Rubin Chiropractic
Health Center

Patient Information

Last Name: _____ **First Name:** _____

Emergency Contact Name: _____ **Emergency Contact Number:** _____

How did you hear about us? _____

Medical Insurance Information

Person Responsible for Payment: _____ **Relationship to Subscriber:** _____

Insurance Company: _____ **Policy/ID#:** _____

Subscriber Name: _____ **Subscriber Date of Birth:** _____

Major Symptoms: _____

Symptoms of Condition

When were you first aware of this problem? _____

How did this condition develop? _____

Have you missed work due to this problem? Yes / No **If yes, how long?** _____

Have you had this or a similar problem before **Yes / No**

Are you currently pregnant? **Yes / No** **If yes, when is your due date?** _____

Medical History Information

Last Name: First Name:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Widow
Email:		**Birth date**:	**Age:**	Sex:
Address:	City:		State:	
ZIP Code:	**Phone:**	**Circle one:**	Home	Mobile
Occupation:	Employer:		Employer phone:	

Medical Care Information

Do You Have a Family Doctor?: ☐ No ☐ Yes, Name of Doctor:			
Address:	City:	State:	ZIP Code:
Date of last Visit: / /	Date of last exam: / /		
Do You Have a Family Chiropractor?: ☐ No ☐ Yes, Name of Chiropractor:			
Address:	City:	State:	ZIP Code:
Date of last Visit: / /	Date of last exam: / /		
Have you had surgeries in the last 5 Years: ☐ Yes ☐ No	If yes, Last Surgery Date:		
Reason for Surgery:			

Present illness /Conditions:

☐ AIDS	☐ Cancer	☐ Heart Problem	☐ Multiple Sclerosis	☐ Spinal Disc Disease	
☐ Allergies	☐ Cirrhosis/hepatitis	☐ High blood pressure	☐ Pacemaker	☐ Thyroid trouble	☐ Epilepsy
☐ Anemia	☐ Diabetes	☐ HIV/ARC	☐ Prostate trouble	☐ Tuberculosis	☐
☐ Arthritis	☐ Dislocated joints	☐ Kidney trouble	☐ Rheumatic fever	☐ Ulcer	☐
☐ Asthma	☐ Diverticulitis	☐ Low Blood Pressure	☐ Scoliosis	☐ Polio	☐
☐ Bone fracture	☐ Hay Fever	☐ Mental/ Emotional Difficulty	☐ Sinus trouble	☐ STD'S	☐

Are you pregnant or breastfeeding?
☐ **Yes** ☐ **No**

Family History of illness:

☐ AIDS	☐ Cancer	☐ Multiple Sclerosis	☐ Spinal Disc Disease	☐ STD'S	
☐ Allergies	☐ Bone fracture	☐ Heart Problem	☐ Low Blood Pressure	☐ Sinus trouble	☐ Ulcer
☐ Anemia	☐ Cirrhosis/hepatitis	☐ HIV/ARC	☐ Mental/ Emotional Difficulty	☐ Epilepsy	☐ Polio
☐ Arthritis	☐ Diabetes	☐ High blood pressure	☐ Prostate trouble	☐ Thyroid trouble	☐ Scoliosis
☐ Asthma	☐ Dislocated joints	☐ Kidney trouble	☐ Rheumatic fever	☐ Tuberculosis	☐ Diverticulitus

Other:

Type of Cancer: ☐ Breast ☐ Lung ☐ Other:

Social History:

Alcohol? ☐ No ☐ Yes Drinks per week?	Cigarettes? ☐ No ☐ Yes Packs per day?	Caffeine? ☐ No ☐ Yes Drinks per day?	Exercise? ☐ No ☐ Yes Hours per week? (circle one) Light / Moderate / Strenuous

Misc.:

Signature: _____ Date: _____

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Smoking:			
❑ Current everyday smoker	❑ Current some day smoker	❑ Former smoker	❑ Never

