Tidal Chiropractic: New Patient Information
4215 Burns Road #250, Palm Beach Gardens, FL 33410

First Name: _____ Last Name: _____

Address: _____ City: _____

State: _____ Zip: _____ Date of Birth: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Emergency Contact: _____ Phone Number: _____

Gender: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widow

Work Status: ☐ Employed ☐ Retired ☐ P/T Student ☐ F/T Student ☐ Unemployed

Employer: _____

Name of Insurance: _____ Insured Name: _____

Insured's ID#: _____ Insured's Date of Birth: _____

Secondary Insurance Carrier: _____ ID#: _____

How did you hear about us/who may we thank for referring you?

_____

Primary Care Doctor: _____ City: _____

Chief Complaint/Reason for Your Visit

Please describe the problem:

_____

_____

_____

When did symptoms begin? _____

On a scale from 1-10, please rate your pain: (none) - 0 1 2 3 4 5 6 7 8 9 10 - (most severe)

Are your symptoms:

☐ Improving ☐ Staying the same ☐ Getting worse ☐ Intermittent (comes and goes)

Please select any activities which aggravate symptoms:

☐ Sitting ☐ Standing ☐ Sleeping ☐ Bending ☐ Lifting ☐ Twisting ☐ Coughing ☐ Exercise

Have you had these symptoms before? ☐ Yes ☐ No If so, when: _____

Have you seen another doctor for this condition? ☐ Yes ☐ No If so, when: _____

Have you received imaging for this condition (x-ray/MRI)? ☐ Yes ☐ No

Date of imaging: _____ Diagnosis: _____

Medical History

Please list any surgeries or hospitalizations: _____

_____

Allergies: _____

Medications: _____

Do you participate in sports, athletics, exercise, etc.? If yes, please describe:

_____

Please check all conditions you currently have or had in the past:

	Diabetes
	High Blood Pressure
	Heart Disease
	Pacemaker
	Headaches/Migraines
	Kidney Problems
	Cancer
	Bowel/Bladder Problems
	Hernia
	Seizures
	Dizziness/Vertigo/Fainting
	Arthritis
	COPD/Lung Problems
	Bone Fracture
	Disc Herniation
	Metal Implants

Patient Signature: _____ Date:_____

Guardian Signature: _____ Date: _____

Tidal Chiropractic

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as “informed consent” and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures, if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including, but not limited to, hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. This occurs in 3-4 of every 100,000 people, whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit. *I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.*

Patient Name: _____Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date: _____

Version: 2019-12-13

Tidal Chiropractic

NOTICE OF PRIVACY PRACTICES

PATIENT ACKNOWLEDGEMENT

I have received this practice's notice of Privacy Practices written in plain language. This notice provides in detail, the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. This notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of this notice currently in effect.
- Types if uses and disclosures that this practice is permitted to make for each of the following purposes: Treatment, payment and healthcare operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will only be made only with my written authorization that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
    - The right to complain to this practice and to the secretary of Health and Human Services if I believe my privacy rights have been violated and that no retaliatory actions will be used against me in the event of such a complaint.
    - The right to request restrictions on certain uses and disclosures on protected health information and that this practice is not required to agree to a requested restriction.
    - The right to inspect and copy protected health information.
    - The right to amend protected health information.
    - The right to receive an accounting of disclosures of protected health information.
    - The right to obtain a paper copy of Privacy Practices from this practice upon request.

This practice reserved the right to change the terms of its notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current notice of Privacy Practices upon request.

PRINT: _____

SIGN: _____

DATE: _____

Tidal Chiropractic

Please Sign and Date Consent Below

By signing below, you understand and consent to the following agreements:

Consent to Medical Care

I authorize Wasserman Chiropractic and its associates to preform medical treatment as specified by Wasserman Chiropractic and its associates. I understand that all medical treatment has some form of inherent risk, and as such, agree to hold harmless Wasserman Chiropractic and its associates for liability related to the administration to medical treatment.

Authorization for Release of Medical Records and X-Rays

I grant specific authorization and consent per FL statute to Wasserman Chiropractic and its associates to obtain and release my medical records, from or to any source, for any applicable reason, for a period of one year from this date. Additionally, I understand that the medical records may include, but is not limited to, sensitive information (per federal regulations) about myself.

Admission of Financial Responsibility

I agree to pay my insurance, Medicare and third-party copays (if applicable) to Wasserman Chiropractic immediately then, pay additional moneys owed (after my insurance, Medicare and third party has paid my claim) to Wasserman Chiropractic. I acknowledge that I am responsible for any non-covered therapies that my insurance may not cover.

Assignment of Benefits

I assign all insurance, Medicare (if applicable) and third-party benefits due to me for treatment by Wasserman Chiropractic and authorize payment to Wasserman Chiropractic.

Pre-Provision of Services Waiver

I acknowledge that there is no "pre-provision of services agreement," per FL insurance regulations, between myself and Wasserman Chiropractic and that I will be asked for payment in full of all copays, deductibles, coinsurance or balances due at each office visit.

Certification of Completion

I certify that all the information contained on this form constitutes complete knowledge of any issue that may affect my treatment.

Date: _____

Patient Name (Printed): _____

Patient Signature: _____

Parent of Guardian Name & Signature: _____

Tidal Chiropractic

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Wasserman Chiropractic to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

Wasserman Chiropractic Chiropractic'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. Wasserman Chiropractic 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 Wasserman Chiropractic.

With this consent, Wasserman Chiropractic may call my home or any other alternative location and leave a message on my 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, laboratory results among others.

With this consent, Wasserman Chiropractic may mail to my home or any 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, Wasserman Chiropractic may e-mail to my home or any 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 Wasserman Chiropractic 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 Wasserman Chiropractic'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, Wasserman Chiropractic may decline treatment to me.

PRINT: _____

SIGN: _____

DATE: _____