GINDELE FAMILY CHIROPRACTIC

7950 DANI DR. STE 310
FT MYERS, FL 33966
239-936-5545

6700 Winkler Rd Unit 2
Fort Myers, Fl. 33919
239-887-3283

DETAILED INFORMATION

DATE:_____

NAME:_____ **NICKNAME:** _____
ADDRESS:_____

CITY:_____ **STATE:**_____ **ZIP:**_____-_____
If you are a seasonal resident please check here ( )
Local Address:
_____ **City**_____ **Zip** _____

E-MAIL ADDRESS: _____

PHONE #:(H) ___-_____ **(W)**___-_____ **(Cell)**___-_____

SS NO.:_____-_____-_____ **AGE:** _____ **DOB:** _____-_____-_____ **SEX:**_____

OCCUPATION:_____ ( )**FT** ( )**PT Employer:**_____ ( )**Unemployed** ( )**Retired** ( )**Homemaker**

STUDENT? ( )**FT** ( )**PT Name of School**_____

MARITAL STATUS: ( )**Single** ( )**Married** ( )**Divorced** ( )**Widow** **NAME OF SPOUSE:** _____

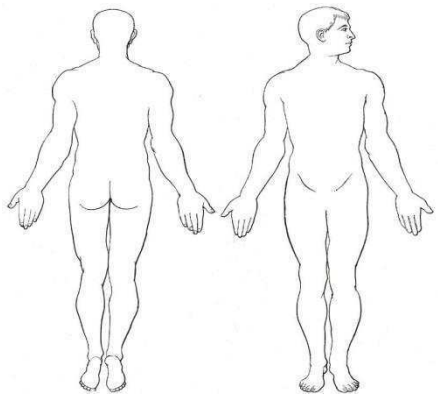
EMERGENCY CONTACT INFORMATION:

Name: _____**Phone:**_____ **Relation to Patient:** _____

How did you find our office?
( ) **INTERNET** ( ) **WALK BY** ( ) **OTHER** _____ ( ) **REFERRAL FROM FRIEND/FAMILY**

WHO can we thank for referring you to the office? _____

PLEASE MARK THE EXACT LOCATION(S) OF YOUR PAIN(S):



LIST MAJOR COMPLAINT(S) (IN ORDER OF SEVERITY):

1) _____

2) _____

3) _____

4) _____

Have you ever been to a Chiropractor ( )yes ( )no
Name(s) & location: _____

Do you have a pacemaker?: YES:____ **NO:**_____

Is there a possibility of pregnancy at this time?: YES____ **How many weeks?** ____ **"Due" date:**_____

 # pregnancy: ___ **# children:** ____ **Healthcare practitioner:** _____

__ Headache	__ Irritability	__ Shortness of breath	__ Face Flushed
__ Neck Pain	__ Chest Pain	__ Fatigue	__ Diarrhea
__ Sleep Problems	__ Pins & Needles in arms	__ Depression	__ Fainting
__ Back Pain	__ Pins & Needles in legs	__ Light bothers eyes	__ Loss of smell
__ Nervousness	__ Numbness in fingers	__ Loss of memory	__ Loss of taste
__ Tension	__ Numbness in toes	__ Ringing in ear(s)	__ Balance
__ Feet Cold	__ Hands Cold	__ Upset stomach	__ Constipated
__ Cold sweats	__ Fever	__ Head seems heavy	__Balance changes

How did CURRENT condition develop?_____
_____

When were you first aware of this problem?_____
_____

Have you ever had this or a similar problem before? if yes, when, where, what were the results:_____
_____

Has your condition been getting better, worse, or staying the same?:_____

Is this keeping you from any daily activities*: ( )dressing ( )driving ( )eating ( )lifting ( )pulling ( )pushing ( )running ( )walking ( )exercising ( )typing ( )working ( )gardening ( )cooking ( )cleaning ( )sleeping ( )up/down stairs ( )bathing ( )using restroom ( )other* _____

