REGISTRATION FORM

Rick L. DaSo, D.C.

SunCoast Family Medical Associates

12020 Seminole Blvd. , Largo Fl. 33778

REGISTRATION FORM

PATIENT NAME: ____ DATE: _______________

Sex : _____ SINGLE MARRIED DIVORCED WIDOWED Primary Language ________________

Date Of Birth: ________________________________

HOME ADDRESS: ____ Apt/Lot#: ___________

CITY: _________________________________ STATE: ________ ZIP CODE: __________________

HOME PHONE: _________________________ CELL PHONE: ______________________________

REFERRED BY: _________________________________ E-MAIL: _____________________________

OTHER FAMILY MEMBERS THAT ARE PATIENTS: ____

EMPLOYED BY: _____________________________________ WORK PHONE: __________________

IN CASE OF EMERGRENCY, WHO DO WE CONTACT? _______________________________________

RELATIONSHIP_____________________________ CONTACT NUMBER ______________________

[ ] SUBMITTED COPY OF INS. CARD(S)

PRIMARY HEALTH INS. __________________________________ POLICY#: ____________________

GROUP#: _______________ NAME OF INSURED IF OTHER THAN PATIENT: ___________________

RELATIONSHIP TO INSURED: _______________________DATE OF BIRTH OF INSURED:_________

SECONDARY HEALTH INS. _________________________________POLICY#: ___________________

GROUP#: _______________ NAME OF INSURED IF OTHER THAN PATIENT: ___________________

RELATIONSHIP TO INSURED: _______________________DATE OF BIRTH OF INSURED:_________

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Confidential Patient Data

PATIENT INFORMATION

Today's Date: ______________

Full Name:____

Name you prefer to be called: ___________________________________

MEDICAL / FAMILY HISTORY S=SELF M=MOTHER F=FATHER

S	M	F	
[ ]	[ ]	[ ]	Anemia
[ ]	[ ]	[ ]	Arthritis
[ ]	[ ]	[ ]	Asthma
[ ]	[ ]	[ ]	Back pain
[ ]	[ ]	[ ]	Bone fracture
[ ]	[ ]	[ ]	Cancer
[ ]	[ ]	[ ]	Chest pain
[ ]	[ ]	[ ]	Concussion
[ ]	[ ]	[ ]	Diabetes
[ ]	[ ]	[ ]	Indigestion
[ ]	[ ]	[ ]	Anxiety

S	M	F	
[ ]	[ ]	[ ]	Epilepsy
[ ]	[ ]	[ ]	German measles
[ ]	[ ]	[ ]	Tension headaches
[ ]	[ ]	[ ]	Migraines
[ ]	[ ]	[ ]	Heart trouble
[ ]	[ ]	[ ]	High blood pressure
[ ]	[ ]	[ ]	HIV
[ ]	[ ]	[ ]	Kidney disorder
[ ]	[ ]	[ ]	Menstrual cramps
[ ]	[ ]	[ ]	Multiple sclerosis
[ ]	[ ]	[ ]	Muscular dystrophy

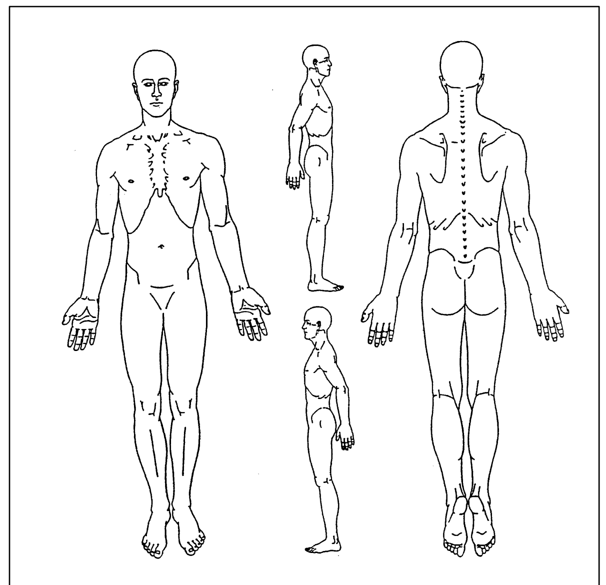
S	M	F	
[ ]	[ ]	[ ]	Neck pain
[ ]	[ ]	[ ]	Nervous condition
[ ]	[ ]	[ ]	Numbness
[ ]	[ ]	[ ]	Polio
[ ]	[ ]	[ ]	Poor circulation
[ ]	[ ]	[ ]	Hepatitis
[ ]	[ ]	[ ]	Rheumatic fever
[ ]	[ ]	[ ]	Rheumatoid arthritis
[ ]	[ ]	[ ]	Scarlet fever
[ ]	[ ]	[ ]	Sinus trouble
[ ]	[ ]	[ ]	Tuberculosis

