HCW

HORNBACK CHIROPRACTIC & WELLNESS, P.A.

Welcome to our practice.

Please read before printing!

Adult patients: please print pages 2 – 8

Auto Accident/Personal Injury patients: please print pages 2-16

Pediatric Patients: please print pages 17-22

HCW
HORNBACK CHIROPRACTIC
& WELLNESS, P.A.

PATIENT INFORMATION

Name: _____**Date of Birth:** _____ **Social Security**_____

Address: _____**Marital Status:** S M W D **Race:** _____

_____**Email Address:** _____

Full Time FL Resident Y N **Alternate Residence State:** _____**Dates of Residency-From:** _____to _____

Address (if applicable): _____

Home phone: _____**Cell Phone**: _____ **Cell Carrier:** _____

Work phone: _____**Extension:** _____

Occupation: _____ **Employer:** _ **Spouse:** _____

How many children? _____ **Names and ages:** _____

Name of nearest relative: _____ _____

Address: _____ **Phone number:** _____

Family Medical Doctor: _____ **Phone number:** _____

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? Y N

How were you referred to our office? __Facebook__Instagram__Google__Website__Insurance__Location, Other_____

By signing below, you acknowledge that communications sent by HCW via text message, phone, and email, could potentially cause additional charges for you under your cell phone or other data plan. If you don't agree, please inform us in writing.

****

INSURANCE

Please check any and all insurance coverage(s) that may be applicable in this case:

_Major Medical _Medicare _Auto Accident _Worker's Comp. _Medical Savings/Flex Plan

Name of Primary Insurance Company: _____

Name of Secondary Insurance Company (if any): _____

Please acknowledge the below for a smooth financial process:

- I recognize my insurance is an agreement between me and my insurance co.
- I authorize direct payment of insurance benefits to HCW.
- I agree to release information for communication with healthcare providers.
- I understand I am responsible for all chiropractic care costs/unpaid balances.
- I authorize a credit card to be kept on file for billing efficiency.
- I understand promotional services aren't submitted to insurance.
- I understand overdue accounts after 90 days may go to collections.
- I understand immediate payment of professional fees are due if care recommended by doctor is suspended or terminated and there are no refunds.
- We verify benefits directly with your insurance provider.
- We prepare insurance forms at no cost for timely submission of claims.

Can we leave voicemail regarding your medical information? Y N **If so, where?**_____

Please list who we may speak with regarding your chiropractic care and account (please note that we CANNOT speak with or release any information to anyone that is not listed below.)

Name(s): _____ _____ _____

Patient/Guardian Signature: _____ Date: _____

CURRENT CONDITION

Chief complaint/Purpose of Visit: _____

_____ **Do you have radiating symptoms?** Y N **If so, where to?** _____

_____ **Rate your pain:** 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 [0 = no pain; 10 = worst pain you have ever felt]

Frequency of symptoms: _____Constant _____Intermittent _____Frequent _____With activities

Quality: _____Aching _____Burning _____Dull _____Sharp _____Shooting _____Stabbing _____Throbbing ____Tightness _____Tingling _____Other: _____

Pain exacerbated/made worse by:

____Bending
____Coughing
____Driving
____Lifting
____Lying down
____Movement
____Extreme motion
____Physical Activity
____Sitting
____Sneezing
____Standing
____Twisting
____Walking
____Other
____

Pain improves with:

____Bending
____Heat
____Ice
____Lying down
____Manipulation
____Massage
____Movement
____OTC medications
____Sitting
____Standing
____Walking
____Other
____

Date Symptoms appeared/accident happened: _____

Are your symptoms due to: _____Auto Accident _____Work _____Other: _____

Secondary Complaint/If Applicable: _____

Do you have radiating symptoms? Y N **If so, where to?** _____

Rate your pain: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 [0 = no pain; 10 = worst pain you have ever felt]

Frequency of symptoms: _____Constant _____Intermittent _____Frequent _____With activities

Quality: _____Aching _____Burning _____Dull _____Sharp _____Shooting _____Stabbing _____Throbbing ____Tightness _____Tingling _____Other: _____

Pain exacerbated/made worse by:

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____Driving
____Lifting
____Lying down
____Movement
____Extreme motion
____Physical Activity
____Sitting
____Sneezing
____Standing
____Twisting
____Walking
____Other
____

Pain improves with:

____Bending
____Heat
____Ice
____Lying down
____Manipulation
____Massage
____Movement
____OTC medications
____Sitting
____Standing
____Walking
____Other
____

Date Symptoms appeared/accident happened: _____

Are your symptoms due to: _____Auto Accident _____Work _____Other: _____

HEALTH HISTORY

Please list all medical conditions/illnesses/diagnoses (related or unrelated to your chief complaint) and date of diagnosis:

_____

_____

Previous surgeries and date of surgery: _____

_____

Previous injuries and date of injury:

____Back injury _____

____Fall _____

____Fracture _____

____Auto Accident _____

Previous Treatments (for your chief complaint or other condition):

____Chiropractic

____Acupuncture

____Physical Therapy

____Other

WOMEN: Are you pregnant? Y N (If yes, please complete section below)

Due date: _____ Weeks pregnant: _ Baby gender: _____

OBGYN/Doula/Midwife: _____Baby position: __Breech __Transverse __Head down Previous child birth dates: _____Chiropractic care with previous pregnancy? Y N

