Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your health.

Patient Information

Name _____ Soc. Sec.# _____
Last Name First Name Initial

Address _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Sex ☐ M ☐ F Age _____ Birth Date _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient employed by _____ Occupation _____

Business Address _____

Business Phone _____ Business Email _____

Notify in case of emergency _____ Home Phone _____ Work Phone _____

Cell Phone _____ Email _____

Whom may we thank for referring you? _____

Primary Insurance

Person Responsible for Account _____
Last Name First Name Initial

Relation to Patient _____ Birth Date _____ Soc. Sec.# _____

Address (if different from patient) _____ Home Phone _____

City _____ State _____ Zip _____

Cell Phone _____ Email _____

Person responsible employed by _____ Occupation _____

Business Address _____

Business Phone _____ Business Email _____

Insurance Company _____

Phone _____ Email _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents under this plan _____

Reason for Visit

Have you ever seen a chiropractor? ☐ Yes ☐ No If yes, when and why? _____

Your reason for *this* visit: _____

Please describe your current pain and its location: _____

When did symptoms begin (date)? _____ Have you had similar conditions in the past? _____

Is pain getting: ☐ Worse ☐ Better ☐ Same ☐ Comes and goes How often do you have this pain? _____

Have you been treated by a medical physician for this condition? _____

If so, when and where? _____

Activities or movements that are difficult/painful to perform: ☐ Sitting ☐ Walking ☐ Bending ☐ Lying down ☐ Lifting

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Aching ☐ Burning ☐ Tingling ☐ Numbness ☐ Cramping
☐ Stiffness ☐ Swelling ☐ Other _____

Is pain interfering with: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Please complete both sides.

Health History

Please list any medication (including pain killers) you are taking: _____

_____

Please list any serious injuries or surgeries you have had in the last 10 years:

	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		
Other Serious Injuries		

Women: Are you pregnant? ☐ Y ☐ N If so, how far along? _____ Nursing? ☐ Y ☐ N

Medical Conditions

Have you ever had or do you currently have any of the following medical conditions?

- ☐ Heart Attack/Stroke
- ☐ Congenital Heart Defect
- ☐ Alcohol/Drug Abuse
- ☐ Fainting/Seizures/Epilepsy
- ☐ Shingles
- ☐ Psychiatric Problems
- ☐ Difficulty Breathing
- ☐ Hepatitis
- ☐ Anemia
- ☐ Arthritis
- ☐ Frequent Neck Pain
- ☐ Jaw Pain
- ☐ Wrist Pain
- ☐ Shoulder Pain
- ☐ Arm Pain
- ☐ Leg Pain
- ☐ Lower Back Problems
- ☐ Severe/Frequent Earaches
- ☐ Ringing in Ears
- ☐ Severe/Frequent Headaches
- ☐ Diabetes/Tuberculosis
- ☐ Dizziness
- ☐ Emphysema/Glaucoma
- ☐ Kidney Problems
- ☐ Artificial Bones/Joints
- ☐ Cancer
- ☐ HIV Positive/AIDS
- ☐ Ulcer/Colitis
- ☐ Gout
- ☐ Numbness, where? _____
- ☐ Tingling, where? _____
- ☐ Muscle Spasms, where? _____

Personal Habits

	Heavy	Moderate	Light	None
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the chiropractor to help determine appropriate and healthful chiropractic treatment. If there is any change in my medical status, I will inform the chiropractor.

I authorize my insurance company to pay to the chiropractor or chiropractic group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the chiropractor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

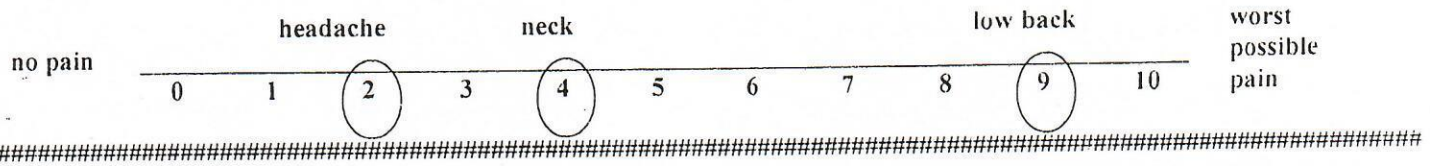
Signature _____ Date _____

Payment is due in full at time of treatment unless prior arrangements have been approved.