PLEASE LIST YOUR PRESENT MAJOR COMPLAINT(S):

Please Rate Your symptoms (1-10, with 1 being minimal, 10 being excruciating)

	COMPLAINT	Type of pain (Ache/Sharp/Dull/Numb/Radiates)	Rate 1-10
1.	________________	__________	_____
2.	________________	__________	_____
3.	________________	__________	_____
4.	________________	__________	_____
5.	________________	__________	_____

MARK AREAS OF PAIN, NUMBNESS, ETC.



SYMPTOMS DEVELOPED FROM:

[ ] Auto injury [ ] Job related injury [ ] Exercise

[ ] Travel [ ] Lifting [ ] Flare up of chronic condition

[ ] Unknown [ ] Other __________________________

SYMPTOMS HAVE PERSISTED FOR ____DAY(S) ___WEEK(S) ___MONTH(S) ___YEAR(S)

SYMPTOMS / COMPLAINTS: ❑COME & GO ❑ CONSTANT **DATE STARTED**: ____________

IF YOU WERE TO GUESS, WHAT DO YOU THINK IS CAUSING YOUR COMPLAINTS?

____

____

WHEN AND HOW
OCCURRED?____

SYMPTOMS ARE WORSE IN ❑MORNING ❑AFTERNOON ❑NIGHT ❑ALWAYS PRESENT

ARE YOU PREGNANT ❑NO ❑YES **BEGINNING DATE OF LAST MENSTRUAL PERIOD** _____

TAKING ANY MEDICATIONS / SUPPLEMENTS? ❑NO ❑YES; WHAT KIND? **[ ] See list**

____

____

HAVE YOU HAD CHIROPRACTIC CARE BEFORE? Y N When? ______________________
Are you apprehensive about your visit today? Y N If yes, Explain: ______________________
NAME AND LOCATION OF DOCTORS PREVIOUSLY SEEN FOR PRESENT CONDITION(S):

____

SURGICAL HISTORY:

1. ____ DATE:______________
2. ____ DATE: ______________
3. ____ DATE: ______________
4. ____ DATE: ______________

DATE OF LAST PHYSICAL EXAM: ___________ PRIMARY CARE DOCTOR: _______________
Have you ever had a metal implant? [ ] YES [ ] NO
Do you have a pace maker or defibulator? [ ]YES [ ]NO

WHAT MAKES YOUR PAIN WORSE:
[ ] Sitting [ ] Standing [ ] Lying Down [ ] Walking
[ ] Nothing [ ] Reaching [ ] Coughing [ ] Sneezing
[ ] Standing from a seated position [ ] Turning head

WHAT MAKES THE PAIN BETTER:
[ ] Sitting [ ] Standing [ ] Lying down [ ] Walking
[ ] Ice [ ] Heat [ ] Stretching [ ] Exercise

WHAT HAVE YOU DONE FOR THE PAIN:
[ ] Seen other doctor [ ] Pain medication [ ] Ice
[ ] Heat [ ] Aspirin [ ] Nothing [ ] Massage
[ ] Chiropractic [ ] Physical therapy [ ] injections

CHECK ACTIVITIES THAT ARE DIFFICULT:

[ ] Walking [ ] Sitting [ ] Sleeping

[ ] Driving [ ] Bending [ ] Lifting

[ ] Dressing [ ] Carrying

[ ] Computer work [ ] Bathing

[ ] Exercise [ ] Yard work

[ ] Reading [ ] Preparing meals

Please check additional symptoms you may be experiencing: [ ] ringing in ears [ ] blurred vision
[ ] cold hands / feet [ ] dizziness [ ] loss of balance [ ] shortness of breath [ ] fatigue [ ] memory

Patient Signature_________________________________ Today's Date: ___________

Suncoast Family Medical Associates

12020 Seminole Blvd, Largo Fl. 33778

Health Considerations

Please inform us at time of scheduling of any health conditions, allergies, special needs or concerns you have. Your safety is important to us and some services may not be appropriate for certain conditions.

Sick Policy

In an effort to maintain a healthy environment, we ask that if you are sick (which includes cold, fever, the flu, etc.) or have the onset of symptoms of an illness that you reschedule your appointment. This is for your well-being as well as the health of our employees, therapist and other patients.

For our massage patients,

Receiving a massage when you are sick is not advised. While in the early and acute stages of a cold, the flu or other illness, a massage can accelerate the onset of the infection and intensify its severity (via additional circulation of blood and lymph). If you get a massage after the infection has peaked, you may experience a relapse of symptoms and feel sick again. Please wait until you have been well for at least a week before getting your massage. If you do need to cancel your appointment, please call us as soon as possible and we will be happy to reschedule your appointment for a time when you are feeling better.

Fragrance – Free Policy

Recognizing that some of our staff, therapist, and patients have sensitivities and/or allergic reactions to various synthetic fragrances, we have a Fragrance-Free Policy. In an effort to create the healthiest environment possible for everyone, we request that you refrain from wearing perfume, scented lotions, body sprays or other similar products while at our office.

Cell Phone Usage

In our efforts to maintain a relaxing atmosphere for our patient, we ask that all cell phones and pagers be silenced or turned off upon entering our office. Cell phone use is not permitted beyond the reception area.

Suncoast Family Medical Associates

Financial Responsibility

I understand that I am financially responsible for all charges, whether or not paid by said insurance. It is my responsibility to pay any deductible amount due at the time of service or any other balance not paid by my insurance within 30 days. I authorize disclosure of necessary medical information to determine benefits payable to related services. By signing this form, I hereby give Suncoast Family Medical Associates consent to perform medical treatment.

Prescription Renewal Policy

Suncoast Family Medical Associates physicians are available for emergencies 24 hours a day. Prescription renewals, however, should not be considered medical emergencies. Prescription renewals should be discussed with your doctor during your office visit or by phone with a Medical Assistant during normal business hours of Monday thru Friday.

Insurance Authorization, Assignment and Guarantee of Payment

I request that payment of authorized Medicare / Other Insurance company benefits be made on my behalf to Suncoast Family Medical Associates for any services furnished to me by that party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

I authorize any holder of medical or other information about me to release to the Social Security Administration a healthcare administration or its intermediaries of carriers any information needed for this or a related Medicare claim/other insurance company claim. I permitted copy of this authorization to be used in place of the original comma and request payment of medical insurance benefits either to myself or the party who accepts assignment. I understand it is mandatory to notify the healthcare provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security act and 31 U.S.C. 3801 – 3812 Provides penalties for withholding this information).

I request that payment under the Medicare or other medical insurance program(s) be made to Suncoast Family Medical Associates for as long as I continue to receive services from them. If I were to receive any checks/payments intended as a payment for services rendered by Suncoast Family Medical Associates from Medicare and/or other insurance company(ies), I will immediately endorse it and turn it over to Suncoast Family Medical Associates.

I understand that I am responsible for payment of all charges and fees to Suncoast Family Medical Associates that they are entitled to collect that they're not paid for by Medicare or other insurance.

Consent for Diagnostic and/or Therapeutic Procedures

I hereby consent to and authorize my physician and any other health professional as designated to perform any physical examination and routine diagnostic procedures upon me. I also consent to and authorize my physician to prescribe a therapeutic regime which I shall follow. Unless I explicitly refuse, I consent that the diagnostic procedure(s) and immunizations(s) ordered by my physician be performed on me despite the risks involved and complications that might be involved, which will be explained to me at the time they are ordered.

