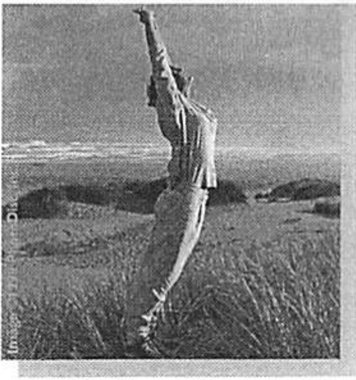

WELCOME

"The doctor of the future will give no medicine but will interest his patients in the care of the human frame, in diet, and in cause and prevention of disease." —Thomas Edison

Patient Information

Thank you for choosing our practice for your chiropractic needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

(Please Print)

Name ______________________________ Date _________ SS/HIC/Patient ID#____________
First Middle Initial Last

Address ____________________________ City ________________ State ______ Zip __________

Sex: ❑ Female ❑ Male Birthdate ______________ E-mail ______________________________

Home Phone (_____)____________ Cell Phone (_____)____________ Work Phone (_____)__________

Do you prefer to receive calls at: ❑ Home ❑ Work ❑ Cell ❑ No Preference

❑ Married ❑ Widowed ❑ Single ❑ Minor ❑ Separated ❑ Divorced ❑ Partnered for_____years

Patient Employer/School ___________________________ Occupation __________________

Employer/School Address _______________________ City ____________ State ____ Zip _______

Spouse or parent's name ________________ Employer ____________ Work Phone (_____)_________

Whom may we thank for referring you to us? ____

Person to contact in case of emergency _________________________ Phone (_____)____________

Responsible Party

Name of person responsible for this account ____

Relationship to patient ________________________ Phone (_____)_________________________

Address ______________________________ City _____________ State ______ Zip _________

Name of employer ___________________________ Work Phone (_____) ____________________

Insurance Information

Name of insured ___________________________ Relationship to patient ____________________

Birthdate _______________ Social Security # _______________ Date employed _______________

Name of employer ___________________________ Work Phone (_____) ____________________

Address ______________________________ City _____________ State ______ Zip _________

Insurance Co. _______________Phone (_____) ________ Group #________ Employer # ___________

Insurance Co. Address _______________________ City _____________ State ______ Zip _________

How much is your deductible? ________ How much have you used? _________ Max. annual benefit?_________

DO YOU HAVE ADDITIONAL INSURANCE? ❑ No ❑ Yes IF YES, PLEASE COMPLETE THE FOLLOWING:

Name of insured ___________________________ Relationship to patient ____________________

Birthdate _______________ Social Security # _______________ Date employed _______________

Name of employer ___________________________ Work Phone (_____) ____________________

Address ______________________________ City _____________ State ______ Zip _________

Insurance Co. ___________________________Group # ______________ Employer # ___________

Insurance Co. Address _______________________ City _____________ State ______ Zip _________

How much is your deductible?________ How much have you used? _________ Max. annual benefit?_________

CONFIDENTIAL

#65387 – © 2004 HMI 1-800-468-4144

Symptoms

Reason for visit ____________________ When did you first notice the symptoms? __________

Is this condition getting progressively worse? ____________________

Where specifically is the problem(s) located? ____________________

Which activities are difficult to perform? ❑ Sitting ❑ Standing ❑ Walking ❑ Bending ❑ Lying down ❑ Other

Type of pain: ❑ Sharp ❑ Dull ❑ Throbbing ❑ Numbness ❑ Aching ❑ Shooting
❑ Burning ❑ Tingling ❑ Cramps ❑ Stiffness ❑ Swelling ❑ Other

Rate the severity of your pain. (1, mild pain or discomfort, to 10, severe pain): 1 2 3 4 5 6 7 8 9 10

Is the pain constant or does it come and go? ____________________

What treatment have you already received for your condition?

❑ Medication ❑ Surgery ❑ Physical Therapy ❑ Other ____________________

Name and address of other doctor(s) who have treated you for your condition:

____

Health History

Check only those conditions which are applicable:

❑ AIDS/HIV	❑ Cataracts	❑ Hepatitis	❑ Osteoporosis	❑ Suicide Attempt
❑ Alcoholism	❑ Chemical Dependency	❑ Hernia	❑ Pacemaker	❑ Thyroid Problems
❑ Allergy Shots	❑ Chicken Pox	❑ Herniated Disc	❑ Parkinson's Disease	❑ Tonsillitis
❑ Anemia	❑ Depression	❑ Herpes	❑ Pinched Nerve	❑ Tuberculosis
❑ Anorexia	❑ Diabetes	❑ High Cholesterol	❑ Pneumonia	❑ Tumors, Growths
❑ Appendicitis	❑ Emphysema	❑ Kidney Disease	❑ Polio	❑ Typhoid Fever
❑ Arthritis	❑ Epilepsy	❑ Liver Disease	❑ Prostate Problems	❑ Ulcers
❑ Asthma	❑ Fractures	❑ Measles	❑ Prosthesis	❑ Vaginal Infections
❑ Bleeding Disorders	❑ Glaucoma	❑ Migraine Headaches	❑ Psychiatric Care	❑ Venereal Disease
❑ Breast Lump	❑ Goiter	❑ Miscarriage	❑ Rheumatoid Arthritis	❑ Whooping Cough
❑ Bronchitis	❑ Gonorrhea	❑ Mononucleosis	❑ Rheumatic Fever	❑ Other __________
❑ Bulimia	❑ Gout	❑ Multiple Sclerosis	❑ Scarlet Fever	__________
❑ Cancer	❑ Heart Disease	❑ Mumps	❑ Stroke	__________

