UPPERCERVICAL
Institute of Florida, P.A.

Personal & Family Information

Name _____ Referred by_____ Date_____
Address _____ City _____ State _____ Zip _____
Phone: home _____ work _____ cell _____
Date of Birth _____ Age _____ Gender ☐M ☐F Email _____
SSN _____ Marital Status ☐S ☐M ☐D ☐W ☐Significant Other
Occupation _____ Employer _____
Spouse's/Significant Other's Name _____
Spouse's/Sig. Other's Occupation _____ Employer
_____

Names & Ages of Children
1st _____ Age _____ 4th _____ Age _____
2nd _____ Age _____ 5th _____ Age _____
3rd _____ Age _____ 6th _____ Age _____

Have you ever been to a Chiropractor before? ☐Y ☐N Results _____
Have you ever been to a NUCCA Doctor before? ☐Y ☐N Results
_____

You deserve to be healthy and have a good Quality of Life. Life is a miracle and so are you. When you were created you were given all the blueprints, intelligence, tools, and systems to live an active healthy life. Unfortunately, your health can be interfered with through accidents and challenges that cause distortion to your health expression, called the Atlas Subluxation. Removing this interference restores your natural health expression and a Quality of Life that you deserve. The information you provide is crucial in order to determine if you have the Atlas Subluxation interference.

Personal Health History

Birth Process (Yours)
☐Long/Difficult Delivery ☐Forceps ☐Caesarian ☐Breach ☐Induced Labor ☐Home Birth

Growth & Development
☐Head Injuries ☐Spine Injuries ☐Child Abuse ☐Falls ☐Ever Unconscious ☐Broken Bones
☐Vaccines Other _____

Current Lifestyle & Habits
☐Smoke Amount _____ ☐Alcohol Amount
_____
☐Exercise Frequency/Type _____ ☐ Never Exercise
☐Recreational Drugs ☐Artificial Sweeteners ☐Yearly Flu Shots ☐Poor Diet
☐High Stress ☐From Family ☐From Work ☐No Stress
☐Other _____

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Current Health Condition

Please list your **current conditions** below in order of priority. Then describe each one.

1. _____ Is it constant or does it come and go? _____
Describe how it feels? _____
How long have you had this symptom? (write in) _____Weeks _____Months _____Years
What activities aggravate your condition? _____
Is it worse at different times of the day? ☐AM ☐PM ☐Sleeping ☐No
It is interfering with ☐Work ☐Sleep ☐Daily Routine ☐Recreation
Is the condition progressively getting worse? ☐Yes ☐No ☐Staying the same

2. _____ Is it constant or does it come and go? _____
Describe how it feels? _____
How long have you had this symptom? (write in) _____Weeks _____Months _____Years
What activities aggravate your condition? _____
Is it worse at different times of the day? ☐AM ☐PM ☐Sleeping ☐No
It is interfering with ☐Work ☐Sleep ☐Daily Routine ☐Recreation
Is the condition progressively getting worse? ☐Yes ☐No ☐Staying the same

3. _____ Is it constant or does it come and go? _____
Describe how it feels? _____
How long have you had this symptom? (write in) _____Weeks _____Months _____Years
What activities aggravate your condition? _____
Is it worse at different times of the day? ☐AM ☐PM ☐Sleeping ☐No
It is interfering with ☐Work ☐Sleep ☐Daily Routine ☐Recreation
Is the condition progressively getting worse? ☐Yes ☐No ☐Staying the same

4. _____ Is it constant or does it come and go? _____
Describe how it feels? _____
How long have you had this symptom? (write in) _____Weeks _____Months _____Years
What activities aggravate your condition? _____
Is it worse at different times of the day? ☐AM ☐PM ☐Sleeping ☐No
It is interfering with ☐Work ☐Sleep ☐Daily Routine ☐Recreation
Is the condition progressively getting worse? ☐Yes ☐No ☐Staying the same

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Other Doctors seen for these conditions _____
_____

Have you ever had any falls, accidents or sports injuries? ☐Yes ☐No
Please explain _____
_____

How many automobile accidents have you been in (even minor)? Write year in the blank
_____Total _____Rear End _____Head On _____Broadside _____Rolled _____Thrown Out

