



GRUSKY CHIROPRACTIC CENTER, P.A.

DATE: _____
 LAST NAME: _____
 FIRST NAME: _____ MI: _____
 DATE OF BIRTH: ___/___/___ SEX: ___M ___F
 SOC. SEC. #: _____
 MARITAL STATUS: _____ SINGLE _____ MARRIED
 # OF CHILDREN: _____ E-MAIL: _____
 STUDENT STATUS: _____ FULL TIME _____ PART TIME CELLPHONE: _____
 HOME ADDRESS: _____ APT #: _____
 CITY _____ STATE _____ ZIP _____ HOME PHONE (____) _____
 EMPLOYER: _____ BUS. ADDRESS: _____
 CITY: _____ STATE: _____ ZIP _____ BUS. PHONE: (____) _____
 OCCUPATION: _____
 WHO MAY WE THANK FOR REFERRING YOU? _____

FOR OFFICE USE ONLY:
 CASE NO. 18737
 OPR NO. _____
 DOCTOR NO. _____

ACCOUNT INFORMATION
 PRIMARY INSURANCE COMPANY NAME: _____
 POLICY # _____ BIRTH DATE OF INSURED: _____
 NAME OF INSURED: _____ INSURED EMPLOYER: _____
 SOCIAL SECURITY # OF INSURED: _____ DEDUCTIBLE \$ _____
 RELATIONSHIP TO INSURED: (CIRCLE ONE) SELF / SPOUSE / CHILD
 RESPONSIBLE PARTY(PARENT/GUARDIAN) _____
 HOME ADDRESS: _____ WORK PHONE: _____

WORKER'S COMPENSATION
 DID YOU REPORT THIS INJURY TO YOUR EMPLOYER? YES / NO
 WERE ANY DAYS LOST FROM WORK? NO / YES - WHAT DATES? _____
 EMPLOYER NAME: _____
 EMPLOYER ADDRESS: _____ CITY: _____ ZIP: _____
 EMPLOYER PHONE: _____
 WHICH SUPERVISOR DID YOU REPORT INJURY TO? _____
 DATE OF INJURY: _____ BRIEF DESCRIPTION OF INJURY: _____

AUTOMOBILE ACCIDENT
 DATE OF ACCIDENT: _____ POLICE REPORT MADE? YES / NO
 TIME OF ACCIDENT: _____ PLACE: (STREETS) _____
 WERE YOU SEAT BELTED? YES / NO WERE YOU HOSPITALIZED? YES / NO
 WERE ANY DAYS LOST AT WORK? IF SO, GIVE DATES _____
 AUTO INSURANCE COMPANY NAME: _____
 POLICY HOLDER: _____ POLICY NUMBER: _____
 ATTORNEY NAME: _____ POLICY NUMBER: _____

HEIGHT: _____ WEIGHT: _____ AGE: _____

HAVE YOU RECEIVED CHIROPRACTIC CARE PREVIOUSLY YES / NO

PLEASE DESCRIBE THE PRINCIPLE HEALTH PROBLEMS FOR WHICH YOU CAME TO THIS OFFICE? _____

LIST ANY OTHER DOCTORS SEEN FOR THESE PROBLEMS: _____

ARE YOU CURRENTLY TAKING ANY MEDICATIONS? _____

LIST ANY OPERATIONS OR MAJOR ILLNESSES YOU HAVE BEEN TREATED FOR: _____

CHECK WHAT REASON YOU HAVE FOR COMING TO THIS OFFICE: _____

- ELIMINATE PAIN
- LOCATE CAUSE OF PROBLEM AND MAKE CORRECTION
- IMPROVE MY HEALTH
- DISCOVER THE BENEFITS OF CHIROPRACTIC AND WELLNESS CARE

ARE YOU PREGNANT? YES / NO

AUTO ACCIDENT

DESCRIPTION OF ACCIDENT: _____

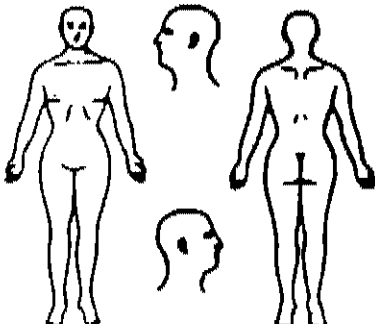
LIST SYMPTOMS IMMEDIATELY FOLLOWING THE ACCIDENT: _____

SYMPTOMS AT THE PRESENT TIME: _____

PATIENT REACTIVATION (OPR)

IS THIS A NEW CONDITION? NO / YES - IF YES, PLEASE EXPLAIN: _____

FOR DOCTORS USE ONLY



I understand that I am responsible for all payments for all services rendered. I agree to pay a collection agency and/or attorneys fees if necessary to collect the amount owed.

