Stuart Family Chiropractic
and
Acupuncture Center

6094 SE Federal Highway
Stuart, Florida 34997
772-781-0193

Today's Date ____/____/_____

PATIENT REGISTRATION

Name: Last_____ First _____ Middle Initial _____

Address _____ Apt/Unit _____

City _____ State_____ Zip _____

Gender: ☐ Male ☐ Female Date of Birth____/____/_____ Marital Status: ☐ Married ☐ Single ☐ Widow ☐ Divorced

Primary Phone _____ Alternate Phone _____

Email _____ Social Security Number _____

Occupation _____ Employer _____

Employer Phone _____ Address _____

Suite_____ City_____ State_____ Zip _____

EMERGENCY CONTACT INFORMATION

Name: Last_____ First _____ Middle Initial _____

Address _____ Apt/Unit _____

City _____ State_____ Zip _____

Gender: ☐ Male ☐ Female Relationship to Patient_____ Phone _____

PERSON RESPONSIBLE FOR ACCOUNT

Is your injury due to a motor vehicle accident ☐ Yes ☐ No *If yes, please provide the following:*

Name of Company Responsible for Your Account? _____

Contact/Case Representative_____ Phone _____

Attorney _____ Phone _____

Primary Coverage Insurance Name_____

Name of Owner _____

Secondary Coverage Insurance Name _____

Name of Owner _____

AUTHORIZATION

I hereby authorize medical benefits billed to my insurance to be paid to Dr. Leon Gonyo, DC., F.I.A.M.A. I hereby accept responsibility for payment for any service(s) provided to me that is not covered by my insurance. I also accept responsibility for fees that exceed or are not covered by the payment made by my insurance. I understand and take responsibility for the costs incurred for services rendered. In the event of default in the payment of the amount due, and if this account is placed in the hands of a collection agency and/or attorney for collection or legal action, an additional charge equal to the cost of collection, including the collection agency, attorney fees, and any court costs incurred, will be paid by me. I authorize the Doctor to order any DME equipment that he deems necessary to further my recovery, and bill said DME to my Insurance Company.

I agree to pay all co-payments, coinsurance, and deductibles at the time the service is rendered, unless other arrangements have been made by Dr. Leon Gonyo, DC., F.I.A.M.A and me. I also hereby authorize Dr. Leon Gonyo, DC., F.I.A.M.A to leave information or a message regarding my care/treatment at the phone numbers provided above, including voicemail or answering devices.

X _____ ____/____/_____

Signature of Patient or Guardian Date

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PATIENT HEALTH HISTORY

Name: Last _____ First _____ Middle Initial _____

Primary Care Physician (PCP) Name _____ PCP Phone _____

May we contact your PCP? ☐ Yes ☐ No Who referred you to our clinic/How did you hear of us? _____

Have you been to a chiropractor before? ☐ Yes ☐ No If yes, how was your experience? _____

Do you:

Smoke: ☐ Yes ☐ No ☐ Quit If yes: packs per day _____ how many years _____ Vape: ☐ Yes ☐ No

Drink alcohol: ☐ Yes ☐ No ☐ Quit If yes, how much _____ how often _____

Use birth control: ☐ Yes ☐ No If yes, please list _____

Have any implants or prosthetics? ☐ Yes ☐ No If yes, please list _____

Exercise: ☐ Yes ☐ No If yes, list type and how many hours per week for each _____

_____

Have allergies? ☐ Yes ☐ No If yes, please list _____

List any medications (prescriptions and over-the-counter), vitamins and supplements you currently take _____

_____

_____

List any accidents or injuries with approximate year _____

_____

List any surgeries with approximate year _____

_____

PLEASE CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING:

GENERAL
- ☐ Fever
- ☐ Tension
- ☐ Fatigue
- ☐ Weakness
- ☐ Tumors

GENITOURINARY
- ☐ Sexually Transmitted Infection

EYES, EARS, NOSE, THROAT
- ☐ Cataracts
- ☐ Ringing in Ears
- ☐ Glaucoma
- ☐ Tonsillitis

HEMATOLOGIC
- ☐ Bleeding Disorders
- ☐ Anemia

RESPIRATORY
- ☐ Pneumonia
- ☐ Emphysema or COPD
- ☐ Tuberculosis
- ☐ Bronchitis
- ☐ Asthma

