

WELCOME

3 Locations to Serve You Better!

**PINES WEST
CHIROPRACTIC**
18501 Pines Blvd., Suite 104
Pembroke Pines, FL 33029

**EAST SIDE
CHIROPRACTIC**
8228 Biscayne Blvd.
Miami, FL 33138

**MARTINEZ
CHIROPRACTIC**
12821 S.W. 88 St.
Miami, FL 33186

PATIENT INFORMATION

Patient: _____ Date: _____
 Address: _____
 City: _____ State: _____ Zip Code: _____
 Sex: M F Age: _____ DOB: _____
 Single Married Widowed Divorced
 Patient SS No. _____ Occupation: _____
 Employer: _____ Employer Phone No. _____
 Employer Address: _____
 Spouse's Name: _____ Birthdate: _____
 SS No. _____ Occupation: _____
 Spouse's Employer: _____
 Children (Names & Ages) _____
 Whom may we thank for referring you: _____

PHONE NUMBERS

Home: _____
 Work: _____
 Ext: _____
 Best time to call _____
 Cell Phone: _____

EMAIL

IN CASE OF EMERGENCY

Name: _____
 Relationship: _____
 Home #: _____
 Work #: _____

INSURANCE

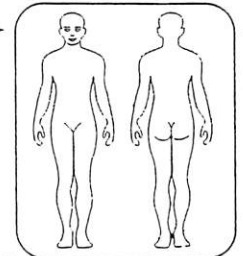
Who is responsible for this account? _____
 Relationship to Patient _____
 Insurance Co. Name _____
 Group or Card No. _____
 Is Patient covered by additional insurance? Yes No
 Subscriber's Name _____
 Birthdate _____ SS No. _____
 Relationship to Patient _____
 Insurance Co. Name _____
 Insurance I.D. No. _____

ACCIDENT INFORMATION

Is condition due to an accident?
 Yes No Date _____
 Type of Accident?
 Auto Work Home Other
 Explain Other: _____
 If yes, please tell our front office and fill out correct accident form in addition to this form.

PATIENT CONDITION

Reason for Visit: _____ Preventive health check up: Yes No
 When did your symptoms appear? _____ Is condition getting progressively worse? Yes No Unknown
 Mark an X on the picture where you continue to have pain, numbness or tingling. _____
 Rate the severity of your pain on a scale of 1 (least pain) to 10 (severe pain) _____
 Type of Pain: Sharp Dull Throbbing Numbness Aching Shooting Burning
 Tingling Cramps Stiffness Swelling Other
 How many days in the last week did you feel the pain? _____ Is it constant or Occasional
 Does it interfere with your Work Family Life Sleep Recreation Exercise
 Activities or movements that are painful to perform Sitting Standing Walking Bending Lying Down Driving
 Do you suffer from any other health conditions? _____



PAST HEALTH HISTORY

Please Check and Describe:

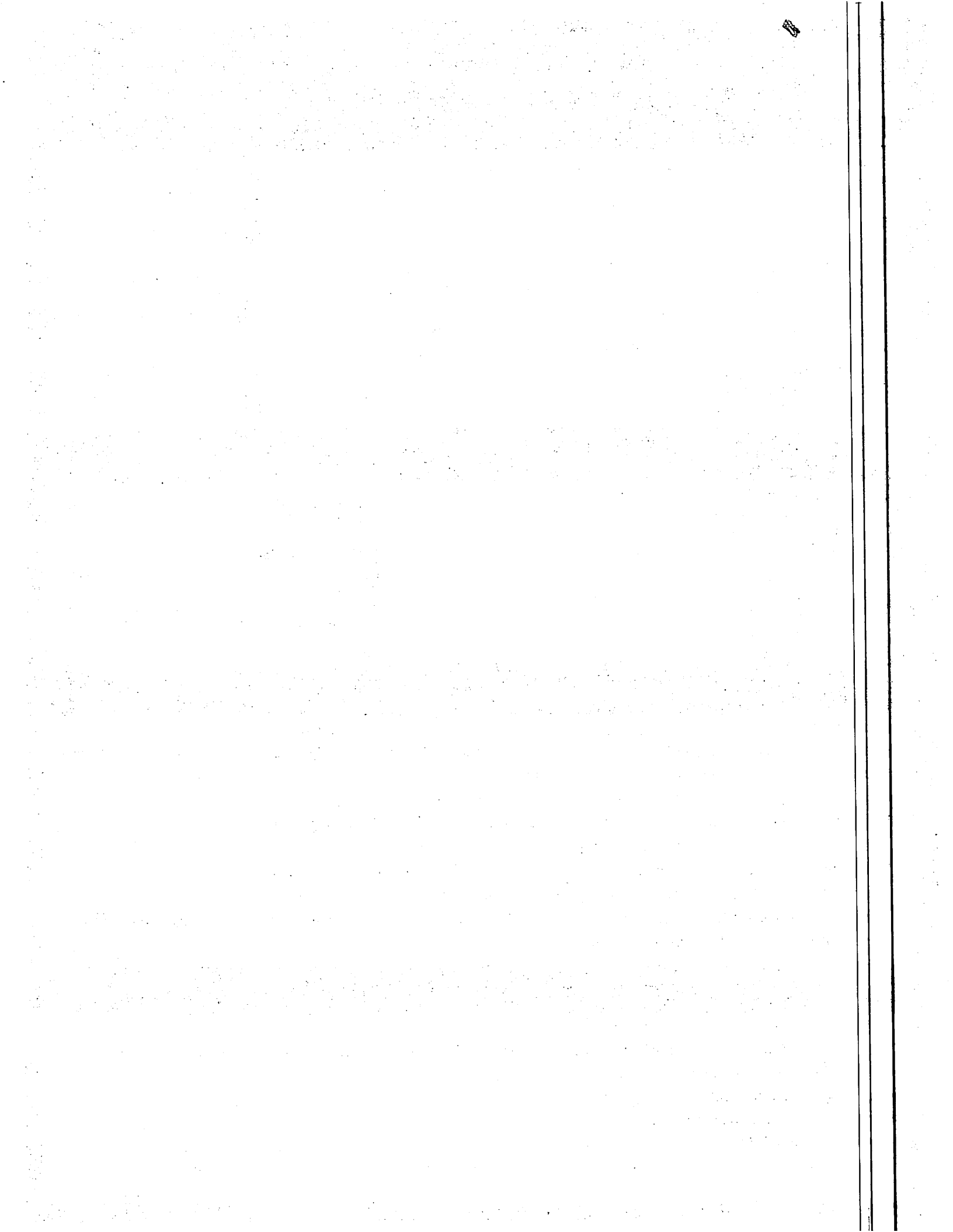
Major Surgery/Operations: Appendectomy Tonsillectomy Gall Bladder Hernia Back Surgery
 Broken Bones Other _____

Car accidents, falls, injuries: _____

Hospitalization (Other Than Above): _____

Previous Chiropractic Care: None Doctor's Name & Approximate Date of Last Visit _____

Drugs You Now Take: Nerve Pills Pain Killers/Muscle Relaxers Blood Pressure Medicine Insulin
 Other _____



Below are a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD OR CURRENTLY HAVE:

- | | | | | |
|--|--|--------------------------------------|---|--|
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Mumps | <input type="checkbox"/> Asthma | <input type="checkbox"/> Lumbago | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Small Pox | <input type="checkbox"/> Aids/H.I.V. | <input type="checkbox"/> Eczema | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Influenza | <input type="checkbox"/> Stroke | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cancer | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Weak Immune System | <input type="checkbox"/> Carpal Tunnel Synd. |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Subluxations | <input type="checkbox"/> Repetitive Strain Synd. |
| <input type="checkbox"/> Chemical Dependency | | | | |

CHECK ANY OF THE FOLLOWING YOU HAVE HAD THE PAST SIX MONTHS:

- | | | |
|--|---|---|
| <p>MUSCULO-SKELETAL CODE</p> <input type="checkbox"/> Low Back Pain
<input type="checkbox"/> Pain Between Shoulders
<input type="checkbox"/> Neck Pain
<input type="checkbox"/> Arm Pain
<input type="checkbox"/> Joint Pain/Stiffness
<input type="checkbox"/> Difficult Chewing/Clicking Jaw
<input type="checkbox"/> General Stiffness
<input type="checkbox"/> Shoulder Pain
<input type="checkbox"/> Knee Pain
<input type="checkbox"/> Hip Pain
<input type="checkbox"/> Hand/Wrist Pain
<input type="checkbox"/> Foot/Ankle Pain <p>GENERAL CODE</p> <input type="checkbox"/> Fatigue
<input type="checkbox"/> Allergies
<input type="checkbox"/> Loss of Sleep
<input type="checkbox"/> Fever
<input type="checkbox"/> Headaches <p>C-V-R CODE</p> <input type="checkbox"/> Chest Pain
<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Blood Pressure
<input type="checkbox"/> Irregular Heartbeat
<input type="checkbox"/> Heart Problems
<input type="checkbox"/> Lung Problems/Congestion
<input type="checkbox"/> Varicose Veins
<input type="checkbox"/> Ankle Swelling
<input type="checkbox"/> Stroke | <p>GASTRO-INTESTINAL CODE</p> <input type="checkbox"/> Poor/Excessive Appetite
<input type="checkbox"/> Excessive Thirst
<input type="checkbox"/> Frequent Nausea
<input type="checkbox"/> Vomiting
<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Constipation
<input type="checkbox"/> Hemorrhoids
<input type="checkbox"/> Liver Problems
<input type="checkbox"/> Gall Bladder Problems
<input type="checkbox"/> Weight Trouble
<input type="checkbox"/> Abdominal Cramps
<input type="checkbox"/> Gas/Bloating After Meals
<input type="checkbox"/> Heartburn
<input type="checkbox"/> Black/Bloody Stool
<input type="checkbox"/> Colitis <p>GENITO-URINARY CODE</p> <input type="checkbox"/> Bladder Trouble
<input type="checkbox"/> Painful/Excessive Urination
<input type="checkbox"/> Discolored Urine <p>MALE/FEMALE CODE</p> <input type="checkbox"/> Menstrual Irregularity
<input type="checkbox"/> Menstrual Cramps
<input type="checkbox"/> Vaginal Pain/Infection
<input type="checkbox"/> Breast Pain/Lumps
<input type="checkbox"/> Prostate/Sexual Dysfunction
<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Other Problems _____