______________________________ Patient Name Printed

______________________ Date of Birth

______________________________ Patient Signature

______________________ Date

Suncoast Family Medical Associates

Patient authorization for use and disclosure of protected health information (PHI) for purposes requested by the practice.

(HIPAA Release of information)

Name: ______________________________ Date of Birth: ______/______/______
(Please Print)

By signing this authorization, I authorize Suncoast Family Medical Associates to release/ disclose my medical information, medical history; progress notes with diagnosis; laboratory data; imaging studies and claims information. "Only as permitted or required by Federal or State Law", we may use your protected healthcare information to do the following:

- To disclose, as may be necessary, your heath information (including HIV+/AIDS status, drug/alcohol abuse/dependency notes and qualified mental health notes) to other healthcare providers and healthcare entities (such as: Referrals to or consultation with, other health care professionals, laboratories, hospitals etc.) or to others as may be required by law or a court order concerning your treatment, payment and or healthcare.
- To request from other healthcare entities and/or healthcare providers (i.e. doctors, dentists, hospitals, labs, imaging centers, etc.) specific healthcare information we may need for planning your care or treatment.
- To submit the necessary information to your insurance company(s) for coverage verification as well as the diagnosis and treatment information to your insurance company(s), other agencies and/or individuals for payment of our services and treatment we provide for you.
- To discuss your healthcare payment information (only the minimum necessary in our judgment) with family members or other persons who are or may be involved with your health care treatment or payments.
- To leave appointment reminders or other minimum necessary information related to your health care or health care payments on your answering machine, mobile voicemail or text mail, email or with a household family member.

[ ] **Please check here if you do not want us to leave messages on your answering machine or with a household family member.**

[ ] **Please check here if you do not want us to leave a voice/text message on your mobile device.**

[ ] **Please check here if you authorized to send your health care information by email (please understand the email may be an unsecured medium of transmission and is potentially accessible by others). In addition to checking the box, we reserve the right to require you to authorize in reading the transmission of your health care information to you by unsecured email.**

- You may request a copy of an you have the right to read our notice of patient privacy practices prior to signing this authorization. The NPP provides a more complete description of health information uses and disclosures.

This information may be released to:

[ ] My Spouse/Partner____
Name(s) Phone #

[ ] My Child(ren)____
Name(s) Phone #

[ ] Other____
Name(s) Phone #

[ ] Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing. My written revocation must be submitted to **Suncoast Family Medical Associates 8050 Seminole Blvd. Suite A, Seminole FL 33772**. This practice will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI. I do not have to sign this authorization in order to receive treatment from Suncoast Family Medical Associates. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

Signed By: ______________________________ Date______/______/______
Signature of Patient or Legal Guardian

Suncoast Family Medical Associates

Privacy Policy

It is the policy of our practice that all physicians and staff preserve the integrity and the confidentiality of *protected health information* (PHI) pertaining to our patients. The purpose of this policy is to ensure that our practice, our physicians and staff have the necessary medical and PHI to provide the highest quality of medical care possible. Our facility will always protect the confidentiality of the PHI of our patients to the highest degree possible. Our patients should not be afraid to provide information to our practice, its physicians and staff for purposes of *treatment, payment and health care operations* (TPO).

To that end, our practice, its physicians and our staff will:

- Adhere to the standards set forth in the Notice of Privacy Practices.
- Collect, use and disclose PHI only in conformance with state and federal laws and current patients covenants and/or authorizations, as appropriate. Our practice, its physicians and staff will not use or disclose PHI for uses outside of our practice's TPO; such as marketing, employment, life insurance applications, etc. without an authorization from the patient.
- Use and disclose PHI to remind patients of their appointments unless they instruct us to not to do so.
- Recognize that PHI collected about the patients must be accurate, timely, complete and available when needed.
- Our practice and its physicians and staff will implement reasonable measure to protect the integrity of all PHI maintained about patients.
- Recognize that patients have the right to privacy. Our practice, its physicians and staff respect the patient's individual dignity at all times. Our practice, its physicians and staff will respect patient's privacy to the extent consistent with providing the highest quality medical care possible and with the efficient administration of the facility.
- Act as responsible information stewards and treat all PHI as sensitive and confidential information. Treat all PHI data as confidential in accordance with professional ethics, accreditation standards and legal requirements. Not disclose PHI data unless the patient has properly authorized the release or law otherwise authorizes the release.
- Recognize that, although our practice "owns" the medical record, the patient has a right to inspect and obtain a copy of his/her PHI. This may generate a bill according to Rule 64B8-10.003, Florida Administrative Code. In addition, patients have a right to request an amendment to his/her medical record if they believe his/her information is inaccurate or incomplete.