Complications: _____

REVIEW OF SYSTEMS

Please place the letter C by your CURRENT conditions/symptoms and the letter P by any PREVIOUS conditions/symptoms:

____Neck pain
____Back pain
____Joint stiffness
____Muscle spasms
____Shoulder/Arm pain
____Arthritis
____Rheumatoid Arthritis
____Osteopenia/Osteoporosis
____Stroke
____Incoordination
____Dysphasia
____Seizure
____Numbness
____Tingling
____Smell disturbance
____Memory loss
____Weakness
____Concussion
____Loss of taste
____Syncope
____Cataracts
____Glaucoma
____Visual Disturbance
____Headaches
____Hearing loss
____Tinnitus
____Vertigo
____Sinusitis/Sinus Pain
____Dental Pain
____Lump in throat
____Bowel changes
____GERD
____Heartburn
____Indigestion

____Ulcers
____Bladder changes

____COPD
____Emphysema
____Myocardial Infarction
____Shortness of breath
____Asthma
____Chest pain
____Chest tightness
____Heart palpitations
____Irregular heartbeat
____Hypertension
____Hyperlipidemia
____Anxiety
____Bipolar disorder
____Dementia
____Depression
____Abnormal thyroid
____Diabetes [type 1/type 2]
____Fatigue

FAMILY HISTORY

Please inform us of any medical conditions/illnesses/diagnoses that are current health problems of the family member.

	Age(s)	Medical conditions/illnesses/diagnoses	Deceased?
Father			
Mother			
Spouse			
Brother(s)			
Sister(s)			
Children			

****

SOCIAL HISTORY

Exercise:

___Does not exercise
___Avoids exercise due to pain
___Exercises regularly
___Participates in aerobic activity
___Exercise habits are frequent and heavy
___Exercises occasionally
___Participates in sports

Work Environment:

___No problems
___Stressful
___Requires constant sitting
___Requires constant standing
___Requires heavy typing or data entry
___Requires lifting

Smoking Status:

___Former smoker
(years since quitting: _____; years smoked: _____)
___Never smoker
___Heavy smoker (years smoked: _____)
___Light smoker (years smoked: _____)
___Lives with smoker

Recreational Drug Use:

___None Other: _____

Alcohol Use:

___None ___Heavily ___Moderately
___Frequently ___Lightly ___Rarely

Caffeine consumption:

___None ___Heavily ___Moderately
___Frequently ___Lightly ___Rarely

Current medications (please note dosage, frequency, and condition for): _____

_____

Allergies: _____

_____ **Do you sleep on your:** _____Back _____Side

_____Stomach **Do you use a cervical pillow?** Y N

****

ADDITIONAL INFORMATION

What are your goals with care? _____

I certify that all the information provided is accurate to the best of my knowledge.

Patient/Guardian Signature: _____ **Date:** _____

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& WELLNESS, P.A.

Credit Card Authorization Form

To maintain PCI compliance, our credit card processor vaults only the last 4 digits of your credit card. This card must be used at our terminal once to securely capture information and is required to be on file for any balance incurred.

Credit Card Information				
Card Type (please circle):	MasterCard	VISA	Discover	Care Credit
Cardholder Name (as shown on card):				
Last 4 Digits of Card Number:				
Expiration Date (mm/yy):		CVV#:		
Cardholder ZIP Code (from credit card billing address):				

I,_____, authorize Hornback Chiropractic and Wellness, PA
(Credit Card Holder Name)
to charge the credit card above for agreed upon purchases/services. I understand that my information will be saved for future transactions on my account.

- Copay, Deductible or amount due after insurance processes.
- Weekly or Monthly payment of _____ , beginning on _____.
- I would like a receipt sent to me through the patient portal.

Date:_____ Patient Name:_____

Cardholder Signature:_____

PATIENT HEALTH INFORMATION INFORMED CONSENT

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

_____ DATE _____

Printed Name

_____

Signature

_____

Signature of Parent or Guardian (if a minor)

INFORMED CONSENT

I will use my hands or a mechanical instrument upon your body in such a way as to move your joints. This procedure is referred to as ”Spinal Manipulation” or Spinal Adjustment” As the joints in your spine are moved, you may experience a “pop” as part of the process..

There are certain complications that can occur as a result of a spinal manipulation. These compilations include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains and dislocations, Bernard-Horner’s Syndrome (also known as oculosympathethetic palsy), costovertebral strains and separation. Rare complications include but are not limited to stroke. The most common complication or complaint following spinal manipulation is an ache or stiffness at the site of adjustment.

I am aware of these complications, and in order to minimize their occurrence I will take precautions. These precautions include but are not limited to my taking a detailed clinical history of you and examining you for any defect which would cause a complication. This examination may include the use of x-rays. The use of x-ray equipment may pose a risk if you are pregnant. If you are pregnant, you should tell me when I take you clinical history.

_____ DATE _____

Printed Name

Signature

Signature of Parent or Guardian (if a minor)

HCW
HORNBACK CHIROPRACTIC
& WELLNESS, P.A.

Authorization for the Release of Medical Records

Patient Name: _____ Date of Birth: _____

I hereby request and authorize:

Hornback Chiropractic and Wellness. P.A.