Medication Allergies:					
❑ ACE Inhibitors	❑ Cephalosporin's	❑ HMG-COA Reductase Inhibitors	❑ Macrolides	❑ Paxil	❑ Sertraline Derivatives
❑ Amoxicillin	❑ Cipro	❑ Ibuprofen	❑ Meperidine	❑ Penicillin	❑ Sulfa
❑ Aspirin	❑ Codeine	❑ Iodine	❑ Metronidazole	❑ Percocet	❑ Tetracycline
❑ Bactrim	❑ Darvon	❑ Keflex	❑ Morphine	❑ Pravachol	❑ Ultram
❑ Benadryl	❑ Demerol	❑ Levaquin	❑ NSAIDS	❑ Propoxyphene	❑ Zestril
❑ Biaxin	❑ Erythromycin	❑ Lipitor	❑ Opioid Analgesics	❑ Quinolones	❑ Zocor
❑ Cefaclor	❑ Flagyl	❑ Lisinopril	❑ Paroxetine Derivatives	❑ Salicylates	❑ Zoloft
Other: What are the reactions you face? (i.e – hives, rash, etc)					

Medications:

Medication Name	Dose	Form	Route	Frequency	Date Started
E.G. Zyrtec	10mg	Tablet	By mouth	Once per day	10/24/2008

Race:	❑ White	❑ Am Indian or AK Native	❑ African American	❑ Native Hawaiian or other Pacific Islander	❑ Decline		
Ethnicity:	❑ Non-Hispanic or Latino	❑ Hispanic or Latino	❑ Decline				
Language Preferred:	❑ English	❑ Spanish	❑ French	❑ Italian	❑ Portuguese	❑ Chinese	❑ Other _____
Preferred Contact:	❑ Phone	❑ Email	❑ Text	❑ USPS	❑ Other		

Signature: _____ Date: _____

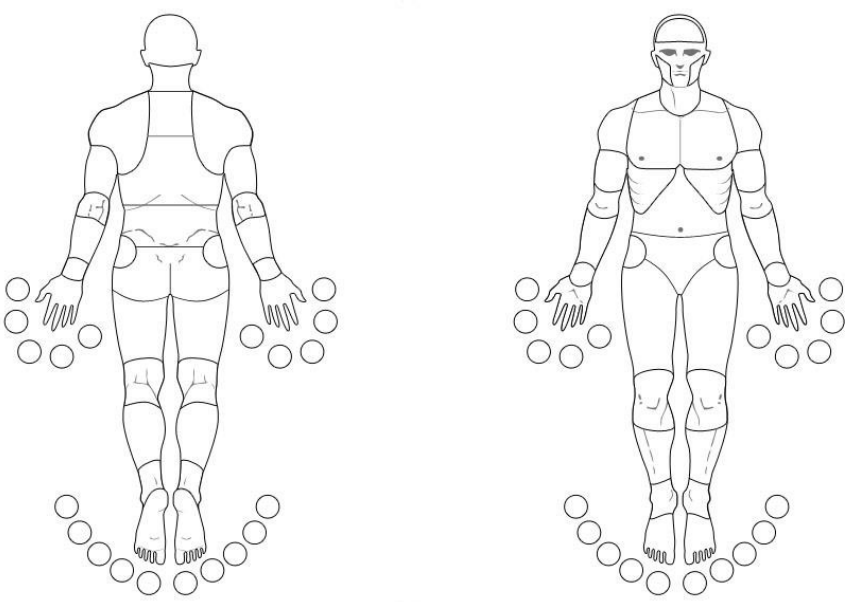
All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

CURRENT COMPLAINTS

Patient's Name: _____ Date: _____

Please indicate the current complaints you are experiencing by marking the areas on the image below and providing details using the sections that follow.