Suncoast Family Medical Associates

Privacy Policy Contd.

- Permit our patient access to their medical records when their written request is approved by our practice. If we deny their request, then we must inform the patients that they may request a review of our denial. In such cases, we will have an on-site health care professional review the patient's appeal,
- Provide the patient an opportunity to request the correction of inaccurate or incomplete PHI in their medical records in accordance with the law and professional standards.
- All physicians and staff of our practice will maintain a list of certain disclosures of PHI for purposes other than TPO for each patient and those made pursuant to an authorization as required by HIPPA rules. We will provide this list to the patient upon request, as long as the request is in writing.
- All physicians and staff in our practice must adhere to this policy. Our practice will not tolerate violations of this policy. Violation of this policy is grounds for disciplinary action, in accordance with our practice rules and regulations.

Our practice may change this privacy policy in the future. Any changes will be effective upon the release of a revised privacy policy. As always, the privacy policy will be made available to patients upon request.

Effective 2016

Suncoast Family Medical Associates

RECEIPT OF NOTICE OF PRIVACY PRACTICE WRITTEN ACKNOWLEDGEMENT FORM

I, ___________________________________, have received a copy of Suncoast Family Medical Associates privacy practice notice.

___________________________________ ____________________

Signature of Patient Date

Suncoast Family Medical Associates

MY MEDICATION LIST

Name:	Birth Date:
Pharmacy:	Pharmacy Phone:
Allergies:	

Latex Allergy	☐ Yes ☐ No	**PLEASE NOTE THIS IS NOT A LATEX FREE ENVIRONMENT. Nitrile Gloves are available.**
Iodine Allergy	☐ Yes ☐ No	

Name of Medication	Strength (ex. mg, units …)	How to Take (ex. Take 1 tablet by mouth 2 times daily)	When to take medication

Provider Signature: ______________________________ Date___________________

Suncoast Family Medical Associates

Authorization for the Release of information

Rick L. DaSo D.C.
12020 Seminole Blvd. Largo, FL. 33778
Phone (727) 595 – 2273 **Fax (727) 559-0052**

I herby give permission to (List physician/Facility name and Address):

____

____

To release a copy of my medical records to:

Rick L. DaSo D.C.

a physician with Suncoast Family Medical Associates. Please forward or Fax records to the following location.

12020 Seminole Blvd. Largo, Fl 33778
Phone (727) 595-2273 **Fax (727) 559-0052**

The undersigned is a patient of Suncoast Family Medical Associates or an authorized representative of the patient and requests that the above-named facility to release any
and all information which the named facility may possess in regard to the patient's
examinations and treatments. Including but not limited to alcohol abuse or drug abuse information, HIV antibody testing information, or any other information related to the patient's total treatment, unless specified below, which may be a part of the medical records.

Types or records we are requesting

☐ Any and all types of records you have for this patient

☐ Doctor Visit notes
☐ Emergency room notes
☐ Urgent care notes
☐ Hospital Notes
☐ Operation or procedure notes
☐ Clinic notes
☐ Pathology notes

☐ Doctors notes
☐ Nurses notes
☐ Discharge Summary
☐ Lab reports
☐ Radiology Reports
☐ Consultations
☐ Other ______________________

Patient's Full Name (print) ____

Patient's Date of Birth: ____

Patient's Signature _______________________________________ Date_____________

Authorized Representative's Signature____

Relationship of Authorized Representative____