Date: _____

Bracken Family Chiropractic
461 Kingsley Ave.
Orange Park, FL 32073

Patient Demographic Form

PERSONAL INFORMATION

Full Name: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Primary Phone#: _____ *Cell/Home/Work* **Alternate Phone#:** _____ *Cell/Home/Work*

Email: _____ **SSN:** _____
SSN MUST BE PROVIDED

DOB: ____/____/____ **Age:** _____ **Sex:** _____ **Marital Status:** S M D W

Occupation: _____

How did you hear about us? *Our Website* *Online/Search Engine* *Facebook* *Insurance Co.* *Event*
Referral: _____ *Other:* _____

(For Medicare Patients Only)
Primary Care Physician: _____ **Phone:** _____

FOR OFFICE USE ONLY

Insur Name: _____ **Insurance:** _____

Member/Policy Number: _____

Copay/Co-Ins: _____ **Deductible:** _____ **Remaining:** _____ **OOP Met:** Yes / No

Visits per year: _____ **Medical Review: Yes / No** **Number of Visits:** _____

_____

INSURANCE VERIFICATION & CARE PLAN

ADJ: _____ **PE:** _____ **TRAC:** _____ **NMR:** _____ **MT/MT AETNA:** _____

Other Information: _____

_____

_____

Maintain Your Spine It's Your Lifeline
BRACKEN FAMILY CHIROPRACTIC

DR. STACI BRACKEN
PRINCIPLED FAMILY CHIROPRACTOR
461 Kingsley Ave
Orange Park, FL 32073
(904) 213-9805 Fax: (904) 213-9806

Patient Consent for Use and Disclosure Of Protected Health Information

I hereby give my consent for Bracken Family Chiropractic to use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO).

Bracken Family Chiropractic's Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Bracken Family Chiropractic reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Bracken Family Chiropractic,461 Kingsley Ave., Orange Park, FL 32073.

With this consent, Bracken Family Chiropractic may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Bracken Family Chiropractic may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, Bracken Family Chiropractic may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Bracken Family Chiropractic restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Bracken Family Chiropractic's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Bracken Family Chiropractic may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Print Name of Patient or Legal Guardian Date

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THIS DOCUMENT CONSTITUTES INFORMED CONSENT FOR CHIROPRACTIC CARE.

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important for each patient to understand both the objective and the method that will be used to attain it. This will prevent confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of ***vertebral*** subluxation. Our Chiropractic method of correction is by specific adjustments of the spine using hands, drop techniques, and/or instrumentation.

Health: A state of optimal, physical, mental and social well being, not merely the absence of disease, symptoms or infirmity.

Vertebral Subluxations: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will so advise you. If you desire advice, diagnosis or treatment for those findings we will recommend that you seek the services of the health care provider who specializes in that area.

We do not offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference caused by vertebral subluxation. Our only method is the specific adjustment of vertebral subluxation. However, we may use other methods or procedures to help your body hold the adjustments.

POLICIES

1. All charges are payable when services are rendered, unless other agreements have been made in advance.
2. The amount paid for X-rays is for the analysis of those X-rays only. The film itself is the property of this office. An X-ray release form must be completed in order to remove X-rays from this location. The X-rays must be returned in a timely manner.
3. I have read Bracken Family Chiropractic's Notice of Patient Privacy Practices.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand Bracken Family Chiropractic Center will prepare any necessary reports and forms to assist in making collections from the insurance company and that any amount authorized to be paid directly to Bracken Family Chiropractic Center will be credited to my account upon receipt. However, I clearly understand and agree that all the services rendered to me are charged directly to me and that I am personally responsible for payment.

In case of emergency, notify _____ **Phone #** _____

I,_____, have read and fully understand the above statements. All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care through Bracken Family Chiropractic Center.

