Elana Kaplove, DC PA
Chiropractic Physician

BACK IN BALANCE HEALING COLLECTIVE

Office # (561) 361-4888
Fax # (561) 361-4999

Confidential Patient Background

Today's Date: _____/ _____/_____

1) Name _____ 2) **Date of birth: _____/_____/_____**
Nickname_____ 3) □ Male □ Female
4) Primary Address _____City_____Zip_____
5) Secondary Address _____City_____Zip_____
6) Home Phone (_____) _____ 7) Cell Phone (_____) _____
8) E-mail _____ 9) Social Security # _____-_____-_____
10) Preferred Contact Method (Circle One): E-mail Phone Calls Text Message
11) Emergency contact _____Phone (_____)_____
12) □ Single □ Partnered □ Married □ Divorced □ Widowed □ Special Circumstances
13) Race/Ethnicity _____ 14) Religious preference (optional) _____
15) Preferred method of payment? _____
16) If insured, type? _____
17) How were you referred to us, or by whom? _____

Occupational History:

1) Employed? □ Yes □ No
2) Occupation _____ 3) Employer _____
4) Address _____5) Work Phone (_____) _____
6) Previous job history_____
7) Is this job-related? □ Yes □ no If yes, describe: _____
8) Are you experiencing any work restrictions as a result of your present condition?
□ yes □ no If yes, describe:_____

Ergonomics:

1) How comfortable is your mattress? _____ Pillow?_____
2) What position do you sleep in (back, side, stomach)? _____
3) How many hours per day are you at a computer (on average)? _____
Position of monitor/keyboard/chair/telephone _____
4) How do you get to work? _____ How long does it take? _____
5) Do you have difficulty sitting for long periods? □ yes □ no
6) Do you have difficulty standing for long periods? □ yes □ no
7) Do you have difficulty walking for long periods? □ yes □ no
8) Primary position (sitting/ standing/ walking)? _____
9) What kind of shoes do you wear? _____
10) Do you wear inserts/arch supports in your shoes? □ yes □ no

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Present Condition:

1) What issues brought you here today? _____
_____
2) Were there specific events that lead to this issue? _____
_____
3) If stress is involved, what is the severity [on a scale of 0-10, 0 being no pain]?_____
4) If pain is involved, what is the severity [on a scale of 0-10, 0 being no pain]?_____
5) What impact has this issue had on you that prompted you to call?_____
_____
6) What are you unable to do as a result of your discomfort / pain/challenge?_____
_____
7) When did this issue start? _____/_____/_____
8) Quality (describe what it feels like)_____
9) What makes it better? _____
10) What makes it worse? _____
11) Does your pain travel? □ Yes □ No 10) Numbness or tingling □ Yes □ No
12) Site (Point to it)_____
13) Timing (Constant or only with certain activities?) _____

Other previous and current conditions

1) Physical, mental and/or emotional _____
_____
2) Do you currently take **any** over-the-counter (OTC) medication? □ yes □ no
If YES, what and how often? _____
3) Are you currently taking any prescriptions, (including birth control)? □ Yes □ no
If so, What? _____
4) Have you had recent significant weight changes? □ Yes □ no
If so, explain _____

Health History

1) Previous/current CHIROPRACTIC care? □ Yes □ no
If so, by whom, when, & for what?_____
2) Other alternative treatments? _____
3) Currently under other care? □ Yes □ no
If so, where, since when, by whom? _____
4) Recent films or diagnostics? □ Yes □ No
(e.g. X-ray, mammogram, MRI, PET, CAT, DEXA, labs)? What / How recent?
_____
5) Surgeries? □ Yes □ No If so, what were they and when?_____
_____
6) Accidents/Traumas□ Yes □ No If so, what were they and when? _____
_____
7) Allergies _____
8) Infections (incl. HIV or Hep C) □ Yes □ No 9) Immunizations_____

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Social / Lifestyle History:

1) Sexual orientation _____ 2) Are you sexually active? □ yes □ no
3) # of work hours / day? _____ 4) # of sleep hours / night? _____
5) Do you have difficulty falling asleep? □ yes □ no
6) Do you sleep through the night? □ yes □ no
7) Do you smoke? □ yes □ in the past □ never
If so, How Many Packs/Day? _____
8) Do you consume **any** alcohol? □ yes □ in the past □ never
Drinks/Week_____
9) Other habits? _____
10) Where did you grow up? _____
11) How long have you lived in FL? _____
12) Current living situation? _____

Dietary/Digestive Fitness:

1) Does your diet include:
Coffee/Tea □ yes □ no **Soda** □ yes □ no **Diet drinks**? □ yes □ no
Fast food □ yes □ no **Red meat** □ Yes □ no **Fruits/vegetables** □ yes □ no
2) How much water do you consume daily? _____
3) Average daily urination habits? _____ any unusual symptoms? _____
4) Do you have bowel movements daily? □ Yes □ no How many? _____
any unusual symptoms? _____
5) Taking any supplements? Ex: vitamins/minerals, fiber and/or herbs? □ yes □ no
If yes, what kind, dosage, & frequency _____
6) What form of exercise do you do? Frequency:_____ Per _____
Type: _____