_____ | <p>NERVOUS SYSTEM CODE</p> <input type="checkbox"/> Nervous
<input type="checkbox"/> Numbness
<input type="checkbox"/> Paralysis
<input type="checkbox"/> Dizziness
<input type="checkbox"/> Forgetfulness
<input type="checkbox"/> Confusion/Depression
<input type="checkbox"/> Fainting
<input type="checkbox"/> Convulsions
<input type="checkbox"/> Cold/Tingling Extremities
<input type="checkbox"/> Stress <p>EENT CODE</p> <input type="checkbox"/> Vision Problems
<input type="checkbox"/> Dental Problems
<input type="checkbox"/> Sore Throat
<input type="checkbox"/> Ear Aches
<input type="checkbox"/> Hearing Difficulty
<input type="checkbox"/> Stuffed Nose <p>FAMILY HISTORY
 The following members have the same or similar problems as I do:</p> <input type="checkbox"/> Mother
<input type="checkbox"/> Father
<input type="checkbox"/> Brother
<input type="checkbox"/> Sister
<input type="checkbox"/> Spouse
<input type="checkbox"/> Child |
|--|---|---|

FEMALES ONLY

When was your last menstrual cycle? _____ Are you pregnant? Yes No Not Sure

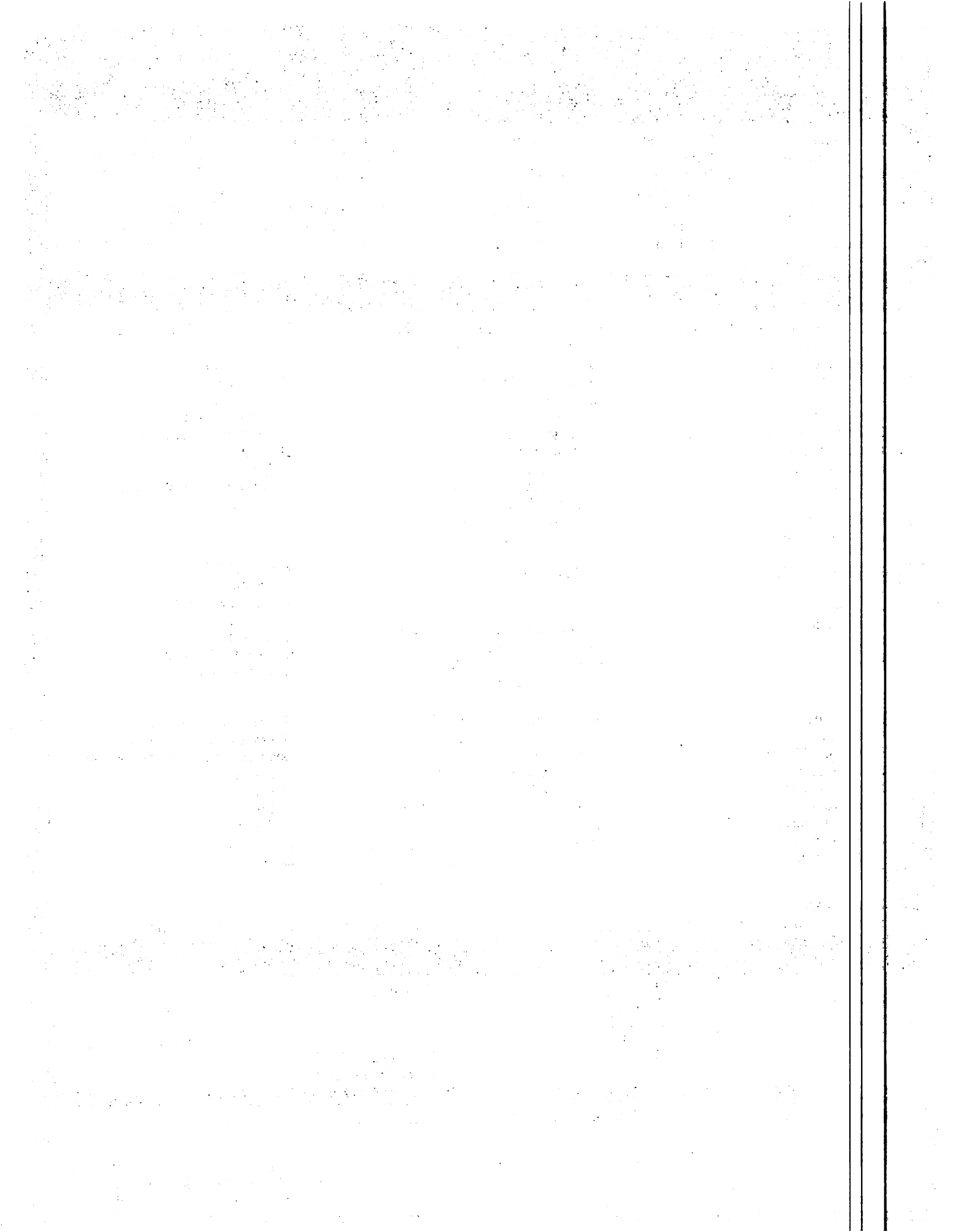
EXERCISE	WORK ACTIVITY	HABITS	
<input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Daily <input type="checkbox"/> Heavy	<input type="checkbox"/> Sitting <input type="checkbox"/> Computers <input type="checkbox"/> Standing <input type="checkbox"/> Light Labor <input type="checkbox"/> Heavy Labor	<input type="checkbox"/> Smoking <input type="checkbox"/> Alcohol <input type="checkbox"/> Coffee/Caffeine Drinks <input type="checkbox"/> High Stress Level	Packs/Day _____ Drinks/Week _____ Cups/Day _____

What is most important in your Doctor/Patient relationship? _____

What are your health goals? pain relief only correct my health problem

Signature _____

WELCOME



AUTO ACCIDENT FORM

ABOUT YOU

Please Fill Out Completely

Name: _____

Today's Date: _____ / _____ / _____

WHAT WE NEED

Please present us with a copy of the police/accident report and/or medical records, hospital and/or Doctor's reports, diagnostic tests results, ex: MRI, C.T. Scans, X-Rays, others.

Thank You.

ACCIDENT INFORMATION

Date & Time of Accident _____ a.m. p.m.

Were you the: driver Front Passenger Rear Passenger

If a traffic violation was issued, to whom was it issued?

Number of people in accident vehicle? _____

Name and addresses/phone no.'s of people in accident _____

Did the police come to the accident site? Yes No

Was a police report filed? Yes No

Were there any witnesses? Yes No

Were you wearing a seatbelt? Yes No

Was this vehicle equipped w/ airbags? Yes No

If yes, did they inflate? Yes No

In relation to the base of your skull, where was the headrest?

Above Below At base of skull

What did your vehicle impact? Another Vehicle Other

If other, explain: _____

Did any part of your body strike anything in the vehicle?

Yes No If yes, explain: _____

Did your vehicle go off the road? _____

Make and model of the vehicle your were occupying? _____

Name of the location/street on which you were traveling? _____

In which direction were you headed? N S E W

What was the approx. speed of your vehicle? _____

Did the impact come from the : Rear Front Side

During the impact, were you facing: Right Left Forward

Were you: Aware surprised by the impact?

If accident vehicle made impact with another vehicle what was Make & Model/Year of the other vehicle _____

Direction other vehicle was headed? N S W E

Speed of the other vehicle? _____

Briefly describe accident: _____

Have you reported your accident to your auto insurance company? Yes No

ACCIDENT INFORMATION (cont.)

Did Accident render you unconscious? Yes No

If yes, for how long? _____

Please describe how you felt immediately after the accident:

Have you gone to a Hospital or seen any other Doctor?

Yes No

When did you go?

Just after accident Next day 2 days plus

How did you get there?

Ambulance Private Transportation

Name of Hospital and/or Attending Doctor: _____

Was he/she a: Chiropractor M.D. Dentist

Describe any treatment you received: _____

Were X-rays taken? Yes No

Was medication prescribed? Yes No

Have you been able to work since this injury? Yes No

Are your work activities restricted as a result of this injury?

Yes No

AUTO INSURANCE

Type of Insurance: _____

CompanyName: _____

Address: _____

Phone No: _____

Insured's Name: _____

Policy No: _____ Claim No: _____

Insured's SS No: _____ DOB: _____

Insured's Employer: _____

Agent's Name: _____

List all automobiles owned by you or any family member living with you at the time of the accident: _____