QUADRUPLE VISUAL ANALOGUE SCALE

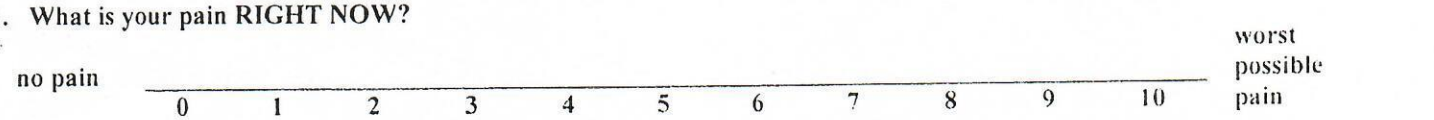
INSTRUCTIONS: Please circle the number that best describes the question being asked.
NOTE: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your average pain levels and pain at minimum / maximum using the last 3 months as your reference. If you have completed this form before, indicate you average pain level since the last time you completed this form.

EXAMPLE:

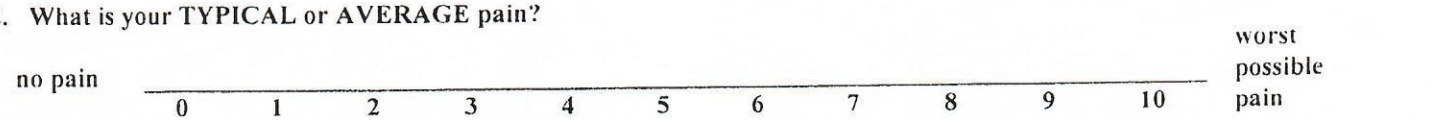


##########

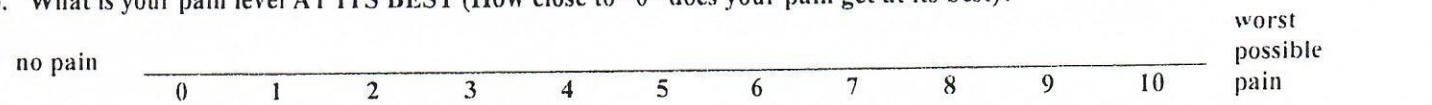
1. What is your pain RIGHT NOW?



2. What is your TYPICAL or AVERAGE pain?

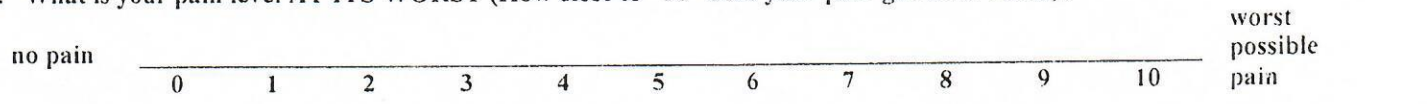


3. What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?



What percentage of your awake hours is your pain at its best? _____%

4. What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?



What percentage of your awake hours is your pain at its worst? _____%

NAME _____ AGE_____ DATE_____ SCORE_____

~~SCORE: #1 _____ + #2 _____ + #4 _____ = _____ 3 x 10 = _____ (Low intensity = 50; High intensity = 50)~~

Informed Consent for Chiropractic Treatment

TO THE PATIENT: *You have a right to be informed about your condition, the recommended chiropractic treatment, and the potential risks involved with the recommended treatment. This information will assist you in making an informed decision whether or not to have the treatment. This information is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or refuse to give your consent to treatment.*

I request and consent to chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays. The chiropractic treatment may be performed by the Doctor of Chiropractic named below and/or other licensed Doctors of Chiropractic working at this clinic or office. Chiropractic treatment may also be performed by a Doctor of Chiropractic who is 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 my chiropractic treatment, the risks and benefits of my chiropractic treatment, alternatives to my chiropractic treatment, and the risks and benefits of alternative treatment, including no treatment at all.

