BROWARD SPINE & JOINT REHABILITATION

Dr. Harley J. Bofshever
Chiropractic Physician

New Patient Intake Form

Patient Data:

First Name: ______________________ Last Name: ______________________ MI: ________

Social Security #: ______________________ Birth Date: ______________________ ❑ Male ❑ Female

Email Address: ______________________ Marital Status: ______________________

Address: ____

City: ______________________ State: ______________ Zip Code: ____________

Cell Phone #: ______________________ Work Phone: ______________________

Emergency Contact: ____

Relationship: ______________________ Emergency Contact Phone #: ______________________

Currrent Complaints:

Chief Complaint: ______________________ Nature of Injury: ❑ Automobile ❑ Work ❑ Other

Have you ever had this condition before? ❑ Yes ❑ No If yes, when ______________________

Do you experience pain every day? ❑ Yes ❑ No
Do your symptoms interfere with daily life? ❑ Yes ❑ No
Does pain wake you up at night? ❑ Yes ❑ No

Past Medical History:

The provider is out of network with most insurance plans. The provider will submit a claim to the insurance carrier on the patient's behalf. It is our policy to accept the processing of the insurance carrier and not balance bill the patient. However, if for any reason the insurance carrier pays the patient directly, it is the patient's responsibility to turn over that payment to Harley Bofshever, DC, with the corresponding explanation of benefits from the insurance carrier. Otherwise, a bill will be generated and mailed to the patient for the full amount of the charges.

Patient Intials: __________

Signatures:

Patient / Legal Guardian Signature: ______________________ Date: ______________________

4213 W. Hillsboro Blvd · Coconut Creek, FL 33073
P: 954.246.3336 · F: 954.426.0643 · www.bofshever.com

BROWARD SPINE & JOINT REHABILITATION

Dr. Harley J. Bofshever
Chiropractic Physician

Medical History Information

Last Name: ______________________ **First Name:** ______________________

Medical Care Information:

Do You Have a Family Doctor?: ❑ Yes ❑ No Name of Doctor: ______________________

Address: ______________________ Date of last visit: ____________

Do You Have a Family Chiropractor?: ❑ Yes ❑ No Name of Chiropractor: ______________________

Address: ______________________ Date of last visit: ____________

Have you had surgeries in the last 5 Years: ❑ Yes ❑ No If yes, Last Surgery Date: ____________

Reason for Surgery: ______________________

Present illness /Conditions:

❑ AIDS
❑ Allergies
❑ Anemia
❑ Arthritis
❑ Asthma
❑ Bone Fracture
❑ Cancer
❑ Cardio Vascular Disease
❑ Cirrhosis/Hepatitis
❑ Diabetes
❑ Dislocated Joints
❑ Diverticulitis
❑ Epilepsy
❑ Hay Fever
❑ High Blood Pressure
❑ HIV/ARC
❑ Kidney Trouble
❑ Low Blood Pressure
❑ Mental/Emotional Difficulty
❑ Multiple Sclerosis
❑ Pacemaker
❑ Prostate trouble
❑ Rheumatic Fever
❑ Scoliosis
❑ Sinus trouble
❑ Spinal Disc Disease
❑ Thryoid Trouble
❑ Tuberculosis
❑ Ulcer
❑ Polio
❑ STD's

Are you pregnant?: ❑ Yes ❑ No Other: ______________________

Family History of Illness:

❑ AIDS
❑ Allergies
❑ Anemia
❑ Arthritis
❑ Asthma
❑ Bone Fracture
❑ Cancer
❑ Cirrhosis/Hepatitis
❑ Diabetes
❑ Dislocated Joints
❑ Diverticulitis
❑ Epilepsy
❑ Heart Problem
❑ High Blood Pressure
❑ HIV/ARC
❑ Kidney Trouble
❑ Low Blood Pressure
❑ Mental/Emotional Difficulty
❑ Multiple Sclerosis
❑ Prostate trouble
❑ Rheumatic Fever
❑ Scoliosis
❑ Sinus trouble
❑ Spinal Disc Disease
❑ Thryoid Trouble
❑ Tuberculosis
❑ Ulcer
❑ Polio

Other: ______________________

Type of Cancer: ______________________

Social History:

Alcohol?: ❑ Yes ❑ No Caffeine?: ❑ Yes ❑ No Cigarettes?: ❑ Yes ❑ No

Drinks per week? ____ Drinks per day? _______ Packs per day?_______

Excercise?: ❑ None ❑ Light ❑ Moderate ❑ Strenuous Hours per week? _______

Signature:______________________

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

4213 W. Hillsboro Blvd · Coconut Creek, FL 33073
P: 954.246.3336 · F: 954.426.0643 · www.bofshever.com

BROWARD SPINE & JOINT REHABILITATION

Dr. Harley J. Bofshever
Chiropractic Physician

Informed Consent

The nature of the chiropractic adjustment:
The primary treatment used by the doctors of chiropractic is spinal manipulative therapy. The doctor will use his 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.

Analysis/Examination/Treatment:
As a part of the analysis, examination, and treatment, you are consenting to the following procedures:
· Spinal Manipulative Therapy · Palpation · Range of Motion Testing · Orthopedic Testing · Basic Neurological Testing
· Muscle Strength Testing · Posture Analysis · EMS · Radiographic Studies · Hot / Cold Therapy · Other: ___________________

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. The Doctor will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to the Doctor's attention, it is your responsibility to inform the Doctor.

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:
· Self-Administered, over-the-counter analgesics and rest
· Medical care and prescription drugs such as anti-inflammatory, muscle relaxants, and pain killers · Hospitalization · Surgery

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.

I have read the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Harley Bofshever and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Have been informed my risks, I hereby give my full consent to treatment.

Patient or Legal Guardian Name: ____

Patient or Legal Guardian Signature: ______________________________ Date: ______________

Physician Name: Dr. Harley J. Bofshever, DC

Physician Signature: ______________________________ Date: ______________

4213 W. Hillsboro Blvd · Coconut Creek, FL 33073
P: 954.246.3336 · F: 954.426.0643 · www.bofshever.com

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Broward Spine & Joint Rehabilitation, hereinafter referred to 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 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. The Practice 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 Our Privacy Officer, at the following address:
Broward Spine & Joint Rehabilitation
4213 W. Hillsboro Blvd. , Coconut Creek, FL 33073

With this consent, the Practice may call my home or 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, the Practice may mail 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 as long as they are marked Personal and Confidential.

With this consent, the Practice 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 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.

By signing this form, I am consenting to the Practice'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, the Practice may decline to provide treatment to me.

____
Signature of Patient or Legal Guardian

______________________________ ______________________________
Patient's Name **Date**