LAURA A. WELLER, D.C., P.A.

2090 MLK STREET NORTH ST PETERSBURG, FLORIDA 33704

DATE____________________

NAME____ BIRTHDATE________________ AGE____ SEX M / F

NICKNAME IF PREFERRED____ MARITAL STATUS M S D W

ADDRESS____ APT /UNIT #______________

CITY___________________________________ STATE_________ ZIP____________

HOME PHONE_____________________ CELL PHONE______________________ WORK PHONE____________________

EMAIL____ OCCUPATION___________________________________

INSURANCE COMPANY______________________________ MEMBER ID____

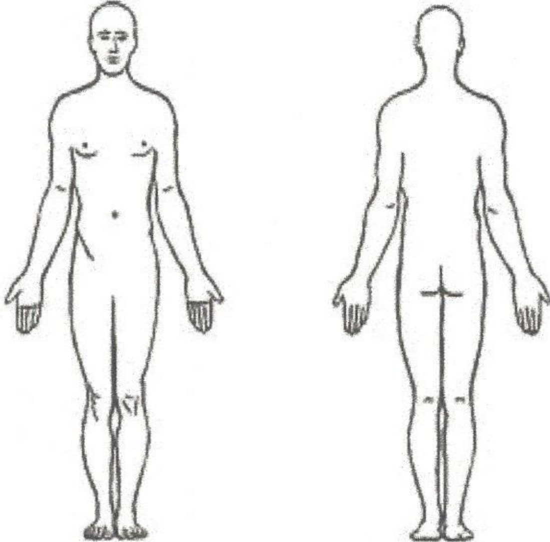
REFERRED BY____

HAVE YOU HAD X-RAYS , MRI, CT SCAN FOR YOUR AREA(S) OF COMPLAINT? [ ] YES [ ] NO

DATES TAKEN ____

WHAT AREAS WERE TAKEN____

YOUR MAJOR AND COMPLAINT AND SYMPTOMS



DATE PROBLEM BEGAN_______________ IS IT ___CHRONIC ___ACUTE ___WORK RELATED ___AUTO ACCIDENT

HOW DO YOU FEEL TODAY? (0 = NO PAIN 10 = UNBEARABLE PAIN) 0 1 2 3 4 5 6 7 8 9 10

HOW OFTEN ARE YOUR SYMPTOMS PRESENT? __ 0-25% __ 26-50% __ 51-75% __76-100% (CONSTANT)

PLEASE INDICATE AREAS OF PAIN AND/OR DISCOMFORT WITH AN "X"

HOW DID THIS HAPPEN?____

DOES THIS INTERFERE WITH YOUR NORMAL LIVING AND WORK?____

ANY PAST MEDICAL HISTORY NOT ONLY RELATED TO TODAY'S COMPLAINT:

ILLNESS____

FRACTURES____

SURGERIES____

CURRENTMEDICATIONS:____

____

PREVIOUS MEDICATIONS:____

____

VITAMINS____

PRIMARY PHYSICIAN____ PHONE__________________________

PATIENT NAME____ DATE___________________________________

HAVE YOU EVER:	YES	NO	DESCRIBE BRIEFLY
BEEN KNOCKED UNCONSCIOUS?	[]	[]	______________________
USED A CANE, CRUTCH OR OTHER SUPPORT?	[]	[]	______________________
BEEN TREATED FOR A SPINE OR NERVE DISORDER?	[]	[]	______________________
HAD A FRACTURED BONE?	[]	[]	______________________

DATE OF LAST:	LESS THAN 6 MONTHS	6-18 MONTHS	OVER 18 MONTHS	NEVER
SPINAL EXAMINATION	[]	[]	[]	[]
CHEST X-RAY	[]	[]	[]	[]
DENTAL X-RAY	[]	[]	[]	[]

CHEK THE FOLLOWING CONDITIONS YOU HAVE HAD :

__ALCOHOLISM __ANEMIA __APPENDICITIS __ARTHRITIS __BACK PAIN
__CANCER __COLD SORES __DIABETES __EPILIPSY __GOUT
__HEART DISEASE __HIGH BLD. PRES. __HEADACHES __ LUNG DISEASE __MISCARRIAGE
__MULT. SCLEROSIS __NECK PAIN __ NEURO. DISORDER __POLIO __RECENT INFECTION
__SIEZURES __SKIN PROBLEMS __STROKE __ULCERS __WHIPLASH