11023 Gatewood Drive Suite 101, Bradenton, FL 34211 941.744.1585 (T); 941.744.1572 (F) chirotech@hornbackchiro.com
8386 Market Street, Lakewood Ranch, FL 34202 941.210.7057 (T); 941.210.7056 (F) marketst@hornbackchiro.com
9544 Buffalo Road, Palmetto, FL 34221 941.417.2069 (T); 941.417.2046 (F)
buffalord@hornbackchiro.com
3090 Fruitville Commons Blvd, Suite 102, Sarasota, FL 34240 941.841.9780 (T); 941.724.8453 (F)
fruitvillerd@hornbackchiro.com

_____To Disclose information to: _____To Receive Information from:

Physician/Medical Facility/Hospital: _____
Email: _____
Address: _____ Phone Number: _____
_____ Fax Number: _____

Information to be disclosed includes copies of:

_____Entire Record
_____Progress Notes
_____Physical Exam forms
_____X-ray Reports
_____X-ray Films
_____Other, specify: _____
_____

Purpose for Disclosure:

_____Treatment, Payment, OR _____Other, Specify: _____

This authorization will be effective after the date signed, unless cancelled in writing. I understand that the cancellation will have no effect on information released prior to receiving the cancellation. A copy of this authorization is as valid as the original.

_____Date: _____
Signature of Patient or Parent/Guardian/Legal Representative

If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law.
Notice to recipient of information: This information has been disclosed to you from confidential records, which are protected by law. Unless you have further authorization, laws may prohibit you from making any further disclosures of this information without the specific written consent of the patient or legal representative.

HORNBACK CHIROPRACTIC & WELLNESS, P.A.

AUTO ACCIDENT/INJURY FORM

NAME_____ DATE_____

Date of Accident_____ Time: _____am/pm Location of Accident_____

Posted speed limit: _____mph Speed upon impact: _____mph

AUTO INJURY

Were You: _____Driver _____Passenger [____Front _____Right Rear _____Left Rear] ___Pedestrian

Were you struck from: ____Behind _____Right Side _Left Side _____Front _____Parked

Did your car strike the others involved? _____Yes ____No ____Undetermined

Did the other car strike yours? _____Yes ____No ____Undetermined

Were you wearing your seatbelt? _____Yes ____No

Did you strike anything in the vehicle at the time of impact? _____Yes _____No

If yes what? _____

Traffic Conditions: _____Heavy/Congested _____Normal _____Rush Hour

Weather Conditions: _____Normal _____Raining _____Foggy _____Poor visibility

Vehicle Information (Year, Make and Model): _____

As a result of the Accident, were traffic citations issued to you? _____Yes ____No

Location after the accident: _____Home _____Hospital _____Urgent Care (Walk-in clinic)

Were you seen/examined at the scene of the accident by a 1st responder? ___Yes ___No Have you been to any other healthcare provider for this accident? _____Yes _____No

Describe the accident: _____

_____

_____

POST INJURY:

Are you able to do mental work? _____Yes _____No

Are you able to do physical work? _____Yes _____No

Did you lose consciousness as a result of the accident? _____Yes _____No

Do you remember the impact? _____Yes _____No

Have you lost any days of work? ____Yes ____No If Yes, _____through _____ Are you limited in movement? _____Yes _____No

Do you have pain/discomfort from the accident? _____Yes _____No

CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT

_Headache
_Neck Pain
_Neck Stiff
_Dizziness
_Back Pain
_Nervousness
_Tension
_Irritability

_Sleeping Problems
_Head Too Heavy
_Pins & Needles in Arms
_Pins & Needles in Legs
_Numbness in Fingers
_Numbness in Toes
_Shortness of Breath
_Fatigue

_Lights Bother Eyes
_Loss of Memory
_Ears Ringing
_Face Flushed
_Buzzing in Ears
_Loss of Balance
_Fainting
_Loss of Smell

_Diarrhea
_Feet Cold
_Hands Cold
_Stomach Upset
_Constipation
_Cold Sweats
_Fever
_Other _____

_Chest Pain

_Depression

_Loss of Taste

_____

INSURANCE INFORMATION

Your Insurance Company _____ Address: _____

Have you been contacted by an insurance adjustor regarding this claim? _____Yes _____No

If yes, name of adjustor: _____Phone Number: _____

Claim number: _____

Do you have an attorney that has advised you in this case? _____Yes _____No

If yes, attorney's name: _____Address: _____

Phone number: _____

Patient/Guardian Signature: _____ Date: _____

HORNBACK CHIROPRACTC AND WELLNESS, PA

11023 Gatewood Drive Suite 101	**8386 Market Street**	**9544 Buffalo Road**	**3090 Fruitville Commons Blvd, Ste 102**
Bradenton, FL	**Lakewood Ranch, FL 34202**	**Palmetto, FL 34221**	**Sarasota, FL 34240**
941-744-1585	**941-210-7057**	**941-417-2069**	**941-724-8451**

ASSIGNMENT OF INSURANCE BENEFITS, LIEN, RELEASE, & DEMAND

Insurer and Patient Please Read the Following in its Entirety Carefully!

