

Dr. Peter Vapnek
Chiropractic, Massage, and Laser Center
14838 S. Military Trail
Delray Beach, Florida 33484
(561) 274-6100

Personal Information

Date: _____

First Name: _____ **Last Name:** _____ **Gender:** Male Female Other

Address: _____

Cell Phone: _____ **Home Phone:** _____ **Email:** _____

Date of Birth: ___/___/___ **Age:** ___ **Marital Status:** Married Single Widow(er) Divorced

Spouse Name: _____ **Occupation:** _____ **Employer:** _____

Referred to the office by: _____

Emergency Contact

First Name: _____ **Last Name:** _____ **Cell Phone:** _____

My Health Insurance

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that the Doctor's Office will provide any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account upon receipt.

Who should receive bills for payment on your account?

- | | | | |
|-----------------------------------|---|---|---------------------------------------|
| <input type="checkbox"/> Patient | <input type="checkbox"/> Spouse | <input type="checkbox"/> Parent | <input type="checkbox"/> Workers Comp |
| <input type="checkbox"/> Medicare | <input type="checkbox"/> Health Insurance | <input type="checkbox"/> Auto Insurance | |

Insurance Company: _____

Policy #: _____ **Group #:** _____

Insured same as patient: Yes No **Insured Name:** _____

Insured Gender: _____ **Insured D.O.B:** _____ **Relation:** _____

Accident/ Illness Information

Is condition related to: Auto Accident Other Accident **Date of Accident:** ___/___/___

Initial Consultation Form

Primary Complaint (s): _____

When did this condition begin? _____

Has this condition: Gotten Worse Stayed Constant Comes and Goes

Has this condition occurred before? Yes No

What was the cause of injury? _____

Rate the pain as it is right now, 0-10 with 0 being no pain and 10 being most excruciating pain: _____

Does anything alleviate the pain? _____

Does anything exacerbate (make worse) the pain? _____

Does pain radiate into extremities? Yes No **Is so where does pain radiate to?** _____

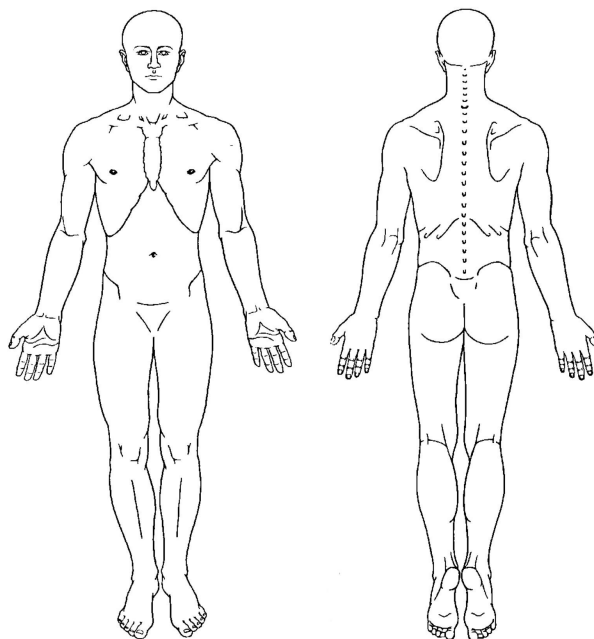
Frequency of pain: Constant - 100% of the time Frequent - 75% Intermittent - 50% Occasional - 25%

Is the pain worse or better at any time of the day? If so, when? _____

Have you seen other doctors for this condition? Yes No **Type of Treatment:** _____

Have you had any imaging for this problem (x-ray, MRI, CT scan, ETC.)? _____

Place an X on the image below, where you feel pain, numbness, or tingling:



REVIEW OF SYSTEMS

(Check any of the following you have or have had)

General Symptoms

- Headaches
- Fever
- Diabetes
- Chills
- Sweats
- Osteoporosis
- Fainting
- Dizziness
- Cancer
- Loss of Sleep
- Fatigue
- Nervousness
- Loss or gained weight.
- Numbness or pain in arms, hands, or legs
- Allergies
- Neuropathy
- Depression, mental health

Eyes, ears, nose, and throat

- Failing vision
- Blurriness
- Eye pain
- Deafness
- Earache
- Ear noises
- Ear discharge
- Nose bleeds
- Nasal obstruction
- Sore throat
- Hoarseness
- Hay fever
- Asthma
- Dental decay
- Gum trouble
- Thyroid
- Tonsillitis
- Sinus infection
- Nasal drainage
- Enlarged glands
- TMJ
- Jaw clicking

Skin

- Rashes
- Itching
- Bruises easily
- Dryness
- Nail problems
- Varicose veins
- Sensitive skin
- Hives or allergy

Respiratory

- Chronic cough
- BOOP
- COPD
- Spitting up blood
- Chest pain
- Difficult breathing
- Asthma
- Emphysema

Cardio-vascular

- Irregular heartbeat
- Pacemaker
- High blood pressure
- Low blood pressure
- High cholesterol
- Pain over heart
- Previous heart attacks
- Hardening of the arteries
- Swelling of ankles
- Anemia
- Poor circulation
- Previous strokes
- Blood disorder