Dates of last exams ____________________

(Women) Are you pregnant? ❑ Yes ❑ No Nursing? ❑ Yes ❑ No Taking birth control pills? ❑ Yes ❑ No

List any types of surgeries which you have had and the dates which they occurred:

____

Please list all medications you are currently taking: ____________________

Allergies: ____________________

Daily Habits

What type of exercise do you perform on a daily basis? ❑ None ❑ Moderate ❑ Heavy

What do your daily work habits include? (ex: sitting, standing, light labor, heavy labor, computer work)

____

What vitamins do you currently take? ____________________

What kind of other nutritional supplements do you take (if any)? ____________________

Do you smoke? ❑ No ❑ Yes How much per day? ____________________

How much liquor do you consume on a weekly basis? ____________________

How much coffee or caffeinated beverages do you consume on a daily basis? ____________________

Certification and Assignment

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with ____________________
Name of Insurance Company(ies)

and assign directly to Dr. ____________________ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

____________________ Signature of Patient, Parent, Guardian or Personal Representative

____________________ Date

____________________ Please print name of Patient, Parent, Guardian or Personal Representative

____________________ Relationship to Patient

Advanced Spine & Joint Institute
10233 Okeechobee Blvd. Suite B-6
Royal Palm Beach, FL 33411

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR

I Hereby instruct and direct the____

Insurance Company to pay by check made out to The Advanced Spine & Joint Institute and mailed directly to:

Advanced Spine & Joint Institute
10233 Okeechobee Blvd. Suite B-6
Royal Palm Beach, FL 33411
Attn Dr. Dean Mammales

Telephone: (561) 721-0492 Fax: (561) 296-0378

If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct you to make out the check to ADVANCED SPINE AND JOINT INSTITUTE and bring it in to the office or mail it to:

Advanced Spine & Joint Institute
10233 Okeechobee Blvd. Suite B-6
Royal Palm Beach, FL 33411
Attn Dr. Dean Mammales

The professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, or attorney involved in this case

Dated at Advanced Spine & Joint Institute this_________________day of__________20_____

____
Patient Signature

_______________________________ _______________
Signature of Policyholder if different than above Witness

Receipt of Notice of Privacy Practices
Written Acknowledgement Form

__________________________ (Patient) has read a copy of Advanced Spine & Joint Institute notice of Privacy Practices.

____________________________ ________________

Signature of Patient or Parent or legal Guardian

Date

ADVANCED SPINE & JOINT INSTITUTE
10233 OKEECHOBEE BLVD.
SUITE B-6
ROYAL PALM BEACH, FL 33411
P.561-721-0492
F. 561-296-0378

THE
ADVANCED SPINE
&
JOINT INSTITUTE

NOTICE OF PRIVACY PRACTICES AS REQUIRED BY THE PRIVACY REGULATIONS CREATED AS A RESULT OF THE HEALTH INSURANCSE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPPA)

EFFECTIVE DATE OF THIS NOTICE: ______________

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentially of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may uses and disclose your PHI.
- Your privacy rights in your PHI.
- Our obligations concerning the use and disclosure of your PHI.

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all your records that our practice has created or maintained in the past, and for any records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE CONTACT:

The Advanced Spine & Joint Institute at 10233 Okeechobee Blvd. Suite B-6 Royal Palm Beach, Fl 33411 or (561) 721-0492.

The Advanced Spine & Joint Institute
10233 Okeechobee Blvd., Suite B-6
Royal Palm Beach, FL 33411

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: ______________________________

Date: ________________

Social Security #: ____-______-_____

I hereby authorize The Advanced Spine & Joint Institute to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for healthcare operations like quality reviews.

I have been informed that I may review The Advances Spine & Joint Institute Notice of Privacy Practices for a more complete description of uses and disclosures before signing this consent.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand The Advanced Spine & Joint Institute is not required to agree to the request. If The Advanced Spine & Joint Institute agrees to my requested restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

Signature: ______________________________
(Patient, Parent, or Legal Guardian)

Date: ____________

If signed by patient representative, state relationship to patient ______________________

Advanced Spine & Joint Institute

Patient Record of Disclosures

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

[ ] Home Telephone ____________________
- [ ] O.K. to leave message with detailed information
- [ ] Leave message with call-back number only

[ ] Work Telephone ____________________
- [ ] O.K. to leave message with detailed information
- [ ] Leave message with call-back number only