HAVE YOU HAD TREATMENT BY ANOTHER DOCTOR FOR THIS? ____M.D. ____D.O. ____D.C.
NAME OF DOCTOR______________________________ DIAGNOSIS______________________________
TREATMENT____
LENGTH OF TIME UNDER HIS/HER CARE____
RESULTS____

FAMILY HISTORY:	**MOTHER**	**FATHER**	**BROTHER**	**SISTER**
ALZHEIMER'S DISEASE	[]	[]	[]	[]
BACK PAIN	[]	[]	[]	[]
DIZZINESS/FAINTING	[]	[]	[]	[]
HEART DISEASE	[]	[]	[]	[]
HIGH BLOOD PRESSURE	[]	[]	[]	[]
HEADACHES/MIGRAINES	[]	[]	[]	[]
NECK PAIN	[]	[]	[]	[]
NEUROLOGICAL DISORDERS	[]	[]	[]	[]
SIEZURES	[]	[]	[]	[]
STROKE	[]	[]	[]	[]

BY MY SIGNATURE, I UNDERSTAND AND ACKNOWLEDGE THAT LAURA A. WELLER, D.C., P.A., ITS PHYSICIANS AND AGENTS WILL TREAT MY CONDITION AS THEY DEEM NECESSARY THROUGH THE USE OF CHIROPRACTIC MANIPULATIVE THERAPY AND ADJUNCTIVE THERAPIES. I ALSO UNDERSTAND THAT ALL ORIGINAL DOCUMENTS AND X-RAYS CREATED AS A RESULT OF THE PERFORMANCE OF EXAMINATIONS WILL REMAIN THE PROPERTY OF LAURA A. WELLER, D.C., P.A., ITS PHYSICIANS AND AGENTS AND WILL NOT BE HELD RESPONSIBLE FOR ANY UNDISCLOSED PRE-EXISTING CONDITIONS.

PATIENT/REPRESENTATIVE SIGNATURE____

HEALTH QUESTIONNAIRE: MARK ALL THAT APPLY

PATIENT NAME_______________________________________ DATE______________________________

GENERAL : [ ]Allergy [ ] Chills [ ] Convulsions [ ] Dizziness [ ] Fainting [ ] Fatigue [ ] Fever [ ] Headache [ ] Loss of Sleep [ ] Loss of Weight [ ] Nervousness/Depression [ ] Neuralgia [ ] Numbness [ ] Sweats [ ] Tremors [ ] Loss of Balance

MUSCLE & JOINT : [ ] Arthritis [ ] Bursitis [ ] Foot Trouble [ ] Hernia [ ] Low Back Pain [ ] Lumbago [ ] Neck Pain/Stiffness [ ] Pain Between Shoulders [ ] Shoulder Pain [ ] Arm Pain [ ] Elbow Pain [ ] Hand Pain [ ] Hip Pain [ ] Leg Pain [ ] Knee Pain [ ] Foot Pain [ ] Tail Bone Pain [ ] Poor Posture [ ] Sciatica [ ] Spinal Curvature [ ] Swollen Joints

EYE, EAR, NOSE & THROAT: [ ] Eye Strain [ ] Eye Inflammation [ ] Vision Problems [ ] Crossed Eyes [ ] Ear Noises [ ] Hearing Loss [ ] Earache [ ] Ear Discharge [ ]Nose Pain [ ] Nose Discharge [ ] Sore Gums [ ] Dental Problems [ ] Sore Mouth [ ] Sore Throat [ ] Hoarseness [ ] Difficult Speech [ ] Asthma [ ] Colds [ ] Enlarged Glands [ ] Enlarged Thyroid [ ] Hayfever [ ] Nasal Obstruction [ ] Sinus Infection

