DeLand Chiropractic & Spinal Decompression

New Patient Application

The information that you will provide on this form will play a key role in determining your ability to be accepted as a patient in this office. your qualification as a patient is determined by the nature of your injury, the doctor's ability to treat your condition, your commitment to getting well, your family and/or spousal support, your ability to pay for recommended care, and your willingness to make sacrifices to ensure your proper healing. Please be sure that you answer all questions. Thank you - Dr. Gordon's Staff.

Name: ____________________ Sex: M / F Marital Status: S M D W
Address: ____________________ City: ____________
State: ________ Zip Code: ________ Date of Birth: ________ SSN: ________
Home Phone: ________ Work Phone: ________ Cell Phone: ________
Employer: ____________ Occupation: ____________
Age: ______ Email: ____________ Hobbies: ____________
Name of your Medical Doctor: ____________ May we contact them: Y / N
Race: ____________ Ethnicity: ____________ Are you pregnant: Y / N
How did you hear about our clinic: ____________ Preferred Language: ________
Emergency Contact Name & Phone #: ____________ Relation: ________

What is your chief complaint: ______________________________
____

Date of your injury: ____________ Work related: Y /N Auto Accident related: Y /N
Have you received Chiropractic Care before: Y / N Have you received Acupuncture before: Y / N

Do you smoke Cigarettes: Y / N Currently: Y / N Formerly: Y / N Never
Do you drink Alcohol: Y / N If yes, how often: ____________ How much: ____________
Do you use Recreational Drugs: Y / N What type: ______________________

Do you have a Family History of: (circle all that apply)

Heart Disease Arthritis Hypothyroid Diabetes (Type I / Type II) Seizures
Stroke Osteoporosis Rare Genetic Disease (type): ____________
Cancer (type): ______________________

Do you have a Past Medical History of: (circle all that apply)

Lower Back Pain Stroke Thyroid Disease Diabetes (Type I / Type II)
Sciatic Pain Birth Control Pills Auto Accidents Hormone Replacement
Hypertension Head Trauma Heart Attack Osteoporosis
Blood Clots Neck / Back Trauma Balance Problems Dizziness
Cancer (type): ____________ Numbness on 1/2 of your Face or Body

Will you be filing through insurance? If yes, please provide insurance company name and member ID number. If not, please move on to the next page.

Provider: ____________________ **Member ID:** ____________________

Please list any Allergies, Surgeries, Accidents, Falls, Pregnancies, or Hospitalizations:

____
____
____
____
____
____
____
____
____

Please list all Medications & Dietary Supplements that you are taking (list dosage & frequency):

____
____
____
____
____
____
____
____
____

When discussing possible treatment options, do you prefer: A lot of details / Just the bottom line

Our team has four goals that drive our practice and quality of care. All are important to us, but out of these values, which would be your priority for today's visit?

Reduce Pain   Do Everyday Activities Normally

Improve Overall Appearance   Maintain Optimal Health & Wellness

Are you willing to do your part to help us achieve your goal? Yes / No

Looking at this list, would any of these be a possible barrier to you when considering treatment?

Fear   Time   Budget   Trust

IF YOU HAVE ANY QUESTIONS OR CONCERNS WITH THE INFORMATION BELOW, IT IS YOUR RESPONSIBILITY TO ADDRESS THOSE CONCERNS WITH THE DOCTOR.

Informed Consent, Financial Responsibility, and Assignment of Benefits:

As with al medical or chiropractic treatments, I acknowledge and understand that there are inherent risks to receiving care including but not limited to sprains, strains, ,fractures, dislocations, muscle pain, bruising, and stroke. Statistically, these risks are extremely rare and uncommon (1 in 1-5 million in the case of strokes), especially when compared to those risks related with alternative treatment options for my condition including the use of over the counter analgesics, prescriptions drugs, and surgery. Due to that fact, I will not hold the physician or staff responsible for those risks listed above. In addition, I understand that the risk and danger of allowing my condition to go untreated may lead to further deterioration of my condition with possible serious and/or permanent consequences to my health. I acknowledge and understand that the use of certain prescription medications (i.e. birth control pills, hormone replacement, aspirin, Coumadin), illicit drug or alcohol use, and cigarette smoking may increase these risks and further inhibit proper healing. I also understand that if I am accepted as a patient, and if I receive care, that I am the ultimate responsible party on my account regardless of the actions of any 3rd party carrier (insurance company). I agree that should my account become delinquent, i will be responsible for all collection costs, including but not limited to the outstanding balance, attorney fees, court costs, collection agency fees, and interest at the rate of 18% per annum (1.5% per month). By signing below, I also agree to allow the doctor to share any and all medical reports and findings with my primary care physician, and I allow the doctor to use my name and case history in monthly newsletters and/or patient testimonial booklets. Lastly, I understand that any physician at DeLand Chiropractic & Spinal Decompression cannot evaluate, examine, x-ray, diagnose, or treat me for my presenting condition without my signature below. by signing below, I acknowledge that I have weighed the risks versus benefits of treatment, and I give the doctor consent to treat me for my condition.