Have you retained an attorney? Yes No

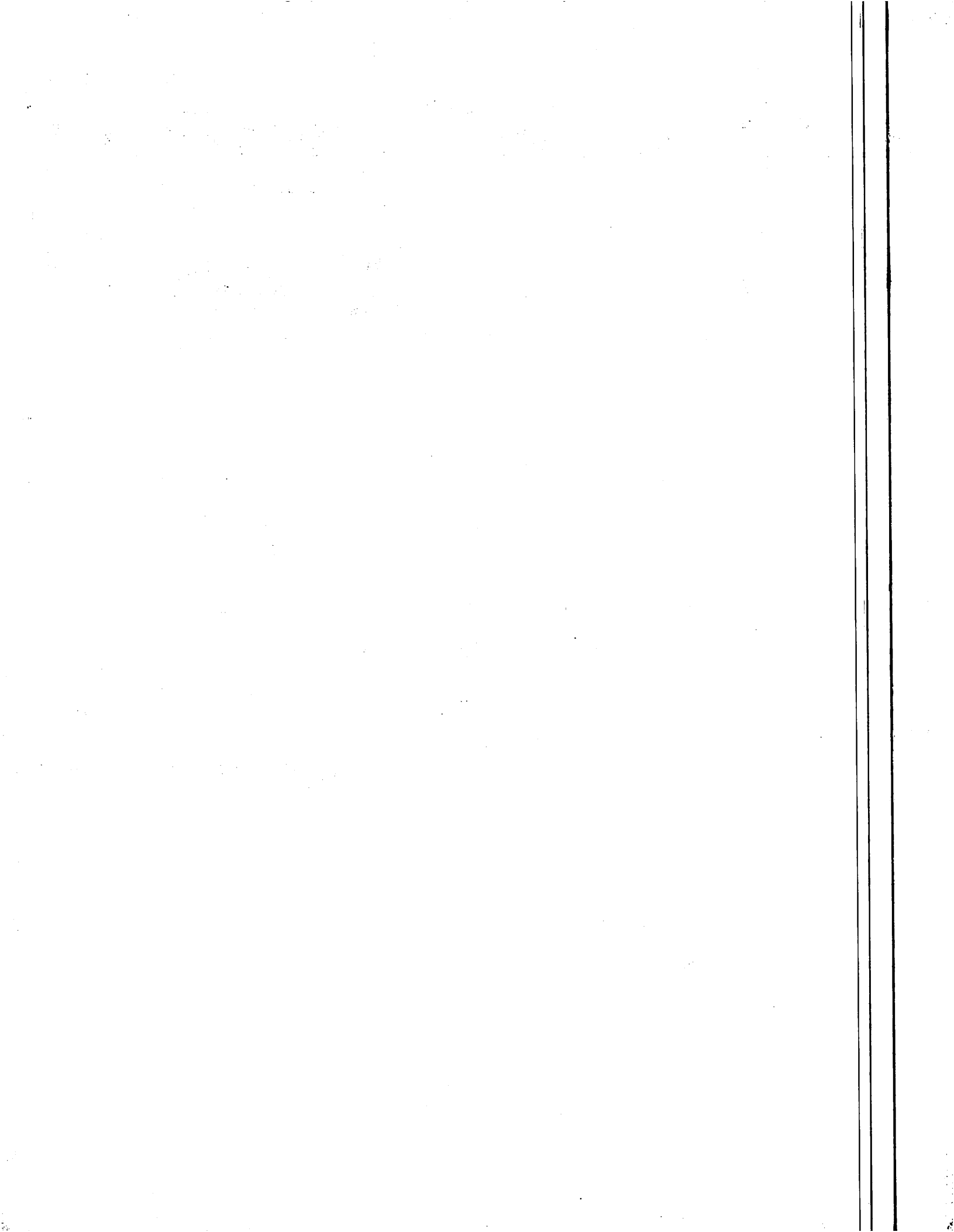
Name of attorney? _____ Phone: _____

Address: _____

City _____ State _____ Zip Code _____

Patient's Signature _____

Date _____





PINES WEST CHIROPRACTIC

18501 Pines Blvd. Ste 104, Pembroke Pines, FL 33029

T: 954-432-3343 | F: 954-450-2565

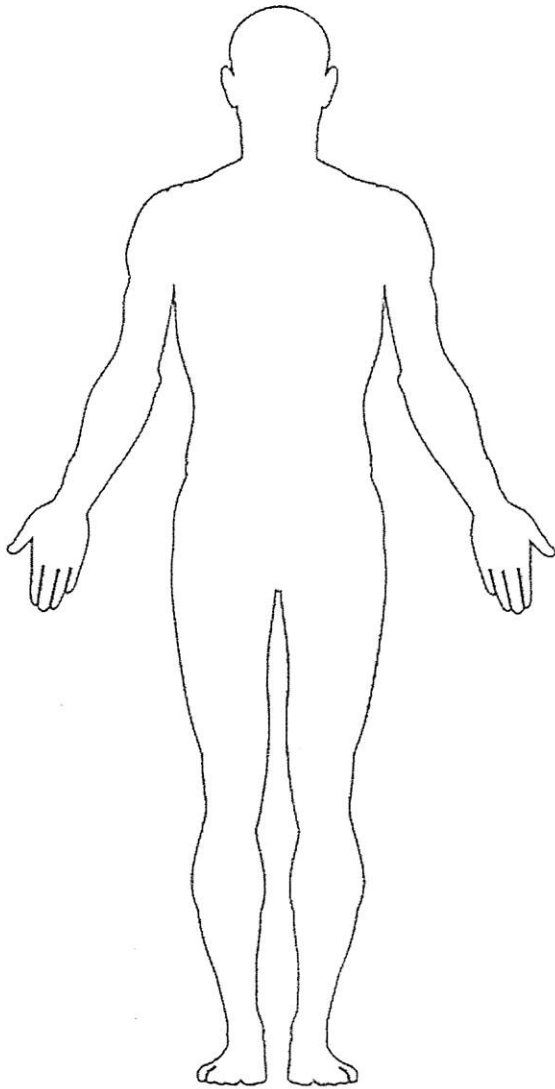
"Live Healthy, Be Happy"

Patient Name : _____ Date: _____ File: _____

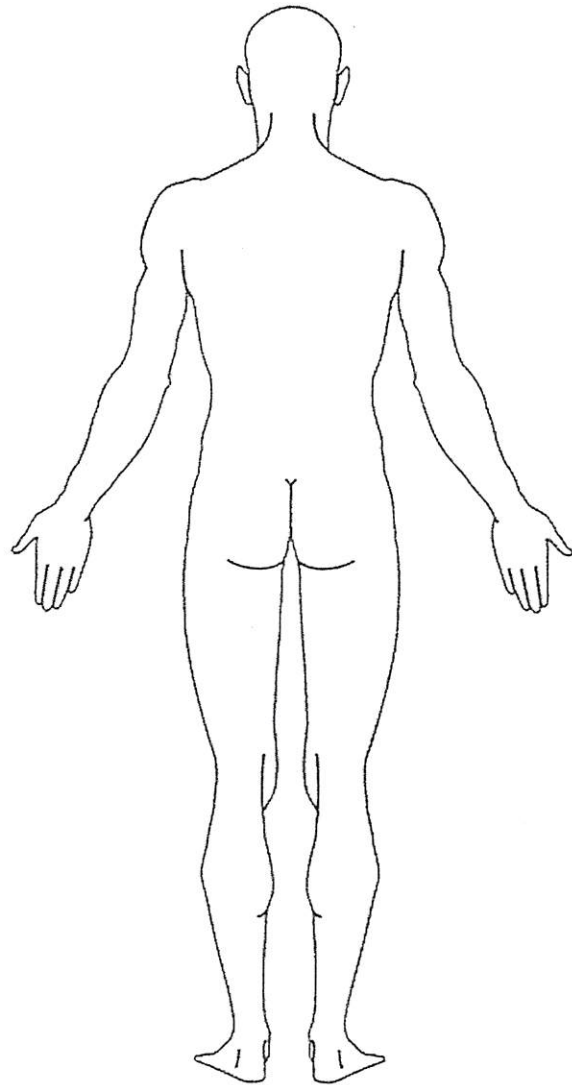
GENERAL SYMPTOMS CHART

Please use the following notations on the figures below to indicate the type and location of your symptoms, as it relates to the purpose of your visit today.

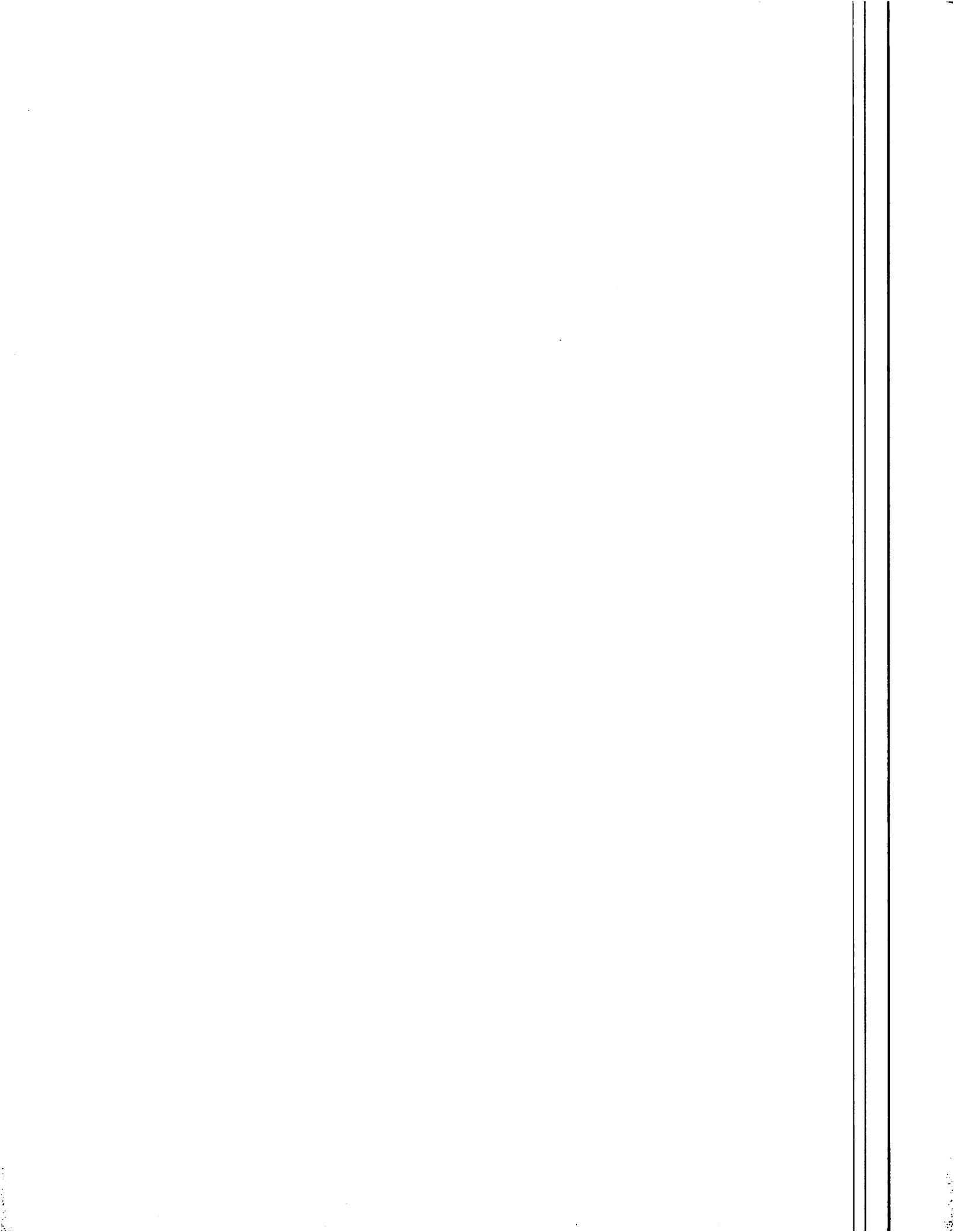
- | | | |
|--------------------|---------------|--------------|
| A = ACHE | G = STABBING | N = NUMBNESS |
| B = BURNING | M = SPASMS | T = TINGLING |
| P = PINS & NEEDLES | F = STIFFNESS | O = OTHER |



