COASTAL HEALTHCARE PARTNERS

Patient Name: _____ Date: _____

SS#/SIN: _____ DOB: _____ Male ☐ Female ☐ Email: _____

Home Phone: _____ Cell Phone: _____

Check the appropriate box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Address: _____ City: _____ State: _____ Zip: _____

Employer Name: _____

Spouse/Guardian Name: _____ Spouse's Employer: _____

Emergency Contact Name: _____ Phone: _____

In case of a medical emergency, if the patient is of school age 15+, it's ok to treat in my absence.

Parent or Guardian: Date:

_____ _____

Do you have Medical Insurance? YES NO If yes, complete the following:

Name of Insured: _____ Relationship to Patient: _____

Birthdate: _____ SS#/SIN: _____ Employer: _____ Work Phone: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Insurance Company: _____ Member ID#: _____ Group#: _____

Ins. Co. Address: _____ City: _____ State: _____ Zip: _____

Responsible Party: _____ Relationship to Patient: _____

Address: _____ Email Address: _____

Home Phone: _____ Cell Phone: _____

Is this person currently a patient in our office? YES NO

Was this due to an accident? YES NO If yes, what kind? Slip and Fall ☐ Auto ☐ Other ☐

Auto Insurance: _____ Claim#: _____ Date of Accident: _____

Policy#: _____ Claim Adjuster: _____ Phone: _____

Palm Coast
50 Leanni Way, Ste. D1
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O (386) 283-5997
F (386) 283-5652

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557 Health Blvd., Unit 100
Daytona Beach, FL 32114
O (386) 256-3520
F (386) 256-3516

DeLand
819 W. Beresford Rd
DeLand, FL 32720
O (386) 218-3799
F (386) 218-3835

COASTAL HEALTHCARE PARTNERS

Health History:

Patient Name:_____ **DOB:**_____ **Date:**_____

Chief Complaint:_____

History Of Present Illness:

Location:_____

_____

Past Medical History:

Have you ever had the following? (check "yes" or "no"/leave blank if you are uncertain)

Measles	Y	N	Anemia	Y	N	Back Trouble	Y	N	Bleeding Tendency	Y	N
Mumps	Y	N	Bladder Infection	Y	N	High Blood Pressure	Y	N	Mitral Valve Prolapses	Y	N
Chicken Pox	Y	N	Migraine Headaches	Y	N	Low Blood Pressure	Y	N	AIDS & HIV	Y	N
Whooping Cough	Y	N	Hemorrhoids	Y	N	Asthma	Y	N	Transfusion	Y	N
Scarlet Fever	Y	N	Tuberculosis	Y	N	Hive or Eczema	Y	N	Stroke	Y	N
Diphtheria	Y	N	Diabetes	Y	N	Hepatitis	Y	N	Any other Disease	Y	N
Smallpox	Y	N	Cancer	Y	N	Kidney Disease	Y	N	Please List:		
Pneumonia	Y	N	Polio	Y	N	Ulcers	Y	N			
Rheumatic Fever	Y	N	Glaucoma	Y	N	Thyroid Disease	Y	N			
Arthritis	Y	N	Hernia	Y	N	Infectious Mass	Y	N			
Venereal Disease	Y		Blood or Plasma	Y	N	Bronchitis	Y	N	Date of last chest Xray:		

Previous Hospitalizations/Surgeries/Serious Illnesses	When	Hospital/City/State

Medication: (Include nonprescription)

_____

_____

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COASTAL HEALTHCARE PARTNERS

Patient Name:_____ DOB:_____ Date:_____

Have you ever taken Fen-Phen/Redux? YES NO

Are you taking any medications (prescriptions or over the counter) for acid indigestion? YES NO

If yes, what type? _____

Do you have any know allergies to either medications, environmental or food related? YES NO

If yes, what type? _____

Patient Social History:

Marital Status	Single	Married	Separated	Divorced	Widowed
Use of Alcohol	Never	Rarely	Moderate	Daily	
Tobacco Use	Never	Rarely	Moderate	Daily	
Drug Use	Never	Type/Frequency			
Excessive exposure at home or work	Fumes	Dust	Solvents	Airborne Particles	Noise

Family Medical History:

	Age	Disease	If Deceased, Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Spouse	_____	_____	_____
Child	_____	_____	_____
	_____	_____	_____

