



**GENERAL PATIENT INTAKE FORM and CHIROPRACTIC CARE AGREEMENT**

**Patient Information:**

Today's Date \_\_\_\_\_

Name \_\_\_\_\_

I prefer to be called \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Sex  Male  Female

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

If minor, name of parent or guardian \_\_\_\_\_

Who should we contact in case of an emergency? \_\_\_\_\_

Relation \_\_\_\_\_

Address \_\_\_\_\_

Primary Care Physician \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

Have you ever been to a chiropractor before?  YES  NO If so, whom? \_\_\_\_\_

How do you prefer to receive communication from our office?  Via Email  Via Regular Mail

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Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

Email \_\_\_\_\_

Social Security No. \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Height \_\_\_\_\_' \_\_\_\_\_" Weight \_\_\_\_\_ lbs

Marital Status \_\_\_\_\_

No of Children \_\_\_\_\_

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## Health History

Have you ever had any of the following diseases or conditions?

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> HEART ATTACK or STROKE    | <input type="checkbox"/> HEART SURGERY or PACEMAKER | <input type="checkbox"/> HEART MURMUR      |
| <input type="checkbox"/> CONGENITAL HEART DEFECT   | <input type="checkbox"/> MITRAL VALVE COLLAPSE      | <input type="checkbox"/> ARTIFICIAL VALVES |
| <input type="checkbox"/> ALCOHOL/DRUG ABUSE        | <input type="checkbox"/> VENEREAL DISEASE           | <input type="checkbox"/> HEPATITIS         |
| <input type="checkbox"/> HIV+/AIDS                 | <input type="checkbox"/> SHINGLES                   | <input type="checkbox"/> CANCER            |
| <input type="checkbox"/> FREQUENT NECK PAIN        | <input type="checkbox"/> EMPHYSEMA                  | <input type="checkbox"/> ANEMIA            |
| <input type="checkbox"/> HIGH/LOW BLOOD PRESSURE   | <input type="checkbox"/> PSYCHIATRIC PROBLEMS       | <input type="checkbox"/> RHEUMATIC FEVER   |
| <input type="checkbox"/> SEVERE/FREQ. HEADACHES    | <input type="checkbox"/> KIDNEY PROBLEMS            | <input type="checkbox"/> ULCERS/COLONITIS  |
| <input type="checkbox"/> FAINTING/SEIZURE/EPILEPSY | <input type="checkbox"/> SINUS PROBLEMS             | <input type="checkbox"/> ASTHMA            |
| <input type="checkbox"/> DIABETES                  | <input type="checkbox"/> DIFFICULTY BREATHING       | <input type="checkbox"/> TUBERCULOSIS      |
| <input type="checkbox"/> LOWER BACK PROBLEMS       | <input type="checkbox"/> ARTIFICIAL BONES/JOINTS    | <input type="checkbox"/> ARTHRITIS         |

Please list **any other** medical conditions that you have or have ever had. \_\_\_\_\_

Please list any allergies. \_\_\_\_\_

Please list previous surgeries and dates. \_\_\_\_\_

Please list any past motor vehicle accidents or traumas and dates. \_\_\_\_\_

Is there anything else about your health history or family health history that you feel is important to share? \_\_\_\_\_

Do you exercise?  YES  NO

Are you on a special diet?  YES  NO Since: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Do you smoke?  YES  NO How much? \_\_\_\_\_ How long? \_\_\_\_\_

Are you wearing:  ORTHOTICS  HEEL LIFTS  ARCH SUPPORTS

*For women:* Are you taking birth control?  YES  NO

Are you pregnant?  YES  NO How long? \_\_\_\_\_ Nursing?  YES  NO

**Patient/Legal Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_



**ASSIGNMENT OF INSURANCE BENEFITS**

Patient Name: \_\_\_\_\_

I hereby authorize payment to be made directly to FOX Spine + Sports Medicine , of all benefits which may be due and payable under insurance coverage for the above named Patient. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments. I further acknowledge that this assignment of benefits does not in any way relieve me of liability and that I will remain financially responsible to FOX Spine + Sports Medicine .

Furthermore, I hereby IRREVOCABLY ASSIGN to FOX Spine + Sports Medicine , the rights and benefits under any policy of insurance, indemnity agreement, or any other collateral source as defined in the state Florida statutes for any service and or charges provided by FOX Spine + Sports Medicine .

Signature of Patient or responsible party: \_\_\_\_\_

Signature of witness: \_\_\_\_\_

**AUTHORIZATION TO RELEASE MEDICAL RECORD INFORMATION**

Patient Name: \_\_\_\_\_

FOX Spine + Sports Medicine is hereby authorized to disclose all or any part of the medical records on the above named patient to such insurance companies, organizations, or agencies as may be responsible for payment of services rendered by FOX Spine + Sports Medicine . This authorization is given with full knowledge that such disclosure may contain information of a confidential nature and may result in a denial of insurance coverage for services rendered by said FOX Spine + Sports Medicine .

The undersigned certifies that he/she has read and understands each of the above paragraphs and is the patient or responsible party with the power to execute this document and accept these terms.

Signature of patient or responsible party: \_\_\_\_\_

Signature of witness: \_\_\_\_\_

**Receipt of Notice of Privacy Practices**  
**Written Acknowledgement Form**

I, \_\_\_\_\_ have read a copy of FOX Spine + Sports Medicine's  
Patient Name  
notice of Patient Privacy Practices.