GASTRO-INESTINAL SYSTEM : [ ] Poor Appetite [ ] Excessive Hunger [ ] Difficult Chewing [ ] Difficult Swallowing [ ] Excessive Thirst [ ] Nausea [ ] Vomiting Food [ ] Vomiting Blood [ ] Abdominal Pain [ ] Diarrhea [ ] Constipation [ ] Black Stool [ ] Hemorrhoids [ ] Gall Bladder Problems

CARDIOVASCULAR/RESPIRATORY: [ ] Hardening of Arteries [ ] High Blood Pressure [ ]Low Blood Pressure [ ] Pain Over Heart [ ] Poor Circulation [ ] Rapid Heart Beat [ ] Slow Heart Beat [ ] Ankle Swelling [ ] Chest Pain [ ] Chronic Cough [ ] Difficult Breathing [ ] Spitting Up Phlegm [ ] Wheezing

GENITO-URINARY: [ ]Bed Wetting [ ] Blood In Urine [ ] Frequent Urination [ ] Inability To Control Kidneys [ ] Kidney Infection or Stones [ ] Painful Urination [ ] Prostate Trouble [ ] Pus In Urine

FEMALE: [ ] Congested Breasts [ ] Cramps or Backache [ ]Excessive Menstrual Flow [ ] Hot Flashes [ ] Irregular Cycle [ ] Menopausal symptoms [ ] Painful Menstruation [ ] Vaginal Discharge [ ] Pregnant

NERVOUS SYSTEM : [ ] Numbness [ ] Loss of Feeling [ ] Paralysis [ ] Dizziness [ ] Fainting [ ] Headache [ ] Muscle Jerking [ ] Convulsions [ ] Forgetfulness [ ] Confusion [ ] Depression

OTHER SYMPTOMS/CONCERNS NOT MENTIONED ABOVE:

____

____

____

____

LAURA A.WELLER, D.C., P.A.
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIVES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSES HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY: We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notices takes effect _____________ and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

USERS AND DISCLOSURES OF HEALTH INFORMATION

We use and disclosed health information about your for treatment, payment, and healthcare operations. For example:

TREATMENT: We may use or disclose health information to a physician or other healthcare provider providing treatment for you.

PAYMENT: we may use and disclosed your health information to obtain payment for services we provide to you.

HEALTHCARE OPERATIONS: We may use and disclose your health information in connection with other healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

YOUR AUTHORIZATION: In addition to our use of your health information for treatment, payments or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

TO YOUR FAMILY AND FRIENDS: We must disclose your health information to you, as described in the Patient Rights section of this notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

PERSONS INVOLVED WITH YOUR CARE: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure, we may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of our health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays or other similar forms of health information.

MARKETING HEALTH RELATED SERVICES: We will not use your health information for marketing communications without your written authorization.

REQUIRED BY LAW: We may use or disclose your health information when we are required by law to do so.

ABUSE OR NEGLECT: We may disclose your health information to appropriate authorities if we reasonably believe that you are the possible victim of abuse, neglect or domestic violence, or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety, or the health and safety of others.

NATIONAL SECURITY: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

APPOINTMENT REMINDERS: We may disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards or letters).

PATIENT RIGHTS

ACCESS: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this notice. We will charge you a reasonable cost-based fee for expenses, such as copies and staff time. You may request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you $_______ for each page, $_______ per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

DISCLOSE ACCOUNTING: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12 month period, we may charge you a reasonable, cost based fee for responding to these additional requests.

RESRICTIONS: You have the right to request that we place additional restrictions on our use or disclosure for your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

ALTERNATIVE COMMUNICATIONS: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

AMENDMENT: You have the right to request that we amend your health information. Your request must be in writing and it must explain why the information should be amended. We may deny your request under certain circumstances.

If you believe your privacy has been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To fila a complaint with our practice, contact Bernadette Bell, our privacy officer, at 2090 MLK Street North, St. Petersburg, Fl. 33704. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

LAURA A. WELLER, D.C., P.A.
2090 MLK STREET NORTH ST. PETERSBURG, FL. 33704

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ____ have received/reviewed a copy of Laura A. Weller, D.C., P.A.'s notice of privacy practices.

