Amelia Island Health & Wellness

5211 South Fletcher Ave, Suite 250. Fernandina Beach, FL 32034

(904) 310-6437

Acct# _____

Confidential Patient Information

Patients Name: _____ Sex [] **M** [] **F** Age: _____

Address:_____

City:_____Zip:_____ Marital Status: Married [ ] Single [ ] Divorced [ ]

Widowed [ ] Separated [ ]

Cell # _____ Date of Birth: _____

Employer or School: _____

Email:_____

How did you hear about our office?

If using insurance, please fill out this boxed section. If not, leave blank and continue below.

Insurance Company:_____ Ins. Phone #: ( )

ID#: _____ Group #: _____

Name of Policy Holder:_____ Policy Holder Birth Date: _____

Patient's relationship to the policy holder: [ ] Self [] Child [] Spouse [] Other

Secondary Ins. Company:_____ Ins. Phone #: ( )

ID#: _____ Group #: _____

Name of Policy Holder:_____ Policy Holder Birth Date:_____

Family Physician: _____ Physician's Phone: _____

Physician's Address: _____

Person to contact in case of emergency (Name & Phone #): _____

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign at clinic's request, and convey directly to Ryan Ohl, DC or Mark Brown DC & Amelia Island Health and Wellness all medical benefits and/or insurance reimbursement otherwise payable to me for services rendered at above clinic. I understand that I am financially responsible for all charges regardless of any insurance or benefit payments. I authorize the release of all medical information necessary to process this claim. I authorize any plan administrator or fiduciary, insurer, and my attorney to release to such doctor/clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor/clinic in order to claim such medical benefits, reimbursement, or any applicable remedies. Any outstanding balances not paid by insurance after 90 days is due immediately. I hereby authorize the doctor/clinic to release any and all medical information to other health care providers involved in my care including but not limited to my primary care physician. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original.

I have read and fully understand this agreement.

SIGNATURE:_____ DATE:_____

Terms of Acceptance

The goal of our office is to enable patients to gain control of their health. To attain this, we believe communication is key. Please read below and if you have any questions, feel free to ask.

Informed Consent for Treatment

A patient, in coming to Amelia Island Health & Wellness, gives the doctor(s) permission and authority to care for the patient in accordance with chiropractic tests, diagnosis, and analysis. I understand that chiropractic care involves evaluation and treatment of the spine and related structures. I have been informed that risks, though rare, may include soreness, stiffness, or temporary symptom aggravation. Serious complications are extremely rare. The doctor(s) of course, will not give any treatment if he is aware that such care may be contraindicated. I understand that if I am accepted as a patient, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment or any other treatment will be explained to me upon my request. No guarantee of results has been made. I may ask questions and may stop care at any time.

Patient/Guardian Signature: _____Date: _____

Consent for Minor (if under 18)

I am the parent/legal guardian of the above-named minor and authorize chiropractic care as described.

Parent/Guardian Signature: _____Printed Name: _____

Communication Consent

I give my permission for Ryan Ohl, DC, Mark Brown DC, and Amelia Island Health & Wellness to communicate with me regarding my appointments, care, announcements, and billing by the methods I check below. I understand that while reasonable safeguards are in place, text and email are not fully secure methods of communication.

Preferred Communication Methods (check all that apply):

☐ Phone Call
☐ Voicemail Messages
☐ Text Message (SMS)
☐ Email

Acknowledgment of Receipt of Notice of Privacy Practices

I have read and fully understand the above statements. I have reviewed the notice of privacy practices (HIPAA), or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that I may request a copy at any time, and that I may ask questions if I need clarification about my rights.

Patient Name (print): _____

Patient Signature: _____

Date: _____

Please list below person(s) that we may discuss your medical information with, if any:

Name:_____ Relationship to patient:_____

Name:_____ Relationship to patient:_____

Name:_____ Relationship to patient:_____

Financial Policy

Regardless of whether you are using insurance or not, we will suggest the care that is in your best interest.

Health Insurance Plans

Your health insurance is a contract between **you and your insurance company**, not between the insurance company and this office. We cannot be certain if your insurance covers chiropractic services. They amount they pay varies from one policy to another. Please call your insurance company to verify benefits. Patient is responsible to tell us if pre-authorization is required. Medical providers are not required to look up your benefit information. Benefits quoted are not a guarantee of payment. As a courtesy to you, our office will complete any necessary insurance forms at no additional charge, and file them with your insurance company to help you collect. You are responsible for all **copays, coinsurance, deductibles, and any services not covered** by your plan. Final determination is made by your insurance company after claims are processed.

If your insurance company delays or denies payment, you remain financially responsible for your balance.

Personal Injury / Auto Accident Cases

- If you are receiving care related to a personal injury (PI) or auto accident, we will work with your insurance company and/or attorney when applicable.
- Please provide all required insurance information, claim numbers, and attorney contact information if you are represented.
- You are ultimately responsible for charges if coverage is denied, delayed, or not paid in full.
- If settlement of your case takes longer than anticipated, we may request that you make payments toward your balance.

Self-Pay Patients

- We strive to provide quality care at affordable rates
- If you do not have insurance or choose not to use it, payment is expected at the time of service.
- A price list can be provided upon request.
- Payment must be received when services are rendered.
- Payment may be made by cash, check, debit, or credit card.