1. Headaches
2. Neck
3. Upper back
4. Mid Back
5. Lower Back
6. Hip
7. Buttock
8. Shoulder
9. Arm
10. Elbow
11. Forearm
12. Wrist
13. Hand
14. Fingers
15. Leg
16. Knee
17. Calf
18. Shin
19. Ankle
20. Foot
21. Toes
22. Chest
23. Ribs
24. Abdomen
25. Pelvis/Groin



Area of Complaint		
Location		☐ Left ☐ Right ☐ Both ☐ Center
Pain Ratings		☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (Excruciating)
Frequency		☐ Infrequent < 25% ☐ Occasional 25% to 50% ☐ Frequent 50% to 75% ☐ Constant > 75%
Pain Type		☐ No Pain ☐ Pain ☐ Numbness ☐ Tingling ☐ Muscle Spasms ☐ Burning
Severity		☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe
What makes it better?		☐ Medication ☐ Lying Down ☐ Standing ☐ Sitting ☐ Stretching ☐ Range of Motion ☐ Nothing
What makes it worse? ☐ ☐		☐ Movements ☐ Bending ☐ Twisting ☐ Weight Bearing ☐ Movements ☐ Neck flexion ☐ Sneezing ☐ Sitting ☐ Standing ☐ Walking ☐ Chewing ☐ Yawning ☐ Opening mouth ☐ Closing mouth ☐ Range of motion ☐ pushing/pulling ☐ Lifting ☐ Watching T.V. ☐ Reading ☐ Working ☐ Driving ☐ Housework ☐ Bright lights ☐ Loud Noises
Does the pain radiate to any other locations?	Upper Body	☐ Head ☐ Forehead ☐ Back of head ☐ Right side of head ☐ Left side of head ☐ Neck ☐ Right Ear ☐ Left Ear ☐ Right Eye ☐ Left Eye ☐ Face ☐ Right Jaw ☐ Left Jaw ☐ Right Upper back ☐ Left Upper back ☐ Right Shoulder ☐ Left Shoulder ☐ Right Chest ☐ Left Chest ☐ Right Ribs ☐ Left Ribs
	Mid Body	☐ Right Mid back ☐ Left Mid back ☐ Right Lower back ☐ Left Lower back ☐ Right Hip ☐ Left Hip ☐ Right Buttock ☐ Left Buttock ☐ Groin ☐ Right Arm ☐ Left Arm ☐ Right forearm ☐ Left forearm ☐ Right hand ☐ Left hand ☐ Right fingers ☐ Left fingers
	Lower Body	☐ Right Thigh ☐ Left Thigh ☐ Right Knee ☐ Left Knee ☐ Right Calf ☐ Left Calf ☐ Right Toes ☐ Left Toes ☐ Right Foot ☐ Left Foot ☐ Right Toes ☐ Left Toes
Described as		☐ Aching ☐ Dull ☐ Sharp ☐ Stabbing ☐ Throbbing
At it's worst		☐ Morning ☐ Afternoon ☐ Evening ☐ Night After Activities: ☐ Light ☐ Moderate
Associated with ☐		☐ Dizziness ☐ Nausea ☐ Visual Problems ☐ Ringing/Buzzing ears ☐ Bright light ☐ Sensitivity ☐ Loss of balance
Comments		

Helping Bodies Perform Better!

Rubin Chiropractic
Health Center

DISCLOSURE OF NON COVERED CHARGES:

THIS SHALL SERVE AS WRITTEN NOTIFICATION: SHOULD YOUR INSURANCE COMPANY NOT COVER CERTAIN SERVICES SUCH AS:

** **THE FIRST INITIAL EXAM** - **CPT CODE 99202**

** **THERAPEUTIC ACTIVITY** - **CPT CODE 97530**

** **ACUPUNCTURE** - **CPT CODE 97810**

YOU ARE RESPONSIBLE FOR THESE SERVICES. PAYMENT IS REQUIRED UP FRONT. WE WILL BE HAPPY TO BILL IT TO YOUR INSURANCE COMPANY FOR YOU. YOU WILL RECEIVE AN EXPLANATION FROM YOUR INSURANCE COMPANY AS TO WHETHER THEY PAID THE SERVICE. IF THEY SHOULD PAY IT WE WILL BE HAPPY TO REIMBURSE YOU FOR THIS. IF PAYMENT IS NOT COLLECTED UP FRONT AND IT IS DENIED THEN YOU WILL BE BALANCED BILLED FOR THE SERVICE.

