CORDERO
FAMILY CHIROPRACTIC

Patient information

Date:_____

Name:_____

Address:_____

City:_____ State:_____ Zip:_____

SS#:_____ Sex ○ Male ○ Female

Date of birth:_____ Age:_____

○ Married ○Single ○Widowed
○ Separated ○Divorced ○ Minor

Employer:_____
Occupation:_____

Spouse or parent's name:_____

Whom may we thank for refering you to our office?

_____

Insurance information

Work or Auto related?_____

Policy Holder's Name_____

Relationship to self:_____

Insurance Company:_____

Is patient covered by additional insurance? YES / NO

Person responsable for Account if other tan self?
Name:_____

Address:_____ Phone:_____

Accident information

Is condition due to an accident? ○Yes ○No Date_____

Type of accident: ○Auto ○Work

To whom have you made a report of your accident

○Auto insurance ○Employer ○Worker's Comp

Claim number (if appliable) _____

Attorneys Name:_____

Phone number

Home Phone: (____)_____

Work Phone: (____)_____

Cell phone: (____)_____

Cell pone carrier _____

Email Adress:_____

In case of emergency, please contact:

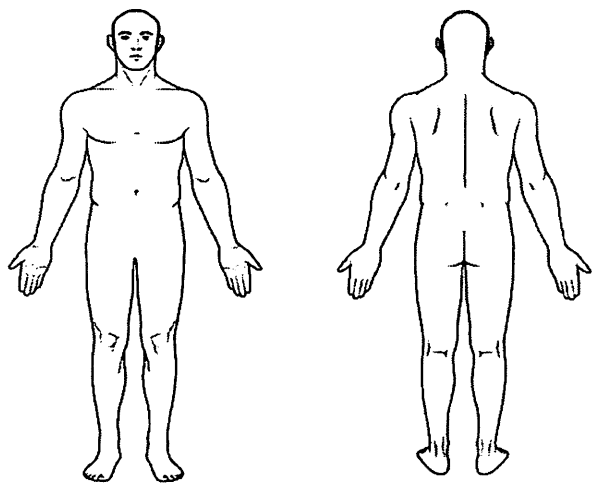
Name:_____ Relationship_____

Phone number: (____)_____

Pain diagram

Please complete the following "pain diagram" using letters to indicate your areas of complaint.

P. Pain
T. Tingling
N. Numbness
B. Burning
S. Stiffness



FRONT **BACK**

Explain:_____

_____

_____

_____

_____

CORDERO
FAMILY CHIROPRACTIC

Health History

Name: Todays's date: Date of onset:

Please select ALL choices that apply to the patient

☐ Abdominal pain	☐ Colitis	☐ Headache	☐ Irritable colon	☐ Osteosporosis	☐ Sinus trouble
☐ Allergies	☐ Colon Cancer	☐ Heart Attacks	☐ Kidney disease	☐ Painful Urination	☐ Spinal Disc Disorder
☐ Angina	☐ Convulsions	☐ Heart Disease	☐ Kidney Stone	☐ Peptic Ulcer	☐ STD's
☐ Anorexia	☐ Diabetes	☐ Hepatitis A	☐ Kyphosis	☐ PMS	☐ Stomach Ulcer
☐ Aortic Aneurism	☐ Dislocated Joint	☐ Irr. Menstrual	☐ Leg Pin	☐ Polio	☐ Stomach cancer
☐ Asthma	☐ Dizzines	☐ High BP	☐ Lordosis	☐ Prostate Cancer	☐ Thyroid disorder
☐ Blood Disorder	☐ Duodenum Ulcer	☐ Hip Pain	☐ Low BP	☐ Prostate Problems	☐ Traumatic Arthritis
☐ Bone Cancer	☐ Emphysema	☐ HIV/AIDS	☐ Low Back Pain	☐ Rapid Heart Rate	☐ Tuberculosis
☐ Brain Cancer	☐ Epilepsy	☐ Hypertension	☐ Lung Cancer	☐ Rectum Cancer	☐ Ulcer
☐ Breast Cancer	☐ Esophageal Cancer	☐ Hyperthyroid	☐ Lung Disease	☐ Rheumatoid arthritis	☐ Upper Back Pain
☐ Breast soreness	☐ Fainting	☐ Hypotension	☐ Migraine	☐ Rheumatic fever	☐ Vaginal Discharge
☐ Bulemia	☐ Gouty Arthritis	☐ Hypothyroid	☐ Multiple sclerosis	☐ Scoliosis	☐ _____
☐ Cancer	☐ Juvenile Diabetes	☐ Irregular Bowel	☐ Neck Pain	☐ Shoulder Pain	☐ _____
☐ Chest Pain	☐ Hay Fever	☐ Hepatitis B	☐ Osteoarthritis	☐ Sickle cell anemia	☐ _____