Clinician Signature:_____ Date Reviewed:_____

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COASTAL HEALTHCARE PARTNERS

Patient Name:_____ DOB:_____ Date:_____

Please indicate which of the below you have experienced in the last 1-2 months

1 = Never; 2 = Rarely; 3 = Occasionally; 4 = Frequently; 5 = Constantly

Eyes/Ears/Nose/Throat

Asthma	1	2	3	4	5	
Stuffy Nose	1	2	3	4	5	
Hay Fever	1	2	3	4	5	
Sore throat	1	2	3	4	5	
Chronic Cough	1	2	3	4	5	
Chest Congestion	1	2	3	4	5	
Frequent Sneezing	1	2	3	4	5	
Itchy/Watery Eyes	1	2	3	4	5	
Drainage	1	2	3	4	5	
Earache/ Ear Infection	1	2	3	4	5	
Itching	1	2	3	4	5	
Hoarseness	1	2	3	4	5	
Shortness of Breath	1	2	3	4	5	
Wheezing	1	2	3	4	5	

Respiratory/Muscular/Skeletal

Muscle Aches	1	2	3	4	5	
Fibromyalgia	1	2	3	4	5	
Arthritis	1	2	3	4	5	
Joint Pain	1	2	3	4	5	
Low Back Pain	1	2	3	4	5	
Neck Pain	1	2	3	4	5	
Wrist/Hand Pain	1	2	3	4	5	
Elbow Pain	1	2	3	4	5	
Shoulder Pain	1	2	3	4	5	
Hip Pain	1	2	3	4	5	
Knee Pain	1	2	3	4	5	
Ankle/Foot pain	1	2	3	4	5	
Pain b/t Shoulder Blades	1	2	3	4	5	
	1	2	3	4	5	

Neurological

Headaches	1	2	3	4	5	
Migraines	1	2	3	4	5	
Dizziness	1	2	3	4	5	
Numbness	1	2	3	4	5	
Tingling	1	2	3	4	5	
Pins/Needles in hands/feet	1	2	3	4	5	
	1	2	3	4	5	
	1	2	3	4	5	
	1	2	3	4	5	

General

Fatigue	1	2	3	4	5	
Malaise	1	2	3	4	5	
Weakness/Tenderness	1	2	3	4	5	
Lightheadedness	1	2	3	4	5	
Irritability	1	2	3	4	5	
Constipation	1	2	3	4	5	
Diarrhea	1	2	3	4	5	
Feeling Foggy	1	2	3	4	5	
Forgetfulness	1	2	3	4	5	

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to preform the necessary services I may need.

Patient/Guardian Signature:_____ Date:_____

Signature of Doctor:_____ Date:_____

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COASTAL HEALTHCARE PARTNERS

Patient Consent to Use and Disclosure of Protected Health Information

Coastal Healthcare Partners

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

Coastal Healthcare Partners Notice of Privacy Practiced 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. Coastal Healthcare Partners reserves the right to revise it's Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Coastal Healthcare Partners.

With this consent, Coastal Healthcare Partners may call my home or other alternative location to leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and calls pertaining to my clinical care, including laboratory results among others.

With this consent, Coastal Healthcare Partners may mail to my home or 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, Coastal Healthcare Partners may email my home or other alternative location ant items that assist the practice in carrying out TPO, such as appointment reminders and patient statements. I have the right to request how Coastal Healthcare Partners uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Coastal Healthcare Partners 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 need this consent, or later revoke it, Coastal Healthcare Partners may decline to provide treatment to me.

Signature of Patient/Guardian _____

Print Patient's Name _____ Date _____

Printed Name of Legal Guardian _____

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COASTAL HEALTHCARE PARTNERS

Consent to Treat

I hereby request and consent to the performance of chiropractic manipulation and manual therapy techniques and other chiropractic procedures, including various modes of physical therapeutic modalities and procedures and diagnostic x-rays where warranted on me (or on the patient named below for who I am legally responsible) by the doctor and or license doctors of chiropractic who now or in the future work at the clinic or office listed below.

I have had an opportunity to discuss with the doctor the nature and purpose of chiropractic adjustments and other procedures I understand that results are not guaranteed.

I understand and informed that as the practice of medicine in the practice of chiropractic there are some risks to treatment and diagnostic services including but not limited to:

Manipulation: Increased pain or discomfort fractures disc injuries strokes dislocations and sprains.

Therapeutic Modalities and procedures: Additional pain and discomfort endurance exercise may cause increased risk of acute myocardial infarction heart attack and patients with known or possible cardiac conditions.