_____ _____/_____/_____

PATIENT'S SIGNATURE DATE SIGNED

Helping Bodies Perform Better!

Rubin Chiropractic
Health Center

Massage Appointment Cancellation and No Show Policy

NOTICE TO ALL MASSAGE PATIENTS/CLIENTS

AS OF AUGUST 1, 2018

ALL NO SHOW'S FOR MASSAGES WILL BE CHARGED A $45.00 NO SHOW FEE UNLESS A PHONE CALL IS MADE TO THE OFFICE NO LESS THAN (1) ONE HOUR PRIOR TO THE MASSAGE.

PATIENTS WILL BE RESPONSIBLE TO PAY THIS FEE ON THEIR NEXT SCHEDULED VISIT.

_____ _____

Printed Name **Signature**

Today's Date: ____/____/____

Helping Bodies Perform Better!

Rubin Chiropractic Health Center

Non-Covered Charges

As of 03/22/2024

Additional Modality Pricing and Patient Responsibility

Active Release Technique, Myofascial Release Technique, Graston Technique, Shockwave Therapy, Cold Laser, Corrective Exercise Rehab, Decompression, Acupuncture, Massage Therapy, Therapeutic Activity and Alter- G Treadmill are all considered a non-covered charge with insurance and are done on a cash pay basis ONLY. The charge for these services varies on your office visit. ***Please be advised*** that if your treating doctor feels one of these services could benefit your treatment and the modality is performed there will be an ***additional charge*** on top of your patient responsibility with your insurance or self-pay rate.

Active Release / Myofascial Release Technique- **$45.00** additional - **$80** by itself
Graston Technique / FAKTR - **$45.00** additional - **$80** by itself
Shockwave Therapy - **$65.00** additional - **$100.00** individual
Aspen Laser **$75.00**- additional
Corrective Exercise Rehab- **$59.00** additional
Neubie- **$125.00**
Spinal Decompression **$100.00** - additional **$150.00** individual
Dry Needling\Acupuncture **$65.00**- additional **$125.00** individual
Massage Therapy- **pricing varies**
Alter- G Treadmill- **$1.00** per minute of use
Therapeutic Activity (Medicare)- **$25.00**

I understand that if these services are performed during my office visit there will be a charge

Print Name: _____ Date: _____

Patient or Guardian Signature: _____

Rubin Chiropractic Health Center

Informed Consent/ Assignment of Benefits/ Financial Agreement

Patient Name:_____

Authorization for Treatment

I hereby authorize the staff of Rubin Health Center, P.A. to render chiropractic and/or massage services as deemed necessary. I also certify that no guarantee or assurance has been made as to the results that may be obtained. I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also certify that all insurance information given to Rubin Health Center, P.A. is correct and complete; I understand that every attempt will be made by this office to verify my insurance benefits. I understand that it is my responsibility to be aware of what services are covered and what my insurance benefits are for the
services rendered. _____(initial)

Provider/Supplier Notice to Beneficiary and Agreement to Pay

Medicare will only pay for services that it determines to be "reasonable and necessary" under the section 1862 (a) (1) of the Federal Medicare statutes. If Medicare determines that a particular service, although it would otherwise be covered, is "not reasonable and necessary" under the Medicare program standards, then Medicare would deny payment for that service. It is our understanding that Medicare only covers chiropractic manipulation
and will deny payment for any Therapy service(s). If Medicare denies payment, I agree to be personally and fully responsible for payment. _____ **(initial)**

Financial Agreement

I understand that I am financially responsible for services rendered by Rubin Health Center, P.A. Payment is to be made by insurance assignment, by myself and/or authorized guarantor. I understand and agree, regardless of my insurance, I am ultimately and fully responsible for my account for any professional services rendered. I also agree to pay all collection, attorney and court fees that may be incurred for the collection of delinquent accounts. _____**(initial)**