Select ALL choices that apply to the patients FAMILY (please DO NOT include relations by marriage)

☐ Abdominal pain	☐ Colitis	☐ Headache	☐ Irritable colon	☐ Osteosporosis	☐ Sinus trouble
☐ Allergies	☐ Colon Cancer	☐ Heart Attacks	☐ Kidney disease	☐ Painful Urination	☐ Spinal Disc Disorder
☐ Angina	☐ Convulsions	☐ Heart Disease	☐ Kidney Stone	☐ Peptic Ulcer	☐ STD's
☐ Anorexia	☐ Diabetes	☐ Hepatitis A	☐ Kyphosis	☐ PMS	☐ Stomach Ulcer
☐ Aortic Aneurism	☐ Dislocated Joint	☐ Irr. Menstrual	☐ Leg Pin	☐ Polio	☐ Stomach cancer
☐ Asthma	☐ Dizzines	☐ High BP	☐ Lordosis	☐ Prostate Cancer	☐ Thyroid disorder
☐ Blood Disorder	☐ Duodenum Ulcer	☐ Hip Pain	☐ Low BP	☐ Prostate Problems	☐ Traumatic Arthritis
☐ Bone Cancer	☐ Emphysema	☐ HIV/AIDS	☐ Low Back Pain	☐ Rapid Heart Rate	☐ Tuberculosis
☐ Brain Cancer	☐ Epilepsy	☐ Hypertension	☐ Lung Cancer	☐ Rectum Cancer	☐ Ulcer
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☐ Breast soreness	☐ Fainting	☐ Hypotension	☐ Migraine	☐ Rheumatic fever	☐ Vaginal Discharge
☐ Bulemia	☐ Gouty Arthritis	☐ Hypothyroid	☐ Multiple sclerosis	☐ Scoliosis	☐ _____
☐ Cancer	☐ Juvenile Diabetes	☐ Irregular Bowel	☐ Neck Pain	☐ Shoulder Pain	☐ _____
☐ Chest Pain	☐ Hay Fever	☐ Hepatitis B	☐ Osteoarthritis	☐ Sickle cell anemia	☐ _____

SMOKING: ☐ I smoke everyday ☐ I smoke on the weekends ☐ I used to smoke ☐ Never smoked

MEDICATIONS: (Please list a ll medications and dosage)_____

_____

_____

ALLERGIES:_____

_____

PAST HOSPITALIZATIONS AND/OR SURGERIES:_____

_____

Who is/was your most recent general physician?_____

Physicians phone number:_____

CORDERO
FAMILY CHIROPRACTIC

History of pregnancy: _____

Previous treatment and diagnosis for current condition: ☐ No ☐Yes

Explain:_____

_____

_____

I understand that the information I have provided above is current and complete to the best of my knowledge

_____

Signature Date

CURRENT / CHIEF COMPLAINT

What is your current complaint? (why are you seeking treatment?)

_____

_____

_____

_____

How severe is this problem?

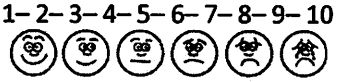
- ☐ Mild
- ☐ Mild to moderate
- ☐ Moderate
- ☐ Moderatly severe
- ☐ Severe

How Frequent?