Radiographs: Ionizing radiation can be harmful to a fetus for those who are pregnant or might be pregnant.

I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the procedure which the doctor feels at the time, based upon the facts then known to him or her is in my best interest the doctor has additionally explained the risks associated with my refusal of treatment.

I have read or have had read to me the above consent I have also had an opportunity to ask questions about its content and by signing below I agree to the above-named procedures I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment

Patient Name:_____

Patient/Guardian Signature:_____ Date:_____

Witness Signature:_____ Date:_____

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COASTAL HEALTHCARE PARTNERS

Office/Patient Agreements

It has been our experience, caring for thousands of patients over the past 12 plus years, that those who agree to understand the following agreements can benefit most from their care in our office, helping save you time and money.

Your consistency of visits: our recommendations for your care are customized to your health goals and body's needs. You need to keep the recommended visits consistent, in order to get the best results:

- Meet all your appointments arrange your activities so you can do this.
- Call us with any emergencies so we can reschedule you.

Re-examinations: In order to monitor your progress, you will receive a re-examination about every 3 weeks where you will be with one of our health professionals and review your progress since your last examination new injuries may also require an exam.

Adjusting area: after completing your daily progress you will go back to the treatment area unless you are scheduled for re-examination.

Special visits: these visits are anything other than your regular chiropractic adjustments and or physical rehabilitation we do our best to keep your waiting in our office to a minimum however, we need your help to continue this goal please be punctual for these visits. If you desire to schedule a special non-emergency visit such as a nutritional consultation or other special visit we ask you give us at least one visit notice in advance.

New symptoms or flare up: if you experienced any new symptoms or change of health you need to let us know immediately before your next visit.

Symptom changes: as we balance your body, just like a new exercise program, you may experience some soreness, this may happen anytime during your care in our office. If this occurs simply inform us when you come in and we can discuss this with you.

Payment of bills: we will expect you to honor the financial agreement you make with our office; if you find that you cannot fulfill the agreement you have made with us you need to go to the front desk and tell one of our staffs that we can discuss with you new arrangements to be made. Insurance companies will be billed for your services rendered if you have such insurance coverage. If you receive any checks from your insurance company it is your responsibility to bring them into our office within 3 days of receiving them along with the explanation of benefits attached to the insurance check. If you fail to bring in the insurance checks and or the explanation of benefits we reserve the right to bill you directly for those services. Methods of payment are Visa, MasterCard, Discover card, check and cash.

Upsets: if you ever have any questions or concerns of any fashion concerning your care in our office please talk to a staff member immediately so that we can answer your questions and help you

I fully understand and accept these policies.

Patient Signature _____ Date___/___/___

Staff Member Signature _____

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COASTAL HEALTHCARE PARTNERS

Authorization for Release of Medical Records

Patient Name:_____ **Date of Birth:**_____

Organization Providing Information:

Organization Requesting Information:

Coastal Healthcare Partners-Palm Coast
50 Leanni Way, Suite D1, Palm Coast, FL 32137
P: 386-283-5997 F: 386-283-5652

Coastal Healthcare Partners-Daytona Beach
557 Health Blvd, Unit 100, Daytona Beach, FL 32114
P: 386-256-3520 F: 386-256-3516

Coastal Healthcare Partners- DeLand
819 W Beresford Rd. DeLand, FL 32720
P: 386-218-3799 F: 386-218-3835

Specific Records to be released: X-Rays☐ History☐ Diagnostic☐ Treatment☐ Reports☐ Medication Prescribed☐
☐ **Records concerning accident on**_____(Date)

☐ **All care given in your facility covering period from** _____ to _____

- I understand that I may refuse to sign this authorization, and that it is strictly voluntary.
- I understand that I have the right to withdraw my authorization at any time, except to the extent that this action has been taken in reliance on this authorization. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the clinic's privacy officer.
- I understand that protected health information released pursuant to this authorization may include records generated by another health care provider or facility.
- I understand that I have the right to inspect or copy the protected health information to be used or disclosed, as permitted under Federal
- I understand the information disclosed by this authorization maybe subject to redisclosure by the recipient and may no longer be protected by confidentiality laws.
- I understand that I have a right to receive a copy of this
- I understand that I do not have to sign this authorization, and that my refusal to sign will not affect my ability to obtain treatment.
- I understand that certain records may be predicted by federal or state law, and I am requesting that any and all such protected records be released under this authorization example treatment of alcohol and drug abuse, mental health services, information about sexually transmitted disease and HIV AIDS related treatment
- I understand that there may be fees associated with some medical record requests.