Family Information

1) # of Children _____ 2) Step Children _____ 3) Grand Children? _____
Names and Ages _____
2) For WOMEN: Age @ 1st Period _____ # Pregnancies _____ Age @ Menopause _____
3) For MEN: prostate issues? _____

Family History:

Any history of diabetes, HBP, cancer, CVA, or arthritis in your family? □ yes □no
1) Mother—Still living? □ yes □ no If no, age and cause of death: _____
Mother's Health history _____
2) Father—Still living? □ yes □ no If no, age and cause of death: _____
Father's Health history _____
3) Grandparents' health history
MGM _____ PGM _____
MGF _____ PGF _____
4) Siblings' health history_____
5) Has 2 or more Family members, on the same side, had Cancer? □ Yes □ no

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Automobile Accident History Form

Your Name: _____ Today's Date: _____
Date of Accident: _____ Time Of Accident: _____
City & State of Accident: _____ Street of Accident: _____

Road Conditions at the time of Accident: **Wet Dry Icy Fog Other _____**

Did you go to the Hospital? **Yes No**
If yes, what is the name and city of the hospital? _____
How did you go to the hospital? _____
What parts your body was x-rayed? _____
What did the hospital do for your injuries? _____
How long did you stay at the hospital? _____

Where were you seated in the vehicle? _____

Were you wearing a seat belt? **Yes No**
If yes, was it a lap seatbelt ___ or a shoulder-lap seatbelt___.

What bleeding cuts did you sustain during this accident? _____

Did you receive any bruises? (Including Seatbelt) _____

At the time of the incident, did any of your body parts hit other parts of the automobile? **Yes No**
If yes, please explain: _____
_____

Is your headrest to the top of your head? **YES NO**
Upon impact did your head hit the headrest? **YES NO**

Were you aware of the approaching collision prior to the impact, or did the impact catch you by surprise? **Aware Surprise**

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Did you slam on the brake? **YES NO**

Did you grip the steering wheel? **YES NO**

Did you lose consciousness (Black out) upon impact? **Yes No** How long? _____

Did you experience a flash of light of explosion in your head? **Yes No**

What were the physical symptoms that you suffered immediately? _____
_____

Did you become… (Please check)
___Confused ___Disoriented ___ Light headed ___Dizzy ___Nauseated
___Blurred Vision ___Ring/Buzz in ears

Do you still have any of these symptoms? _____

Are you currently suffering from any of the following Neurological symptoms?
(Please check all that apply):

___Restlessness **___Irritable** **___Other**
___Difficult concentrating **___Difficult with Memory**
___Sleeplessness **___Forgetfulness**
___Reduced tolerance to heat **___Reduced tolerance to alcohol**

Did you have additional symptoms later on? Musculoskeletal? Digestive? Emotional? ETC…
_____
_____

Was your car stopped at the time of impact? **Yes No**
If yes, was the driver's foot also on the break? **Yes No**
If no, then estimate the speed of the vehicle you were in: **_____MPH**

If your vehicle was moving at the time of impact, was it:
___ slowing down ___ Gaining speed ___ traveling at a steady speed

List the year, make, and model of the vehicle **you** were in:
Year _____ Make_____ Model_____

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What is the estimated cost damage to the vehicle you were in? $_____

Which of the following car parts broke during the accident? (Please Check)
____Windshield ____Front seatbelt ___Steering wheel
___Right side window ____Left side window other: _____

Did your air bag deploy? **YES NO**

What was the position of your body at the time of the collision? _____

What was the position of your head at the time of collision? _____

List the year, make, and model of the **other** vehicle involved:
Year _____ Make_____ Model_____

Was the other vehicle moving at the time of the collision? **Yes No**
If yes, what was the approximate speed of the vehicle? _____MPH

If the other vehicle was moving at the time of the collision, was it (Please Check):
____ Slowing down ____Gaining speed ____Traveling at a steady speed

Please describe, to the best of your knowledge, what happened, what happened during this accident?

_____

_____

_____

_____

_____

_____

_____

_____

_____

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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 understands both the objective and the method that will be used to obtain 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 the relationship may effect the restoration and preservation of health. **Health** is a state of physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called **vertebral Subluxation**. This occurs when one or more of the 24 vertebra in the spinal column becomes misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain 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 preformed by hand but maybe preformed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

All health care procedures carry some risk. Risks associated with chiropractic care may include, but are not limited to, muscle or ligament injuries, nerve injuries, vascular injuries, and fractures. Alternatives to chiropractic care may include medications, surgery and other alternative treatments.

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 patient or legal guardian of_____
Have read and fully understand the above 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

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Notice of Privacy Policies HIPPA

I consent to the use or disclosure of my protected health information by, Elana Kaplove, Dc, PA, dba Back in Balance, for the purpose of analyzing, diagnosing, or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations and my consent is evidenced by my signature below.

