Today's Date:_____

How Did You Hear About Us?

- ❏ Mall Promotion
- ❏ Walmart Promotion
- ❏ Yellow Pages
- ❏ Other Patient_____
- ❏ Doctor Referral
- ❏ Attorney Referral_____
- ❏ Other_____

Your Name (First and Last): _____ Date of

Birth:_____Social Security:_____-_____-_____ Phone Numbers:

Cell:_____Home:_____Work:_____

Address:_____

City:_____ State:_____ Zip:_____

Email:_____ Occupation:_____ Emergency

Contact:_____ Phone Number:_____ **Chief**

Complaint_____ Cause of

Pain Auto Accident Slip & Fall Other:_____

What makes your pain worse_____

What makes your pain better_____

Any health conditions we should be aware of?_____

Have you had massage therapy before?____ Chiropractic care?_____Physical Therapy?_____

Do you have health insurance?_____Company Name:_____

Is it a: PPO/POS_____ HMO_____ Medicare/Medicaid_____

Do you have a secondary policy?_____ Company Name:_____

Medical Doctor:_____ Phone Number:_____

Patient's Signature:_____

We are HIPPA compliant! Your information WILL be protected.

******No tipping allowed, it's our pleasure!******

Consent To Treat

I hereby request and consent to the performance of chiropractic adjustment and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below for whom I am legally responsible) by the doctors and staff members who work at the office located at the address below.

I have had an opportunity to discuss with the doctors of chiropractic, at the location listed below, and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations, and sprains. 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 judgement during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my interest.

I have read, or have 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 above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature:_____Date:_____

Consent to treat minor:_____
Guardian Signature

Print Name:_____

Relationship:_____

7797 N University Drive, Suite 101 Tamarac, Florida 33321
Telephone: (954)722-6050 Fax: (954)720-7776

Patient Form

Patient's Name:_____ Date of Birth:____/_____/_____

Address:_____

City:_____State:_____Zip Code:_____

Cell:_____Home:_____Work:_____

Email:_____

Insurance Information:

Insurance Name:_____ Insurance ID:_____

Insurance Group number:_____

Subscriber Name:_____

Subscriber Relation to Patient:_____

Authorization to pay medical and surgical benefits directly to attending physician:

I hereby authorize my insurance _____to make payments directly to ***University Health Center*** for all services and medical expense benefits. I understand that I am financially responsible for all charges not covered by my insurance benefits. I also authorize release of my records to the insurance company for the purpose of billing.

_____

Signature of Patient/Parent/Guardian/ Insured

_____ _____

Print Name of Patient/Parent/Guardian/ Insured Date

PATIENT AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION (PHI) TO PROVIDE/BILLING AGENT (HIPPA COMPLIANT)

I_____ (the patient/policyholder) hereby authorize _____ (insurance carrier legal representative) its agent, employees, and associates to release the protected health information that is described below, to the provider's office of _____, or the billing and collection agent/ representative of the same.

My insurance carrier, or my legal representation (should this case involve a legal matter) is directed to make available all of my insurance information including coverage information, and all billing records showing all charges, expense costs, and payments. Failure to prove such requested information, of which I hereby authorized the release of by my signature, may have adverse affects on my physical, mental, emotional well-being. I will hold any entity liable for such non-compliance with my authorization.

At my request this information will be used for the purpose of establishing coverage or payments or billing or establishing medical claim.

This authorization may be revoked at any time by giving written notice to the healthcare provider and/or billing agent a revocation of the authorization.

I understand that I have the right to refuse to sign this authorization and that the healthcare provider may not condition treatment payment enrollment, or eligibility for benefits on whether I sign this authorization.

I understand that once PHI is disclosed, it may be re-disclosed to individuals or organizations that are not subject to the federal privacy regulation such as an expert, witness, litigants, and insurance companies and even may become public record if filed with a court of law.

A copy of this signed authorization will be provided to me after it has been signed. This authorization will expired on:

Dated this_____day of_____20___

_____

(Patient/Policyholder)

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Medical Conditions: (Circle all that apply to you)

Arthritis Cancer Diabetes Heart Disease Hypertension Psychiatric Illness Skin Disorder Stroke

Fibromyalgia Asthma Osteoporosis Other:_____

Surgeries: (Circle all that apply to you)

Appendectomy Cardiovascular Procedure Cervical Spine Hysterectomy Joint Replacement

Prostate Lumbar Spine Gallbladder Brain Shoulder Thoracic Spine Knee Carpal Tunnel

Gastro-intestinal Uro-genital Hernia Breast Augmentation Other:_____

Allergies: (Circle all that apply to you)

Mold Seasonal Milk or Lactose Animal(s)_____ Chemical_____

Sulfites Wheat/Glutens Other:_____ **Would you be interested in filling your prescriptions? Yes or No**

What medications are you currently taking?_____ What vitamins/supplements are you currently taking?_____ How many nights per week do you drink alcohol?_____

How many drinks do you have?_____Do you smoke? Yes or No

How much mental stress do you experience? ____Mild ____Moderate ___Severe How many hours of sleep do you get per night?____ What time do you go to bed?_____ What general physical activity do you do?____ No exercise _____LIght _____Strenuous

ARE YOU PREGNANT? YES OR NO

If no, please certify that you have no intention to become pregnant while under our care. You are being instructed that during your treatment here you may receive medications, x-rays, and/or other treatment that may be potentially harmful and could cause fetal damage. I am releasing UHC and its affiliates or contracted groups from any liability and responsibility for fetal injuries or dmage should pregnancy occur while in their care.