I understand that, there are some risks to chiropractic treatment including, but not limited to:

- ☐ Broken bones
- ☐ Dislocations
- ☐ Sprains/strains
- ☐ Burns or frostbite (physical therapy)
- ☐ Worsening/aggravation of spinal conditions
- ☐ increased symptoms and pain
- ☐ No improvement of symptoms or pain
- ☐ Infection (acupuncture)
- ☐ Punctured lung (acupuncture)
- ☐ Other _____

In rare cases there have been reported complications of arterial dissections n (stroke) when a patient receives a cervical adjustment. The complications reported can include temporary minor dizziness, nausea, paralysis, vision loss, locked in syndrome (complete paralysis of voluntary muscles in all parts of the body except for those that control eye movement), and death.

I do not expect thehe doctor to be able to anticipate and explain all risks and complications. I also understand that no guarantees or promises have been made to me concerning the results expected from the treatment.

TREATMENT PLAN: _____

_____

_____

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions. All of my questions have been answered to my satisfaction. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my current condition.

To be completed by the patient:

_____
print name

_____
signature of patient

_____
date signed

To be completed by the patient's representative:

_____
print name of patient

_____
print name of patient's representative

_____
signature of patient's representative

as:_____
relationship/authority of patient's representative

_____
date signed

To be completed by doctor or staff:

_____ _____
witness to patient's signature date

_____ _____
translated by date

Revised May 2017

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

DR. MARK FIGLER, D.C.

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

DR. MARK FIGLER'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. Dr. MARK FIGLER reserves the right to revise its notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Carol Shain at 525 Northlake Blvd., North Palm Beach, FL 33408.

With this consent, DR. MARK FIGLER and staff 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, DR. MARK FIGLER and staff may mail to my home or other alternative location any items that assist the practice in carrying TPO, such as appointment reminder cards and patient statements as long as they are marked Person and Confidential.

With this consent, DR. MARK FIGLER and staff may email 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 DR. MARK FIGLER restrict how it uses or discloses my PHI to carry our 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 DR. MARK FIGLER'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, DR. MARK FIGLER may decline to provide treatment to me.

_____ _____

Signature of Patient or Legal Guardian Print Name of Patient or Legal Guardian

_____ _____

Patient's Name Date

DR. MARK FIGLER
525 Northlake Blvd. #2
North Palm Beach, Florida 33408

ASSIGNMENT OF BENEFITS/POLICY RIGHTS

PATIENT:

I, the undersigned patient hereby assign the rights and benefits of insurance of the applicable personal injury protection, medical payments, and/or other insurance to **MARK FIGLER**, for services and/or supplies rendered for treatment of personal injuries sustained in the incidents of _____ to the undersigned patient and covered by Personal Injury Protection (PIP) Coverage or other insurance coverage under_____in the accordance with Florida Statute 627. 736(5). The undersigned agrees to pay any applicable deductible or co-payment not covered by the PIP or other insurance coverage. I have read the "information herein and it is true to the best of my knowledge and belief.

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 for any reason the insurance company fails to make payments of benefits to which I am due. Specifically, this assignment includes the right to collect payment for the reasonable costs connected with copying and mailing records to the insurer at the insurers request and in accordance with Florida Statute 627.736(6). This assignment also includes any right to recover attorney's fees and costs for such action brought by the provider as Patient's assignee. I agree that **MARK FIGLER** may select any attorney he/she/it wishes and understand and agree that the attorney selected by them may be different than the attorney handling my personal injury/bodily injury claim or case.

As part of this agreement of rights 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 **MARK FIGLER,** 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/it may exercise their legal rights. I understand that any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement containing any false, incomplete or misleading information is guilty of a felony of the third degree. I have read the information herein and it is true to the best of my knowledge and belief.

