Welcome

ROSE WELLNESS CLINIC

WE LISTEN. WE CARE. WE GET RESULTS

Patient Information

Date _____

Name: _____ _____ _____
Last First Middle Initial

Email address: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Phone #: (H) _____ (C) _____ Can We Call You? ☐ Yes or ☐ No

Sex: ☐ Male ☐ Female

Date of Birth: _____

Marital Status: _____

Occupation: _____

Employer Address: _____

How did you hear about our practice? _____

Emergency Contact: Name: _____ Relation: _____ Phone: _____

Alternate contact address (Full Address): _____

Accident Information

Is this visit due to an accident? ☐ Yes ☐ No

Has it been reported? ☐ Yes ☐ No

Are you a year round Florida Resident or a Snow Bird?
What months are you in Florida?
_____

Insurance Information

Policy Holder Name: _____

Relationship to patient (if other than self): _____

Do you have health insurance? ☐ Yes ☐ No

Do you have secondary insurance? ☐ Yes ☐ No

State that your Medicare originated from: _____

PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)

Assignment and Release (insured patients)

I certify that I (or my dependent) have insurance coverage with _____ and I AUTHORIZE, REQUEST and ASSIGN MY INSURANCE COMPANY TO PAY DIRECLTY TO THE PHYSICIAN/MEDICAL PRACTICE, INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

Signature: _____ Date: _____

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352-775-2180
www.rosewellnessclinic.com

To help us better understand your problem, please complete **ALL QUESTIONS** on **ALL** of the attached forms.

Date_____

Name_____ Age_____ Date of Birth_____

Height_____ Weight_____ Eye Color_____Tattoos/site_____ Scars/site_____

Who referred you to us? _____

Family/Primary Care Physician _____

Which part of your body hurts the most? _____

How long have you had this pain? _____

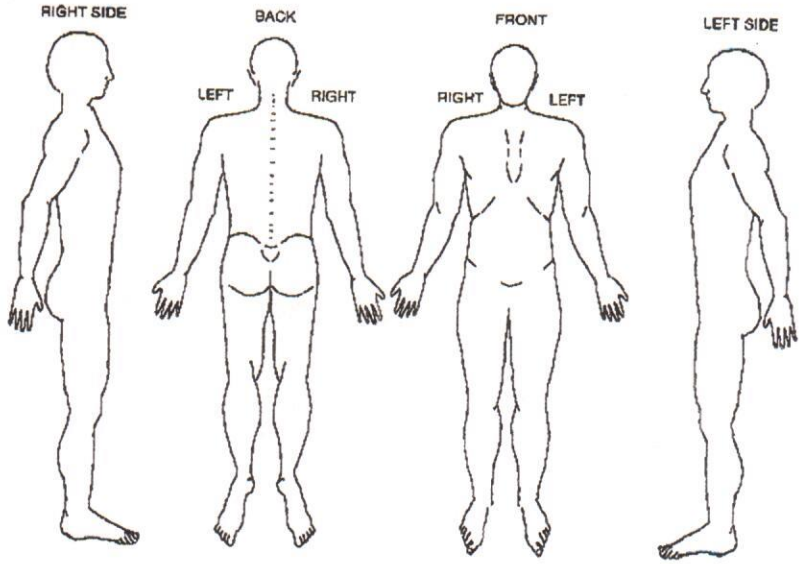
Was pain caused from MVA/Trauma ☐Yes ☐No Illness: ☐Yes ☐ No Unknown Cause: ☐Yes ☐No

If MVA/Trauma Please Explain and give dates: _____

Are you involved in any litigation or lawsuit as a result of your pain? ☐Yes ☐ No

Are you seeking Worker's Compensation as a result of your pain? ☐ Yes ☐ No

On a scaled of 0 to 10, "0" being no pain and "10" being the worst pain imaginable, circle the number that describes your level of pain:



No pain= 0 1 2 3 4 5 6 7 8 9 10= Worst pain imaginable.

Shade in areas where you have pain and check ALL the words that describe your pain:

☐ Aching	☐Shooting	☐Tingling	☐Radiating	☐Tightness	☐Coldness
☐Dullness	☐Stinging	☐Burning	☐Stabbing	☐Numbness	☐Excruciating
☐Sharpness	☐Constant	☐Frequent	☐Intermittent	☐Occasional	☐Other

Patient Name: _____ Date: _____

Please indicate the factors of activities of daily living that increase or decrease your pain:

Factors	Increase	Decrease	No Effect		Factors	Increase	Decrease	No Effect
Weather Change	☐	☐	☐		☐	☐	☐	☐
Heat	☐	☐	☐		☐	☐	☐	☐
Cold	☐	☐	☐		☐	☐	☐	☐
Physical Activity	☐	☐	☐		☐	☐	☐	☐
Posture	☐	☐	☐		☐	☐	☐	☐
Walking	☐	☐	☐		☐	☐	☐	☐
Laying Down	☐	☐	☐		☐	☐	☐	☐
Appetite	☐	☐	☐		☐	☐	☐	☐
Occupation	☐	☐	☐		☐	☐	☐	☐
Other	☐	☐	☐		☐	☐	☐	☐

Do you have any of the following?