Patient's Signature:_____

_____give authorization for_____ to submit any and all payments for services rendered in the office directly to University Health Care Center.

University Health Care Center

7797 North University Drive Suite 101

Tamarac FL, 33321

Tax ID: 208791396 **Phone number**: (954)722-6050

I_____am aware that any payments received, cashed, or deposited in error to myself for payment regarding services provided by University Health Care, will need to reimbursed to University health Center with no exemptions and may include a penalty fee for such action. In the event, checks or monies are not distributed to University Health Center directly as requested please sign and forward checks to University Health Center for payment for services rendered or legal action through Debt Collection Company will be in effect.

Patient's Signature_____

Date:_____

Assignment of Benefits/ Authorized Representative Form

Financial Responsibility:

I have requested professional services from *University Health Center P.A.* on behalf of myself and/or my dependents, and understand that by making this request, I am responsible for all charges incurred during the course of said services. I understand that all fees for said services are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement unless other arrangements have been made in advance.

Assignment of Insurance Benefits:

I hereby assign all applicable health insurance benefits to which I and/or my dependents are entitled to Provider. I certify that the health insurance information that I provided to Provider is accurate as of the date set forth below and that I am responsible for keeping it updated.

I hereby authorize Provider to submit claims, on my and/or my dependent's behalf, to the benefit plan (or its administrator) listed on the current insurance card I provided to Provider, in good faith. I also hereby instruct my benefit plan (or its administrator) to pay Provider directly for services rendered to me or my dependents. To the extent that my current policy prohibits direct payment to Provider, I hereby instruct and direct my benefit plan (or its administrator) to provide documentation stating such non-assignment to myself and Provider upon request. Upon proof of such non-assignment, I instruct my benefit plan (or its administrator) to make out the check to me and mail directly to the Provider.

I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from the Provider are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductibles.

Authorization to Release Information:

I hereby authorize Provider to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

A photocopy of this Assignment/ Authorization shall be as effective and valid as the

original. Patient's Signature:_____

Date:_____ Policyholder/Insured

_____ Date:_____

Dr.Steven Cane
Medical Records Release

Patient's Name:_____ Date of Birth:____/_____/_____

I hereby request and authorize:

University Health Care Center

7797 North University Drive Suite 101

Tamarac FL, 33321

Phone number: (954)722-6050 Fax: (954)720-7776 ____To disclose information ____To receive information

Name/Provider:_____

Address:_____City:_____Zip:_____

Phone:_____ FAX:_____ Information to be disclosed include copies of:

___Entire Record ___X-ray Reports ___Progress Notes

___X-ray Films ___Physical Exam ___Daily Chart Notes

Other:_____

Purpose for Disclosure:

_____

_ This authorization will be effective for six months after the date signed unless cancelled in writing. I understand that the cancellation will have no effect on information released prior to receiving the cancellation. A copy of this authorization is as valid as the original

Patient's Signature:_____ Date:_____

_____

Date:_____ Signature of Legal Representative/Relationship

If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law. Notice to recipient of information: this information has been disclosed to you from confidential records, which are protected by law. Unless you have further authorization, laws may prohibit you from making any further disclosures of this information without the specific written consent of the patient or legal representative.

COVID-19 SCREENING QUESTIONNAIRE

Please respond to each of the following questions truthfully and to the best of your ability. Your participation is important to help us take precautionary measures to protect you and those around you.

Name:_____ Date:_____

1. **Are you currently experiencing, or have experienced in the past 14 days, any of the following symptoms?**

   ❏ Fever (100.4° F/37.8° C or greater as measured by an oral thermometer) ❏ Cough

   ❏ Shortness of breath or difficulty breathing

   ❏ Sore throat

   ❏ New loss of taste or smell

   ❏ Chills

   ❏ Head or muscle aches

   ❏ Nausea, diarrhea, vomiting

   ❏ I have not experienced none of the options above

2. **In the past 14 days, have you been in contact with someone who tested positive for Covid-19?** ☐ Yes ☐ No

3. **In the past 14 days, have you been on commercial flight or traveled outside of the United States?** ☐ Yes ☐ No

4. **Have you tested positive for Covid-19?** ☐ Yes ☐ No **5. Have you been tested for Covid-19 and are waiting to receive test results?** ☐ Yes ☐ No

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I hereby certify that the responses provided above are true and accurate to the best of my knowledge.

Signature:_____Date:_____

May our office inform your physician of our exam findings, diagnosis, and treatment plans?

Yes or No