[ ] Written Communication
- [ ] O.K. to mail my home address
- [ ] O.K. to mail my work address
- [ ] O.K. to fax to this number ____________

[ ] Other ____________________
____

______________________________ Patient Signature

____________________ Date

______________________________ Print Name

____________________ Birthdate

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use of disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Health care entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.
Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

Record of Disclosures of Protected Health Information

Date	Disclosed to Whom Address or Fax #	(1)	Description / Purpose of Disclosure	By Whom Disclosed	(2)	(3)

(1) Check this box if the disclosure is authorized
(2) Type key: T= Treatment Records P= Payment Information O= Healthcare Operations
(3) Enter how disclosure was made: F= Fax; P= Phone; E= Email; O= Other

Receipt of Notice of Privacy Practices
Written Acknowledgement Form

Advanced Spine & Joint Institute

I, ______________________________ have read a copy of Advanced Spine & Joint Institute Notice
Patient Name
Of Patient Privacy Practices.

______________________________ Signature of Patient of

____________________ Date

Advanced Spine & Joint Institute
10233 Okeechobee Blvd. Suite B-6
Royal Palm Beach, FL 33411

Payment Policy

Thank you for choosing us as your health care provider. We are committed to providing you with the best of healthcare. The following are our payment polices. Please review and sign. We are happy to answer any questions.

1. **Insurance:** Please note that Dr. Mammales and Dr. Frye and The Advanced Spine and Joint Institute are "non participating" providers with your insurance company. If your insurance company does not accept assignment, they may write the reimbursement check payable to you and mail it to you and mail it you directly. Should this be the case, by signing below you agree that upon receipt you will endorse and forward the check(s) to us in a timely manner. If we do not receive the endorsed checks(s) we will assume that you have retained the insurance payment and you personally will be held responsible for the total balance of your care.

   If you are not insured, a payment in full is expected at each visit. If you are insured, but do not have an up-to-date insurance card, payment in full is required at each visit until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. **Proof of Insurance:** All patients must complete our patient information form before seeing the doctor. We will need a copy of your driver's license and current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of the claim.

3. **Co-payments and Deductible:** All co-payments and deductibles are your responsibility. This arrangement is part of your/our contract with your insurance company. If you have a co-payment or deductible, payment or payment schedules, will be discussed and determined prior to the inception of care.

4. **Claims Submission:** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that any balance unpaid by your insurance company is your responsibility. If your insurance changes, please notify us before your next visit so that we can make the appropriate changes to help your receive you maximum benefits. If your insurance company does not pay your claim within 45 days, the balance will automatically be billed to you. Your insurance benefit is a

contract between you and your insurance company; we are not a party to that contract.

5. **Non-covered Services:** Any "non-covered services" will be discussed with you prior to the inception of care. These "non-covered services" are your financial responsibility. Payment and / or payment schedules will be determined before care begins.

6. **Non-payment:** If your account is over 45 days past due, you will receive a letter stating that you have 15 days to pay your account in full. Partial payments will not be accepted unless otherwise discussed. Please be aware that if a balance remains unpaid, we may need to refer your accounts to an outside agency, and your care may be postponed until the balance is satisfied.

7. **Non- Sufficient Funds (NSF):** Please be aware that a $35.00 fee may be charged for returned checks due to non-sufficient funds.

8. **Missed Appointments:** We reserve the right to charge you for missed appointment and for canceled appointments if the cancellation is not made prior to the day of scheduled visit. These charges will be your responsibility and will be billed directly to you. Please help us to serve you better by keeping your scheduled appointment or by canceling prior to the day of the scheduled visit.

-Knee Injection: $100.00
-Other: $35.00

-NSSD: $35.00
-Physical Therapy- $35.00

Thank you for your understanding and anticipated cooperation.

Advanced Spine and Joint Institute.

I, ____________________________ attest that ____________________________

Is my primary insurance and ____________________________ is my secondary insurance.

Patient Signature: ____________________________

Date: ____________________________

ADVANCED SPINE
&
JOINT INSTITUTE

MISSION STATEMENT

OUR MISSION AT ADVANCED SPINE & JOINT INSTITUTE, IS TO PROVIDE EXCEPTIONAL PATIENT CARE AND TO EASE OUR PATIENTS SUFFERING.

WE WILL UTILIZE A CONSERVATIVE, MULTI-DICIPLINARY APPROACH, COMBINING MEDICAL EVALUATION, PHYSICAL THERAPY AND SPECIALIZED TREATMENT PROTOCOLS. THESE PROGRAMS WILL ENHANCE PATIENT OUTCOMES, PROVIDE EXCEPTIONAL BENEFITS TO YOUR LIFESTYLE AND PROMOTE BETTER HEALTH. IT IS OUR COMMITMENT TO PROVIDE YOU THESE SERVICES.

BY SIGNING THIS MISSION STATEMENT BELOW, YOU ARE COMMITTING YOURSELF TO RECEIVE THESE BENEFITS AND COMPLETE YOUR PROGRAM TO BETTER HEALTH.