Genitourinary

- Frequent urination
- Painful urination
- Blood in urine
- Kidney infection or stones
- Bed wetting
- Inability to control urine
- Prostate trouble
- Hernia

Muscle and Joint

- Stiff neck
- Shoulder pain
- Back pain
- Arthritis
- Swollen joints
- Tremors
- Painful tail bone
- Foot trouble
- Pain between shoulders
- Spinal curvature

Gastrointestinal

- Poor appetite
- Excessive hunger
- Belching or gas
- Nausea
- Vomiting
- Pain over stomach
- Distention of abdomen
- Constipation
- Diarrhea
- Hemorrhoids
- Liver Trouble
- Gall bladder trouble
- Jaundice
- Appendicitis
- Colitis

Female

- Painful menstrual periods
- Hot flashes
- Irregular cycle
- Abdominal cramping
- Previous miscarriage
- Vaginal discharge
- Cancer
- Menopausal symptoms

History

List any previous accidents you have had and conditions you have been diagnosed with such as diabetes, cancer, heart disease, etc. : _____

List any surgeries, major traumas (including concussions and broken bones), illnesses or other hospitalizations: _____

Have you ever been diagnosed with a spondylolisthesis, compression fracture, or other spinal fracture? _____

List all medications you are currently on or have recently taken: _____

List all vitamins or other supplements you currently take: _____

What are your hobbies/ recreational interests? _____

Yes No Are you currently taking NSAIDS (Ibuprofen, Acetaminophen, etc.) How often? _____

Yes No Do you drink alcohol? If yes how many drinks and how often? _____

Yes No Do you smoke? How many packs a day? _____ How many years? _____

Yes No Do you use recreational drugs? What/How often? _____

Yes No Are you practicing risky sexual behavior? _____

Yes No Do you exercise on regular basis? How? _____

Yes No Do you drink water on a regular basis? How many glasses a day? _____

Yes No Do you have difficulty sleeping soundly through the night? _____

Yes No Do you feel fatigued on a regular basis? _____

Yes No Do you have allergies? _____

Yes No Do you eat healthy? Briefly explain your diet. _____

Yes No Have you been to a chiropractor before? If so, why and when? _____

What is your level of stress? HIGH MED LOW Explain: _____

Physician signature: _____

Date: _____

Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation.

Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves, or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke has been estimated at one in one million to one in twenty million and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare". Other treatment options which could be considered may include the following:

- Over-the-counter analgesics. The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
 - Medical care, typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
 - Hospitalization in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- Surgery in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual risks: I have had the following unusual risks of my case explained to me.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.

Printed Name _____ **Signature** _____ **Date** _____

**Dr. Peter Vapnek
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SIGNATURE ON FILE

I authorize use of this form on all my insurance submissions.

I authorize release of information to all my insurance companies.

I understand that I am responsible for my bill.

I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies.

I authorize payment to be made directly to my doctor.

I permit a copy of this authorization to be used in place of the original.

Printed Name _____ Signature _____ Date _____

Financial Hardship Agreement

To Whom It May Concern:

By my signature below I am requesting that my doctor reduce normal and customary fees charged so as to allow me to receive chiropractic care. My financial circumstances are such that if I were to pay the customary fees charged I would be forced (due to economic reasons) to not receive care.

I recognize that any agreement made to assist me is purely confidential and that my fee arrangement would be different than that which is standard in the office.

If my insurance company policy demands full payment of the deductible or co-payments, I agree that it is my responsibility to notify my insurance carrier that due to economic hardship I am only making partial payment.

Printed Name _____ Signature _____ Date _____

Authorization for Care:

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he or she deems appropriate. I clearly understand and agree that all the services rendered to me are charged directly to me and that I am personally responsible for all payment. I agree that I am responsible for all the bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered to me will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider of services rendered.

Agreement:

My signature below signifies my agreement for payment in full on a cash basis if I have not provided all the necessary documents and information by the time of the second visit.

Printed Name _____ Signature _____ Date _____

Missed Appointments:

We strive to provide you with the utmost professionalism and excellence of service. Our commitment to your well-being and health is something we take seriously.

We care about you and realize it would be a disservice to you if we did not emphasize the importance of your commitment to the care you need and the actions we recommend.

- Your faithfulness to the recommended number of treatments is vital to ensuring optimum results.
- With the exception of emergencies, it is vital that you keep all your appointments. Reminder cards are provided to help you save the date and a reminder text 24 hours before your appointment. If you need to reschedule an appointment, please call our office at least the day prior (by phone or voice message) and arrange a make-up appointment with our chiropractic assistants. We prefer the make up appointment to be within the same week.
- If appointments are missed or canceled at the last minute (less than the day prior by phone call or voice message), we reserve the right to charge you for a visit.

Thank you for your understanding. We greatly appreciate you as our patient and strongly desire excellent results and success for you!

I understand and agree to all the information written above.

Printed Name _____ Signature _____ Date _____

HIPAA Notice of Privacy Practices

Dr. PETER VAPNEK
CHIROPRACTIC, MASSAGE, & LASER CTR.
14838 S. MILITARY TRAIL
DELRAY BEACH, FL 33484

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

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

I. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and

Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Printed Name _____ **Signature** _____ **Date** _____