Medicare Patients

- We are a Medicare provider and will file claims on your behalf.
- Medicare **only covers spinal manipulation for active treatment of a diagnosed condition**.
- Medicare does **not cover exams, therapies, x-rays, or maintenance/wellness care**; these services are your responsibility.
- You will be asked to sign an **Advance Beneficiary Notice (ABN)** for any non-covered services so you are aware of your responsibility before receiving care.

Agreement

I have read and understand the Financial Policy of Amelia Island Health & Wellness. I agree to be personally responsible for payment of all services rendered, regardless of insurance coverage or settlement status.

Patient (or Legal Guardian) Signature: _____

Printed Name: _____

Date: _____

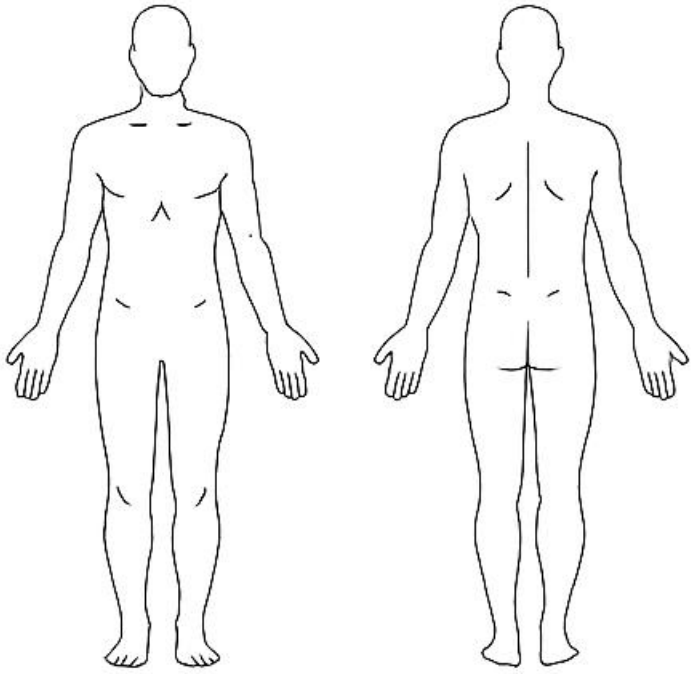
Amelia Island Health & Wellness

New Patient Information

1. Main Health Concerns:

List your health concerns in order of severity	Rate of severity on a scale of 1-10. 1: Minimal 10: Severe	When did it begin?	Have you ever had this problem before?	% of the day that symptoms are present?

2. Indicate on the drawing below where you have pain/symptoms:



(Mark areas of pain, numbness, tingling, stiffness.
Symbols: X = pain, O = numbness, //// = tingling)

If you have any scars, surgical sites, or internal metal, please notate as well.

☐ Sharp ☐ Stabbing ☐Dull

☐Stiff ☐ Diffuse ☐Achy

☐Shooting ☐Tingling ☐Numb

☐Electrical ☐Burning ☐Tight

3. How are these symptoms changing with time: ☐Getting Better ☐ Same ☐Getting Worse

4. How much has these problems interfered with your daily life?

☐Not at all ☐A little bit ☐Moderately ☐Quite a bit ☐Extremely

Affected Areas: ☐Work ☐Exercise ☐Sleep ☐Driving ☐Household tasks ☐Other: _____

5. Is there anything you can do yourself to alleviate the problem:_____

6. Have you seen anyone else for these problems, such as ER visit, primary care, massage, physical therapist?_____

7. Have you seen another Chiropractor for this problem? _____ Results: ☐Good ☐Fair ☐Poor

8. Have you had any X-rays, MRIs, or CT Scans before? _____

9. Have you received an official diagnosis for any condition by another healthcare provider: ☐Yes ☐No
If Yes, what was the diagnosis?_____

10. Please list any allergies, medications, or nutritional supplements currently or recently taken:

Allergies:	**Medications:**	**Vitamins/Herbs/Minerals:**

11. List any Accidents, Surgeries, Hospitalizations, Injuries, Major Traumatic Events

Area of Body	**Date of Injury**

12. Family Health History: You, Parents, Siblings: Mark an X in the box next to the condition.

ADD/ADHD		Herniated Disc		Restless Leg Syndrome	
AIDS/HIV		Herpes		Rheumatoid Arthritis	
Appendicitis		High Cholesterol		Seizures	
Arthritis		Kidney Disease		Stroke	
Asthma		Liver Disease		Thyroid Problems	
Bleeding Orders		Memory Problems		Tonsillitis	
Bronchitis		Nausea/Vomiting		Tuberculosis	
Cancer		Migraines		Tremors / Shaking	
Chronic Fatigue		Miscarriage		Tumors/Growths	
Diabetes		Multiple Sclerosis		Typhoid Fever	
Dizziness		Osteoporosis		Ulcers	
Epilepsy		Pacemaker		Vision Problems	
Fibromyalgia		Parkinson's		Implants (Medical/Electrical/Mechanical)	
Fractures		Pinched Nerve		Other:	
Gout		Pneumonia		Other:	
Heart Disease		Polio		Other:	
High Blood Pressure		Prosthesis		Other:	
Hepatitis		Psychiatric Care		**NONE**	
Hernia					

13. Basic Lifestyle Questions: **Exercise:** ☐None ☐ Light ☐Moderate ☐Heavy
Habits: **Smoking:** Yes / No **Alcohol:** Yes / No
What do you like to do for fun?_____

Print Name:_____ Signature:_____Date:_____