I authorized the disclosure of the records information described. I have read and understand this form. I am the patient listed or I am authorized to act on behalf of the patient as the patient's personal representative. This authorization is effective for one year.

Patient Signature:_____ **Date:**_____
If signed by someone other than the patient, please indicate the relationship: Circle one: Parent/Guardian of Minor Child, Guardian/Conservator of incompetent patient, Beneficiary of personal representative of deceased patient, other(specify)_____

Identification Verified By:_____
Photo Identification: State/Other:_____

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COASTAL HEALTHCARE PARTNERS

Assignment Of Benefits, Authorization to Settle Claim and Direction to Pay Medical Provider Directly

Patient Name:_____ Claim#:_____

My signature below, for good and valuable consideration (including but not limited to the extension of credit to me), I hereby assign transfer and convey to coastal health Care partners LLC (hereinafter "the provider") the provider all my rights, title and interest in and two medical expense reimbursement in whatever form, including but not limited to any automobile liability medical expense payments or health benefit indemnification and or agreement otherwise payable to me. This payment shall not exceed my indebtedness to the above-named assignee, and I acknowledge that I will timely pay any indebtedness owed by me to the assignee that is not otherwise satisfied by the above-mentioned assigned proceeds. I also acknowledge that any medical expenses not covered under my insurance policy will be my responsibility.

I further authorized the provider to negotiate, collect and settle any claim with any insurance carrier or other third-party payer with regard to these services, which authorization shall include authority to 1) request and receive from any insurer or any other party any and all documentation and records that I am empowered to request regarding this claim, including without limitation, any independent medical examination reports, policies notices sent to me regarding appointments for independent medical examinations under oath regarding appointments for independent medical examination including proof of mail record review reports, coverage denial letters, explanations of benefits, and benefit payment sheets or logs (PIP payout sheets), without regard as to whether such documentation has already been provided to me and 2) to endorse in my name any check issued for payment where benefits were assigned by way of this assignment and notice I further instruct in this claim including, without limitation, any notices of requested medical examinations or statements.

I further direct my insurer to direct all payments for services rendered by the provider directly to the provider at the billing address contained on the provider's medical bill.

This is a direct and irrevocable assignment of my rights and benefits under my policy of insurance

A photocopy of this form shall be considered as effective and valid as the original.

I have read the four going and understand and agree to each of the above provisions.

Signature of Patient:_____

Signature of PARENT or GUARDIAN of minor child:_____

Witness:_____

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COASTAL HEALTHCARE PARTNERS

Financial Responsibility Agreement

I, the below-named patient, hereby knowingly and voluntarily agree, acknowledge, and represent to Coastal Healthcare Partners that in addition to any other contract(s) existing or hereafter entered into between myself and the said healthcare provider, I am responsible for paying the full amount(s) billed to me or on my account for the healthcare services provided to me or for my benefit, including but not limited to care, treatment, other services, medicine, and supplies, and that no act or omission by the healthcare provider shall constitute a waiver of the right to charge to and be paid by me the entire amount(s) billed to me or on my account. In further consideration of the care, treatment, services, medicine, and/or supplies provided to me or on my behalf by the healthcare provider, I do hereby waive any and all statutes of limitation on any claim or cause of action that the healthcare provider may have or hereafter acquire against me regarding the care, treatment, services, medicine, and supplies provided to me or for my benefit, including the charges and bill(s) due therefor, whether any such claim be in law or equity, and do further waive any and all head of family or other protection(s) from collection by a creditor under Florida and/or Federal law. If you provide more than one-half of the support for a child or other dependent, all or part of your income is exempt from garnishment under Florida law. You can waive this protection only by signing this document. By signing below, you agree to waive the protection from garnishment. I understand and agree that the said healthcare provider is relying on my aforesaid inducements, promises, agreements, and representations in agreeing to provide me with healthcare, and I agree that such reliance by the healthcare provider is reasonable in all respects. Further, if I should have any right to seek or compel arbitration of any matter with the said healthcare provider, I hereby irrevocably waive that right, and agree that all of the rights given to the healthcare provider by me herein, are and shall constitute a grant coupled with an interest, and therefore, among other things, shall be irrevocable by me, the undersigned patient, and no obligation of mine to this healthcare provider is or can become delegable to any other person.