FRONT



BACK





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"Live Healthy, Be Happy"

PAIN DISABILITY QUESTIONNAIRE

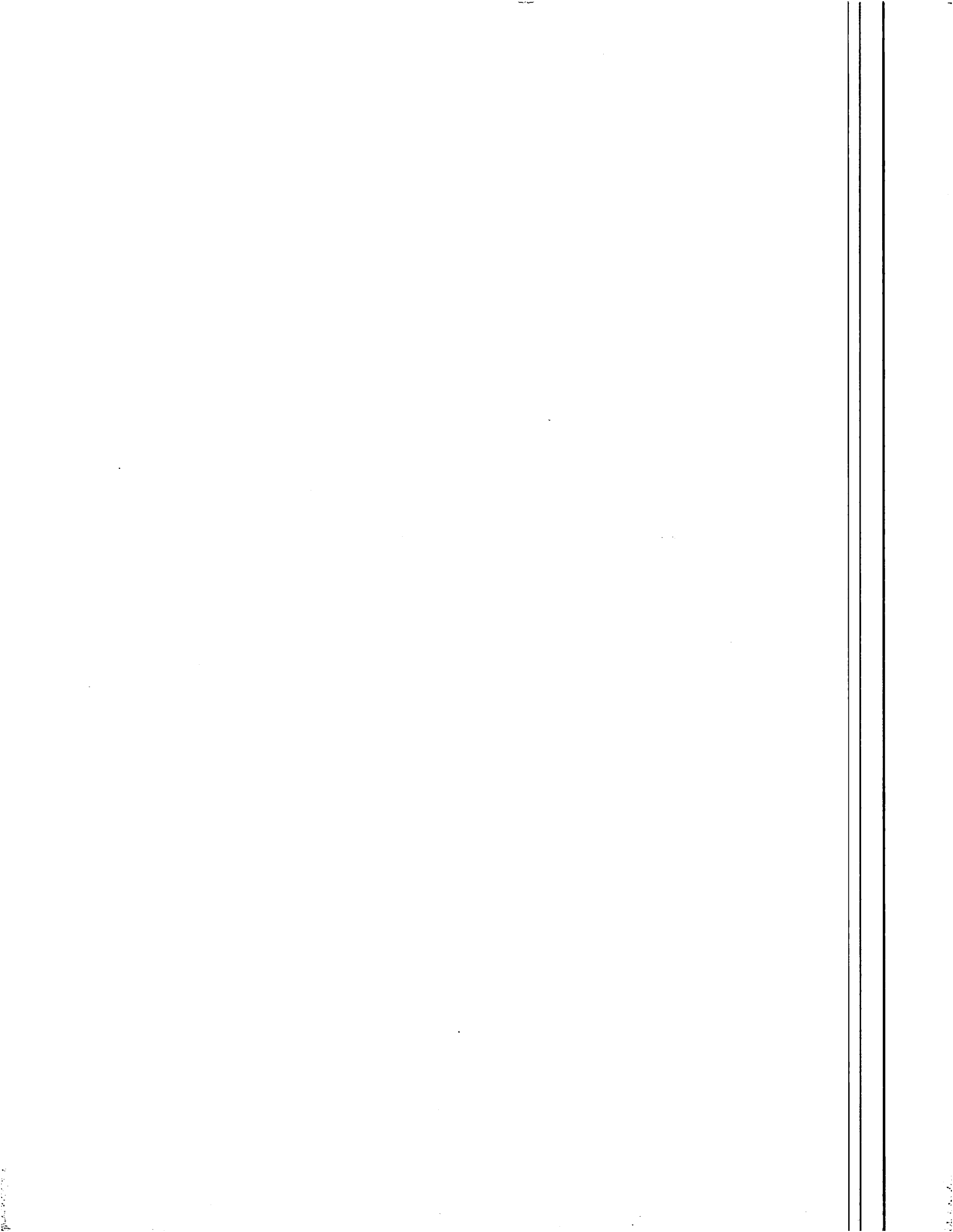
Patient Name _____ Date _____

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 completely 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 On pain medication 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 the people who are important to you as much as you would like?
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 that are important to you?
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 (including both work outside the home and housework) because of your pain?
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 Severe problems
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10

Patient Signature

Doctor Signature





PINES WEST CHIROPRACTIC

"Live Healthy, Be Happy"

18501 Pines Blvd. Ste 104, Pembroke Pines, FL 33029

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INFORMED CONSENT FORM

I hereby request and consent to the performance of chiropractic treatments and other chiropractic/medical procedures, including various forms of physical therapy and diagnostic x-rays by Pines West Chiropractic Center. This consent is extended to other licensed chiropractic Physicians, Chiropractic assistants or licensed Massage Therapists, who now or in the future, are employed by, working with or associated with this office.

I certify that I have had the opportunity to discuss, with the doctor of Chiropractic and/or other office personnel, that nature and purpose of the care that is being provided. I understand that the results are not guaranteed. Further, I have been informed and I understand that, as in the practice of any of the healing arts, in the practice of Chiropractic, there are some risks to treatment including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I also understand that the doctor, who has explained all these things to me, is not expecting to be able to anticipate judgment during the course of care, based on the facts known at this time, and in my best interest.

My signature below certifies that I have read, or have had read to me the above consent. I also certify that I have had the opportunity to ask questions and options to care have explained. By signing this consent form, I agree to the care being provided to me for the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

Patient's Name (please print)

Witness' Name (please print)

Patient's Signature

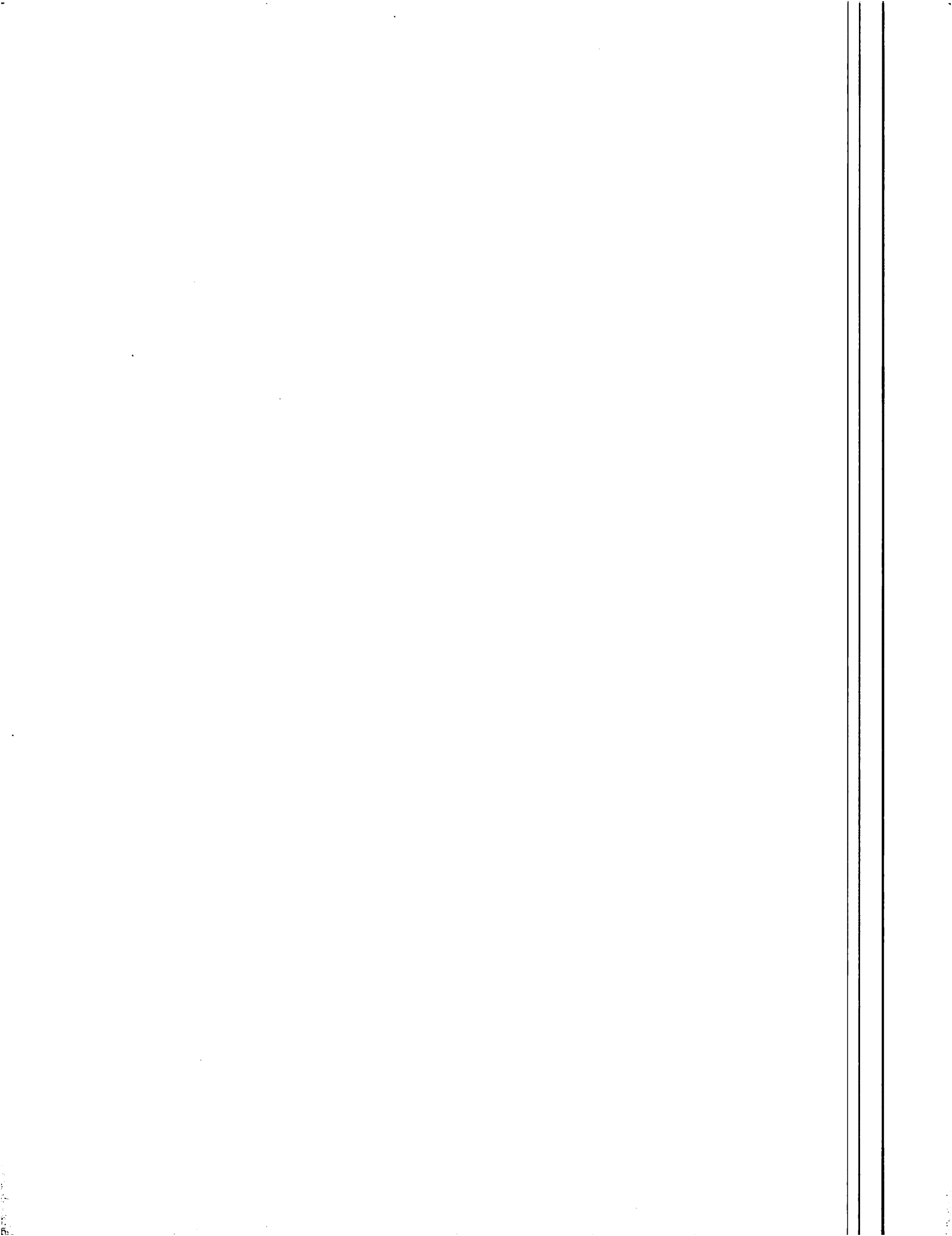
Witness' Signature

Date Signed

Date Signed

Patient's Representative
(If patient is a minor or if physically
or mentally impaired)

Representative's relationship to Patient





PINES WEST CHIROPRACTIC

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Irrevocable Assignment of Benefits/Policy Rights

I, the undersigned patient hereby assign the rights and benefits of insurance of applicable personal injury protections. Medical payment, and/or other insurance to **Pines West Chiropractic Center** of services and/or supplied rendered for treatment of personal injuries sustained in the accident of (DOA) _____ to the undersigned patient and covered by Personal Injury Protection (PIP Coverage of other insurance) coverage under _____ in accordance with Florida Statute 627.736(5). The undersigned agrees to pay any applicable deductible or co-payment not covered by the P.I.P. or other insurance coverage. I have read the information herein and is true and to the best of my knowledge.