I, the undersigned patient/insured knowingly, voluntarily and intentionally irrevocably assign the rights and benefits of my automobile Insurance, also known as Personal Injury Protection (hereinafter PIP), Uninsured Motorist and Medical Payments policy of insurance to the above health care provider. I understand it is the intention of the provider to accept this assignment of benefits in lieu of demanding payment at the time services are rendered. I understand this document will allow the provider to file suit against an insurer for payment of the insurance benefits or an explanation of benefits and to seek §627.428 damages from the insurer. This assignment of benefits includes transportation, medications, supplies, overdue interest and any potential claim for common law or statutory bad faith/unfair claims handling. If the insurer disputes the validity of this assignment of benefits then the insurer is instructed to notify the provider in writing within five days of receipt of this document. Failure to inform the provider shall result in a waiver by the insurer to contest the validity of this document. Failure to inform the provider shall result in a waiver by the insurer to contest the validity of this document. The undersigned directs the insurer to pay the health care provider the maximum amount directly without any reductions & without including the patient's name on the check. To the extent the PIP insurer contends there is a material misrepresentation on the application for insurance resulting in the policy of insurance is declared voided, rescinded, or canceled, I as he named insured under said policy of insurance, hereby assign the right to receive the premiums paid for my PIP insurance to this provider and to file suit for recovery of the premiums. The insurer is directed to issue such a refund check payable to this provider only. Should the medical bills not exceed the premium refunded, then the provider is directed to mail the patient/named insured a check which represents the difference between the medical bills and the premiums paid.

Lien: I, the undersigned patient guarantee full payment to Hornback Chiropractic and Wellness, PA and agree that I will remain personally responsible for unpaid charges as a result of any deductible, co-payment, and treatment after benefits are exhausted and/or for any other treatment/service that remains unpaid. Furthermore, I grant Hornback Chiropractic and Wellness, PA a lien against any recovery, which I may have against any tortfeasor, responsible party, or any responsible insurance carrier. I direct my attorney to withhold any funds I receive from any settlement to pay for any outstanding balance to Hornback Chiropractic and Wellness, PA. I agree to and instruct my attorney to promptly advise Hornback Chiropractic and Wellness, PA of any settlement as a result of the injuries sustained in the _____(Date) motor vehicle accident, slip-n-fall, or motorcycle accident. Additionally, I agree and instruct my attorney that I will not accept any settlement check until the remaining balance is resolved with Hornback Chiropractic and Wellness, PA.

Disputes: The insurer is directed by the provider and the undersigned to not issue any checks or drafts in partial settlement of a claim that contain or are accompanied by language releasing the insurer or its insured/patient from liability unless there has been a prior written settlement agreed to by the health provider (specifically the office manager) and the insurer as to the amount payable under the insurance policy. The insured and provider hereby contests and objects to any reductions or partial payments. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by the provider shall be done so under protest, at the risk of the insurer, and the deposit shall not be deemed a waiver, accord, satisfaction, discharge, settlement or agreement by the provider to accept a reduced amount as payment in full. The insurer is hereby placed on notice that this provider reserves the right to seek the full amount of the bills submitted. If the PIP insurer states it can pay claims at 200% of the Medicare Fee Schedule or any other fee schedule contained within F.S. 627.736 then the insurer is instructed & directed to provide this provider with a copy of the policy of insurance within 10 days. Any effort by the insurer to pay a disputed debt as full satisfaction must be mailed to the address above, after speaking with the office/billing manager and mailed to the attention of the office/billing manager. *See Fla. Stat. §673.3111*.

This assignment applies to both past and future medical expenses and is valid even if undated. A photocopy of this assignment is to be considered as valid as the original. I agree to pay any applicable deductible, co-payments, for services rendered after the policy of insurance exhausts and for any other services unrelated to the automobile accident. The health care provider is given the power of attorney to: endorse my name on any check for services rendered by the above provider; and to request and obtain a copy of any statements or examinations under oath given by patient.

Release of information: I hereby authorize this provider to: furnish an insurer, an insurer's intermediary, the patient's other medical providers, and the patient's attorney via mail, fax, or email, with any and all information that may be contained in the medical records; and for my insurance carrier to **send insurance coverage information (declaration sheet & policy of insurance) in writing and telephonically to the above-named provider**; request from any insurer all explanation of benefits (EOBs) for all providers and non-redacted PIP payout sheets; obtain any written and verbal statements the patient or anyone else provided to the insurer; obtain copies of the entire claim file and all medical records, including but not limited to, documents, reports, scans, notes, bills, opinions, X-rays, IMEs, and MRIs, from any other medical provider or any insurer. The provider is permitted to produce my medical records to its attorney in connection with any pending lawsuits. The insurer is directed to keep the patient's medical records from this provider private and confidential. The insurer is not authorized to provide these medical records to anyone without the patient's and the provider's prior express written permission. **PLEASE NOTE: The insurer is not authorized to release protected health information (PHI) to third party vendors that schedule independent medical examinations or independent medical examination physicians**.

Demand: Demand is hereby made for the insurer to pay all bills within 30 days without reductions and to mail the latest non-redacted PIP payout sheet and the insurance coverage declaration sheet, and the insurance policy to the above provider within 15 days, as well as notify the provider pursuant to F.S. 627.736(6)(f) when benefits have been exhausted. The insurer is directed to pay the bills in the order they are received. However, if a bill from this provider and a claim from anyone else is received by the insurer on the same day the insurer is directed to not apply this provider's bill to the deductible. If a bill from this provider and claim from anyone else is received by the insurer on the same day then the insurer is directed to pay this provider first before the policy is exhausted. The insurer is instructed to inform, in writing, the provider of any dispute.