Have you lost any days from work due to this condition? If yes, dates:_____

Occupation ergonomic (on your feet, drive, at a computer, etc)**:**_____

LIFESTYLE

Exercise/Recreation Activities: *( )run ( )walk ( )lift weights ( )stretches ( )golf ( )tennis ( )swim ( )other:* _____

Rest & Sleep (#hours/position): _____ Hrs; Position: *( )right side ( )left side ( )stomach ( )back*
Quality: ( )poor ( )restless ( )good ( )sound ( )insomnia

Diet: *( )controlled ( )out of control ( )vegetarian ( )vegan ( )no red meat ( )gluten free ( )diabetic*
Allergies/restrictions_____ *( )personal ( )medical necessity*

Alcohol: *( )none ( )social ( )light ( )moderate ( )heavy;* **Caffeine:** *( )none ( )1 cup/day ( )2+ cups/day ( )5+ cups/day*
Cigarettes: *( )none ( )light ( )moderate ( )heavy;* **IF NONE:** *( ) Never smoked ( ) Quit: _____ ago*
Medications/supplements/vitamins/recreational drugs:_____
(provide a separate list if need be)

Any auto accidents: *( )yes ( )no* **Date:**_____ **Any Falls:** *( )yes ( )no* **Date:**_____

Explain:_____

Have you had ANY surgeries: ( ) None _____

_____

ANY hospitalizations? ( ) None _____

_____

PERSONAL HISTORY ( ) None

Do YOU have/had: high or low blood pressure? _____ Any heart problems ___ Aneurysms_____
Phlebitis____ HIV____ Diabetes _____ Cancer _____ Other _____
If YES to any, explain:_____

FAMILY HISTORY ( ) None

Has anyone in your immediate family had high or low blood pressure? ____ heart problems ____ Aneurysms_____
Phlebitis____ HIV____ Diabetes _____ Cancer _____ Other _____

Explain: (who/what) _____

Fees are payable at time of examination and treatment are received unless other arrangements are made in advance. Records remain the property of this clinic.

SIGNATURE:_____**DATE:**_____ [2]

Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may effect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

_____ _____ _____

Print Name Signature Date

Consent to evaluate and adjust a minor child:

I, _____ being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

Dr's Signature _____

PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name: _____ Signature_____ Date _____

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To Our Valued Patient:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine a appropriate use of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients.

Patient Authorization for Open Adjusting Environmental and contact regarding Chiropractic care, Related Health Services And/or related Health Products

It is our desire for our staff to use your name, address, email, and/or telephone number for the purpose of contacting you to advise you about health related meetings, workshops, and products. In addition this information may be used to remind you about scheduled appointments, re-evaluation or other appointment related issues.

The use of this information is intended to make your experience with our office more efficient, productive and to further enhance you access to quality health care.

This office utilizes an “open-adjusting” environment for ongoing patient care. “Open-adjusting” involves several patients being seen in the same adjusting area. Patients are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and this is NOT the environment used for taking patient histories, or providing examinations. These procedures are completed in a private, confidential setting. The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. If you have private issues to discuss we have several individual services available, see the front to schedule.

Your signature on the lines provided below indicates your authorization for open adjusting only.

_____

Patient Name (please print)

_____ _____

Patient Signature or Authorized representative Date

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

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

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: _____ Date:_____

For office use only

Height: _____ Weight:_____ Blood Pressure:_____/_____

Temp:_____ Pulse:_____

The use of these machines is for symptomatic relief of chronic, intractable pain, muscle spasms and joint contractures.