\_\_\_\_\_  
Signature of Patient or Parent or Legal Guardian

\_\_\_\_\_  
Date



## OFFICE POLICIES

The following are FOX Spine + Sports Medicine 's office policies. Please read carefully, and be sure to ask any questions you might have before signing the document.

**Consent for Treatment.** The Patient and/or the undersigned, give FSSM and Dr. Christopher Fox my/our permission to evaluate and treat the Patient's injury or condition. I further understand that, in the course of recommended treatment, conditions may worsen on rare occasions. I further understand that **no guarantee or promise** has been made to me concerning the results of evaluation, care treatment.

**Appointment Scheduling and Cancellation Policy.** At FOX Spine + Sports Medicine , we understand that unanticipated events happen occasionally in everyone's life. Business meetings, project deadlines, flight delays, car problems, and illness are just a few reasons why one might consider canceling an appointment. In our desire to be effective and fair to all of our patients and staff **24 hour advance notice is required when canceling an appointment otherwise the full fee for the missed appointment will be charged to your account.** This allows the opportunity for someone else to utilize our services during that appointment time.

**Office Visits.** We understand that the undersigned and/or the Patient may come to the office with family, friends or others. The Patient (or, if a minor, the undersigned) acknowledges that the Patient (or undersigned) is solely responsible for children or those in their care. This is an office; we are busy with patients. Please be careful and aware of your surroundings!

**Private Health Insurance.** I understand that I am responsible for whatever fees my insurance company does not pay on my claim. (Typically, this includes deductibles and/or co-payments.) It is further understood that I, the undersigned, **agree to pay the full amount** of the charges should my condition be such that it is not covered by my health insurance policy, or if, for any reason, the insurance company and/or my attorney refused to pay my balance at this office.

## DISPUTE RESOLUTION

**Arbitration.** The undersigned and the Patient agree that any dispute or claim arising from or relating to the office visit(s) and/or the care provided by FOX Spine + Sports Medicine and/or Dr. Christopher Fox (jointly, "FSSM"), shall be resolved exclusively by binding arbitration pursuant to the Florida Arbitration Code, Florida Statutes 682. This includes any injury or losses by you or your children on the premises. Arbitration shall occur in West Palm Beach, Florida and nowhere else.

**County Court Exception.** The undersigned, the Patient, and FSSM all agree that any dispute or claim arising from or relating to the office visit(s) and/or the care provided by FSSM which is within the monetary jurisdiction of county court, Florida Statute 34.01(1)(c), may be brought in arbitration as set forth above or Palm Beach County Court and nowhere else.

**Severability/Jury Waiver.** In the event any portion of this Chiropractic Care Agreement is deemed unenforceable, that portion shall be severed and all other provisions remain in full force and effect. The undersigned, the Patient, and FSSM agree that each has waived its rights to a jury trial for any disputes or claims among them.

**Chiropractic Care.** The undersigned and the Patient agree and acknowledge that FSSM provides chiropractic care only. The Patient is advised and agrees to consult a medical doctor routinely and as needed. Please ask questions about your health!

**Patient/Parent or Legal Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

## **CHIROPRACTIC INFORMED CONSENT**

The undersigned Patient (which includes the parent/guardian) understands and acknowledges that the Patient is only receiving chiropractic care from FOX Spine + Sports Medicine and Dr. Christopher Fox (jointly, "FSSM").

Dr. Fox is a "chiropractic physician" as defined in Florida Statute 460.403(5)(2008). Chiropractic physicians examine, analyze, and diagnose the human living body and its diseases by use of (a) any physical, chemical, electrical or thermal methods, (b) x-ray for diagnosing, (c) blood tests, and (d) other chiropractic methods. See Florida Statute 460.403(3)(b).

**Before you, the Patient, receive chiropractic care, it is important that you read this Consent and understand the nature and risks of chiropractic medicine.** The "practice of chiropractic medicine" (or chiropractic care) involves the adjustment, manipulation, and treatment of your body in which vertebral subluxations and other malpositioned articulations and structures may be interfering with the normal generation, transmission, and expression of nerve impulse between the brain, organs, and tissue cells, thereby causing disease. See Fla.Stat. 460.403(9)(a). Chiropractic adjustments, manipulations, and treatments are intended to restore the normal flow of nerve impulse which produces normal function and consequent health. See Fla.Stat. 460.403(9)(a).

The undersigned Patient understands and acknowledges that there are risks associated with the practice of chiropractic medicine and chiropractic care including but not limited to ataxia, bruising, thermal injuries, dislocations/subluxations, dizziness, "drop attacks," fracture(s), mobility disruption, paralysis, quadriplegia, spinal injury, stroke/disruption of blood flow to brain, vision problems, and death.

The Patient is encouraged to ask questions! Although we are not affiliated with and cannot confirm the content of internet sites, resources such as WebMD, Chiro.org, AmerChiro.org, and others may be helpful. The Patient is specifically instructed to consult a medical doctor before receiving (and during/after) chiropractic medicine.

I, the undersigned Patient, understand the risks and limitations associated with the practice of chiropractic medicine, including the use of chiropractic care, evaluation, diagnosis, adjustments, manipulations, and treatments by FSSM. I hereby give my informed consent to receive chiropractic medicine from FSSM.

\_\_\_\_\_  
Patient Name/Signature (and date)

\_\_\_\_\_  
Guardian/Parent's Name/Signature (and date)