Neck Pain? ☐ Yes ☐ No

Back Pain? ☐ Yes ☐ No

Neuropathic/Nerve Pain? ☐ Yes ☐ No

Numbness/Tingling? ☐ Yes ☐ No

Weakness? ☐ Yes ☐ No

Bowel/Bladder Incontinence? ☐ Yes ☐ No

Neurological Deficits (MS, Parkinsons, CVA, etc.) ☐ Yes ☐ No

Headache: ☐ Yes ☐ No

Pain Site: _____ Nature of Pain: _____ Duration of Pain: _____

Pain Triggers: ☐ Tobacco ☐ Alcohol ☐ Exercise ☐ Noise ☐ Sex ☐ Weather ☐ Menstrual Cycle ☐ Other

Pain Symptoms: ☐ Nausea/Vomiting ☐ Photophobia/Phonophobia ☐ Myosis/Ptosis ☐ Lacrimal/Nasal Congest

Pain Relievers: ☐ Quiet ☐ Dark Room

Please list any physicians you have seen for your pain:

Name	Recommendation	Specialty

Please check any of the following treatments you have received for this pain problem:

		Improved Pain Yes	No
☐ Nerve Blocks			
☐ Physical Therapy			
☐ Acupuncture			
☐ Chiropractor			
☐ Psychiatrist/Psychologist			
☐ Surgery			
☐ Other			

Patient Name: _____ Date: _____

Please indicate which diagnostic procedures (tests) you have had for this pain problem:

	Body Part	Approximate Date	Facility Performed
☐ MRI Scan			
☐ CT Myelogram			
☐ X-Ray			
☐ EMG/NCS			
☐ Discogram			
☐ Bone Scan			
☐ Other			

Please list past or current medical problems:

☐ Heart Disease	☐ Lung Disease	☐ Diabetes	☐ Stroke	☐ Herpes (shingles)
☐ Hypertension	☐ Kidney Problems	☐ Liver Disease	☐ Seizure	☐ Open Wound
☐ Migraines	☐ Thyroid Disease	☐ Depression/Anxiety	☐ GERD/Ulcer	☐ Current Infection
☐ Metal Implants	☐ Visual Deficits	☐ Hearing Deficits	☐ Pacemaker	☐ Other

Have you ever been diagnosed with Cancer? ☐ Yes ☐ No If yes, What type(s)? _____
Currently receiving treatment? ☐ Yes ☐ No If yes, what type(s) of treatment? _____

Please list all medications you are currently taking:

1.	4.	7.	10.
2.	5.	8.	11.
3.	6.	9.	12.

Are you taking narcotics from any physician? ☐ Yes ☐ No
Do you have any allergies from medication or food? ☐ Yes ☐ No

Please list your allergies and reactions below:

Medication	Reaction	Medication	Reaction
1.		4.	
2.		5.	
3.		6.	

Have you ever taken or been given:	Yes	No	Adverse Reaction?
Anticoagulants, Blood-Thinners, Coumadin, Plavix, Pletal	☐	☐	
Cortisone or Steroids	☐	☐	

Please list any Surgeries:

Surgery/Date	Surgery/Date
1.	5.
2.	6.
3.	7.
4.	8.

Patient Name: _____ Date: _____

Review of Systems: Please check if you have or have ever had any of the following:

Cardiovascular	Respiratory	Genitourinary	Muscle/ Joint Disease
☐ Palpitations	☐ Chronic Cough	☐ Change in bowel control	☐ Redness in Joints
☐ Leg/Ankle Swelling	☐ Wheezing	☐ Change in bladder control	☐ Arthritis/Joint Disease
☐ Chest Pain/ Angina	☐ Sputum Production	☐ Blood in Urine	☐ Frequent Muscle Spasm
☐ Hypertension	☐ COPD/Asthma	☐ Painful Urination	☐ Back or Neck Problems
☐ Shortness of Breath	☐ Other	☐ Other	☐ Swelling of joints
☐ Other			☐ Other

Neurological	Endocrine	Gastrointestinal	Hematologic
☐ Epilepsy or Seizures	☐ Frequent Urination	☐ Nausea	☐ Easy Bleeding
☐ Weakness	☐ Change in Appetite	☐ Diarrhea	☐ Poor Blood Clotting
☐ Dizziness/Fainting	☐ Heat/Cold Intolerance	☐ Rectal Bleeding	☐ Bleeding Disorder
☐ Numbness	☐ Sweating	☐ Heart burn/ GERD	☐ Other
☐ Headache	☐ Other	☐ Constipation	
☐ Other		☐ Liver Disease	
		☐ Other	

Psychiatric	Constitutional
☐ Depression	☐ Recent Weight loss
☐ Anxiety	☐ Recent Weight Gain
☐ Stress	☐ Fever/Chills
☐ Previous Psychiatric Care	☐ Visual Change
☐ Other	☐ Hearing Change
	☐ Sleep Abnormalities
	☐ Other

Have you been treated for HIV Virus? ☐ Yes ☐ No

Date _____ ☐ Positive ☐ Negative

Have you been diagnose with any of the following?