Check other symptoms you have experienced in the past 6 months

☐Allergies	☐Arthritis	☐Asthma	☐Arm Pain
☐Athletic Injuries	☐ADD/ADHD	☐Back Pain	☐Bed Wetting
☐Balance	☐Carpal Tunnel	☐Cerebral palsy	☐Chronic Infections
☐Chest Pain	☐Cold Sweats	☐Constipation	☐Depression
☐Digestive problems	☐Diarrhea	☐Diabetes	☐Ear Infections
☐Eye Infections	☐Fainting	☐Fatigue	☐Fever
☐Flu	☐Foot Pain	☐Frequent Colds	☐Fibromyalgia
☐Gas	☐Hacking Cough	☐Hay Fever	☐Headaches
☐Herniated Discs	☐High Blood Pressure	☐Hip Pain	☐Hyperactivity
☐Weak Immune System	☐Indigestion	☐Infertility	☐Insomnia
☐Irritability	☐Knee Pain	☐Learning Disability	☐Leg Pain
☐Low back Pain	☐Menstrual Pain	☐Memory Loss	☐Migraine
☐Multiple sclerosis	☐Muscle Spasms	☐Neck Pain	☐Nervousness
☐Neuralgia	☐Neuritis	☐Numbness	☐Pain (chronic)
☐Panic Attack	☐Parkinson's	☐Poor Vision	☐Restlessness
☐Scoliosis	☐Shoulder Pain	☐Sinus Problem	☐Sore Throat
☐Tendonitis	☐Tinnitus	☐Trigeminal Neuralgia	
☐ Tourett's Syndrome	☐TMJ Disorder	☐Whiplash	

Other Symptoms _____

Pregnant? ☐Yes ☐No

Explain any surgeries in the past year _____
_____

List your medications and what they are for _____
_____

If you could get rid of one symptom, what would that symptom be? _____
Explain why_____

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If you could get rid of this symptom, what would your commitment be from 1 to 10 (10 the highest commitment, 1 the lowest) Circle 1 2 3 4 5 6 7 8 9 10
As a result of my NUCCA Spinal Care in this office, I would like to achieve: (Please check all that apply)

☐Symptom Relief ☐More Energy ☐Become More Active ☐Healthier Spine

☐Healthier Body ☐Healthier Lifestyle ☐Better Quality of Life

What type of care do you want?

☐ Relief Care that is necessary to reduce or eliminate my symptoms or pain, but not the cause of it. This care is not typically recommended because the health problem is never handled and usually gets worse over time.

☐ Corrective Care to correct the problem by addressing the cause of why my body may not be healing, adapting or repairing and Stabilization Care for long lasting results. Corrective and Stabilization Care varies in length of time, but is more lasting, improves your overall health, and its goals are to enhance your Quality of Life.

☐ Wellness Care to maintain my health and Quality of Life and to prevent my body from losing its ability to heal, adapt and repair. I may or may not have symptoms.

☐ Not sure what type of care I want.

I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment and should I desire credit to be extended, I authorize any necessary credit verification. I also understand that if I suspend or terminate my care, fees for professional services rendered will be immediately due and payable. I have been advised and concur, past due accounts will bear interest at 1% per month on the past due balance. I am responsible for costs required to enforce collection of my account including, but not limited to, collection fees, attorney fees and court costs. There is a $35.00 charge for returned checks.

_____ _____
Signature of Patient or Guardian Date

_____

DO NOT WRITE BELOW THIS LINE

X-Rays ☐Yes ☐No ☐Consultation Only

Current Health Care Providers

With your permission we would like to communicate about your care with your other providers.

Primary Physician
Office Name: _____
Physician Name: _____
Address: _____
Phone Number: _____

Dentist
Office Name: _____
Physician Name: _____
Address: _____
Phone Number: _____

Chiropractor
Office Name: _____
Physician Name: _____
Address: _____
Phone Number: _____

Other Provider
Office Name: _____
Physician Name: _____
Address: _____
Phone Number: _____

Other Provider
Office Name: _____
Physician Name: _____
Address: _____
Phone Number: _____

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Informed Consent For Upper Cervical Chiropractic Care

Chiropractic care, like all forms of health care, while offering considerable benefit, may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care in general include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic adjustments and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in early stages of a stroke. In essence, there may be a stroke already in process. There have been no reports of any such injuries occurring in association with the gentle upper cervical correction that we perform in this office.

Prior to receiving care in this office, a health history and examination will be completed. These procedures are performed to assess your specific condition, your overall health, and, in particular, your spinal health. These procedures will assist us in determining if upper cervical care is needed or if any further examinations or studies are needed before initiating care, and all relevant findings will be reported to you prior to care.

We do not offer to diagnose or provide care for any disease or condition other than your Atlas Subluxation. However, if during the course of evaluation and care we encounter non-chiropractic or unusual findings, we will inform you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a healthcare provider that specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY GOAL IS TO ALLOW THE BODY TO DO ITS JOB.

I understand and accept that there are risks associated with chiropractic care and give my consent to the examinations that the doctor deems necessary, and to the upper cervical chiropractic care including upper cervical spinal corrections, as reported following my assessment.

_____	_____
Patient Name (PRINTED)	Relationship to Patient
_____	_____
Patient or Legal Guardian Signature	DATE
_____	_____
Witness Signature (Office Staff)	DATE

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MEDICARE STATUS

Is Medicare Primary or Secondary for your services today?