Patient's Signature _____

Parent's Signature (if minor) _____

Wellness Questionnaire/Cuestionario De Salud

1. Are you at your ideal weight?/*Usted esta en su peso ideal?* _____
If not, how much would you like to gain? _____ lbs
Or lose _____ lbs/*Si no, cuanto quiciera subir _____ lbs*
o bajar _____ lbs

2. Do you exercise? _____ /*Usted hace ejercistos diarios?* _____
Check all that apply:
Flexibility exercise _____ Strength exercise _____ Aerobic exercise _____

Chequee todo lo que le aplica:
Ejercicio de flexibilidad _____ Ejercicio de Resistencia _____ Ejercicio de aerobico _____

3. Do you take supplements? _____
If yes, please list:

Usted toma suplementos/vitaminas? _____
escribio si, porfavor de listar los:

4. Do you have ways to deal with stress? _____
Usted tiene una manera de lidiar con el estress? _____

5. Do you understand the benefits of a chiropractic adjustment on your Nervous System and overall health? _____
Usted entiende los beneficios de un ajuste de un chiropractico en el sistema nervioso en su salud? _____

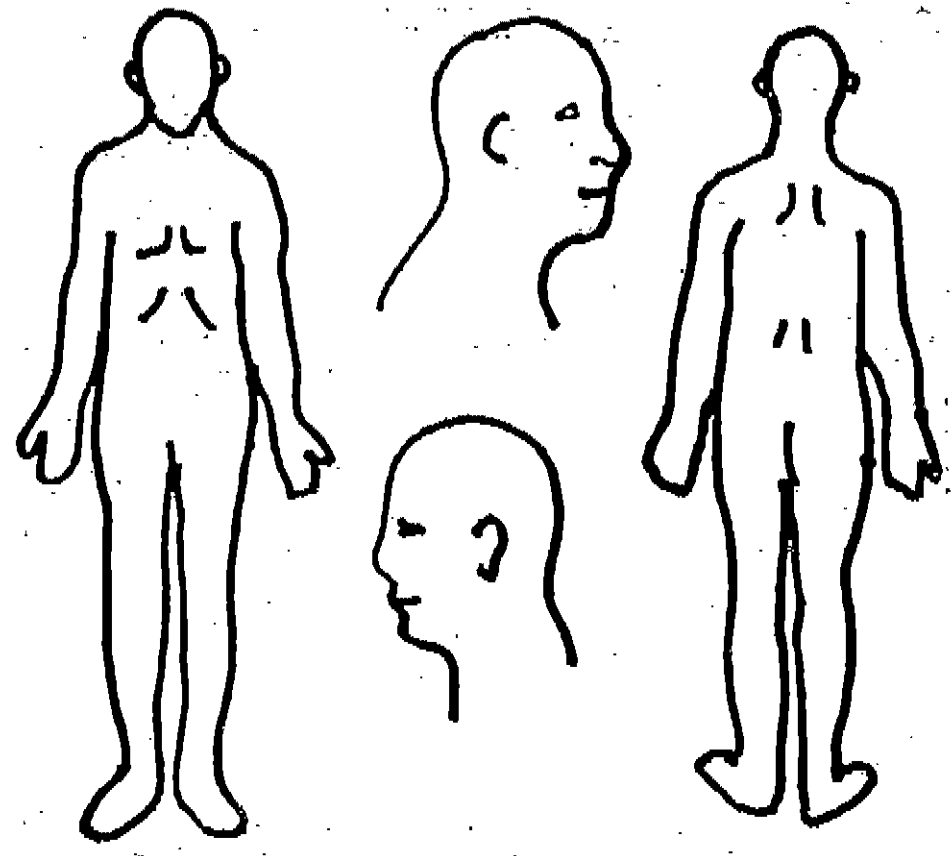
6. Rate your overall health from 1 to 10, 10 being the best you have ever felt. (Place an X on the scale)
Evalue su salud, desde el numero 1 hasta el 10, 10 siendo lo mejor que usted se ha sentido. (Coloque una X en la escala)

