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Joint and Spine Center

Application for Treatment

Please check the type of care desired:

○ Temporary Relief ○ Lasting Correction ○ Doctor to recommend the best type of care for you

Name | Today's Date | Age

Date of Birth | Social Security Number

Address | Apt. Number

City | State | Zip Code

Home Phone | Work Phone | Cell Phone

Email address | Family M.D. Name

Insurance Company's Name

Check if you are: ○ Married ○ Single ○ Widowed ○ Divorced ○ Separated

Name of Husband or Wife | Ages of Children

Your Occupation | Where are you Employed

Emergency Contact Name | Phone

Who is responsible for bill? ○ Self ○ Spouse ○ Employer ○ Insurance
○ Other ______________________________

How will payment be made? ○ Cash ○ Check ○ Charge ○ Automobile Insurance
○ Health Insurance ○ Workers Compensation

Treatment Needed

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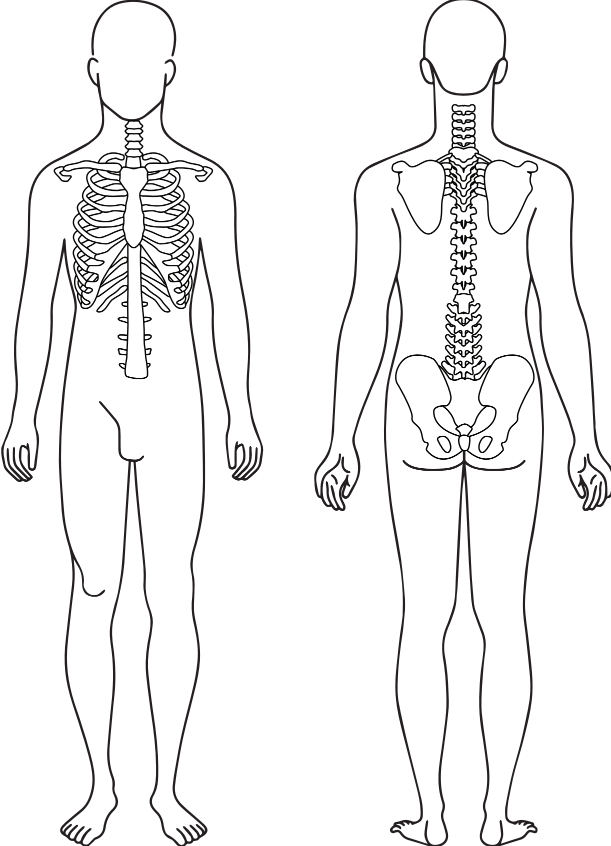
Please mark the exact location of your problems



Please list below all health problems you are currently having.

____

____

____

____

____

____

Treatment History

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How did this condition develop?   What caused it?   How did it start?

When was the first time you were aware of this problem?

Have you ever had this problem(s) before?   O Yes   O No   If yes, please explain:

Have you ever received any treatment for this condition(s)?   O Yes   O No
If yes, where and when, and what were your results?

Has this problem(s) been getting better, worse or staying the same?

Is there anything you do that make your condition(s) worse?

How has this condition affected your life?   (Ex: Home, Occupational, Recreational, Rest and Sleep)   Please explain:

Have you ever been in an automobile accident?   O Past year   O Past 5 years   O Over 5 years   O Never

Any accidents, falls, etc., that might have caused your problem(s)?

What surgeries have been done?

Please list all medication(s) you are currently using:

Any chiropractor consulted in the past?   O Yes   O No

Name   Dates Consulted

For what problem?

Fees are payable at the time X-rays, examinations, and treatments are received. I agree to accept,full responsibility for all services in the-event my insurance or other responsible party does not reimburse you.

Patient Signature

Family Health History

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Patient ______________________ Date ______________________

Please review the below-listed diseases and conditions and indicate those that are current health problems of yours or of a family member. Leave blank those spaces that do not apply. If you require more space, use the reverse side of this form. Circle your answers if your relative lives around this locality, as some hereditary conditions are affected by similar climate.

Condition	**Yourself**	**Father**	**Mother**	**Spouse**	**Brother**	**Sister**	**Child**	**Child**
	Age	**Age**	**Age**	**Age**	**Age**	**Age**	**Age**	**Age**
Allergies								
Arthritis								
Asthma								
Back Trouble								
Bed wetting								
Bursitis								
Cancer								
Carpal Tunnel								
Constipation								
Diabetes								
Disc Problems								
Ear Infection								
Emphysema								
Epilepsy								
Headaches								
Heart Disease								
High Blood Pressure								
Impotency								
Insomnia								
Joint Pain								
Kidney Trouble								
Liver Trouble								
Menstrual Disorders								
Migraines								
Neck Pain								
Numbness hands/feet								
Pinched Nerve								
Sciatica								
Spinal Curvature								
Sinus Trouble								
Stomach Trouble								
TMJ								
Urinary Tract								
Other:								

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for **Justine W. DeMaio D.C.** (hereinafter referred t as the “Practice”) to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

The Practice’s Notice or 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. The Practice 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

Justine W. DeMaio D.C. our Privacy Officer, at the following address:
7242 South Beneva Road Sarasota, FL 34238

With this consent, the Practice 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 appointments reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, the Practice may, mail to my home or other alternate 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, the Practice may e-mail to my home or 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 the Practice 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. With this consent I hereby give **Justine W. DeMaio D.C.** permission to post my name on the referral board in acknowledgment for the referral of new patients and also to use my name, picture and testimonials.

By signing this form, I am consenting to the Practice’s use and disclosure of my PHI to carry out TPO. I acknowledge that I have read a copy of **Justine W. DeMaio, D.C’s** Notice of patient privacy practices.

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 so not sign this consent, or later revoke it, the Practice may decline to provide treatment to me.

____
Signature of Patient or Legal Guardian

____
Patient ‘s Name Date

____
Print Name of Patient or Legal Guardian

Disclosure and Consent for Care

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TO THE PATIENT: You have the right as a patient to be informed about your condition and the recommended physical procedures to be used so that you may make the decision whether or not to undergo the procedure after knowing the potential risks and hazards involved. This disclosure is not meant to scare you or alarm you it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

I hereby request and consent to the performance procedures, including various modes of physical therapy on me (or the patient named below, for whom I am legally responsible) by the Doctor of Chiropractic at United Joint & Spine Center LLC named below and/ or other licensed Doctors of Chiropractic/Medicine or those working at the clinic or office who now or in the future treat me while employed by, working or associated with, or serving as a backup for the Doctor of Chiropractic named below.

I have had the opportunity to discuss with the Doctor of Chiropractic named below, my diagnosis, the nature and purpose of injections or chiropractic adjustments and other procedures and alternatives.

I understand and I am informed that, in the practice of chiropractic there are some risks to exam and treatment including, but not limited to, fractures, disc injuries, strokes, dislocations, sprains and increased symptoms and pain or no improvement of symptoms or pain. Along with the consent form I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, and is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions, and all my questions have been answered 1'fully and satisfactorily. By singing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

To be completed by the patient's representative, if necessary

____
Patient 's Name

____
Patient Signature

____
Witness to Patient's Signature

____
Date

Justine DeMaio D.C.

____
Print Name of Patient

____
Print Name of Patient Representative

____
Signature of Patient Representative

____
Relationship or Authority of Patients Representative

____
Date

Justine DeMaio D.C.

Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

Print Patient's Name Date

Print Name of Patient or Legal Guardian

Patient Signature

This form will be placed in the patient's chart and maintained for six years.

List below the names and relationship of people to whom you authorize the Practice to release PHI.