages whatsoever that I may hereafter have from liability for any violation of any personal or proprietary right I may have in connection with such use of my likeness, voice, or name in any medium. Additionally, I expressly waive any rights to privacy I may have under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Florida Statutes, and any other federal or state laws with respect to photographic, audio, video, or digital content relating to this release. I understand and agree that all such recordings, in whatever medium, shall remain the property of DHW.

By signing this form, I acknowledge that I have completely read and fully understand the above release and agree to be bound thereby. I hereby release any and all claims against any person or organization utilizing this material for educational or promotional purposes.

□ Opt Out
Please do not use my name, image, video or likeness in any manner listed above

_____
Print Name (Photo Subject)

_____ _____
Signature Date

If this release is obtained from a presenter under the age of 18, then the signature of that presenter's parent or legal guardian is also required.

_____ _____
Print Name Parent/Guardian (If Minor) Age

_____ _____
Parent/Guardian's Signature Date