LaRocca CHIROPRACTIC

Patient Information	**Medical Information**
Patient: ___________________________	Primary Care Physician: ___________________________
Email Address: ____________________	PCP phone # ____________________
Address: ___________________________	**Are you presently taking an medications (Over the counter or Prescription) or vitamins?**
Sex: M or F	**1.**___________________________
Age: ______	**2.**___________________________
Birthdate:______________	**3.**___________________________
Social Security #: __________________	**4.**___________________________
Occupation: _______________________	**What treatment have you already received for this condition you are coming in for today? (Circle)**
Employer: _________________________	Medication Surgery PT None
Phone Numbers	Chiropractic Injections
Home : ___________________________	**If currently being treated, by whom and when for this condition?**
Cell: ____________________________	___________________________
Work: ___________________________	___________________________
Emergency Contact	**Trauma or Accidents Information:**
Name: ___________________________	Is condition due to accident? Y/N
Relationship: _____________________	Date_______
Contact Phone Number__________________	__Auto __Work __ Home __ Other
Pregnancy Disclaimer:	
Women: Is there any chance you are pregnant?	
Yes ______ **Due date:** ___________	
No_________	

Please Be Sure to Give the Receptionist a copy of your Insurance Cards and Drivers License

Christopher LaRocca, DC

5465 Commercial Way Spring Hill, FL 34606 / 43 W. Fort Dade Ave Brooksville, FL

Phone: 352-835-7985 Fax: 352-835-7987 / Phone: 352-593-5937 Fax: 352-593-5939

Website: www.laroccachiro.com

Patient Name: ___________________________ Date: ________________

General Information about Condition

What is the main reason for coming in? ____

When did the symptoms appear? ____

How did you injure the area? ____

Headaches: How many times per day/ week? Location? ______________________________

Neck: Type of Pain: __ Sharp __ Dull__ Stabbing __Aching ___Radiating __ burning

__ Throbbing __ Numbness __ Tingle __ Weakness

Pain Radiates Into: Shoulder / Arm / Hand ___ Right ___Left __ both

Severity of Pain: ___ Mild ___ Moderate ___ Severe

Mid back: Type of Pain: __ Sharp __ Dull__ Stabbing __Aching ___Radiating __ burning

__ Throbbing __ Numbness __ Tingle __ Weakness

Severity of Pain: ___ Mild ___ Moderate ___ Severe

Low Back: Type of Pain: __ Sharp __ Dull__ Stabbing __Aching ___Radiating __ burning

__ Throbbing __ Numbness __ Tingle __ Weakness

Pain Radiates Into: Hip / Leg / Feet ___ Right ___Left __ both

Severity of Pain: ___ Mild ___ Moderate ___ Severe

Other area: _______________ Type of Pain: __ Sharp __ Dull__ Stabbing __Aching
___Radiating __ burning __ throbbing __ Numbness __ Tingle __ Weakness

Severity of Pain: ___ Mild ___ Moderate ___ Severe

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Medical History:

Have you missed work or school due to injury? Y / N

Do you smoke? Y / N If yes, number of packs _______________

Do you drink? Y / N If yes, number of drinks _______________

Have you been to this office before? Y / N

If yes list dates and reasons:

1. ____ __/__/__
2. ____ __/__/__
3. ____ __/__/__

Past Surgeries or Hospitalizations:

4. ____ __/__/__
5. ____ __/__/__
6. ____ __/__/__

Allergies: Y / N

____

Please mark any conditions that you currently have or conditions that you have had in the past: Please check "P" for past and "C" for current!!!

P / C	P / C	P / C
__/__ AIDS/HIV	__/__ Hepatitis__	__/__ Rheumatoid Arthritis
__/__ Prostate Problems	__/__ Heart Burn	__/__ Osteoarthritis
__/__ Asthma	__/__ Herniated disc	__/__ Pneumonia
__/__ Osteoporosis	__/__ Multiple Sclerosis	__/__ Hernia
__/__ High Cholesterol	__/__ Heart Attack	__/__ Cancer Type_______

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Medical Release Information

I, ______________________________________, Authorize LaRocca Chiropractic LLC to receive copies of all my medical records / and or x-ray films and reports for the purpose of Dr. Christopher LaRocca to view as part of my treatment.