Caution: Please read before signing. **If you do not completely understand this document please ask us to explain it to you. If you sign below we will assume you understand and agree to the above. I certify that I have read and agree to all of the above and was not solicited or promised anything in exchange for receiving health care. I agree that the prices for the medical care is reasonable.**

Patient's Name _____ Patient's Signature _____

(Please Print) (If patient is a minor, signature of parent/guardian)

Date _____

OFFICE OF INSURANCE REGULATION
Bureau** of **Property** & **Casualty Forms and Rates

Standard Disclosure and Acknowledgement Form Personal Injury Protection - Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

1. The services or treatment set forth below were **actually rendered.** This means that those services have **already been provided.**

Therapeutic activity, Therapeutic exercise, Exam, X-ray, Electric Stimulation, Ultrasound, Traction Spinal manipulation, Manual therapy, Neuromuscular re-education, ice/heat, Decompression therapy

2. I have the right and the **duty to confirm** that the services have already been provided.

3. I was **not solicited** by any person to seek any services from the medical provider of the services described above.

4. The medical provider has **explained** the services to me for which payment is being claimed.

5. Ifl notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to $500.

Insured Person (patient receiving treatment or services) or Guardian of insured Person:

Name *(PRINT or TYPE)*	Signature	Date

The undersigned licensed medical professional or medical director, if applicable, affirms the statement numbered 1 above and also:

A. I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.

B. The treatment or services rendered were explained to the insured person, or his or her guardian, **sufficiently** for that person to sign this form with informed consent.

C. The accompanying statement or bill is **properly completed** in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to **truthfully, accurately,** and in a **substantially complete** manner.

D. The coding of procedures on the accompanying statement or bill is proper. This means that **no service has been upcoded, unbundled,** or constitutes an invalid **or not medically necessary diagnostic test** as defined by Section 627.732(14) and (15), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Licensed Medical Professional Rendering Treatment/Services or Medical Director, if applicable *(Signature by his/ her **own hand):***

Name *(PRINT or TYPE)*	Signature	Date

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of Claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234(1)(b), Florida Statutes.

Note: The **original** of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may **not** be electronically furnished. Failure to furnish this form may result in non-payment of the claim

The Roland-Morris Low Back Pain and Disability Questionnaire

Patient Name: _____File #: _____Date: _____

Please read instructions: When your back hurts, you may find it difficult to do some of the things you normally do. Mark only the sentences (by circling the number) that describe you today.

1. I stay at home most of the time because of my back.
2. I change positions frequently to try to get my back comfortable.
3. I walk more slowly than usual because of my back.
4. Because of my back, I am not doing any jobs that I usually do around the house.
5. Because of my back, I use a hand rail to get upstairs.
6. Because of my back, I lie down to rest more often.
7. Because of my back, I have to hold onto something to get out of an easy chair.
8. Because of my back, I try to get other people to do things for me.
9. I get dressed more slowly than usual because of my back.
10. I only stand up for short periods because of time because of my back.
11. Because of my back, I try not to bend or kneel down.
12. I find it difficult to get out of a chair because of my back.
13. My back is painful almost all of the time.
14. I find it difficult to turn over in bed because of my back.
15. My appetite is not very good because of my back pain.
16. I have trouble putting on my socks or stockings because of my pain in my back.
17. I only walk short distances because of my back pain.
18. I sleep less well because of my back.
19. Because of my back pain, I get dressed with help from someone else.
20. I sit down for most of the day because of my back.
21. I avoid heavy jobs around the house because of my back.
22. Because of my back pain, I am more irritable and bad tempered with people than usual.
23. Because of my back, I go upstairs more slowly than usual.
24. I stay in bed most of the time because of my back.

Neck Pain and Disability Index (Vernon-Minor)

Patient Name: _____File #: _____Date: _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

SECTION 1 - PAIN INTENSITY

0. I have no pain at the moment.
1. The pain is very mild at the moment.
2. The pain is moderate at the moment.
3. The pain is fairly severe at the moment.
4. The pain is very severe at the moment.
5. The pain is the worst imaginable at the moment.

SECTION 2 - PERSONAL CARE (Washing, dressing, etc)

0. I can look after myself normally without causing extra pain.
1. I can look after myself normally but it causes extra pain.
2. It is painful to look after myself and I am slow and careful.
3. I need some help but manage most of my personal care.
4. I need help every day in most aspects of self-care.
5. I do not get dressed, I wash with difficulty and stay in bed.

SECTION 3 - LIFTING

0. I can lift heavy weights without extra pain.
1. I can lift heavy weights but it gives extra pain.
2. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, i.e. on a table.
3. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
4. I can lift very light weights.
5. I cannot lift or carry anything at all.

SECTION 4 - READING

0. I can read as much as I want to with no pain in my neck.
1. I can read as much as I want to with slight pain in my neck.
2. I can read as much as I want with moderate pain in my neck.
3. I can't read as much as I want because of moderate pain in my neck.
4. I can hardly read at all because of severe pain in my neck.
5. I cannot read at all.

SECTION 5 - HEADACHES

0. I have no headaches at all.
1. I have slight headaches which come infrequently.
2. I have moderate headaches which come infrequently.
3. I have moderate headaches which come frequently.
4. I have severe headaches which come frequently.
5. I have headaches almost all the time.