Attorney Representation and Protection of Balance

I, the undersigned patient, am directing my Attorney _____to pay any outstanding bills out of my settlement, and in effect, protecting any such balance. I fully understand that I am directly responsible for all medical bills and this agreement is made solely for Rubin Health Center P.A's additional protection and consideration of awaiting payment. And, I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, Rubin Health Center, P.A. will not await payment, but will require me to make payment on a current basis. _____**(initial)**

Consent for Treatment of Minor

I hereby authorize Rubin Health Center, P.A. to administer chiropractic care as necessary to my child _____(name). I further attest that I am the parent/legal guardian of said child and legally eligible to approve such authorization. _____**(initial)**

_____ _____

Patient/Legal Guardian Signature **Date**

Rubin Chiropractic Health Center

HIPAA PRIVACY & RELEASE OF MEDICAL RECORDS AUTHORIZATION

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 {P.L. 104-191), 42 U.S.C. Section 1320d, et.seq., and regulations promulgated thereunder, as amended from time to time (collectively) referred to as "HIPAA".

This authorization affects your rights in the privacy of your personal healthcare information. Please read it carefully before signing.

Rubin Health Center, P.A. will not condition treatment, payment, enrollment in a health plan or eligibility for benefits, as applicable, on your providing authorization for the requested use or disclosure. *YOU MAY REFUSE TO SIGN THIS AUTHORIZATION.*

By signing this authorization you acknowledge and agree that Rubin Health Center, P.A. may use, disclose or obtain protected health information for the purpose(s) of treatment, payment or health care operations.

By signing this authorization you agree that Rubin Health Center, P.A. may disclose your personal health care information to other medical professionals relating to your treatment, payment or health care operations.

Further, by signing this authorization you acknowledge that you have been provided a copy of and have read and understand Rubin Health Center's HIPAA Privacy Notice containing a complete description of your rights, and the permitted uses and disclosures, under HIPAA. While Rubin Health Center, P.A. has reserved the right to change the terms of its Privacy Notice, copies of the Privacy Notice as amended are available from Rubin Health Center, P.A's office or by sending a written request with return address to 1700 Dr. MLK Jr. St. N. St. Petersburg, FL 33704.

In accordance with your rights under, and subject to certain restrictions imposed by HIPAA, you may inspect or copy your Personal Health Information {PHI) in the designated record set maintained by Rubin Health Center, P.A. for as long as the Personal Health Information {PHI) is maintained in the designated record set.

You have the right to revoke this authorization, in writing, at any time, except to the extent that Rubin Health Center, P.A. has taken action in reliance on it. A revocation is effective upon receipt by Rubin Health Center, P.A. of a written request to revoke this authorization at the address listed above.

This authorization shall expire upon the earlier occurrence of: (a) revocation of the authorization, (b) a finding by the Secretary of the U.S. Department of Health and Human Services, Offices of Civil Rights that this authorization in not in compliance with requirements of HIPAA, (c) complete satisfaction of the purpose for which this authorization was originally obtained, to be determined in the reasonable discretion of Rubin Health Center, P.A. or (d) six years from the date this authorization was executed.

By signing this authorization you acknowledge and agree that any information used, disclosed or obtained pursuant to this authorization could be at risk for re-disclosure by the recipient and no longer protected under HIPAA. Rubin Health Center, P.A. will provide you with a copy of this signed authorization if requested.

By signing this authorization you further agree and acknowledge that Rubin Health Center, P.A. will obtain your medical records as they pertain to your treatment with Rubin Health Center. The records will be obtained for continuity of care purposes only and may include reports, notes, dictation, x-rays, MRIs, lab work

_____ _____

Patient Name **Patient or Parent/Guardian Signature**

____/____/____ ____/____/____

Date of Birth **Today's Date**

Records to be disclosed:

_____

_____

Rubin Chiropractic Health Center

Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: The doctor will use his/her 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. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used.

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, bums or minor complications.

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:

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

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.

Unusual risks: I have had the following unusual risks of my case explained to me.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.

Printed Name	Signature	Date

WITNESS:

Printed Name	Signature	Date