This authorization is given pursuant Florida Statute 456.057 and HIPPA regulations. I understand that Florida Statute 4566.057(10) makes clear that third party to whom records are disclosed and prohibited from further disclosing any information in the medical record request without the expressed written consent of the patient or patient's legal representatives.

Patient Signature: ______________________________________

Patients Date of Birth: ______________________________________

Today's Date: ______________________________________

Acknowledgement of Receipt of Notice of Privacy Practices

I, ________________________________ acknowledge that I was provided with copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be in my patient file for 6 years.

Patient / Guardian Signature: ________________________ Date: ______________

LaRocca Chiropractic may leave messages on my answering machine or cell phone: Y / N

Patient / Guardian Signature: ________________________ Date: ______________

In addition to the allowable disclosures described in the "Notice of Privacy Practices", I specifically authorize disclosure of my protected health information to the following:

Please print name and what is your relationship to said person:

1. ____
2. ____
3. ____

For treatment period between ________ and __________ **"If left blank we may release all dates"**

Patient / Guardian Signature: ________________________ Date: ______________

Office Staff Witness Signature: ________________________ Date: ______________

Dr. Christopher LaRocca, DC

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Our Financial Policy:

Thank you for choosing LaRocca Chiropractic LLC as your healthcare provider. Our staff and I are committed to providing the best quality of care possible. The staff will work promptly to make sure your paperwork is filed accurately in a timely manner.**I understand that the Health and Accident insurance policies are an arrangement between the insurance company and me the policy holder. I understand that the services provided by LaRocca Chiropractic LLC is in no way a promise of payment by my insurance company. If my insurance company denies my claim(s) for any reason or misquotes my benefits to LaRocca Chiropractic LLC, the balance of the account will be billed to me and due to LaRocca Chiropractic LLC.** Direct payments made from the insurance companies to the Doctor's office will be credited to my account upon receipt and any balances due will be my responsibilities. All services rendered by LaRocca Chiropractic LLC to me are my personal responsibility and I agree to make payment for services to the Doctor's office. **I understand that if I suspend or terminate my care and treatment any and all fees for services rendered will be immediately due and payable.** Should third party collection become necessary, I agree to pay all fees involved in the collections process. I have read and fully understand the financial policy as written. I authorize the doctor at LaRocca Chiropractic LLC to examine and treat my condition as deemed appropriate through the use of Chiropractic Health Care. I give permission for these procedures to be performed.

I am the responsible party and or legal guardian for payment and treatment received on this account. The doctor provides only Chiropractic Care and is not responsible for any pre-existing medically diagnosed conditions or for making any medical diagnosis.

Print Patietnts Name: ____ **Date:** ________

Patient's /Guardians Signature: ______________________________________ **Date:** _________

Witness Signature: ____ **Date:** _________

Authorization and Assignment:

By LaRocca Chiropractic LLC providing care to me, I agree to the following:

1. Authorization to release any medical information deemed appropriate concerning my condition to any insurance company, attorney or adjustor in order to process any claim for reimbursement for charges incurred.
2. I authorize the direct payment to LaRocca Chiropractic LLC for the monetary summed owed by my attorney out of any settlements of my case.
3. In the event an insurance company is obligated by contractual agreement to make payment to me, or to you for the charges made for service rendered and refuses to make payment upon demand by you, I hereby assign and transfer to you the cause of action that exist in my favor against any such company and authorize you to prosecute said action earlier in my name as you see fit and further authorize you to compromise, settle or otherwise resolve said claim as you see fit. It is understood, however that all reasonable efforts have been made to collect the sums due from the insurance company or companies contractually obligated, you will refrain from attempt and efforts to collect he amounts owed directly from me. I understand that whatever amounts you do not collect from insurance company's proceeds, whether it be all or part of what is due, I personally owe you.
4. In addition to the above, I hereby waive the statute of limitations on collections and/or recovery in this state of Florida.
5. I further agree that this authorization is irrevocable until all monies owed to LaRocca Chiropractic LLC are paid in full.
6. I authorize the use of this signature on all insurance submissions.

Patients / Guardians Signature ________________________________ **Date** _______________