This assignment includes, but is not limited to all rights to collect benefits directly from the insurance company for services that I have received; and all rights to proceed against the insurance company obligated to provide benefits in any action including legal suit, if any reason the insurance company fails to make payment of benefits of which I am due. Specifically, this assignment includes the right to collect payment for reasonable costs connected with coping and mailing records to the insurer at the insurer's request and in accordance with Florida Statute 627.736(6) . This assignment also includes any right to recover attorney's fees and cost for such action brought by the provider as Patient's assignee. I agree that **Pines West Chiropractic Center** may select any attorney he/she wishes and understand and agree that the attorney selected by them may be different than the attorney handling my personal injury/bodily claim or case.

As part of this assignment of right and benefits, I hereby instruct the insurance carrier that in the event the subject medical benefits are disputed for any reason, including medical reasonableness and or necessity that the amount of benefits claimed by **Pines West Chiropractic Center** is to be set aside and not disbursed until the dispute is resolved. As part of this assignment of rights and benefits, I further instruct the insurance carrier to notify the provider immediately of any dispute as to payment so that he/she may exercise their legal rights. I understand that any person who knowingly files anything containing any false, incomplete or misleading information with the intent to injure defraud, or deceive any insurance company is guilty of a felony of the third degree. I have read the information herein and it is true and correct to the best of my knowledge and belief.

Patient Signature

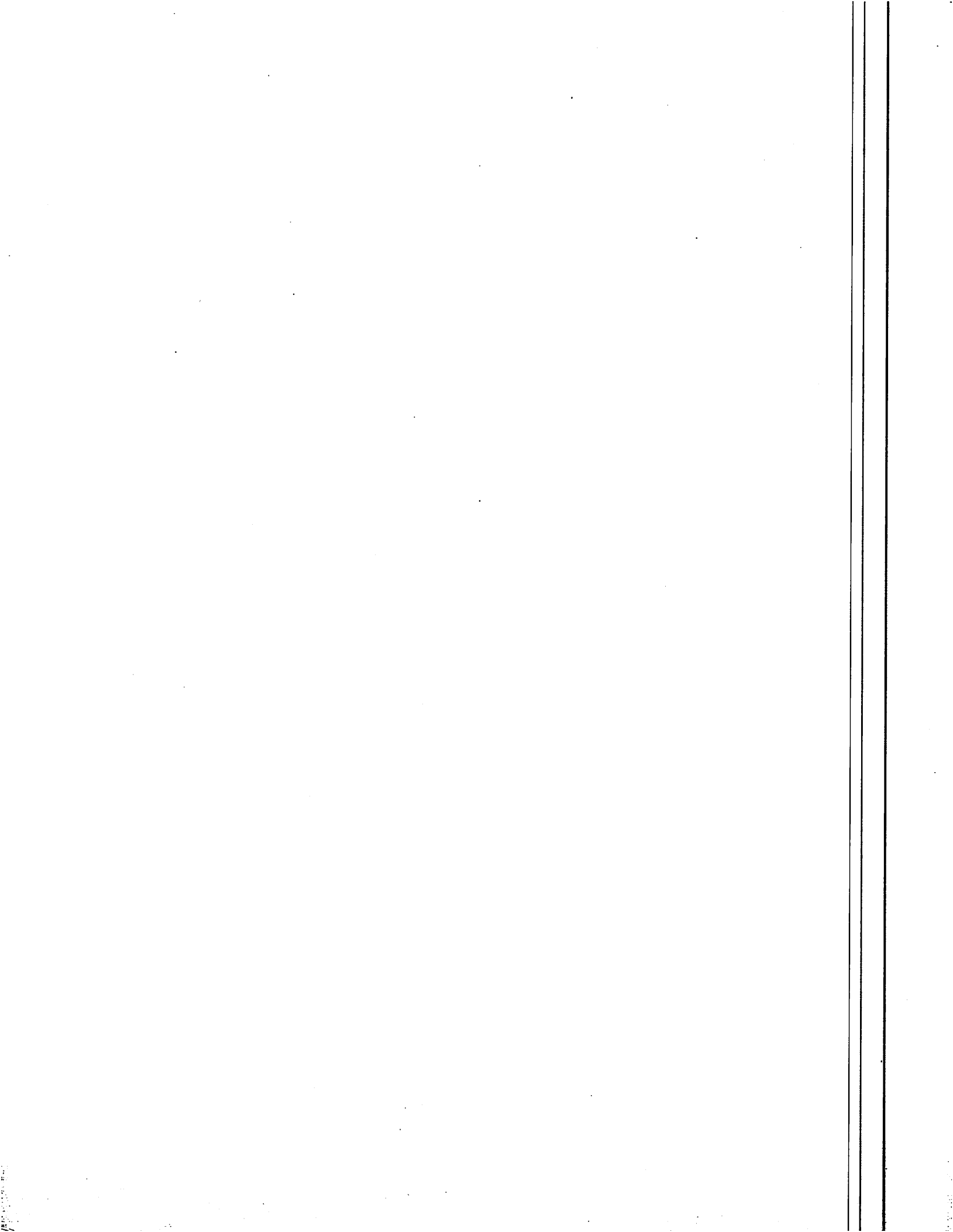
Date

The undersigned on behalf of **Pines West Chiropractic Center** here by accepts assignment of the insurance right and benefits for the services rendered to: _____
And to be paid directly to **Pines West Chiropractic Center** Under

Personal Injury Protection (PIP) or other insurance coverage with _____
And in accordance with the Florida Statute 627.736(5).

Provider Representative's Signature

650705019
Tax ID#





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Official Certification of Patient as to Insurance Information

Insurance Carrier: _____

Policy #: _____

Insured: _____

Relationship
To Insured: _____

Date of Accident: _____

I, as the above captioned patient hereby attest that to the best of my knowledge, that the insurance claim/policy information I have provided above is in fact the correct insurance information under which I am entitled to medical and or PIP insurance coverage.

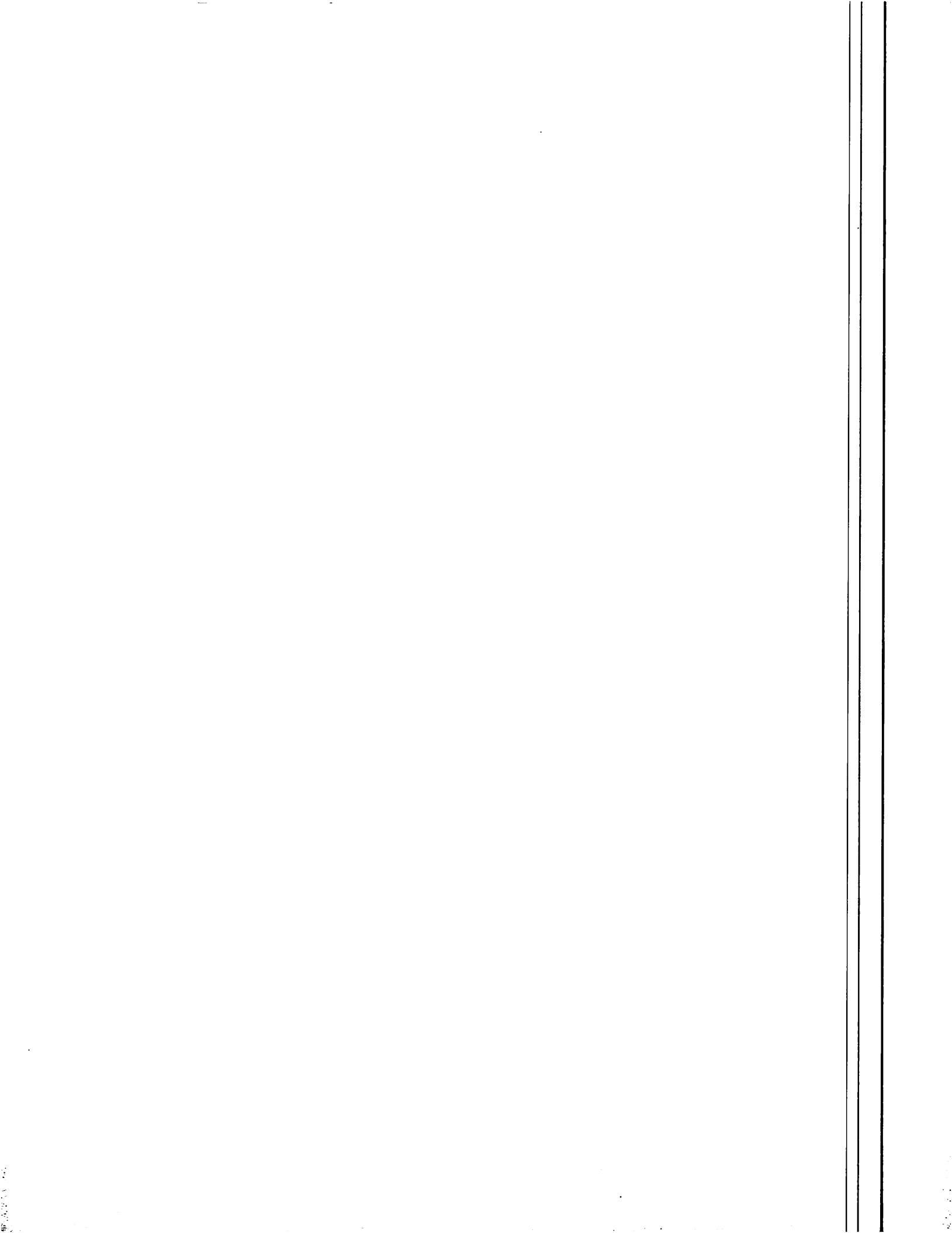
I understand that the medical provider is relying on this correct information in order to receive the appropriate coverage and qualify for payment for medical services provided to me.

Signature of Patient

Date

This notice is sent in good faith so I may utilize the benefits stated in my PIP policy for which I have paid premiums or I am claiming benefits from.

If the claim or policy number listed above is not correct or your company is not able to match the insured you must notify the providers office within 5 business days or this information will be assumed correct and the providers office will not be prejudiced in its efforts collecting for services provided.





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Authorization Form

Pines West Chiropractic Center

Patient Authorization for Use and Disclosure of Protected Health Information

By signing, I authorize Pines West Chiropractic to use and/or disclose certain protected health information (PHI) about me to _____.

This authorization permits Pines West Chiropractic to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.)