Print Name: ______________________________   Date: ______________

Signature: ______________________________

Deland Chiropractic & Spinal Decompression
Jeremy Gordon, DC PA, Michael Munson, DC, Jason Job, DC, & John Damrath, DC
905 North Stone Street, Deland, FL 32720 (386) 734-9995

Patient Name: ____________________________ **Identification Number:** __________________________

Advance Beneficiary Notice of Non-Coverage (ABN)

NOTE: If Medicare doesn't pay for the services 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 forth below.

Items, Services, Procedures	Reasons Medicare May Not Pay	Estimated Cost
Examinations/Re-examinations	Not a Medicare Covered Service/Benefit	$50-$200
Mechanical Traction	Not a Medicare Covered Service/Benefit	$41
PEMF	Not a Medicare Covered Service/Benefit	$30-$100
Low Level Laser Therapy	Not a Medicare Covered Service/Benefit	$16
Maintenance Treatment	Not a Medicare Covered Service/Benefit	$27-$75
Electrical Stimulations	Not a Medicare Covered Service/Benefit	$39
DRX-9000	Not a Medicare Covered Service/Benefit	$165
Cold/Hot Packs	Not a Medicare Covered Service/Benefit	$21

WHAT YOU NEED TO KNOW:

- 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 services 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.

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

☐ OPTION 1. I want the items/services 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, you will refund any payments I made to you, less copays or deductibles.

☐ OPTION 2. I want the items/services 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 items/services listed above. I understand with this choice I am not responsible for payment, and **I cannot appeal to see Medicare would pay.**

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 received a copy.

Signature: ____ Date: ___________________

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Pain Disability Questionnaire

Patient Name: ____ Date: ___________________

Instructions: These questions ask your views about how your pain now affects how you function in everyday activities. Please answer every question and mark the ONE number on EACH scale that best describes how you feel.

1. **Does your pain interfere with your normal work inside and outside the home?**

Work Normally — Unable to work at all

0 ---------- 1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7 ---------- 8 ---------- 9 ---------- 10

2. **Does your pain interfere with personal care (such as washing, dressing, etc.)?**

Take care of myself — Need help with all my personal care

0 ---------- 1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7 ---------- 8 ---------- 9 ---------- 10

3. **Does your pain interfere with your traveling?**

Travel anywhere I like — Only travel to see doctors

0 ---------- 1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7 ---------- 8 ---------- 9 ---------- 10

4. **Does your pain affect your ability to sit or stand?**

No problems — Can not sit/stand at all

0 ---------- 1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7 ---------- 8 ---------- 9 ---------- 10

5. **Does your pain affect your ability to lift overhead, grasp objects or reach for things?**

No problems — Can not do at all

0 ---------- 1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7 ---------- 8 ---------- 9 ---------- 10

6. **Does your pain affect your ability to lift objects off the floor, bend, stoop or squat?**

No problems — Can not do at all

0 ---------- 1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7 ---------- 8 ---------- 9 ---------- 10

7. **Does your pain affect your ability to walk or run?**

No problems — Can not walk/run at all

0 ---------- 1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7 ---------- 8 ---------- 9 ---------- 10

8. **Has your income declined since your pain began?**

No decline — Lost all income

0 ---------- 1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7 ---------- 8 ---------- 9 ---------- 10

9. **Do you have to take pain medication every day to control your pain?**

No medication needed — Medication needed throughout the day

0 ---------- 1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7 ---------- 8 ---------- 9 ---------- 10

10. **Does your pain force you to see doctors much more often than before your pain began?**

Never see doctors — See doctors weekly

0 ---------- 1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7 ---------- 8 ---------- 9 ---------- 10