MUSCULOSKELETAL
- ☐ Osteoporosis
- ☐ Neck Pain
- ☐ Stiff Neck
- ☐ TMJ
- ☐ Disc Degeneration
- ☐ Hand or Wrist Pain
- ☐ Back Pain
- ☐ Numbness
- ☐ Arthritis
- ☐ Rheumatoid Arthritis
- ☐ Gout
- ☐ Pinched Nerve

INFECTIOUS DISEASE
- ☐ Whooping Cough
- ☐ Mumps
- ☐ Scarlet Fever
- ☐ Typhoid
- ☐ Measles
- ☐ Mononucleosis
- ☐ Polio
- ☐ Rheumatic Fever
- ☐ Chicken Pox
- ☐ AIDS/HIV

DIGESTIVE
- ☐ Constipation
- ☐ Ulcers
- ☐ Liver Disease
- ☐ Kidney Disease
- ☐ Hernia
- ☐ Hepatitis

PSYCHIATRIC
- ☐ Anxiety
- ☐ Depression
- ☐ Suicide Attempt
- ☐ Psychiatric Care
- ☐ Bulimia
- ☐ Anorexia

CARDIOVASCULAR
- ☐ High Cholesterol
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Deep Vein Thrombosis
- ☐ Blood Clots
- ☐ Heart Attack
- ☐ Vascular Disease
- ☐ Pacemaker

NEUROLOGIC
- ☐ Headaches
- ☐ Migraine
- ☐ Stroke
- ☐ Parkinson's Disease
- ☐ Dizziness
- ☐ Loss of Balance
- ☐ Epilepsy
- ☐ Shingles
- ☐ Alcoholism
- ☐ Multiple Sclerosis

ENDOCRINE
- ☐ Diabetes
- ☐ Thyroid Problems
- ☐ Goiter

CANCER
- ☐ List type(s) _____

MEN ONLY
- ☐ Prostate Problems

WOMEN ONLY
- ☐ Miscarriage
- ☐ Vaginal Infections
- ☐ Breast Lump

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AUTHORIZATIONS AND RELEASES

Patient Health Information and Privacy Policy

This policy outlines the way Patient Health Information (PHI) will be used in this office and the patient's rights concerning those records. You must read and consent to this policy before receiving services. A complete copy of the Health Information Portability and Accountability Act (HIPAA) is available here: http://www.cms.hhs.gov/SecurityStandard/Downloads/securityproposedrule.pdf

1. The patient understands and agrees to allow this office to use their PHI for the purpose of treatment, payment, healthcare operations and coordination of care. The patient agrees to allow this office to submit requested PHI to the payor(s) named by the patient for the purpose of payment. This office will limit the release of all PHI to the minimum necessary to receive payment.
2. The patient has the right to examine and obtain a copy of their health records at any time and request corrections. The patient may request to know what disclosures have been made, and submit in writing any further restrictions on the use of their PHI. This office is not obligated to agree to those restrictions.
3. The patient's written consent shall remain in effect for as long as the patient receives care at this office, regardless of the passage of time, unless the patient provides written notice to revoke their consent. A revocation of consent will not apply to any prior care or services.
4. This office is committed to protecting your PHI and meeting its HIPAA obligations: Staff have been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures.
5. Patients have the right to file a formal complaint with our privacy official about any suspected violations.
6. This office has the right to refuse treatment if the patient does not accept the terms of this policy.

_____ Initial Here

Consent to Professional Treatment

The patient certifies that all information provided to this office is true and correct, to the best of their knowledge. The patient grants their consent to this office and its staff to render treatment as deemed necessary by the attending physician. If the patient is a minor child, under the age of eighteen (18) at the date of treatment, I hereby stipulate that I am the legal guardian of the child, and grant my consent for the treatment of the child as provided for herein. The patient may refuse treatment at any time.

_____ Initial Here

Consent to Perform, Interpret X-rays, and Perform Exams

The patient consents to the performance of X-rays as deemed necessary by the attending physician of this office. The patient acknowledges that certain risks are associated with X-rays. The patient, hereby states that they have no known limitations that would forbid the taking of X-rays. The patient further agrees that this office may seek outside interpretation of patient X-rays by a qualified professional not employed by this office. Exams and X-rays are no longer billed to insurance companies. The patient agrees to any additional fees associated with this service and assigns benefits to be paid directly to that professional by your third-party payer.

_____ Initial Here

Non Disparagement

The patient consents to take no action which is intended, or would reasonably be expected, to harm Stuart Family Chiropractic or their reputation or which would reasonably be expected to lead to unwanted or unfavorable publicity to Stuart Family Chiropractic.

