CHIP SHEMANSKY, D.C.
24830 BURNT PINE DRIVE STE 3
BONITA SPRINGS, FL 34134

GULFSHORE
CHIROPRACTIC CLINICS

PH: (239) 948-5727
FAX: (888) 657-4642
Gulfshorechiropractic.com

PERSONAL INFORMATION

Date: _____

First Name:_____M.I._____ Last Name:_____ Nickname: _____

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

Other Address:_____ City: _____ State:___ Zip:_____

Birthdate:_____/_____/_____ Age_____ Gender: □ Male □ Female □ Unspecified

SSN:_____-_____-_____ Primary Phone:_____ Cellphone: _____

Work Phone:_____ Email:_____

Preferred Contact Method: (check one) □ Primary Phone □ Cell Phone □ Work Phone

May we your permission to send you text messages regarding appointment reminders, and promotions?

(check one) □Yes □No By providing my email address and cellphone number, I authorize my doctor to contact me via the email address and cellphone provided.

Status: (check one) □ Single □ Married □ Divorced □ Widowed Preferred Language: □ English □ Spanish

Occupation:_____

Emergency Contact: (Name, Relationship, Phone #)

_____

INSURANCE INFORMATION

Insurance Name: _____ Policy #: _____

Name of Policy Holder:_____ Group # _____

Subscriber DOB: _____ Subscriber SS#_____

CHIP SHEMANSKY, D.C.
24830 BURNT PINE DRIVE STE 3
BONITA SPRINGS, FL 34134

PH: (239) 948-5727
FAX: (888) 657-4642
Gulfshorechiropractic.com

OFFICE POLICIES

Missed/Cancelled Appointments: We understand that situations arise that are unforeseen and cause you to reschedule an occasional appointment. Please notify us within 24 hours if you cannot keep a scheduled appointment. The second missed appointment without prior notification will result in a $25.00 no-show charge. Our goal is to help you get well as quickly as possible. Your time is important as well as the time we set aside for your specific treatment. Last minute cancellations affect our office greatly as we have turned away other patients who require care.

Workers Compensation: We do accept workers Compensation cases. Communication with your employer is very important. Notify us immediately if you feel your case should be filed under Workers Compensation. By Law, your employer and our office are bound to certain time frames for filing claims under Workers Compensation.

Self-Pay Patients: Once you have become an established patient, other options such as patient plans, etc. may be discussed.

Personal Injury: We will accept Personal Injury cases. We must receive all insurance information prior to accepting your auto insurance as payment. We will call your insurance company and verify your coverage. We will discuss your coverage with you in detail and whenever possible prior to treatment or examination.

Financial Policy: There are many varied types of financial arrangements that are available to our patients. These range from self-pay patients, payment plans, and partial insurance coverage to full insurance coverage. Workers' compensation, auto insurance, and Medicare are also some of the other options. Please make certain to read all your office and financial policies and ask any questions you may have. We do not want you to discontinue your treatment because of a problem.

If collection procedures are necessary, a 30% fee will be added.

I have read through and understand the office policies for Gulfshore Chiropractic Clinics. I also understand that I will ultimately be responsible for serviced rendered regardless of my insurance coverage, cancellation and if any missed or cancelled appointment fees as outlined above.

X_____ _____

Signature of Patient, Parent, or Legal Guardian (if minor) Date:

CHIP SHEMANSKY, D.C.
24830 BURNT PINE DRIVE STE 3
BONITA SPRINGS, FL 34134

PH: (239) 948-5727
FAX: (888) 657-4642
Gulfshorechiropractic.com

REASON FOR VISIT

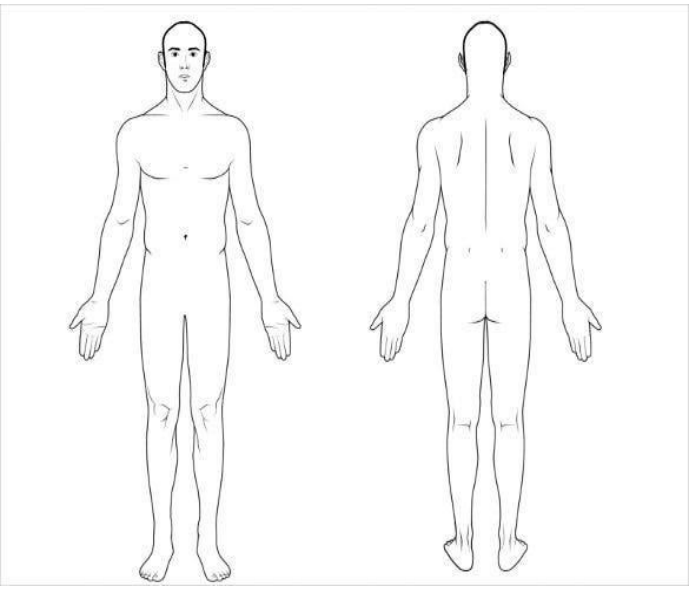
DATE:_____

What is the reason for your visit today? □ Headache □ Neck Pain □ Mid-Back Pain □ Low Back Pain □ Shoulder Pain □ Wrist Pain □ Elbow Pain □ Foot Pain □ Knee Pain □ Hand Pain □ Asthma □ Neuritis □ Nervousness □ Digestive Disorders □ Sinus Trouble □ Heart Condition □ Diabetes □ Other: _____

What is the major complaint(s)? _____

When did this complaint begin? ____/____/_____ Is it getting worse? □ Yes □ No □ Constant □ Comes and goes

What does your complaint(s) feel like? (circle all that apply) Sharp / Burning / Tingling / Numbness / Shooting Dizziness/Vertigo / Dull / Sore / Stiff/ Tight / Aching / Spasms / Throbbing / Stabbing / Cramping / Nagging



Please circle or make an "x" on the body diagram to the left where you have pain or other symptoms.

On the scale below, please circle the severity of your main complaint right now:

0	1	2	3	4	5	6	7	8	9	10

No Pain Moderate Pain Worst

What aggravates this pain? (check all that apply)

□ Sitting □ Standing □ Rising from chair □ Lying down
□ Walking □ Other: _____

Is the pain interfering with: □ Work □ Sleep □ Daily Routines □ Exercise □ Golfing □ Other: _____

What relieves the pain? □ Sitting □ Standing □ Walking □ Resting □ Medication □ Ice □ Heat □ Activity

WOMEN ONLY : Currently Pregnant? □ Yes □ No

CHIP SHEMANSKY, D.C.
24830 BURNT PINE DRIVE STE 3
BONITA SPRINGS, FL 34134

GULFSHORE
CHIROPRACTIC CLINICS

PH: (239) 948-5727
FAX: (888) 657-4642
Gulfshorechiropractic.com

HEALTH HISTORY

Primary Care Physician (PCP): _____ Last Physical: _____

If you do not have a PCP, would you like to be referred to one? □ Yes □ No

Most recent Bone Density Test? _____

Height: _____ Weight: _____ Family Medical History: _____

How often do you exercise? _____ Do you smoke? □ Yes □ No

Fractures (Broken Bones, Sprains, Strains, Major Trauma/Injury: _____

Surgeries and/or Hospitalizations (List and when): _____

Have you had any recent vehicle accidents, if yes, was the pain caused by the vehicle accident?

_____

List current medications:_____

List any known allergies. If NO allergies, check here □ _____

Have you ever had Chiropractic Care? (check one) □ Yes □ No Home Treatments: _____

Have you had treatment for your current condition recently or in the past? (check one) □ Yes □ No

Past diagnostic tests: □ X-rays □ MRI □ CT Scan □ Other _____ Findings: _____

How were you referred to our office? (check all that apply) □ Google □ Website □ Facebook □ Instagram □ Twitter □ Youtube □ Pinterest

□ Word of mouth □ Article or blog post □ Other (please, specify) _____

X_____ _____

Signature of Patient, Parent, or Legal Guardian (if minor) Date:

CHIP SHEMANSKY, D.C.
24830 BURNT PINE DRIVE STE 3
BONITA SPRINGS, FL 34134

PH: (239) 948-5727
FAX: (888) 657-4642
Gulfshorechiropractic.com

FINANCIAL POLICY NOTICE

Assignment/Authorization/Release

I certify that I, and/or my dependents, have insurance with the above-named insurance company(s) and assign directly to GulfShore Chiropractic Clinics, if any otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. I understand that I am financially responsible whether paid by insurance. The above-named providers office may use my health care information and may disclose such information to the above-named insurance company(s) and their agents for the purpose of obtaining payment for services and determining benefits payable for related services. Please note at ALL visits there will be a fee collected; whether it be, deductible, co-pay, or co-insurance for the serviced rendered at the time of service. If for some reason we have collected a larger amount than needed, your account will be credited accordingly.