1. Are you currently employed and covered by a group health plan?	☐YES ☐NO
2. Are you covered by any active group health plan through your spouse or family member?	☐YES ☐NO
3. Is your appointment today associated with a work injury or illness, either past or present?	☐YES ☐NO
4. Is your appointment today associated with a motor vehicle accident?	☐YES ☐NO
5. Is your appointment today associated with an accident, other than a vehicle?	☐YES ☐NO
6. Are you entitled to Black Lung benefits?	☐YES ☐NO
7. Are you entitled to Medicare solely because of SSA Disability?	☐YES ☐NO
8. Are you entitled to Medicare solely because of End Stage Renal Disease?	☐YES ☐NO
9. Are you enrolled in the VA Fee Basis Program?	☐YES ☐NO

If all answers are NO, stop here. If you answered "YES" to any question, Medicare is probably the secondary payer (MSP) and additional information is required. Please complete any information below that applies to you.

PRIMARY INSURANCE (MEDICARE SECONDARY PAYOR)

Employment
If "Yes" to Questions 1, 2, 3

Insured's Name (Employee)_____

Insured's Date of Birth ___/___/___ ☐Male ☐Female

Employer_____

Number of employees _____1-10 _____11-19 _____ 20 or more

Accident
If "Yes" to Questions 4, 5

_____ Work injury or illness (Industrial/Workers Compensation)

_____ Auto accident: Is there "Medical Payment" coverage? ☐Yes ☐No

_____ Home or other: Is there "Medical Payment" coverage? ☐Yes ☐No

Date of accident _____

Location of Accident _____

How did it happen? _____

Attorney (if any) _____

Entitlements
If "Yes" to Questions 6, 7, 8, 9

_____SSA – Disability (Under age 65 and my company has over 100 employees)

_____VA – Fees Basis Program

_____ Black Lung Benefits

_____ Kidney (Under age 65 and End Stage Renal Disease (ESRD

Part A entitlement date (from the card) _____

Employer name (If employed within the last 18 months) _____

INSURANCE COMPANY INFORMATION

(Fill out this information for any of the above categories)

Policy # _____ ID #_____

Insurance Plan or Name _____

Address_____ City_____ State_____ Zip_____

Completed by:_____ Date_____

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ABOUT MEDICARE CHIROPRACTIC COVERAGE

Your Medicare coverage of chiropractic care is limited. They will only pay for the spinal correction (chiropractic adjustment) when it meets Medicare's rules. There are three categories of Medicare services: 1) non-covered, 2) perhaps covered, and 3) always covered.

NON-COVERED SERVICES

According to existing Medicare law, most of the available services in our office are NON-COVERED. Hopefully, the U.S. Congress will change that someday and treat Doctors of Chiropractic like all other doctors. Until then, here is a summary:

Examples of Non-Covered Services

*Office Visits (without spinal correction) – to evaluate and manage, re-evaluate, advise, or counsel.
*Maintenance Care – you are stable and not making any more improvement.
*Wellness Care – to promote health.
*X-rays, Laboratory, Supplies, Vitamins, etc.

Non-covered items will appear on your insurance claim form. They will show as a Medicare Non-covered service like this: " 72010-GY." The "72010" code is for an x-ray. The "-GY" means that it is not covered, allowing your service to go through the Medicare system. After denial by Medicare, it can then go on to your other insurance. If you have Medigap insurance (also known as Medicare Secondary or Supplemental insurance) they will pay according to the terms of your contract.

PERHAPS-COVERED SERVICES

A typical example of a Medicare PERHAPS COVERED service is when you are injured or you are in much pain due to a bad spinal condition. Medicare may pay for spinal corrections for your rehabilitation as long as you are improving. This phase of care is called "active treatment." It will be shown on your Medicare claim form and payment reports with your service code. For example, "98940-AT."

Your spinal correction must be clinically needed according to Medicare rules. If Medicare determines that your condition is not "Medically Necessary" they won't pay. If we know or believe that Medicare will not pay for your spinal correction, we will discuss this matter with you. We will also give you a special Medicare form known as the Advance Beneficiary Notice (ABN).

ALWAYS COVERED SERVICES

No chiropractic services can claim to be ALWAYS COVERED.

MY FINANCIAL RESPONSIBILITY

I certify that the above information is correct. I understand that I am personally financially responsible for all services not paid for by my insurance. I am also responsible for any annual deductibles applicable, co- payments, or non-covered services as may be required by my insurance plan.

X_____ _____

Signature of patient or person acting on patient's behalf Date

MY AUTHORIZATION

I authorize the release of any medical or other information necessary to process my claims. I also request payment of government or private benefits either to myself or to the party who accepts assignment. This is a permanent authorization that I may revoke at any time by written notice.

X_____ _____

Signature of patient or person acting on patient's behalf Date