_____ Initial Here

Assignment of Benefits and Release of Records

The patient hereby assigns benefits to be paid directly to this provider by all of the third party payers. This assignment is irrevocable. Failure to fill this obligation will be considered a breach of contract between the patient and this office. The patient authorizes this office to release any information required by a third party payer necessary for reimbursement of charges incurred.

_____ Initial Here

Financial Return Policy

The patient agrees that any money spent on a Treatment Package is an agreement to complete said visits. Any money returned for services is at the discretion of the Doctor and a fee of $25 will be applied.

_____ Initial Here

_____	X _____	____/____/_____
Patient's Printed Name	Patient's Signature	Date
_____	X _____	____/____/_____
Witness's Printed Name	Witness's Signature	Date

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CHIEF COMPLAINT Provide information for your most significant issue (You will have chance to describe other issues on next page)

Describe the main reason for your visit _____

_____

Date when symptom started _____ How did this start? _____

Have you seen anyone for this complaint? ☐ Yes ☐ No

Are you taking any medication(s) for this complaint? ☐ Yes ☐ No

If yes, list_____

_____

Are your symptoms: ☐ Improving ☐ Getting Worse

☐ Same ☐ Sometimes Better/Sometimes Worse

What increases your symptoms? _____

_____

What decreases your symptoms? _____

_____

What activities are limited by your discomfort?

☐ Bending	☐ Pushing	☐ Turning Head
☐ Bowel Movement	☐ Reading	☐ Urination
☐ Coughing	☐ Sitting	☐ Running
☐ Driving	☐ Sleeping	
☐ Getting Up	☐ Sneezing	
☐ Lifting	☐ Standing	
☐ Lying Down	☐ Working	
☐ Pulling	☐ Walking	

☐ Daily Routine_____

_____

☐ Other _____

_____

How often do you experience this symptom throughout the day?

☐ 100% ☐ 75% ☐ 50% ☐ 25% ☐ 10%

Describe your pain: ☐ Sharp ☐ Dull ☐ Ache

☐ Burning ☐ Throbbing ☐ Constant ☐ Intermittent ☐ Frequent

Does it radiate into your: ☐ Arm ☐ Leg ☐ Head ☐ None

Do you have numbness or tingling? ☐ Yes ☐ No

Please rate your pain/symptom on a scale of 1 to 10

No Pain				Moderate Pain						Extreme Pain
☐ 0-	☐ 1-	☐ 2-	☐ 3-	☐ 4-	☐ 5-	☐ 6-	☐ 7-	☐ 8-	☐ 9-	☐ 10

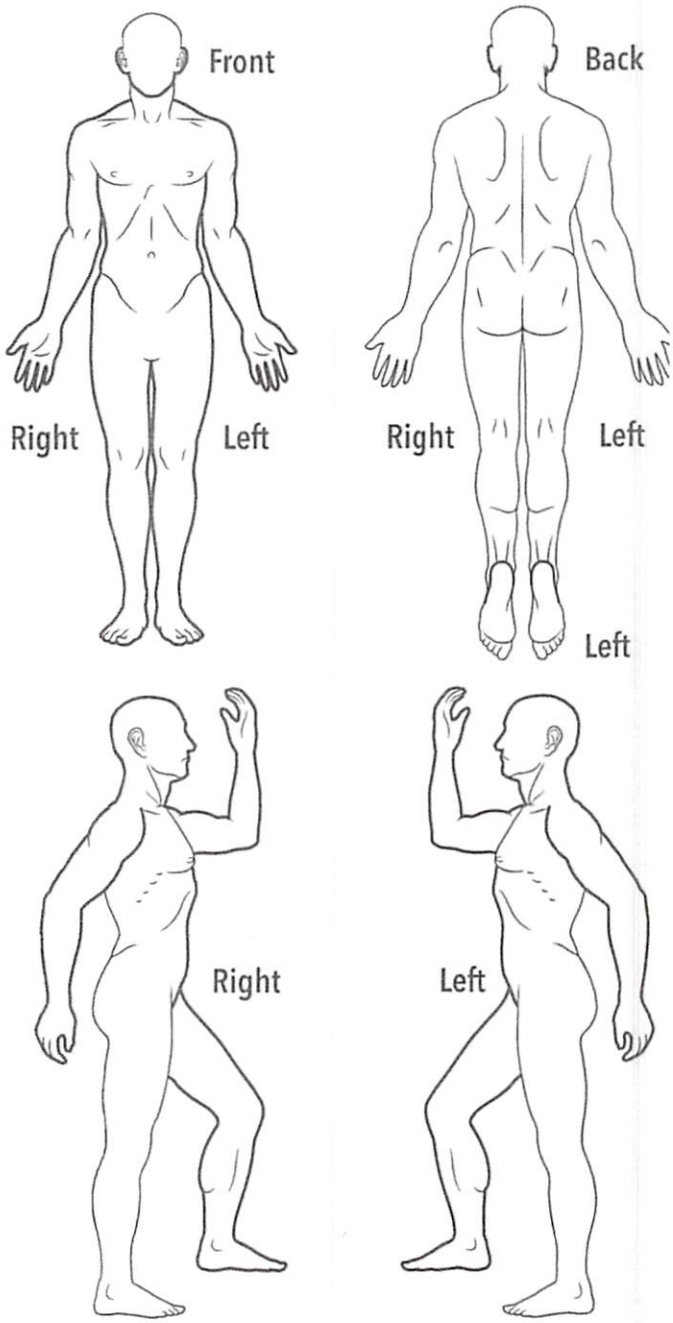
Provide approximate date (month and year) of your most recent:

Spinal X-ray _____ MRI _____

Blood Work _____ Physical Exam _____

CT Scan _____ Nerve Tests _____

Please mark off the areas of your complaint on the diagram below with the following indicators: PPP = pain • NNN = numbness TTT= tingling • BBB= burning • CCC= cramping • XXX = other



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SECONDARY COMPLAINT(S)

Describe other issues or concerns _____

_____

Date when symptoms started _____ How did this start? _____

Have you seen anyone for this complaint? ☐ Yes ☐ No

Are you taking any medication(s) for this complaint? ☐ Yes ☐ No

If yes, list _____

_____

Are your symptoms: ☐ Improving ☐ Getting Worse

☐ Same ☐ Sometimes Better/Sometimes Worse

What increases your symptoms? _____

_____

What decreases your symptoms? _____

_____

What activities are limited by your discomfort?

☐ Bending	☐ Pushing	☐ Turning Head
☐ Bowel Movement	☐ Reading	☐ Urination
☐ Coughing	☐ Sitting	☐ Running
☐ Driving	☐ Sleeping	
☐ Getting Up	☐ Sneezing	
☐ Lifting	☐ Standing	
☐ Lying Down	☐ Working	
☐ Pulling	☐ Walking	

☐ Daily Routine _____

☐ Other _____

_____

How often do you experience this symptom throughout the day?

☐ 100% ☐ 75% ☐ 50% ☐ 25% ☐ 10%

Describe your pain: ☐ Sharp ☐ Dull ☐ Ache

☐ Burning ☐ Throbbing ☐ Constant ☐ Intermittent ☐ Frequent

Does it radiate into your: ☐ Arm ☐ Leg ☐ Head ☐ None

Do you have numbness or tingling? ☐ Yes ☐ No

Please rate your pain/symptom on a scale of 1 to 10

No Pain				Moderate Pain						Extreme Pain
☐ 0-	☐ 1-	☐ 2-	☐ 3-	☐ 4-	☐ 5-	☐ 6-	☐ 7-	☐ 8-	☐ 9-	☐ 10

Provide approximate date (month and year) of your most recent:

Spinal X-Ray _____ MRI _____

Blood Work _____ Physical Exam _____

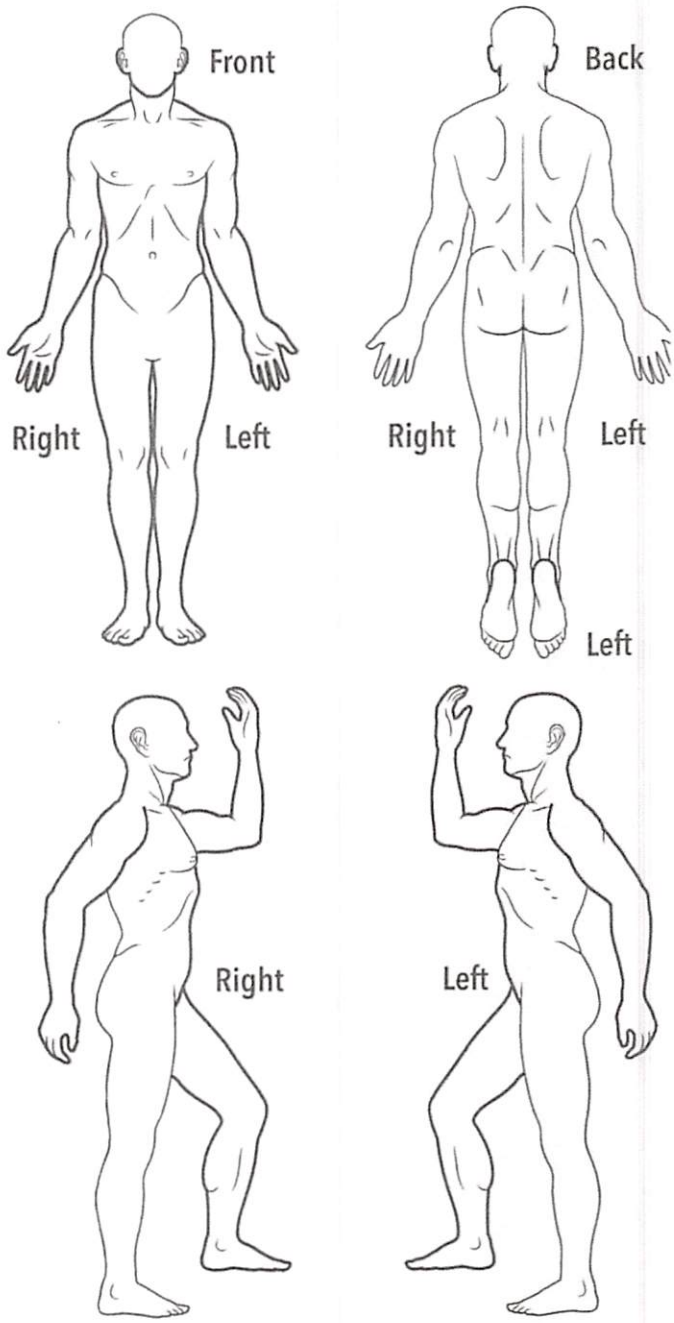
CT Scan _____ Nerve Tests _____

Patient's Printed Name _____

Patient's Signature X _____

Date _____ /_____ /_____

Please mark off the areas of your complaint on the diagram below with the following indicators: PPP = pain • NNN = numbness TTT= tingling • BBB= burning • CCC= cramping • XXX = other



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INFORMED CONSENT

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 healthcare 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 incident 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, burns or minor complications.

Other Treatment Options: May include over-the-counter analgesics, prescription medications, injections, and surgery.

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.

No Warranty: I understand that my doctor at Stuart Family Chiropractic, cannot make any promises or guarantees regarding a cure for or improvement in my condition. I understand that my doctor will share with me his opinion regarding potential results from chiropractic treatment for my condition and will discuss treatment option with me before I consent to treatment.

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 herby give my full consent to treatment.

_____	X _____	____/____/_____
Patient's Printed Name	Patient's Signature	Date
_____	X _____	____/____/_____
Witness's Printed Name	Witness's Signature	Date

CANCELATIONS

Please be courteous:

If you cannot make your appointment please call our office at **772-781-0193** so that we can make sure you'll be seen quickly. Also note that some of our equipment is designed for specific therapy and we carefully time things for each session. Prompt arrivals help ensure that patient wait times are not extended or appointments do not get unduly delayed.

We are grateful for your assistance with this, as are your fellow patients.

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a 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 placed in my patient chart and maintained for six years.

By checking the lines below I authorize being contacted for practice reminders from Stuart Family Chiropractic Center by:

Mail _____;
Email_____; at email address
_____;
Telephone numbers_____;
_____;
By voice mail _____;
By text message _____;
By FaceBook address _____.

By checking this checking the lines below I authorize being contacted for birthday greetings or promotions about the practice by:

Mail _____;
Email _____ at email address
_____;
Telephone numbers_____;
_____;
By voice mail _____;
By text message _____;
By FaceBook address _____.

By checking this checking the lines below I authorize the doctor to personally discuss with me products that may benefit my health or condition. _____

_____ _____
Patient Name (please print) Date

_____
Name of Parent, Guardian or Patient's legal representative

_____
Signature of Patient, Parent, Guardian or Patient's legal representative

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.

List below the names and relationship of people to whom you authorize the Practice to release PHI.

_____	_____
_____	_____
_____	_____

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Fax 772-781-0197

PREGNANCY AFFIRMATION

I affirm, to the best of my knowledge, that I am NOT currently pregnant. Should this condition change, I will notify Dr. Gonyo and/or his staff as soon as possible.

Date of Last Menstrual Period_____

Patient Signature_____ Date_____

Guardian/Representative signature_____