BROWARD SPINE & JOINT REHABILITATION

Dr. Harley J. Bofshever
Chiropractic Physician

# New Patient Intake Form (PIP - Commercial Insurance)

**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

**Insurance Information:**

Medical Insurance Carrier: _____ Phone #: _____

Insured Name: _____ Insured Date of Birth: _____

Policy #: _____ Group # _____ ❑ HMO ❑ PPO ❑ POS

**For Office Use Only:**

Date Verified: _____ Spoke with: _____ ❑ Participating ❑ Non-Participating

Authorization Required: ❑ Yes ❑ No # of visits per year: _____ Date of first symptom: _____

Copay: _____ Deductible: _____ Coinsurance: _____

Verified by: _____ Call Reference #: _____

**Signatures:**

I understand and agree that health/accident insurance policies are an arrangement between me and the insurance carrier. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient / Legal Guardian Signature: _____ Date: _____

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

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# 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.

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# MEDICAL RELEASE AND ASSIGNMENT OF BENEFITS

Release authorization to BROWARD SPINE & JOINT REHABILITATION, to endorse checks and/or to sign any piece of paper which will enhance or expedite payment to the provider for services rendered. Including but, not limited to a release of MEDICAL RECORDS and ASSIGNMENT OF BENEFITS/ AUTHORIZATION TO PAY.

Know by all these present that: The undersigned has made, constituted and appointed, and by these presents does hereby make, constitute, and appoint BROWARD SPINE & JOINT REHABILITATION., and any of its duly authorized agents and employees as and to be the undersigned's true and lawful attorney for and in the undersigned's name, place and stead to endorse any and all checks, drafts or money orders which are made payable to the undersigned alone or to the undersigned and the said BROWARD SPINE & JOINT REHABILITATION. Which checks, drafts, or money orders are made payable for services which may have been made by BROWARD SPINE & JOINT REHABILITATION, which at the request or with the knowledge and approval of the undersigned and/or the maker of the check, draft, or money order.

Furthermore, the undersigned allows BROWARD SPINE & JOINT REHABILITATION, or any of its agents to sign any paper that will be necessary to enhance, expedite, and /or allow payment to said provider. This may include affidavits of non-ownership of vehicles, insurance forms, and other statements.

The undersigned by these presents does give and grant the said BROWARD SPINE & JOINT REHABILITATION, as the attorney the full power and authority to do and perform all and every act whatsoever requisite and necessary to be done in and about the premises as fully to all intents and purposes as the undersigned might or could do to personally present insofar as the endorsing and cashing of said checks are concerned as well as any other document.

## MEDICAL RELEASE

A photocopy of this document shall be sufficient to authorize any person having records of medical treatment, services, or supplies pertaining to me to release true copies of same to BROWARD SPINE & JOINT REHABILITATION, or any insurer providing coverage to me in connection with the processing of any claim for benefits made by me or by the assignee herein. A photocopy of this document shall be as binding as an original signature page.

The undersigned does hereby ratify and confirm any and all actions taken by the said attorney in accordance with this special power and which the said attorney shall do or cause to be done by virtue of their presents.

## ASSIGNMENT OF BENEFITS

I, _____ hereby authorize: _____

(Name of Insured/Patient) (Name of Insurance Carrier)

To make medical benefit payments otherwise payable to me for services rendered by BROWARD SPINE & JOINT REHABILITATION, Which but not to exceed the charges of those services, payable to, and mailed to:

**BROWARD SPINE & JOINT REHABILITATION**
**4213 WEST HILLSBORO BLVD**
**COCONUT CREEK, FL 33073**

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 unpaid benefits claimed by BROWARD SPINE & JOINT REHABILITATION, is to be set aside and not disbursed until the dispute is resolved. Furthermore, I hereby IRREVOCABLY ASSIGN to BROWARD SPINE & JOINT REHABILITATION, the rights and benefits and any and all causes of action resulting from non-payment under any policy of insurance, indemnity agreement, or any other collateral source as defined in Florida Statutes for any service and/or charges provided by BROWARD SPINE & JOINT REHABILITATION.

IN WITNESS WHEREOF the undersigned have hereunto set their hands, this _____day of_____, 20____

_____ _____

PATIENT NAME (PLEASE PRINT) PATIENT SIGNATURE

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: _____

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# 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**