11. **Does your pain interfere with your ability to see people who are important to you?**

No problem — Never see them

0 ---------- 1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7 ---------- 8 ---------- 9 ---------- 10

12. **Does your pain interfere with recreational activities and hobbies?**

No interference — Total interference

0 ---------- 1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7 ---------- 8 ---------- 9 ---------- 10

13. **Do you need the help of your family and friends to complete everyday tasks?**

Never need help — Need help all the time

0 ---------- 1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7 ---------- 8 ---------- 9 ---------- 10

14. **Do you now feel more depressed, tense, or anxious than before your pain began?**

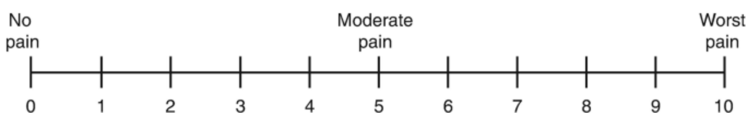
No depression/tension — Severe depression/tension

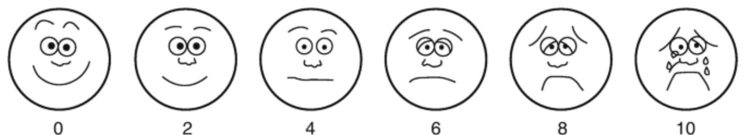
0 ---------- 1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7 ---------- 8 ---------- 9 ---------- 10

15. **Are there emotional problems caused by your pain that interfere with your family, social and/or work activities?**

No problems — Sever problems

0 ---------- 1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7 ---------- 8 ---------- 9 ---------- 10





Dr. Jeremy M. Gordon | Dr. Michael T. Munson | Dr. Jason T. Job | Dr. John J. Damrath
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Nutritional Counseling DRX Spinal Decompression Chiropractic Wellness Acupuncture Ideal Protein Weight Loss

HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

Patient Name: ____ DOB: ______________________

Address: ___________________________________ City: ___________________ State: _______ ZIP: _________

You may use this form to allow limited access to your health information by certain persons for certain purposes. Your choice on whether to sign this form will not affect your ability to get medical treatment, payment for medical treatment, or health insurance enrollment or eligibility for benefits.

By signing this form, I voluntarily authorize, give my permission, and allow use and disclosure of (including paper, oral and electronic interchange): *(initial one)*

______ **ALL MY HEALTH INFORMATION** including information about sensitive conditions (if any). Health information includes , but is not limited to, all records and other information regarding my health history, treatment, hospitalization, test, and outpatient care, and also educational records that may contain information about my health. This includes my specific permission to release any and all of the following information:

a. Drug, alcohol, or substance abuse
b. Psychological, psychiatric or other mental impairment(s) or developmental disabilities (excludes "psychotherapy notes" as defined in HIPAA at 45 CFR 164.501)
c. Sickle cell anemia
d. Birth control and family planning
e. Records which may indicate the presence of a communicable disease or noncommunicable disease; and tests for or records of HIV/AIDS or sexually transmitted diseases or tuberculosis
f. Genetic (inherited) diseases or tests
g. Copies of educational tests or evaluations, including Individualized Educational Programs, assessments, psychological and speech evaluations, immunizations, recorded health information)such as height, weight), and information about injuries or treatment.

______ **ONLY THE INFORMATION INDICATED BELOW** (initial next to all that you want disclosed):

______ History and Physical ______ Operation Reports ______ Discharge Summary

______ Radiology Reports & Imaging ______ Pathology Reports ______ EKG Reports

______ Progress Notes ______ Consultation Reports ______ Lab Results

______ Physicians Orders ______ Family Planning Records ______ Prenatal Records

______ Drug, Alcohol or Substance Abuse Records

______ Mental Health Records (excluding “psychotherapy notes” as defined in HIPAA at 45 CFR 164.501)

______ Diagnostic Test Reports (specify type of test): ____

______ Other (please specify)

Note: Information created before or after the date of this form may be disclosed, unless you specify a date range of records here:

From (mm/dd/yyyy): ____________________ To (mm/dd/yyyy): ____________________

From Whom:

All information sources, including but not limited to medical and clinical sources (hospitals, clinics, labs, pharmacies, physicians, psychologist, etc) including mental health, correctional, addiction treatment, Veterans Affairs healthcare facilities, state registries and other state programs, all educational sources (schools, records administrators, counselors, etc.), social workers, rehabilitation counselors, insurance companies, health plans, health maintenance organizations, employers, pharmacy benefit managers, worker’s compensation programs, state Medicaid, Medicare and other governmental program.