The information will be used or disclosed for the following purpose:

(If disclosure is requested by the patient, purpose may be listed as "at the request of the individual")

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on _____.

The Practice will ___ will not ___ receive payment or other remuneration from third party in exchange for the using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from Pines West Chiropractic Center. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer at.

**Pines West Chiropractic Center, 18501 Pines Blvd, Suite 104, Pembroke Pines, FL 33029
(954) 432-3343**

I have received a copy of the "Notice of Privacy Practices" and have read it.

Signature of Patient or Legal Guardian

Relationship to Patient

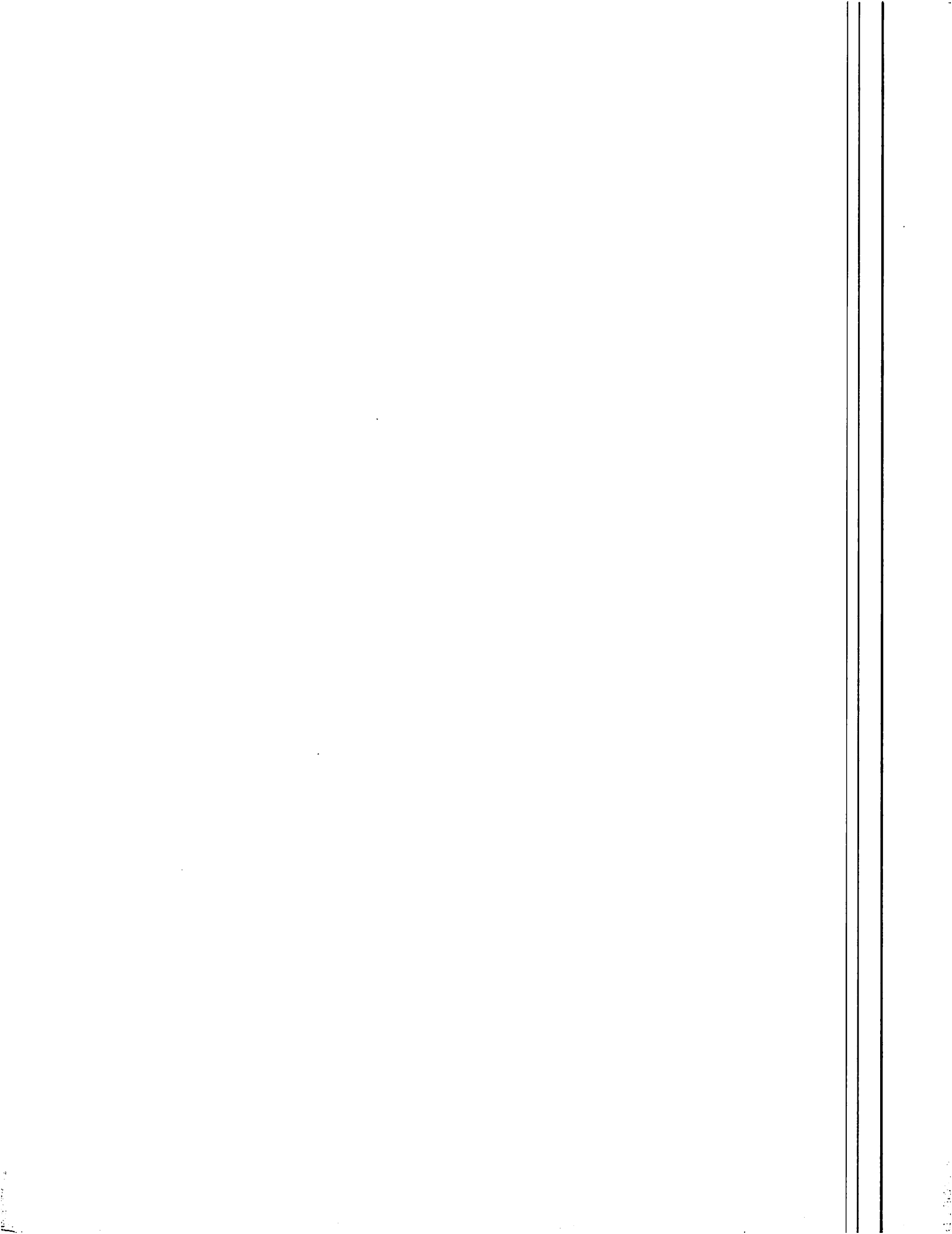
Print Patients Name

Date

Print Name of Legal Guardian

Date

Patient/Guardian must e provided with signed copy of the authorization form





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Patient Demographics

First Name: _____ Last Name _____

Language: check one
 English
 Spanish
 Other please Specify _____

Race: check one
 Decline to Specify
 American Indian or Alaska Native
 Asian
 Black or African American
 White
 Other please specify _____

Ethnicity: check one
 Decline to Specify
 Not Hispanic or Latino
 Hispanic or Latino

Smoking: check one
 Current every day smoker
 Ex-smoker
 Never smoked

Religion: _____

Preferred Communication Type: check one
 Phone
 Email
 Mail/letter

Mother's Maiden Name: First _____ Last _____

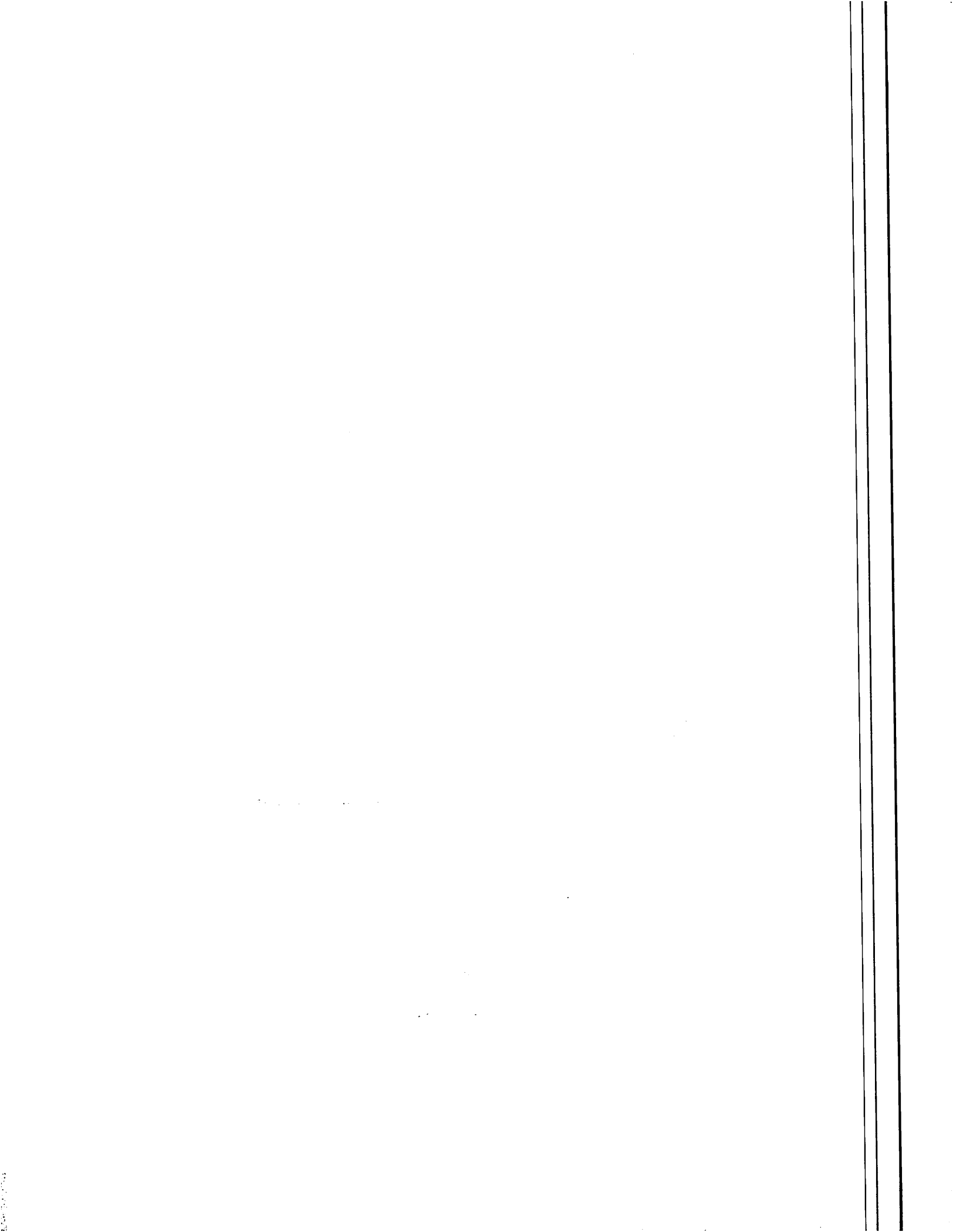
Cognitive Status: check one
 Memory Impairment
 No Memory Impairment
Cognitive Status Start Date _____

Functional Status: check one
 Depends on Walking stick
 No Impairment
Functional Status Start Date _____

Next of Kin: First Name _____ Last Name _____

Relationship: _____

Address: _____





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Massage Therapy Policy to ALL Patients

In fairness to our office, massage therapists, and other patients, we have made the following policy pertaining to Massage Therapy Appointments.

- ❖ A minimum **24 hour** notice of cancellation is **REQUIRED**.
- ❖ A **\$30 fee** will be charged directly to you for cancelling with a notice of less than 24 hours.
- ❖ This charge is your responsibility and **will not** be submitted to your insurance company.
- ❖ Children under age 16 cannot be left unattended while you are receiving a massage.