SECTION 6 - CONCENTRATION

0. I can concentrate fully when I want to with no difficulty.
1. I can concentrate fully when I want to with slight trouble
2. I have a fair degree of difficulty in concentrating when I want to.
3. I have a lot of difficulty in concentrating when I want to.
4. I have a great deal of difficulty in concentrating when I want to.
5. I cannot concentrate at all.

SECTION 7 - WORK

0. I can do as much work as I want to.
1. I can only do my usual work, but no more.
2. I can do most of my usual work, but no more.
3. I cannot do my usual work.
4. I can hardly do any work at all.
5. I can't do any work at all.

SECTION 8 - DRIVING

0. I can drive my car without any neck pain.
1. I can drive my car as long as I want with slight pain in my neck.
2. I can drive my car as long as I want with moderate pain in my neck.
3. I can't drive my car as long as I want because of moderate pain in my neck.
4. I can hardly drive at all because of severe pain in my neck.
5. I can't drive my car at all.

SECTION 9 - SLEEPING

0. I have no trouble sleeping
1. My sleep is slightly disturbed (less than 1 hr. sleepless).
2. My sleep is mildly disturbed (1-2 hrs. sleepless).
3. My sleep is moderately disturbed (2-3 hrs. sleepless).
4. My sleep is greatly disturbed (3-5 hrs. sleepless).
5. My sleep is completely disturbed (5-7 hrs. sleepless).

SECTION 10 - RECREATION

0. I am able to engage in all my recreation activities with no neck pain at all.
1. I am able to engage in all my recreation activities, with some pain in my neck.
2. I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
3. I am able to engage in a few of my usual recreation activities because of pain in my neck.
4. I can hardly do any recreation activities because of pain in my neck.
5. I can't do any recreation activities at all.

Pain Severity Scale: Rate the severity of your pain by checking the corresponding box on the scale below:

0------1------2------3------4------5------6------7------8------9------10

Oswestry Back Index

Patient Name: _____File #: _____Date: _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you.

Pain Intensity

0. The pain comes and goes and is very mild.
1. The pain is mild and does not vary much.
2. The pain comes and goes and is moderate.
3. The pain is moderate and does not vary much.
4. The pain comes and goes and is very severe.
5. The pain is very severe and does not vary much.

Personal Care

0. I do not have to change my way of washing or dressing in order to avoid pain.
1. I do not normally change my way of washing or dressing even though it causes some pain.
2. Washing and dressing increases the pain but I manage not to change my way of doing it.
3. Washing and dressing increases the pain and I find it necessary to change my way of doing it.
4. Because of the pain I am unable to do some washing and dressing without help.
5. Because of the pain I am unable to do any washing and dressing without help.

Lifting

0. I can lift heavy weights without extra pain.
1. I can lift heavy weights but it causes extra pain.
2. Pain prevents me from lifting heavy weights off the floor.
3. I can only lift very light weights.
4. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
5. Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.

Walking

0. I have no pain while walking.
1. I have some pain while walking but it doesn't increase with distance.
2. I cannot walk more than 1 mile without increasing pain.
3. I cannot walk at all without increasing pain.
4. I cannot walk more than 1/2 mile without increasing pain.
5. I cannot walk more than 1/4 mile without increasing pain.

Sitting

0. I can sit in any chair as long as I like.
1. I can only sit in my favorite chair as long as I like.
2. Pain prevents me from sitting more than 1 hour.
3. I avoid sitting because it increases pain immediately.
4. Pain prevents me from sitting more than 1/2 hour.
5. Pain prevents me from sitting more than 10 minutes.

Standing

0. I can stand as long as I want without pain.
1. I have some pain while standing but it does not increase with time.
2. I cannot stand for longer than 1 hour without increasing pain.
3. I avoid standing because it increases pain immediately.
4. I cannot stand for longer than 1/2 hour without increasing pain.
5. I cannot stand for longer than 10 minutes without increasing pain.

Sleeping

0. I get no pain in bed.
1. I get pain in bed but it does not prevent me from sleeping well.
2. Because of pain my normal sleep is reduced by less than 25%.
3. Pain prevents me from sleeping at all.
4. Because of pain my normal sleep is reduced by less than 50%.
5. Because of pain my normal sleep is reduced by less than 75%.

Social Life

0. My social life is normal and gives me no extra pain.
1. My social life is normal but increases the degree of pain.
2. I have hardly any social life because of the pain.
3. Pain has restricted my social life and I do not go out very often.
4. Pain has restricted my social life to my home.
5. Pain has no significant effect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).

Traveling

0. I get no pain while traveling.
1. I get some pain while traveling but none of my usual forms of travel make it worse.
2. I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
3. Pain restricts all forms of travel.
4. I get extra pain while traveling which causes me to seek alternate forms of travel.
5. Pain restricts all forms of travel except that done while lying down.

Changing degree of pain

0. My pain is rapidly getting better.
1. My pain fluctuates but overall is definitely getting better.
2. My pain seems to be getting better but improvement is slow.
3. My pain is neither getting better or worse.
4. My pain is gradually worsening.
5. My pain is rapidly worsening.

Pain Severity Scale: Rate the severity of your pain by checking the corresponding box on the scale below:

0------1------2------3------4------5------6------7------8------9------10

HCW
HORNBACK CHIROPRACTIC
& WELLNESS, P.A.

