UPTER CHIROPRACTIC
ACUPUNCTURE & AUTO INJURY CENTER

PATIENT INFORMATION

Date: _____

Last Name: _____

First Name: _____

Preferred Name: _____

Address: _____

City: _____

State: _____ Zip: _____

Date of Birth: _____

Gender: M F Marital Status: S M D W

Spouse's Name: _____

Referral Source: _____

INSURANCE

Responsible Party: _____

Relationship to patient? _____

Insurance Company: _____

Assignment and Release
I certify that I have insurance coverage with the above-named insurance company and assign any and all insurance payments directly to:

FL Auto Injury & Pain Center PL
Dr. Terry Quan, D.C.

The above-named doctor may disclose my health care information to my insurance company for the purpose of obtaining payment for services and treatment. Further, I understand that I am financially responsible for all charges whether or not paid by insurance.

_____
Patient/Guardian Signature Date

CONTACT INFORMATION

Home Phone: _____

Cell Phone: _____

Cell Phone Provider: _____

Email: _____

Emergency Contact
Name: _____

Relationship: _____

Phone: _____

ACCIDENT INFORMATION

Is this condition due to an auto accident?
☐ Yes ☐ No

Is this condition due to a work accident?
☐ Yes ☐ No

Date of accident: _____

To whom did you make a claim of the accident?
☐ Auto Insurance ☐ Worker's Comp

Attorney's Name (if applicable):
_____

PATIENT CONDITION

Reason for your visit: _____

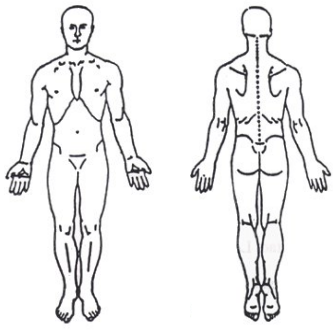
When did your symptoms appear? _____

Rate severity of pain from 1 (least pain) to 10 (severe pain): _____

How often is pain present? _____

Mark an X on the figures where you have pain, numbness, or tingling.

Activities with which the pain interferes: _____



HEALTH HISTORY

What treatments have you already had for your condition?
☐ Medications ☐ Surgery ☐ Chiropractic ☐ Physical Therapy ☐ None ☐ Other: _____

Date of last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____
Spinal Exam _____ Chest X-Ray _____ Urine Test _____
MRI _____ CT-scan _____ Bone Scan _____

Indicate if you have had any of the following:

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

Exercise	**Work Activity**	**Habits**	
☐ None	☐ Sitting	☐ Smoking	Packs/Day _____
☐ Moderate	☐ Standing	☐ Alcohol	Drinks/Week_____
☐ Daily	☐ Light Labor	☐ Caffeine Drinks	Cups/Day _____
☐ Heavy	☐ Heavy Labor	☐ High Stress Level	Reason _____

For women: Are you Pregnant? ☐ Yes ☐ No Due Date: _____

Injuries/Surgeries you have had: Description
Falls _____
Head Injuries _____
Broken Bones _____
Disclocations _____
Surgeries _____

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

OFFICE FINANCIAL POLICY

Our policy is to extend to you the courtesy of allowing you to assign your insurance benefits directly to us. This policy reduces your out-of-pocket expense and allows you to place yourself and your family under care.

1. **If you do not have insurance**: All payments are expected at the time of service or by an authorized payment plan. Your personal balance may not exceed $200 or care may be terminated. Our payment plans make care an affordable part of your budget.

2. **If you have insurance**: All deductibles, co-payments, co-insurances, or other payments are expected at the time of service or by an authorized payment plan. You are considered a cash patient until you bring in completed insurance forms and we qualify and accept your insurance coverage.

If your insurance company has not paid a claim within 60 days of submission, you agree to take an active part in the recovery of your claim. If your insurance company has not paid a claim within 90 days of submission, you accept responsibility for payments in full for any outstanding balance.

If you discontinue care for any reason other than discharge by the doctor, all balances will become immediately due and payable in full by you.

_____

Patient/Guardian Signature Date

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided the opportunity to read the Notice of Privacy Practices and that I understand this Notice. I am aware that I have the right to request a copy of this Notice at any time and that this signed form will be placed in my patient chart and maintained for six years.

_____

Patient/Guardian Signature Date

List below the names of people to whom you authorize to access your private health information:

_____

Name Relationship

_____

Name Relationship

_____

Name Relationship

UPTER CHIROPRACTIC
ACUPUNCTURE & AUTO INJURY CENTER

CHIROPRACTIC INFORMED CONSENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures on me (or on the patient for whom I am legally responsible) by the doctor of chiropractic named below and/or other support staff who now or in the future treat me while working with the chiropractor named below, whether signatories to this form or not.

I have had the opportunity to discuss with the chiropractor and/or with other clinic personnel the nature and purpose of chiropractic adjustments and procedures. I understand that results are not guaranteed.

I understand that, like all health modalities, results are not guaranteed, and there is no promise of cure. I further understand that, as in the practice of medicine, the practice of chiropractic includes possible risks including fractures, disc injuries, strokes, dislocations, or sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment to perform procedures which the doctor feels are in my best interests (based upon the facts then known).

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include: over-the-counter analgesics and rest; prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand that I have the right to a second opinion if I have concerns about the nature of my symptoms and treatment options.

I have read the above consent and have had the opportunity to ask questions about its content, and by signing below I agree to chiropractic procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Dr. Terry Quan, DC

_____

Patient/Guardian Signature Date

ACUPUNCTURE INFORMED CONSENT

I hereby request and consent to the performance of acupuncture and other procedures within the scope of acupuncture on me (or on the patient for whom I am legally responsible) by the acupuncturist named below and/or other licensed acupuncturists who now or in the future treat me while working with the acupuncturist named below, whether signatories to this form or not.

I understand that methods of treatment may include acupuncture, electrical stimulation, Chinese massage, Chinese herbal medicine, and nutritional counseling. I will immediately notify a member of the clinical staff if any unanticipated or unpleasant effects associated with treatment occur. I understand that results are not guaranteed.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects. Possible side effects include bruising, numbness or tingling near the needling sites, dizziness or fainting, and burns from the use of heat lamps. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage, and organ puncture. Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements that have been recommended are traditionally considered safe, although some may be toxic in large doses. Some possible side effects of taking herbs are nausea, gas, vomiting, headache, diarrhea, and rashes. I understand that some herbs may be inappropriate during pregnancy and I will notify a clinical staff member if I am or become pregnant. I do not expect the clinical staff to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment to perform treatment that is in my best interest (based on facts known at the time).

I have read the above consent, have been made aware of the risks and benefits of acupuncture, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Dr. Terry Quan, DC

_____

Patient/Guardian Signature Date