Patient Signature

Date

Optional Appointment Reminder via Text or Email

Please choose an option:

Text Message: Phone Number: _____

Email: Address _____

Chiropractic Newsletter

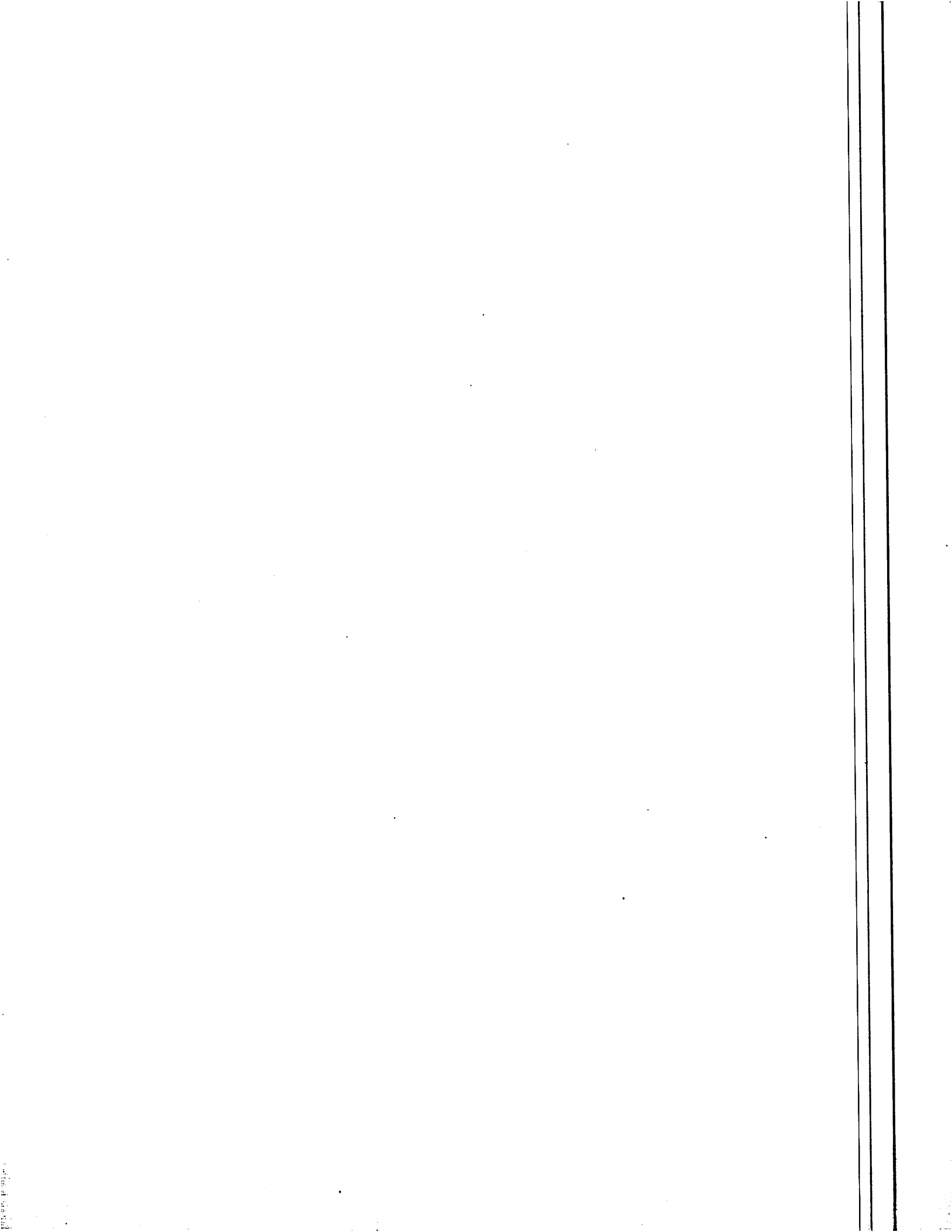
Receive our interesting, health improving monthly newsletter online

This monthly Chiropractic Newsletter delivers credible and current health information to help you and your family live healthier and happier. Please fill out the information below for your authorization.

- Yes, I would like to receive this monthly newsletter.
- No, I would not like to receive this monthly newsletter.

Email: _____

Signature: _____





PINES WEST
CHIROPRACTIC

"Live Healthy, Be Happy"

18501 Pines Blvd. Ste 104, Pembroke Pines, FL 33029

T: 954-432-3343 | F: 954-450-2565

Release of Medical Records

Pines West Chiropractic Centers
Dr. Joseph Buckley
18501 Pines Blvd
Suite 104
Pembroke Pines, Florida 33029

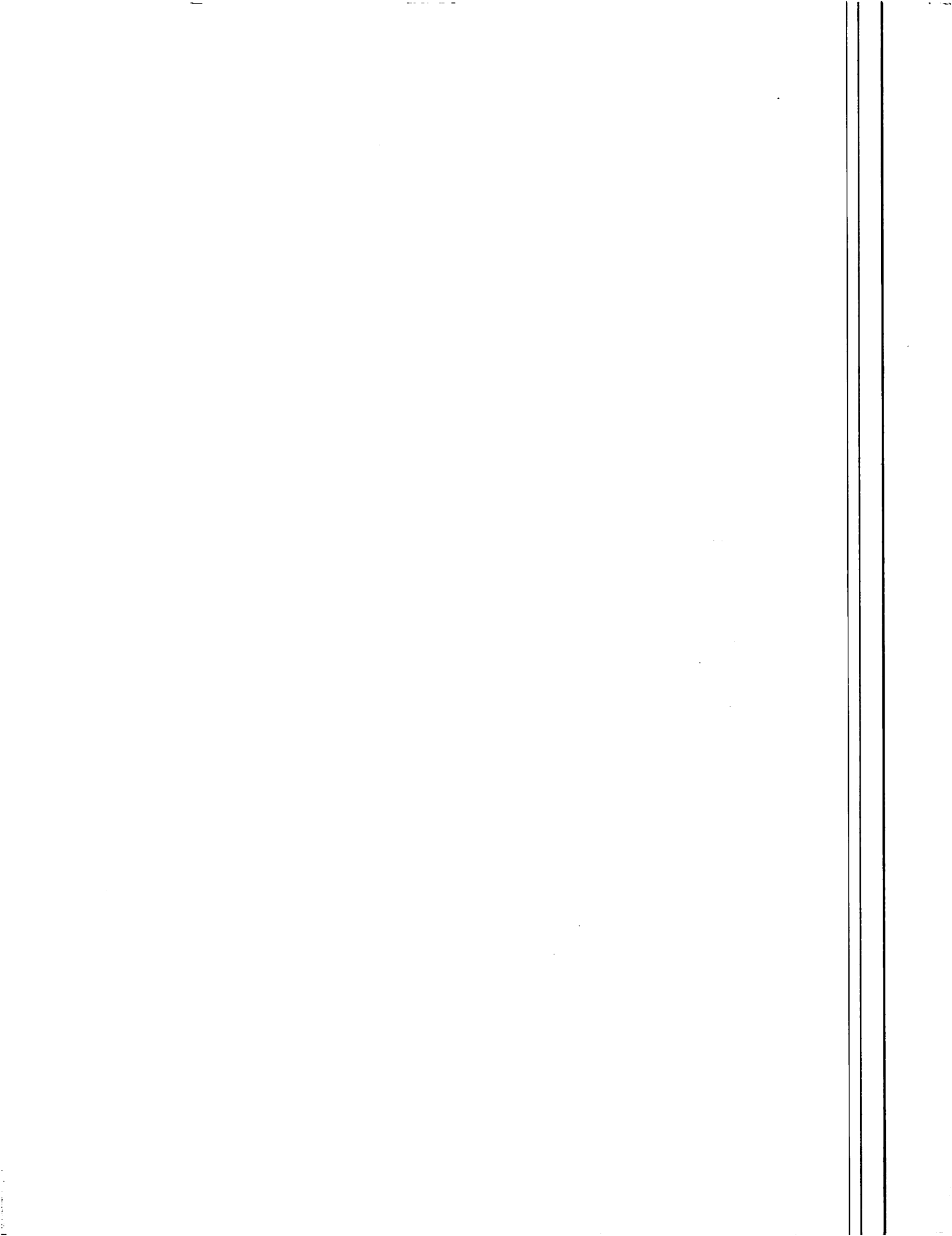
To whom it may concern:

Please release all records, including but not limited to progress notes, operative notes, laboratory test results, diagnostic tests, and x-rays.

I, _____ (please print) hereby authorize the release of my medical records as provided above.

Patient Signature

Date





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Irrevocable Lien

I do hereby authorize Pines West Chiropractic Center, Dr. Joseph Buckley, Dr. Damian Martinez, to furnish you my attorney, with full report of my examination, diagnosis, treatment, prognosis, etc., in regard to the accident in which I was involved.