Child's Name: _____ Date of Birth: _____/____/_____ Sex: ❑ Male ❑ Female

Address: _____ Phone: _____

City/State/Zip:_____

Parent/Guardian information

Mother's Name: _____ Date of Birth: __/__/_____

Social Security #: _-_-_____ Cell Phone: _____ Cell Carrier: _____

Address: _____ Email: _____

City/State/Zip:_____

Father's Name: _____ Date of Birth: __/__/_____

Social Security #: _-_-_____ Cell Phone: _____ Cell Carrier: _____

Address: _____ Email: _____

City/State/Zip:_____

I, _____, hereby authorize and consent to the chiropractic evaluation and treatment of my child by the doctors of Hornback Chiropractic & Wellness, P.A.

Parent/Guardian Signature: _____ Date: ____/____/_____

Witness: _____ Date: ____/____/_____

By signing below you acknowledge that periodic communications sent by HCW via text message, phone and email could potentially cause additional charges for you under your cell phone or data plan. If you do not want to receive such communications, please notify us in writing of your desire to be removed from such communications.

How did you hear about our office? Google/Facebook/Insurance/Existing Patient (Name: _____)

Insurance Information

Insurance Company: _____ Policy Holder: _____

Please acknowledge the below for a smooth financial process:

- I recognize my insurance is an agreement between me and my insurance co.
- I authorize direct payment of insurance benefits to HCW.
- I agree to release information for communication with healthcare providers.
- I understand I am responsible for all chiropractic care costs/unpaid balances.
- I authorize a credit card to be kept on file for billing efficiency.
- I understand promotional services aren't submitted to insurance.
- I understand overdue accounts after 90 days may go to collections.
- I understand immediate payment of professional service fees is due if care recommended by doctor is suspended or terminated.
- We verify benefits directly with your insurance provider.
- We prepare insurance forms at no cost for timely submission of claims.

Please list who we may speak with regarding your child's chiropractic care and account (please note that we CANNOT speak with or release any information to anyone that is not listed below):

Names: _____ _____ _____

Parent/Guardian Signature: _____ Date: ____/____/_____

Physicians

Pediatrician/Primary Care Physician: _____

Address: _____ Phone: _____

City/State/Zip:_____

Date of last visit: ____/____/_____ Reason for visit: _____

Previous Chiropractor: _____

Address: _____ Phone: _____

City/State/Zip:_____

Date of last visit: ____/____/_____ Reason for visit: _____

Birth History

Birth Place: ❑Hospital ❑Home ❑Birthing Center Duration of Gestation: _____weeks

Was the birth assisted? ❑Yes ❑No If yes, how? ❑Forceps ❑Vacuum ❑C-section ❑ Induced

Were medications given to the mother at birth? ❑Yes ❑No If yes, what? _____

Was the delivery normal? ❑Yes ❑No Complications: _____

Growth and Development

APGAR score at birth: _____ APGAR score after 5 minutes: _____ Birth Weight: ____lbs____oz. Birth Length: _____ in. At what age did the child:

Respond to sound _____ Hold head up _____ Crawl _____ Walk independently_____

Follow an object _____ Sit alone _____ Stand _____

Chemical Stressors

During pregnancy, did the mother:

(1) Smoke: ❑yes ❑no (2) Drink alcohol: ❑yes ❑no (3) Take supplements/vitamins: ❑yes ❑no

(4) Take medications/drugs: ❑yes ❑no if yes, what? _____

(5) Become ill: ❑yes ❑no if yes, describe: _____

(6) Receive invasive procedures (amniocentesis, CVS): ❑yes ❑no

Was the child breast fed? ❑yes ❑no If yes, for how long? _____weeks/months/years

At what age was (a) formula introduced? _____ (b) cow's milk: _____yrs. (c) solid foods: _____yrs.

Did your child receive vaccinations? ❑yes ❑no If yes, which ones?_____

Has your child had antibiotics? ❑yes ❑no If yes, how many and why? _____

Do you have any pets at home? ❑yes ❑no Any smokers? ❑yes ❑no

Psychological Stressors

Any difficulties with lactation? ❑yes ❑no Any problems bonding? ❑yes ❑no

Does the child have any behavior problems? ❑yes ❑no If yes, describe: _____

Does your child have difficulty sleeping (night terrors, sleep walking, etc? ❑yes ❑no If yes, describe: _____

Average number of hours of TV/computer per week? _____hrs.

Traumatic Stressors

Any evidence of trauma at birth? ❑bruises ❑odd-shaped head ❑stuck in birth canal ❑fast and/or excessively long birth ❑respiratory depression ❑cord around neck ❑other: _____

Any falls/accidents during pregnancy? ❑yes ❑no If yes, describe: _____

Has the child had any major falls since birth? ❑yes ❑no If yes, describe: _____

Has the child had any hospitalizations? ❑yes ❑no If yes, describe: _____

Does your child play sports? ❑yes ❑no If yes, number of hours per week and sport: _____

_____ Weight of school backpack: _____ lbs

Current Condition/Reason for Care

Chief complaint/Purpose of visit:_____

Onset date: ____/____/_____ Onset was: ❑sudden ❑gradual ❑associated with an event: _____

Duration of problem or episode: ❑minutes ❑hours ❑days ❑months ❑years

Pattern of problem: ❑constant ❑intermittent ❑occasional ❑cyclical

Aggravating factors: _____

Relieving factors:_____

How does the problem affect your child's body function and daily activities? _____

_____

Prior occurrences or episodes? _____

Other providers seen for the problem: ❑none ❑provider name_____

Past History

Has the child suffered from any of the following?