Patient Signature: _____ Date: _____

Medical Provider Signature: _____ Date: _____

If the patient is a minor, the parent must sign below on the parent's and the minor's behalf:

Patient Name: Parent Signature: _____ Date: _____

COASTAL HEALTHCARE PARTNERS

Notice of Privacy Practices Acknowledgement

Notice of Privacy Practices (NPP) is provided to all patients. This **Notice of Privacy Practices** identifies: 1) how medical information about you may be used or disclosed; 2) your rights to access your medical information, amend your medical information, request an accounting of disclosures of your medical information, and request additional restrictions on our uses and disclosures of that information; 3) your rights to complain if you believe your privacy rights have been violated; and 4) our responsibilities for maintaining the privacy of your medical information.

The undersigned certifies that he/she has read the foregoing, received a copy of the **Notice of Privacy Practices** and is the patient, or the patient's personal representative.

Name of Patient Signature of Patient

Date Signed: _____

Name of Patient's Personal Representative Signature of

Representative Date Signed: _____

FOR INTERNAL USE ONLY

Name of Employee Signature of Employee

If applicable, reason patient's written acknowledgement could not be obtained:
__Patient was unable to sign.
__Patient refused to sign
__Other_____

557 Health Blvd., Unit 100 Daytona Beach, FL 32114 Phone: 386.256.3520 Fax: 3862.256 .5652
50 Leanni Way, Suite D1 Palm Coast, FL 32137 Phone: 386.283.5997 Fax: 386.283.5652
819 W Beresford Road DeLand, FL 32720 Phone: 386.218.3799 Fax: 386.218.3835

OFFICE OF INSURANCE REGULATION
Bureau of Property & Casualty Forms and Rates

Standard Disclosure and Acknowledgement Form
Personal Injury Protection - Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

1. The services or treatment set forth below were **actually rendered.** This means that those services have **already been provided.**

_____

_____

2. I have the right and the **duty to confirm** that the services have already been provided.
3. I was **not solicited** by any person to seek any services from the medical provider of the services described above.
4. The medical provider has **explained** the services to me for which payment is being claimed.
5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to $500.

Insured Person (patient receiving treatment or services) or Guardian of Insured Person:

_____	_____	_____
Name *(PRINT or TYPE)*	Signature	Date

The undersigned licensed medical professional or medical director, if applicable, affirms the statement numbered 1 above and also:

A. I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.

B. The treatment or services rendered were explained to the insured person, or his or her guardian, **sufficiently** for that person to sign this form with informed consent.

C. The accompanying statement or bill is **properly completed** in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to **truthfully, accurately**, and in a **substantially complete** manner.

D. The coding of procedures on the accompanying statement or bill is proper. This means that **no service has been upcoded, unbundled**, or constitutes an invalid **or not medically necessary diagnostic test** as defined by Section 627.732 (15) and (16), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Licensed Medical Professional Rendering Treatment/Services or Medical Director, if applicable *(Signature by his/ her **own** hand):*

_____	_____	_____
Name *(PRINT or TYPE)*	Signature	Date

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of Claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234(1)(b), Florida Statutes.

Note: The **original** of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may **not** be electronically furnished. Failure to furnish this form may result in non-payment of the claim.

COASTAL HEALTHCARE
PARTNERS

Notice of Initiation of Treatment

Patient Name: _____

Insurance Carrier: _____

Insurance Policy # _____

Claim # _____

DOL: _____

Date First Seen: _____

Patient DOB: _____

From: Coastal Healthcare Partners

Dear Personal Injury Protection Insurer:

We are hereby submitting notice to you that we have initiated examination and/or treatment for the above patient. The patient's first date of treatment occurred on _____.

Enclosed, please find a direction to pay, in which the patient has directed you to send all payments for services rendered to the undersigned. The patient has also granted us lien on benefits.

This document shall serve as our formal Notice of Initiation of Treatment in accordance with F.S. 627.736(5)(c). This notice is being sent, pursuant to Florida Statutes, within 21 days after this facility's first examination or treatment of the above referenced claimant. Because this notice has been timely provided, the law allows statements from this provider to include charges for treatment or services rendered up to, but not more than 75 days before the postmark date of the statement sent. Please retain this notice in your claim file.