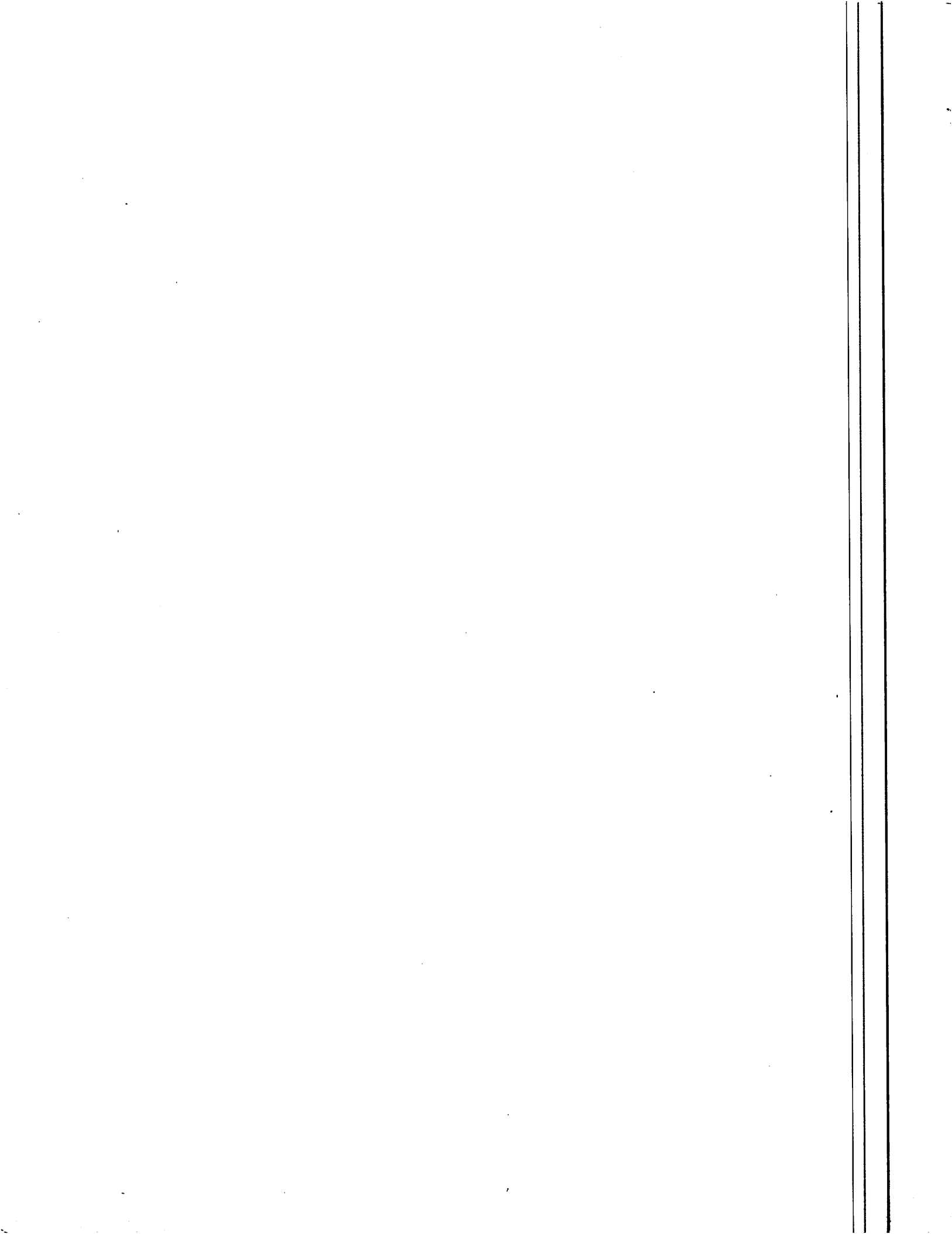
I hereby authorize and direct you, my attorney, to pay directly to said facility such sums as may be due and owing for medical services rendered both by reason of this accident and by reason of any other bill that are due to this facility and to withhold such sums from the settlement, judgement or verdict as may be necessary to adequately protect said doctors. I hereby further give a lien on my case to said satisfy against any and all proceeds of my settlement, judgement or verdict which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said facility for all medical bills submitted for service rendered me and that this agreement is made solely for said facility's additional protection and in consideration of them awaiting payment. I further understand that such payment is not contingent on any settlement, judgement or verdict by which I may eventually recover said fee.

Patient's Signature: _____ Date: _____

The undersigned, being attorney of records for the above patient, does hereby agree to observe all terms of the above and agrees to withhold such sums from any settlement, judgement or verdict as may be necessary to adequately protect said facility above named.

Attorney's Signature: _____ Date: _____



HIPAA Notice of Privacy Practices

PINES WEST CHIROPRACTIC CENTER, INC.

18501 Pines Blvd, Ste 104 Pembroke Pines, FL 33029-1414

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

If you have any questions about the above notice, please contact our Office at

954-432-3343

Our Obligations

We are required by law to:

- Maintain the privacy of protected health information
- Give you the notice of your legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

How We May Use and Disclose Health Information

Described as follows are the ways we may use and disclose health information that identifies you ("Health Information"). Except for the following purposes, we will use and disclose health information only with your written permission. You may revoke such permissions at any time by writing to our practice's privacy officer.

Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company, or a third party for treatment and services you receive. For example, we may give your health plan information so that they will pay for your treatment.

Health Care Operations. We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care to operate and manage our office. For example, we may use and disclose information to make sure the obstetric or gynecologic care you receive is of the highest quality. We also may share information with our entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives, and Health Related Benefits and Services. We may use and disclose Health Information to contact you and remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who receive one treatment to those who receive another for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes.

Special Situations

As required by law. We will disclose Health Information when required to do so by international, federal, state, or

1. The first part of the document discusses the importance of maintaining accurate records of all transactions. It emphasizes that this is crucial for ensuring the integrity of the financial statements and for providing a clear audit trail. The text notes that any discrepancies or errors in the records can lead to significant complications during an audit and may result in the disallowance of certain expenses.

2. The second part of the document outlines the specific procedures that must be followed when recording transactions. It details the requirements for proper documentation, including the need for original receipts and invoices. It also discusses the importance of timely recording and the use of appropriate accounting methods to ensure that the records are consistent and reliable.

3. The third part of the document addresses the issue of expense allocation. It explains how certain expenses, such as those for travel or entertainment, must be properly allocated to the appropriate cost center or project. The text provides guidance on how to determine the appropriate allocation method and how to document these decisions to ensure transparency and accountability.

4. The fourth part of the document discusses the importance of regular reconciliation of accounts. It explains that this process is essential for identifying any errors or discrepancies in the records as soon as possible. The text provides instructions on how to perform a reconciliation and how to resolve any issues that may arise.

5. The fifth part of the document discusses the importance of maintaining proper custody of records. It explains that records must be stored in a secure and accessible location and that appropriate controls must be in place to prevent unauthorized access or destruction. The text also discusses the importance of retaining records for the appropriate period of time as required by law.

6. The sixth part of the document discusses the importance of training and education for staff involved in the financial reporting process. It explains that staff must be properly trained in the applicable accounting principles and procedures to ensure the accuracy and reliability of the records. The text provides guidance on how to develop and implement a training program for staff.

7. The seventh part of the document discusses the importance of internal controls. It explains that internal controls are essential for preventing and detecting errors and fraud. The text provides guidance on how to design and implement effective internal controls and how to monitor their effectiveness over time.

8. The eighth part of the document discusses the importance of communication and collaboration between different departments. It explains that effective communication is essential for ensuring that all staff are aware of their responsibilities and for resolving any issues that may arise. The text provides guidance on how to establish a culture of communication and collaboration within the organization.

9. The ninth part of the document discusses the importance of regular reviews and audits. It explains that regular reviews and audits are essential for ensuring the accuracy and reliability of the records and for identifying any areas for improvement. The text provides guidance on how to conduct regular reviews and audits and how to use the results to improve the financial reporting process.

10. The tenth part of the document discusses the importance of staying up-to-date on changes in accounting principles and procedures. It explains that the accounting profession is constantly evolving and that staff must stay up-to-date on the latest developments to ensure the accuracy and reliability of the records. The text provides guidance on how to stay up-to-date on changes in accounting principles and procedures.

local law.

To Avert a Serious Threat to Health or Safety. We will disclose Health Information when necessary to prevent a serious threat to your health and safety or the public, or another person. Disclosure, however, will be made only to someone who may be able to help provide treatment.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or to provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than that as specific in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement; banking or transportation of organs, eyes, or tissues to facilitate organ, eye, or tissue donation, and transplantation.

Military and Veterans. If you are a member of the army forces, we may use or release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Worker's Compensation. We may release Health Information for worker's compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosure to prevent or control disease, injury, or disability; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; inform a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and report to the appropriate government authority if we believe a patient has been a victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or a court administrator order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: 1) in response to a court order, subpoena, warrant, summons, or similar process; 2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; 3) about the victim of crime even if, under certain circumstances, we are unable to obtain the person's agreement; 4) about a death we believe may be the result of criminal conduct; 5) about criminal conduct on our premises and; 6) in an emergency to report a crime to the location of the crime if victims, or the identity, description, or location of the person who committed the crime.

Coroners, Medical Examiners, Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations.

Protective Services and Intelligence Activities. We may release Health Information to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations.

1. The first part of the document discusses the importance of maintaining accurate records of all transactions and activities. It emphasizes that this is essential for ensuring transparency and accountability in the organization's operations.

2. The second part of the document outlines the various methods and tools used to collect and analyze data. It highlights the need for consistent and reliable data collection processes to support effective decision-making.

3. The third part of the document focuses on the role of technology in data management and analysis. It discusses how modern software solutions can streamline data collection, storage, and reporting, thereby improving efficiency and accuracy.

4. The fourth part of the document addresses the challenges associated with data management, such as data quality, security, and privacy. It provides strategies to mitigate these risks and ensure that data is used responsibly and ethically.

5. The fifth part of the document discusses the importance of data governance and the establishment of clear policies and procedures. It stresses that a strong governance framework is necessary to ensure that data is managed in a consistent and compliant manner.

6. The sixth part of the document explores the role of data in strategic planning and performance management. It explains how data-driven insights can help organizations identify trends, opportunities, and areas for improvement.

7. The seventh part of the document discusses the importance of data literacy and training for all employees. It emphasizes that having a data-driven culture is essential for maximizing the value of data and driving organizational success.

8. The eighth part of the document provides a summary of the key points discussed and offers recommendations for implementing a robust data management strategy. It encourages organizations to embrace data as a core asset and invest in the necessary resources and capabilities.

9. The ninth part of the document discusses the future of data management and the emerging trends that will shape the industry. It highlights the growing importance of artificial intelligence, machine learning, and cloud-based data solutions.

10. The tenth part of the document concludes by reiterating the importance of data in driving organizational growth and innovation. It encourages organizations to continue to explore new ways to leverage data and stay ahead of the competition.

11. The eleventh part of the document provides a final summary and offers contact information for further assistance. It expresses the organization's commitment to providing high-quality data management solutions and services.

12. The twelfth part of the document is a closing statement that expresses gratitude to the reader and wishes them success in their data management journey. It also includes a disclaimer and a note about the document's confidentiality.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or other custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be made if necessary 1) for the institution to provide you with health care; 2) to protect your health and safety or the health and safety of others, or; 3) for the safety and security of the correctional institution.

Your Rights

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have the right to inspect and copy Health Information that we may use to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this information, you must make your request in writing, to our Privacy Officer.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to our Privacy Officer.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment, and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to our Privacy Officer.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operation. You also have a right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you can ask that we not share information about your particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to our Privacy Officer. **We are not required to agree with your request.** If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential Communication. You have the right to request that we communicate with you about your medical matters in a certain way or at a certain location. For example, you can ask that we contact you only by mail or at work. To request confidential communications, you must make your request, in writing, to our Privacy Officer. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You must ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice by contacting our office.

Changes to This Notice

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a current copy of our notice at our office. The notice will contain the effective date on the first page, in the top right hand corner.

Complaints

If you believe your privacy has been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact our Privacy Officer. All complaints must be made in writing. **You will not be penalized for filing a complaint.**

By Subscribing my name below, I acknowledge receipt of a copy of this notice, and my understanding and my agreement to its terms.

Patient Signature

Date

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