To Whom: (choose one)

Only the following specific sources of my health information:

Person/Organization Name: ____

Address: ____

Phone: (_____)____________________

Fax: (_____)_______________________

Purpose: (check all that apply)

______ My medical treatment and related services and products
______ To evaluate and improve patient safety and the quality of medical care provided to all patients
______ Payment (as defined in HIPAA at 45 CFR 164.501)
______ Eligibility for certain health care services (e.g. hospice)(please specify:) ________________________________
______ Eligibility for clinical trials (if limited, please specify here:) ____
______ Scientific research with proper Institutional Review Board approval or waiver

______ Personal Health Record for my use
______ Personal Use
______ Other, please specify: ____

Effective Period: This authorization/permission form will remain in effect until (check one):

______ The day I withdraw my permission or date of my death
______ A specific date (mm/dd/yyyy): ____
______ A specific event. Please specify: ____

Revoking Your Permission: I can revoke my permission at any time by giving written notice to the person or organization to whom I originally gave this form. In addition:

- I authorized the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- I understand that there are some circumstances in which this information may be disclosed to other parties (see page 2 for details).
- I understand that refusing to sign this form does not stop disclosure of my health information that is otherwise permitted by law without my authorization or permission.
- I have read all pages of this form and agree to the disclosures above from the types of sources listed.

____ ___________________________

Signature of Patient or Patient's Legal Representative Date Signed (mm/dd/yyyy)

____

Printed Name of Legal Representative (if applicable)

Check one to describe the relationship of Legal Representative to Patient (if applicable):

_____ Patient of minor _____ Guardian _____ Other (explain): _________________________________

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Nutritional Counseling - DRX Spinal Decompression - Chiropractic - Wellness - Acupuncture - Ideal Protein Weight Loss

Assignment, Lien and Authorization of Benefits

I, ______________________________, hereby authorize and direct you, my insurance company, and/or attorney, to pay directly to DeLand Chiropractic and Spinal Decompression such sums as may be due and owing this office for services rendered me, both by reason of accident or illness, and by reason of any other bills that are due this office, to withhold such sums from any disability benefits, medical payments benefits, "no-fault benefits", health and accidental benefits, workmen's compensation benefits, or any other insurance benefits obligated to reimburse me or from my settlement, judgment or verdict on my behalf as may be necessary to adequately project this office. I hereby further give a lien to said office against any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by this office. Signature of this document authorizes the release of any medical or other information necessary to process this claim, and I request payment of government benefits and authorize payment of medical benefits to the undersigned physician or durable medical goods supplier for goods or services provided. This is to act as an assignment of my rights and benefits to the extent of the office's services provided.

In the event my insurance company which is obligated to make payments to me for the charges incurred at this office refuses to make such payments, upon demand of this office, I hereby assign and transfer to this office any and all causes of action that I might have or that might exist in my favor against such company and authorize this office to prosecute said cause of action either in my name or in the office's name and further I authorize this office to compensate settle or otherwise resolve said claim or cause of action as they see fit.

DeLand Chiropractic and Spinal Decompression accepts the aforesaid assignment and hereby notifies any insurer issuing payment that DeLand Chiropractic and Spinal Decompression objects to any repricing or reduction of billed amounts unilaterally made by any insurer. Any such reduced payments issued by any insurer are accepted under protest and without waiving any right of the provider to pursue all legal remedies against the insurer.

I, ______________________________, understand that I remain personally responsible for the total amounts due the office for their services that are not paid by the insurance company.

I, ______________________________, authorize the office to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under this assignment, lien and authorization. I agree that the above-mentioned office be given power of attorney to endorse/sign my name on any and all checks for payment of my doctor (medical) bill.

Please read this document completely before signing. If you do not understand this document or have any questions about this document, please ask us to explain it to you. If there is any portion of this document that you so mot wish to authorize, we will remove that portion from this document. Your signature below is your agreement you fully understand this document and you fully agree to the terms of this document.

______________________________ ______________________________
Signature of Patient/Guardian Date

______________________________ ______________________________
Print Name of Patient/Guardian Date