1-----10

GRUSKY CHIROPRACTIC CENTER, P.A.
11400 N. KENDALL DRIVE – STE 100
MIAMI, FLORIDA 33176
305-598-2005

Place an "X" on the drawing below on areas causing you pain and a letter describing it.

- A=ACHE
- B=BURNING
- S=STABING
- N=NUMBNESS
- P=PIN & NEEDLES



SIGNATURE: _____

GRUSKY CHIROPRACTIC CENTER, P.A.

ELLIOT C. GRUSKY, D.C.
LAWRENCE E. GRUSKY, D.C., C.C.S.P.

11400 N. Kendall Drive
Suite 100 • Miami, Florida 33178
305.598.2005 • Fax 305.598.8518

Jordan H. Kaplan, D.C.
June Gentle, D.C.

OUR FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we require you read and sign.

FULL PAYMENT IS DUE AT TIME OF SERVICE.
WE ACCEPT CASH, CHECKS, OR VISA/MASTER CARD.
PATIENT CONTRACT PLANS ARE ALSO OFFERED.

Regarding Insurance.

We may accept assignment of insurance benefits after your second visit. We require the full amount of your first visit to be paid at time of service. The account balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information and a completed original claim form. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event we do accept assignment of benefits we require that you are responsible for any amount unpaid by your insurance company. If your insurance company has not paid on your account within 45 days, the balance will be automatically transferred to your "patient balance." You will then be required to make payment using one of the payment options listed above. Please be aware that some of the services provided may be "non-covered" services and not considered reasonable and necessary under Medicare and / or other medical insurance.

Regarding Insurance Plans where we are a participating provider. All co-pays and deductibles are due at the time of treatment. In the event that your insurance coverage changes to a plan where we are not participating providers, refer to above paragraph.

Usual and Customary Rates.

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Adult Patients.

Adult patients are responsible for full payment at time of service.

Minor Patients.

The adult accompanying a minor and/or the parents (or guardians of the minor) are responsible for full payment.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns. I have read the Financial Policy. I understand and agree to this Financial Policy:

x _____

Date _____

Signature of Patient or Responsible Party

Grusky Chiropractic Center, P.A.

Elliott C. Grusky, D.C.
Lawrence E. Grusky, D.C., C.C.S.P.
Jordan H. Kaplan, D.C.
June Gentle, D.C.

11400 N. Kendall Drive
Suite 100 - Miami, Florida 33176
305-598-2005 - Fax 305-598-8518

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.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

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.

Pregnancy Release:

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: _____

Signature

Date

GRUSKY CHIROPRACTIC CENTER PATIENT HEALTH INFORMATION PRIVACY
AGREEMENT.

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTH OPERATIONS.

I consent to the use or disclosure of my protected health information by Grusky Chiropractic for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Grusky Chiropractic. I understand that diagnosis or treatment of me by Grusky Chiropractic may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Grusky Chiropractic is not required to agree to the restrictions that I may request. However, if Grusky Chiropractic agrees to a restriction that I request, the restriction is binding on Grusky Chiropractic and Elliott C. Grusky, D.C., Lawrence E. Grusky, D.C., Jordan H. Kaplan, D.C., and June Gentle, D.C.

I have the right to revoke this consent, in writing, at any time except to the extent that the doctor or Grusky Chiropractic Center has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Grusky Chiropractic's Notice of Privacy Practices prior to signing this document. The Grusky Chiropractic's Notice of Privacy has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Grusky Chiropractic. This notice also describes my rights and Grusky Chiropractic's duties with respect to my protected health information.

Grusky Chiropractic Center reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative

Relationship of Personal Representative

Printed name Patient or Personal Rep

Date

I give my consent to Grusky Chiropractic Center P.A. to speak to any family members regarding my appointment/s.

Patient's Initials _____