_____ _____
(Signature) ***(Date)***

COMPLETE IF THE PATIENT IS A MINOR CHILD: child's name: _____
I, _____, being the parent or legal guardian of the aforementioned child have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

_____ _____
(Signature) ***(Date)***

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ASSIGNMENT OF INSURANCE BENEFITS AND DIRECTION TO PAY

I,_____, hereby instruct and direct any insurance carrier that is providing insurance benefits on my behalf under any policy of insurance to make out a check to, and directly pay, **Bracken Family Chiropractic** for professional medical and rehabilitative services rendered to me. This includes a direct assignment of my rights and benefits under any such policy of insurance and may only be revoked with the express written consent of **Bracken Family Chiropractic**. This assignment of insurance benefits pertains to any and all professional services, including past services, provided by **Bracken Family Chiropractic** in relation to my health insurance and/or motor vehicle accident of _____.
(Date of MVA)

This assignment of insurance benefits is provided so that **Bracken Family Chiropractic** may attempt to collect any unpaid and overdue insurance benefits directly from the insurance carrier. This includes the assignment of any cause of action that might accrue against any such insurance carrier for its failure to pay insurance proceeds. Such assignment is given in consideration of professional medical and rehabilitative services.

I authorize any holder of insurance information about me to release such information to **Bracken Family Chiropractic** needed to determine the insurance benefits or to assist in the collection of payment for services. I authorize **Bracken Family Chiropractic** to contact the insurance company for an exact dollar amount of insurance benefits that are available under any policy of insurance that affords coverage, and to obtain any payout or check ledger reflecting insurance benefits that have been paid out on my behalf.

A copy of this agreement will be as valid as the original.

I have read and I do understand this assignment thoroughly.

_____ _____
Patient's Signature Date

_____
Signature of Legal Guardian *(when patient is a minor child)*

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Authorization to perform X-Rays

Patient Name: _____ **Date:** _____

I, _____, understand the need for x-rays to properly diagnose and treat my condition. I authorize the doctor to perform diagnostic x-rays.

Signature: _____

Female Patients:

I hereby certify that to the best of my knowledge I am **NOT PREGNANT.**

Signature: _____

Parental/Legal Guardian Consent – for children under 18 years old

I, _____, being the parent or legal guardian of _____, hereby consent to the performance of x-ray studies and treatment of this minor at Bracken Family Chiropractic Center.

Parental/Legal Guardian Signature: _____

MASSAGE THERAPY
461 KINGSLEY AVE
ORANGE PARK, FL 32073
(904) 213-9805 FAX: (904) 213-9806

Massage Therapy Informed Consent

I, _____, (client) understand that massage therapy provided by the **Tammy Corkins** LMT is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, improve circulation and offer a positive experience of touch. Any other intended purposes for massage therapy are specified as:
_____.

_____ I understand that the massage therapist does not diagnose illness, disease, or any other physical or mental disorder; does not prescribe medical or pharmaceutical treatment and does not do spinal manipulations.

_____ It is clear to me that massage is not a substitute for medical examinations and/or diagnosis, and it is recommended that I see a physician for any physical ailments.

_____ I have stated all my known medical conditions and medications/drugs/supplements taken, and understand I am responsible to update my massage therapist on my current state of health on all subsequent visits.

_____ I understand that the control of the pressure is mine. I will honestly communicate my pain tolerance with the therapist prior to the massage and indicate my expectations from this massage and the pressure I prefer.

_____ If I "no show" for an appointment I understand that I am responsible for paying a $25 fee. 6 business hours notice is needed for canceling an appointment, if proper notice isn't given, I will be responsible for paying a $25 "no-show" fee.*

_____ If I am late for an appointment I understand that the session will end at the scheduled end time. There will be no compensation given for the late start and I am responsible for the full amount of the time reserved or a $25 "no-show" fee if I am more than 10 minutes late.*

_____ I understand the massage offered is for therapeutic purpose only.

*All fees MUST be paid before any more services can be rendered at Bracken Family Chiropractic.
**Inappropriate suggestions or behavior will be unequivocally refused. Failure to follow this rule will result in immediate law enforcement reporting and termination of the session with no refund.

I have read the therapist's policies; I understand them and agree to abide by them.

_____ _____
Client Signature Date
(I attest that I am over 18 years of age. If a minor, parent or guardian must sign)