_____ _____
Patient's Signature Date

_____
Print Patient's Name

PROVIDER:

The undersigned on behalf of **DR. MARK FIGLER** hereby accepts assignment of the insurance rights and the benefits for the service rendered to_____and to be paid directly to **DR. MARK FIGLER** under _____ Personal Injury Protection (PIP) or other insurance coverage with _____in accordance with Florida Statute 627.736 et. Seq (5).

DR. MARK FIGLER

By_____ _____
Authorized Agent/Representative Date

EIN #: 65-0628774

Mark Figler D.C.
525 Northlake Blvd. North Palm Beach FL, (561) 844-1133

Advanced Notice and Agreement of Patient Financial Responsibility

Patient Name: DOB: Identifier:

Your doctor has recommended the following treatment plan to facilitate the best recovery from your current condition. The expected advantages of receiving the care and the disadvantages of not receiving the care have been discussed with you and you have indicated he/she has adequately answered any questions you may have.

Unfortunately, each insurer has different opinions about what care is and is not medically necessary. This makes it difficult to accurately determine the amount that will be reimbursed by the insurer and the amount for which the patient is responsible for payment until the insurer processes the claim and makes payment. The resources required to render the care and appeal their decisions exceed the potential reimbursement.

Treatment Plan and Estimated Costs

I want the services Initialed	Service	Estimated Cost if Prepaid / Paid at Time of Service
	Office Examination	$48
	Spinal Decompression	$25
	Laser Therapy	$25
	Physiotherapy (Electrical Stimulation, Mechanical Traction, Ultrasound, Therapeutic Exercises…)	$19
	Massage Therapy	$65/hr

Options

Do you want the services initialed? Yes / No
Do you want your insurer(s) billed? Yes / No Medicare Advantage Plan Yes / No Other insurer
Do you understand you are financially responsible for charges not paid by your insurer? Yes / No

	I want the services initialed. Bill my insurer. I accept financial responsibility for services not paid by my insurer.
	I want the services initialed. Do NOT bill my insurer. I accept full financial responsibility
	I do not want the services I have not initialed

Additional Information:

_____

_____

_____

Date: _____

Patient's Signature:

_____

Date: _____

Provider's Signature:

_____

Good News! Medicare is likely to cover at least some of your chiropractic care.

Your Coverage: Medicare ONLY covers the cost of chiropractic adjustments designed to help correct vertebral subluxation. This is when bones of the spinal column lose their normal motion and position. The resulting nerve involvement can have far-ranging health effects. If you have a Medicare Replacement plan, your coverage may differ from traditional Medicare.

The Examination: An examination is necessary to identify the presence of vertebral subluxation. Medicare requires this. But Medicare does not pay for the cost of the exam or any needed x-rays.

Your Responsibility: Regardless of the type of doctor you see, Medicare requires you to pay an annual deductible amount. Then, you'll be responsible for a 20% co-payment for the cost of each chiropractic adjustment. Medicare will pay the remaining 80% of the cost of adjustments that Medicare deems medically necessary.

Medical Necessity: For Medicare to pay for your adjustments, they must be "medically necessary." That means: Your adjustment must relate directly to your specific health complaint, your adjustment must hold the promise of making functional improvements and you must follow your chiropractor's specific plan for active treatment.

Functional Improvement: Instead of judging your progress simply by how you feel, Medicare wants to see improvement function. That means a restored ability to turn, bend, walk, sleep and generally perform daily activities. Once improvement stops, Medicare coverage stops. That's because they consider further care to be maintenance care and expect you to self-pay.

Maintenance Care: Medicare does not pay for chiropractic care to maintain your progress or help prevent problems. While most patients see the wisdom of some type of wellness care, Medicare does not pay for it. Recognizing the value of protecting their improvement, many opt to self-pay.

Excluded Services: We only recommend the care that is clinically appropriate. That might include other procedures such as massage, traction or other therapies. Medicare does not pay for these, nor do they pay for adjustments to your wrist, ankle or other extremity.

Maximum Improvement: The number of adjustments covered by Medicare varies. It's based on the severity of your condition(s).

Our Participation: Our practice is a participating provider with Medicare. We will bill Medicare and they will pay us directly. If you have a supplemental insurance, it will assume some or all of your 20% co-payment.