□ **Self-Pay**: By checking this box, I acknowledge that I am financially responsible for all services at the time they are rendered. Name of person responsible for this account: _____

Maintenance/Therapy/Wellness Care/ Supported Care: "is not considered to be medically reasonable or necessary under the Medicare program, and is therefore, NOT PAYABLE. Maintenance therapy is defined as a treatment plan that seeks to prevent diseases, promote health, and prolong and enhance the quality of life; or therapy is performed to maintain or prevent deuteriation of a chronic condition. When further clinical improvements cannot reasonably be expected from continuous ongoing care and the chiropractic treatment becomes supportive rather than corrective in nature, the treatment is then considered maintenance therapy and is, therefore, not medically necessary".

New Patient: If you have been treated by Dr. Shemansky before but have not been treated by him within the last three years, the law requires Dr. Shemansky to evaluate you as a new patient again to go through any medical changes within that time period in which you were not treated.

Re-Evaluation: Medicare and private insurance companies REQUIRE us to re-evaluate you, order a treatment plan, and then discharge you from care (a start and finish to treatment MUST be established.) An existing patient will be re-examined when a new symptom/injury occurs, or the patient's previous symptom(s) becomes exacerbated and/or aggravated so a treatment plan can be established showing the care you are going to receive is medically necessary to satisfy Medicare guidelines. 90 days is the maximum before a re-evaluation is due again.

To maintain compliance with various state & federal regulations, managed care and preferred provider agreements; as well as billing & coding guidelines, we have adopted the following financial polices: Our clinic has established a single fee schedule that applies to all patients for each service provided. You may be entitled to a network or contractual discount under the following circumstances: we are a participating provider in your health plan, you are covered by a State of Federal Program with a mandated fee schedule, or patients who meet state and/or federal poverty guidelines or other special circumstances outlined in our "hardship policy" may be offered a discount for a period as determined by the clinic. Verification will be required.

X_____ _____

Signature of Patient, Parent, or Legal Guardian (if minor) Date:

CHIP SHEMANSKY, D.C.
24830 BURNT PINE DRIVE STE 3
BONITA SPRINGS, FL 34134

PH: (239) 948-5727
FAX: (888) 657-4642
Gulfshorechiropractic.com

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

The nature of the chiropractic adjustment:

The primary treatment I use, as a Doctor of Chiropractic, is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. This may cause an audible "pop" or "click" much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis/ Examination / Treatment

As part of the analysis, examinations, and treatment, you are consenting to the following procedures:
□ spinal manipulative therapy □ palpation □ vital signs □ range of motion testing □ orthopedic testing □ EMS
□ basic neurological testing □muscle strength testing □ postural analysis □ ultrasound □ hot/cold therapy □ radiographic studies □ Other (please explain) _____

The material risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains, separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatments. I will make every reasonable effort during examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention it is your responsibility to inform me.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The risks and dangers attendant to remaining untreated.

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

□ **I have read** the above explanation of the chiropractic adjustment and related treatment. I have satisfaction. I certify that the information I have provided is correct to the best of my knowledge. I will not hold my doctor or any staff member at Gulfshore Chiropractic clinics responsible for any errors or omissions that I may have made in the completion of this form. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

_____ _____ _____

Signature of Patient, Parent, or Legal Guardian (if minor) Date Physicians Signature

CHIP SHEMANSKY, D.C.
24830 BURNT PINE DRIVE STE 3
BONITA SPRINGS, FL 34134

PH: (239) 948-5727
FAX: (888) 657-4642
Gulfshorechiropractic.com

HIPAA Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment: including direct or indirect treatment by other healthcare providers involved in my treatment.
- Obtaining payment from third party payer(s) and day to day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

_____ _____

Print Patient Name Date

_____ _____

Signature of Patient Signature of Legal Guardian