My protected health information means health information, including my demographic information, collected from me any information created or received by my physician, another health care provider, a health plan, my employer or health care clearinghouse. This protected health information related 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.

This office will never sell any of your protected health information.

I understand that 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 on my behalf. I understand that the quality of my treatment will not be effected, should I decide to restrict authorization of my protected health information. I understand that this office will contact me by phone to discuss billing and insurance questions and to remind me of my appointment. On occasion, this office may contact patients via text messaging.

Please check here [ ] If you do not wish to be contacted by phone for appointment reminders.
Please check here [ ] If you do not want to receive text messages.

This privacy notice will remain in effect for seven years from the time of authorization, unless permission is revoked by me, in writing, and submitted to this office. I understand that if there are outstanding payments due that any revocation relating to release of information to my insurance company or third party billing entity will remain in effect until all my accounts are paid in full.

I have been provided an opportunity to receive a copy of my Notice of Privacy Practices, and understand that I have a right to review the Notice of Privacy Practices prior to signing this document. The Notice of Privacy Policies 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 for this office. A Notice of Privacy Policies is posted in this office, so that it is freely visible. This Notice of Privacy Policies also describes the rights and duties of this office, with respect to my protected health information. This office reserves the right to update or changes its privacy policies from time to time.

_____ _____
Please print name Signature

_____ _____ / _____/ _____
Witness Date

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COPAYMENT / COINSURANCE AGREEMENT

As per my policy with _____ I understand and agree to pay

My copayment / coinsurance of _____ each visit once my deductible

Of _____ has been met.

For Medicare-

1st Visits Exam is not covered by Medicare or secondary however, it is required in order give a proper diagnosis. Therefore, you will be charged $40 for the 1st exam and $20 for any re evaluations needed for continued care along with your 20% Co-Insurance if applicable.

Initial_____

For Personal Injury-

If you have Med Pay, it will pick up your 20% responsibility until you have reached your maximum of $_____ There after the additional 20% co-insurance becomes your responsibility.

If you do **not** have Med Pay- You will be responsible for the 20% Co-Insurance. If you hire an attorney, they will assist in collecting a settlement to pay for your 20% and/or deductible owed to Back in Balance once the case has settled. If the other party is at fault, and you choose to opt out of having an attorney, it then becomes your responsibility to properly settle with the person(s) at fault companies to ensure that they will reimburse you for you 20% owed to Back in Balance.

Initial_____

I have been made aware of the fact that Dr. Elana Kaplove is considered a specialist and not a Primary Care Physician, therefore resulting in payment of a specialist copay.

I understand that verification of benefits is not a guarantee of payment and I am financially responsible to Elana Kaplove DC for all charges whether or not covered by my insurance coverage.

Patient Name: _____

Patient Signature: _____

Date Signed: _____

Office Staff: _____

Date Signed: _____

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Appointment Policy

These days, everyone seems to have more things to do and less time available to do them in. Because we know that, we organize our schedule so that waiting time is kept to a minimum, and every patient can be treated in an efficient, safe and courteous manner.

It is important that you keep your scheduled appointments and are on time to insure optimal response to your prescribed treatment plan and for us to be able to measure your response to treatment.

Many patients are treated under a treatment plan that may be requested by your insurance company. Failure to follow your prescribed program may jeopardize your recovery and /or your insurance benefits.

CANCELING OR RESCHEDULING YOUR APPOINTMENT

If you need to change or cancel an appointment, please notify us at least **24 hours** before your scheduled time, so that we can use the time we have reserved for you. We reserve the right to charge an appointment fee for no-shows.

Thank you for your understanding!

There are two things that we cherish:
Your health and your time

_____ _____
Patients Signature Date

_____
Witness Signature

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PIP Assignment of Insurance Benefits

I, _____, hereby voluntarily and intentionally assign, transfer and convey the rights and benefits of my automobile insurance, for policy/ claim #_____including Personal Injury Protection (hereafter PIP), Uninsured Motorist, and Medical Payments policy of insurance to the above named medical provider, Elana Kaplove DC PA. It is my full intention to assign, transfer and convey to the above named medical provider all of my rights, title and interest in and to medical expense reimbursement in whatever form. I understand that this document will allow the provider to file suit against an insurer for payment of the insurance benefits or an explanation of benefits and to seek Fla. Stat. 627.428 and 627.736 damages from the insurer. It is my intention to transfer and convey the right to bring suit for insurance benefits to the above named medical provider. If the insurer disputes the validity of this assignment of benefits, then the insurer is instructed to inform the medical provider within five days of receipt of this document. Failure to inform the provider shall result in a waiver by the insurer to contest the validity of this document.

I authorize and direct that payment for covered services to be made by my insurer to Elana Kaplove DC PA.

I understand that I am financially responsible to Elana Kaplove DC PA for all charges whether or not covered by my insurance coverage.

_____
Date

_____ _____
Patient Name Patient Signature

_____ _____
Witness Name Witness Signature

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