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) 256-3520
F (386) 256-3516

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DeLand, FL 32720
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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 exsposure 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	Muscle Aches	1	2	3	4	5
Stuffy Nose	1	2	3	4	5	Fibromyalgia	1	2	3	4	5
Hay Fever	1	2	3	4	5	Arthritis	1	2	3	4	5
Sore throat	1	2	3	4	5	Joint Pain	1	2	3	4	5
Chronic Cough	1	2	3	4	5	Low Back Pain	1	2	3	4	5
Chest Congestion	1	2	3	4	5	Neck Pain	1	2	3	4	5
Frequent Sneezing	1	2	3	4	5	Wrist/Hand Pain	1	2	3	4	5
Itchy/Watery Eyes	1	2	3	4	5	Elbow Pain	1	2	3	4	5
Drainage	1	2	3	4	5	Shoulder Pain	1	2	3	4	5
Earache/ Ear Infection	1	2	3	4	5	Hip Pain	1	2	3	4	5
Itching	1	2	3	4	5	Knee Pain	1	2	3	4	5
Hoarseness	1	2	3	4	5	Ankle/Foot pain	1	2	3	4	5
Shortness of Breath	1	2	3	4	5	Pain b/t Shoulder Blades	1	2	3	4	5
Wheezing	1	2	3	4	5		1	2	3	4	5

Respiratory/Muscular/Skeletal

Neurological

Headaches	1	2	3	4	5	Fatigue	1	2	3	4	5
Migraines	1	2	3	4	5	Malaise	1	2	3	4	5
Dizziness	1	2	3	4	5	Weakness/Tenderness	1	2	3	4	5
Numbness	1	2	3	4	5	Lightheadedness	1	2	3	4	5
Tingling	1	2	3	4	5	Irritability	1	2	3	4	5
Pins/Needles in hands/feet	1	2	3	4	5	Constipation	1	2	3	4	5
	1	2	3	4	5	Diarrhea	1	2	3	4	5
	1	2	3	4	5	Feeling Foggy	1	2	3	4	5
	1	2	3	4	5	Forgetfulness	1	2	3	4	5

General

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

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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 HEALTH PLAN BENEFITS AND RIGHTS AS WELL AS AN APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay **Coastal Healthcare Partners** as well as all employees, employers, representatives and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests or medications provided. I hear by authorized payment of and assign my rights to any health insurance or medical plan benefits directly to healthcare provider for any and all medical/health services supplies, test, treatments and/or medications that have been or will be rendered or provided; as well as designating and appointing healthcare provider as my beneficiary under all health insurance or medical plans which I may have benefits under. I hear by authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with the same. I hereby assigned directly to healthcare provider all rights to payment, benefits and all other legal rights under, or pursuant to any health plan (including but not limited to any ERISA governed plan insurance contract PPACA governed plan/insurance contract) rights that I (or my child's spouse or dependent) may have under my/our applicable health plans or health insurance policies. I also hereby appoint and designate the healthcare provider can act on my/our behalf as my/our personal representative ERISA representative or PPACA representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and or legal action including in my name and on my behalf to obtain and or protect benefits and/or payments that are due or have been previously paid to either health care provider, myself and or my family members as a result of services rendered by healthcare provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan and the insurer or any administrator. I hear by also declare that healthcare provider is or my beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA and that the healthcare provider can pursue any and all rights that I/we may have under State and/or federal law regarding my/our health plan. This assignment appointment and designation will remain in effect unless revoked by me in writing. It is my intent that the effective date of this document shall relate back to include all services, supplies, tests, treatments or medications that have been previously provided by the healthcare provider. A photocopy or scan of this document is to be considered as valid as an enforceable as the original.

Signed this____day of_____,20_____ X_____

(Patient Signature)

X_____ X_____

(Signature of Guardian if applicable) (Please print patient name)

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COASTAL [illegible]
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_____

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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.

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	

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