❑Neck pain
❑Back pain
❑Muscle pain
❑Poor posture
❑Headaches
❑Seizures
❑Dizziness
❑Fainting
❑Seizures
❑Concussion
❑Stomachaches
❑Constipation
❑Diarrhea
❑Reflux
❑Heart trouble
❑Visual disturbance
❑Chronic earaches
❑Sinus trouble
❑Asthma
❑Colic
❑Bed wetting
❑Allergies
❑Other _____

Has the child ever been treated on an emergency basis? ❑yes ❑no If yes, describe: _____

Has the child ever sustained injuries from an auto accident? ❑yes ❑no If yes, describe: _____

_____

Has the child ever sustained an injury playing organized sports? ❑yes ❑no If yes, describe: _____

Family History

Please inform us of any medical conditions/illnesses/diagnoses that are current health problems of the family member.

	Age(s)	Medical conditions/illnesses/diagnoses
Father		
Mother		
Brother(s)		
Sister(s)		

HCW

HORNBACK CHIROPRACTIC
& WELLNESS, P.A.

Credit Card Authorization Form

To maintain PCI compliance, our credit card processor vaults only the last 4 digits of your credit card. This card must be used at our terminal once to securely capture information and is required to be on file for any balance incurred.

Credit Card Information				
Card Type (please circle):	MasterCard	VISA	Discover	Care Credit
Cardholder Name (as shown on card):				
Last 4 Digits of Card Number:				
Expiration Date (mm/yy):		CVV#:		
Cardholder ZIP Code (from credit card billing address):				

I,_____, authorize Hornback Chiropractic and Wellness, PA
(Credit Card Holder Name)

to charge the credit card above for agreed upon purchases/services. I understand that my information will be saved for future transactions on my account.

- Copay, Deductible or amount due after insurance processes.
- Weekly or Monthly payment of _____ , beginning on _____.
- I would like a receipt sent to me through the patient portal.

Date:_____ Patient Name:_____

Cardholder Signature:_____

PATIENT HEALTH INFORMATION INFORMED CONSENT

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

_____ DATE _____

Printed Name

_____

Signature

_____

Signature of Parent or Guardian (if a minor)

INFORMED CONSENT

I will use my hands or a mechanical instrument upon your body in such a way as to move your joints. This procedure is referred to as ”Spinal Manipulation” or Spinal Adjustment” As the joints in your spine are moved, you may experience a “pop” as part of the process..

There are certain complications that can occur as a result of a spinal manipulation. These compilations include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains and dislocations, Bernard-Horner’s Syndrome (also known as oculosympathethetic palsy), costovertebral strains and separation. Rare complications include but are not limited to stroke. The most common complication or complaint following spinal manipulation is an ache or stiffness at the site of adjustment.

I am aware of these complications, and in order to minimize their occurrence I will take precautions. These precautions include but are not limited to my taking a detailed clinical history of you and examining you for any defect which would cause a complication. This examination may include the use of x-rays. The use of x-ray equipment may pose a risk if you are pregnant. If you are pregnant, you should tell me when I take you clinical history.

_____ DATE _____

Printed Name

_____

Signature

_____

Signature of Parent or Guardian (if a minor)

HCW
HORNBACK CHIROPRACTIC
& WELLNESS, P.A.

Authorization for the Release of Medical Records

Patient Name: _____ Date of Birth: _____

I hereby request and authorize:

Hornback Chiropractic and Wellness. P.A.

11023 Gatewood Drive Suite 101, Bradenton, FL 34211 941.744.1585 (T); 941.744.1572 (F) chirotech@hornbackchiro.com
8386 Market Street, Lakewood Ranch, FL 34202 941.210.7057 (T); 941.210.7056 (F) marketst@hornbackchiro.com
9544 Buffalo Road, Palmetto, FL 34221 941.417.2069 (T); 941.417.2046 (F)
buffalord@hornbackchiro.com
3090 Fruitville Commons Blvd, Suite 102, Sarasota, FL 34240 941.841.9780 (T); 941.724.8453 (F)
fruitvillerd@hornbackchiro.com

_____To Disclose information to: _____To Receive Information from:

Physician/Medical Facility/Hospital: _____
Email: _____
Address: _____ Phone Number: _____
_____ Fax Number: _____

Information to be disclosed includes copies of:

_____Entire Record
_____Progress Notes
_____Physical Exam forms
_____X-ray Reports
_____X-ray Films
_____Other, specify: _____
_____

Purpose for Disclosure:

_____Treatment, Payment, OR _____Other, Specify: _____

This authorization will be effective after the date signed, unless cancelled in writing. I understand that the cancellation will have no effect on information released prior to receiving the cancellation. A copy of this authorization is as valid as the original.

_____Date: _____
Signature of Patient or Parent/Guardian/Legal Representative

If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law.
Notice to recipient of information: This information has been disclosed to you from confidential records, which are protected by law. Unless you have further authorization, laws may prohibit you from making any further disclosures of this information without the specific written consent of the patient or legal representative.