PLEASE READ THE FOLLOWING INFORMATION REGARDING CONTRAINDICATION AND NOTIFY THE DOCTOR IF ANY OF THESE CONDITIONS APPLY TO YOU OR **IF YOU ARE UNSURE, PLEASE ASK!!**

Electrical Stimulation Contraindications:

- Demand type cardiac pacemakers
- Use over cancerous lesions

Ultrasound Contraindications:

- An area of the body where a malignancy is known to be present
- An acute infection or sepsis
- Pregnancy
- Deep Vein thrombosis (DVT)
- Arterial Disease
- An anesthetized area or condition that causes impairment of sensation, such as chemotherapy
- Cardiac pacemaker
- A healing fracture
- Ischemic tissue in individuals with vascular disease where the blood supply would be compromised
- Any metal in the body

I, _____, I have read the above statement and to the best of my knowledge do not have any of the above listed contraindications to the use of the electric stimulations and ultrasound equipment, or have indicated which I do have and am aware I cannot receive that particular therapy.

_____ _____

Signature Date

Manual Therapy Policy & Procedures:

We want everyone to get the most out of their massages. Please arrive for your scheduled time 5-10 minutes early in order to get properly signed in. Please note that each therapy time allows for approximately 5 minutes before hand to discuss your treatment with the therapist and undressing and approximately 5 minutes after for dressing. Total hands-on time is therefore approximately 50 minutes for an "hour", approximately 20 minutes for a half hour. etc.

We understand that circumstances come about where appointments will need to be rescheduled or cancelled. Please be courteous and provide at least 24 hours' notice. **We retain the right to charge 50% fee for any appointments cancelled less than 24 hours and the full fee for a "no show/no call" scenario.**

As this is a clinical environment, tipping is neither expected nor necessary however are accepted by the therapists.

Lastly, please remember that this is a professional establishment; we do not tolerate any inappropriate comments or behavior toward our licensed massage therapist(s) or staff.

I acknowledge that I've read and agree to the terms of this establishment.

Signature Date

GINDELE FAMILY CHIROPRACTIC

PHONE: (239) 936-5545
7950 Dani Drive, Suite 310, Fort Myers, FL 33966
FAX: (239) 206-4880

CONSENT TO DISCLOSE MEDICAL INFORMATION

Patient Name:_____ Date of Birth:_____

Please check one of the following:

____ I give my permission to the employees of Gindele Family Chiropractic to disclose my Protected Health Information to me and the following friends or family:

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

____ I request that all my Protected Health Information be disclosed ONLY to me and no other family or friends.

I understand that I may revoke or change this consent at any time by filling out another consent form to replace this one.

_____ _____
(Signature of Patient) (Date)

Gindele Family Chiropractic

Date:_____
Patient: _____
ID#:_____
Acct #_____

I, _____, understand that services rendered to me by

Gindele Family Chiropractic is my financial responsibility and that the provider will bill my insurance company, _____as a courtesy. I authorize my insurance company to pay my benefits directly to Dr. Gindele and I understand that I will be full responsible for any outstanding balance on my account.

I have been given the opportunity to pay my estimated deductible and co-insurance at the time of service. I have chosen to assign the benefits, knowing that the claim must be paid within all state or federal prompt payment guidelines. I will provide all relevant and accurate information to facilitate the proper payment of the claim by _____.

I authorize the provider to release any information necessary to adjudicate the claim and understand that there may be associated costs for providing information above and beyond what is necessary for the adjudication of a clean claim.

I also understand that should my insurance company send payment to me, I will forward the payment to Dr. Gindele. Within 48 hours. I agree that if I fail to send payment to the Provider and they are forced to proceed with the collection process; I will be responsible for any cost incurred by the office to retrieve the monies.

I authorize the provider to initiate a complaint to the insurance commissioner for any reason on my behalf and I personally will be active in the resolution of claims delay or unjustified reductions or denials. I also acknowledge if the insurance does not cover the visit I am ultimately responsible.

_____ _____

Signature of Policyholder Patient/Guardian Printed Name

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

SIGN & DATE ONLY

APPROVED OMB-0938-0008

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☐

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ ***If yes***, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ◀ ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. ____ . __ 3. ____ . __

2. ____ . __ 4. ____ . __

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1												
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500