Hepatitis ☐ Yes ☐ No

Any sexually transmitted disease? ☐ Yes ☐ No

Social History:

Do you currently work? ☐ Yes ☐ No What is/was your occupation? _____

Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed Number of Children: _____

Education: _____

Dominate Hand: ☐ Right ☐ Left Is there any possibility that you are pregnant? ☐ Yes ☐ No

Do you use any of the following? ☐ Cigarettes ☐ Alcohol ☐ Cocaine ☐ Marijuana

☐ Heroin ☐ Club Drugs ☐ Methamphetamine ☐ Prescription Drugs ☐ Other

If yes, the last time used: _____

Family History:

Describe current health, age, cause of death, illness, diabetes, cancer, hypertension, etc.

	Age	Living Yes	Living No	Medical History or Cause of Death
Father				
Mother				
Brother				
Sister				

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Informed Consent to Care

A patient coming to the doctor gives his/her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician. This office does not perform breast, pelvic, prostate, rectal, or full skin evaluations. Theses examinations should be performed by your family physician, GYN, and dermatologist to exclude cancers, abnormal skin lesions that should undergo biopsy/removal or other treatment. This clinic does not provide care for any condition (such as high blood pressure, diabetes, and high cholesterol) other than those addressed in your physical medicine care plan.

The patient assumes all responsibility/liability if the patient does not report on health forms any past medical history, illnesses, medicines, or allergies.

I agree to settle any claim or dispute with any of these persons or entities, whether related to the prescribed care or otherwise, which will be resolved by binding arbitration under the current malpractice terms; which can be obtained by written request.

Prior to receiving care at Rose Wellness Clinic, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health, and; in particular, your spine health. These procedures will assist us in determining if chiropractic or medical care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care. I understand and accept that there are risks associated with chiropractic and medical care and give consent to the examinations that the doctor deems necessary.

This notice is effective as of the date it is signed and will expire seven years after the date on which you last received services from us.

_____ _____

Patient Signature Date

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HIPAA

Purposes of Treatment, Payment & Healthcare Operations

In this document, "I" and "my" refer to the patient, and "Rose Wellness Clinic" refers to all treating physicians, doctors, physical therapists, and chiropractors. I consent to the use or disclosure of my protected health information by Rose Wellness Clinic for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations by Rose Wellness Clinic. I understand that analysis, diagnosis or treatment of me by Rose Wellness Clinic may be conditioned upon my consent as evidenced by my signature below.

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 of the practice. Rose Wellness Clinic is not required to agree to the restrictions that I may request. However, if Rose Wellness Clinic agrees to a restriction that I request, the restriction is binding on Rose Wellness Clinic.

I have the right to revoke this consent, in writing, at any time, with exception if Rose Wellness Clinic 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. The 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.

It is my right to request to be provided with a copy of the Notice of Privacy Practices of Rose Wellness Clinic. I understand that I have a right to review the Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will in my treatment, payment of my bills or in the performance of health care operations of Rose Wellness Clinic. The Notice of Privacy Practices for Rose Wellness Clinic is also posted in the waiting room at Rose Wellness Clinic. This Notice of Privacy Practices also describes my rights and duties of Rose Wellness Clinic with respect to my protected health information.

Rose Wellness Clinic 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 of Rose Wellness Clinic and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Signature of Patient/Guardian Printed Name of Patient/Guardian

_____ _____

Date Relationship to Patient

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910 Old Camp Rd., Suite 92 ~ The Villages, Florida 32162 ~ 352-775-2180 Phone
www.rosewellnessclinic.com

Cancellation Policy

Our goal is to provide quality medical care in a timely manner. No-shows, late shows and cancellations inconvenience those who need access to medical care. We would like to remind you of our policy regarding missed appointments for our Physical Therapist and Medical Doctor.

We understand that there are times when you must miss an appointment due to emergencies or obligations for family, work or other appointments. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book. **In order to be respectful of the medical needs of others, please be courteous and call Rose Wellness Clinic atleast 24 hours in advance if you are unable to keep an appointment.**

We understand that delays can happen as well that may cause you to be late for your appointment, however we must try to keep the other patients and doctors on time. If you are going to be late for your appointment, please call as soon as you know this is going to happen so that we can try to best use that time that has just become available. Your early cancellation will allow another patient access to timely medical care.

To cancel your appointment, please call **352-775-2180**. If you do not reach the receptionist, you may leave a detailed message on our voice mail that is checked regularly. If you would like to reschedule your appointment, please leave your name and phone number and we will return your call promptly.

The first "no-show", late cancellation or cancellation without a reasonable excuse will result in a fee of $25. A 2nd occurrence will result in a fee of $50. The 3rd occurrence will result in a fee of $50 and you may be discharged from the practice.

_____	_____	_____
Signature Patient/Guardian	Printed name	Date