____
SIGNATURE

____
DATE

LAURA A. WELLER, D.C., P.A.
2090 MLK STREET NORTH ST. PETERSBURG, FL. 33704

PLEASE LIST FAMILY MEMERS OR OTHER PERSONS, IF ANY, WHOM WE MAY INFORM ABOUT YOUR GENERAL MEDICAL CONDITION AND DIAGNOSIS INCLUDING TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.

NAME:____ PHONE:___________________________________

NAME: ____ PHONE:___________________________________

EMERGENCY CONTACT:_______________________________ PHONE:____________________________________

PLEASE PRINT THE ADDRESS OF WHERE YOU WOULD LIKE YOUR BILLING STATEMENTS AND/OR CORRESPONDENCE FROM OUR OFFICE TO BE SENT IF OTHER THAN YOUR HOME:

____

PLEASE INDICATE IF YOU WANT YOUR CORRESPONDENCE FROM OUR OFFICE SENT IN A SEALED ENVELOPE MARKED "CONFIDENTIAL" __________ YES __________ NO

CAN CONFIDENTIAL MESSAGES (APPOINTMENT REMINDERS) BE LEFT ON YOUR ANSWERING MACHINE, VOICEMAIL AND EMAIL? ______________YES _____________NO

PLEASE PRINT TELEPHONE NUMBER WHERE YOU WANT TO RECEIVE CALLS ABOUT APPOINTMENTS, LAB/X-RAY RESULTS OR OTHER HEALTH CARE IF NOT YOUR HOME OR CELL NUMBER
PHONE ____ EMAIL____

FINANCIAL RESPONSIBILITY: I AGREE TO E FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCURRED AT THIS OFFICE, INCLUDING MY INSURANCE DEDUCTIBLE, CO-PAYMENT AND ANY SERVICES DENIED BY MY INSURANCE.
SIGNATURE____ DATE_________________________

INSURANCE: I AUTHORIZE THIS OFFICE TO RELEASE INFORMATION PERTINENT TO MY CASE TO ANY INSURANCE, ADJUSTER AND ATTORNEY INVOLVED IN MY CARE AND HEREBY RELEASE THIS OFFICE OF ANY CONSEQUECE THEREOF.
SIGNATURE____ DATE_________________________

ASSIGNMENT OF BENEFITS: I HEREBY INSTRUCT AND DIRECT MY INSUANCE COMPANY TO PAY BE CHECK MADE OUT TO AND MAILED DIRECTLY TO DR. LAURA A. WELLER, D.C., P.A. THE PROFESSIONAL AND/OR MEDICAL BENEFITS ALLOWABLE AND OTHERWISE PAYABLE TO ME UNDER MY CURRENT INSURANCE POLICY AS PAYMENT TOWARD THE TOTAL CHARGES FOR PROFESSIONAL SERVICES RENDERED BY THIS OFFICE. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY, HOWEVER THE PAYMENTS SHALL NOT EXCEED MY INDEBTEDNESS TO THIS OFFICE.
SIGNATURE____ DATE_________________________

LAURA A. WELLER, D.C., P.A.
2090 MLK STREET NORTH ST. PETERSBURG, FL. 33704

DISCLOSURE AND CONSENT CHIROPRACTIC ADJUSTMENTS

TO THE PATIENT: *You have a right as a patient to be informed about your condition and the recommended chiropractic adjustments and other chiropractic procedures to be used so that you may make the decision whether or not to undergo the procedures after knowing the potential risks and hazards involved. This disclosure is not meant to scare or alarm you. It is simply an effort to make you better informed so you may give or withhold your consent to the procedure.*

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays on me (or the patient named below for whom I am legally responsible by the Doctor of Chiropractic named above and/or other licensed Doctors of Chiropractic or those working at the clinic or office who now or in the future treat me while employed by, working or associated with, or serving as backup for the Doctor of Chiropractic named above.

I understand and I am informed that in the practice of chiropractic there are some risks to exam and treatment including but not limited to fracture, disc injuries, dislocations, sprains and increased symptoms and pain or not improvements of symptoms or pain. I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions, and all my questions have been answered fully and satisfactorily. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatments for my present condition and for any future condition(s) for which I seek treatment.

TO BE COMPLETED BY THE PATIENT:

____
Print Name

______________________________ ________________
Signature of Patient Date

______________________________ ________________
Witness Date