Thank you,
Coastal Healthcare Partners

50 Isaac Way, Suite D1
Palm Coast, FL 32137
Phone: 386.223.5997 Fax
386.283.5652

557 Health Blvd Unit #100
Daytona Beach, FL 32114
Phone: 386.256.3929
Fax: 3862.256.5652

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Fax: 386.218.3835

COASTAL HEALTHCARE PARTNERS

CONSENT TO EMAIL OR TEXT USAGE FOR APPOINTMENT REMINDERS AND OTHER HEALTHCARE COMMUNICATIONS.

Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information. If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from the Practice.

[Patient Initials] I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing. I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information to the following Cell Phone number:

Cell Phone Number	( ) -

I authorize to receive email/text messages for appointment reminders and general health reminders/feedback/ information in the Patient Portal to the following Email Address:

_____

The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details.

Signature		Name (please print)		Date	

557 Health Blvd., Unit 100 Daytona Beach, FL 32114 Phone: 386.256.3520 Fax: 3862.256 .5652
50 Leanni Way, Suite D1 Palm Coast, FL 32137 Phone: 386.283.5997 Fax: 386.283.5652
819 W Beresford Road DeLand, FL 32720 Phone: 386.218.3799 Fax: 386.218.3835

COASTAL HEALTHCARE PARTNERS

NO SHOW/LATE CANCELLATION POLICY

We understand that there are times when you miss an appointment due to emergencies or work/family obligations.

However when you do not call to cancel an appointment you may be preventing another patient from getting needed treatment.

IF YOU DO NOT CALL 24 HOURS IN ADVANCE OF YOUR APPOINTMENT TIME TO CANCEL OR RESCHEDULE YOU WILL BE CHARGED THE FOLLOWING

$50.00 NO SHOW FEE FOR CHIROPRACTIC/THERAPY

$150.00 FOR MEDICAL OR EMG/NCV(Nerve Test)

ALSO 15 MINUTES OR MORE LATE FOR YOUR APPOINTMENT YOU WILL BE ASKED TO RESCHEDULE

Patient Signature_____

Date_____

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COASTAL HEALTHCARE PARTNERS

Pain Disability Questionnaire (PDQ)

Patient Name: _____ **Date:** _____

Instructions:

These questions ask for your view about how your pain now affects how you function in everyday activities. Please answer every question and mark the ONE number on EACH scale that best describes how you feel.

Does your pain interfere with your normal work inside and outside the home?

Work Normally									***Unable to work at all***
1	2	3	4	5	6	7	8	9	10

Does your pain interfere with personal care (such as washing, dressing, etc.)?

Take care of myself completely								***Need help with all my personal care***	
1	2	3	4	5	6	7	8	9	10

Does your pain interfere with traveling?

Travel anywhere I like								***Only to travel to see doctors***	
1	2	3	4	5	6	7	8	9	10

Does your pain affect your ability to sit or stand?

No Problems								***Cannot sit/stand at all***	
1	2	3	4	5	6	7	8	9	10

Does your pain affect your ability to lift overhead, grasp objects, or reach for things?

No Problems									***Cannot do at all***
1	2	3	4	5	6	7	8	9	10

Does your pain affect your ability to lift objects off the floor, bend, stoop, or squat?

No Problems									***Cannot do at all***
1	2	3	4	5	6	7	8	9	10

Does your pain affect your ability to walk or run?

No Problems									***Cannot walk/run at all***
1	2	3	4	5	6	7	8	9	10

Has your income declined since your pain began?

No decline									***Loss of income***
1	2	3	4	5	6	7	8	9	10

Do you have to take pain medication everyday to control your pain?

No medicine needed								***on pain medicine throughout the day***	
1	2	3	4	5	6	7	8	9	10

Does your pain force you to see doctors much more often than before your pain began?

Never see doctors									***See doctor's weekly***
1	2	3	4	5	6	7	8	9	10

Does your pain interfere with your ability to see the people who are important to you as much as you would like?

No Problems									***Never see them***
1	2	3	4	5	6	7	8	9	10

Does your pain interfere with recreational activities and hobbies that are important to you?

No interference									***Total interference***
1	2	3	4	5	6	7	8	9	10

Do you need help of your family and friends to complete everyday tasks (including work outside the home and housework) due to your pain?

Never need help									***Need help all the time***
1	2	3	4	5	6	7	8	9	10

Do you feel more depressed, tense, or anxious than before your pain began?

No depression/tension									***Severe depression/tension***
1	2	3	4	5	6	7	8	9	10

Are there emotional problems caused by your pain that interfere with your family, social and or work activities?

No problems									***Severe problems***
1	2	3	4	5	6	7	8	9	10

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