- ☐ Constant
- ☐ Occasional
- ☐ Intermitent
- ☐ Frequent

On a 1-10 scale, how would you rate your pain? (10=most painful, 1=least painful)

1– 2– 3– 4– 5– 6– 7– 8– 9– 10



Improvement (%)

10% 20% 30%
40% 50% 60%
70% 80% 90%
100%

When was the onset of this problem ?

☐Gradual ☐About a day ago ☐About a month ago
☐Insidious ☐Several days ago ☐Several months ago
☐Sudden ☐About a week ago ☐Several years ago
☐Several weeks ago ☐About a year ago

Select each choice that applies to you.

Movement

☐Cramps ☐Spasm
☐Inflexibility ☐Stiffness
☐Restricted Movement

Sensation

☐Crawling ☐Pins and Needles
☐Dead ☐Prickly
☐Numb ☐Tigling

Select the type of pain that best describes your complaint.

☐Achy ☐ Burning ☐ Dull ☐ Excruciating ☐ Numb ache ☐ Pounding

☐ Pulsating ☐ Sharp ☐ Shooting ☐ Stabbing ☐ Stinging ☐ Throbing

AT WHAT TIME OF THE DAY DOES IT FEEL BETTER?

☐Usually better in the morning ☐Usually better during the day ☐Usually better at night ☐It is never better

AT WHAT TIME OF THE DAY DOES IT FEEL WORST?

☐Usually worst in the morning ☐Usually worst during the day ☐Usually worst at night

I understand that the information I have provided above is current and complete to the best of my knowledge.

Signature_____ **Date**_____

CORDERO
FAMILY CHIROPRACTIC
561-533-3884
WWW.CORDEROCHIROPRACTIC.COM

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 of us to be working for the same objective. It is important that each patient understand both the objective(s) and the method(s) that will be used to attain this objective. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition and the recommended care to be provided so that you make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks, and alternatives.

Chiropractic is a science, philosophy and art which concern itself with the relationship between the spinal structure and the health of the nervous system. As chiropractors we understand that health is a state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebra in the spinal column become misaligned and/or do not move properly. This causes an unhealthy change to nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by a chiropractic adjustment. An adjustment is the specific application of force to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments to the spine. Adjustments are done by hand where the doctor will put pressure on the specific segment(s) of the spine to adjust the vertebrae into a better position.

If at the beginning or during the course of care we encounter a non-chiropractic or unusual findings, we will advise you of those findings and recommend some further testing or refer you out to another health care provider.

Chiropractic care has been proven to be very safe and effective. It is not unusual however, to be sore after your first few corrective adjustments. Although rare it is possible to suffer from other side effects; i.e. muscle spasms, stiffness, rib fracture, headache, dizziness and stroke.

All questions regarding the doctor's objective to my care in this office has 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 parent or legal guardian of _____ have read and fully understand the above Informed 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-rays can be hazardous to an unborn child.

Date of last menstrual cycle: _____

_____

Signature Date

CORDERO
FAMILY CHIROPRACTIC
561-533-3884
WWW.CORDEROCHIROPRACTIC.COM

Patient Name:_____ File:_____

Standard Waiver of Liability:

I understand that I am financially responsible for any charges incurred at this office, for those patients using insurance, this would include co-pays, deductibles, and charges denied or not covered by my insurance company.

I realize my care may be subject to pre-authorization by my insurance company, and I accept any responsibility for charges which may not be approved. My insurance company will review any/all documentation submitted by Cordero Family Chiropractic for review for medical necessity, however, final determination is based upon my insurance company's medical guidelines. Insurance policy limitations are per individual insurance policy plans, as are co-payments, co-insurance, deductibles, referrals, etc.

I understand this office agrees to notify me as soon as possible whether my care is approved or denied by my insurance company. I further understand my initial visit may be denied and this may be beyond the office ability to notify me prior to rendering acute care, while waiting for insurance coverage approval. These charges will be my responsibility if denied by my insurance company.

NOTE: our office does not bill secondary insurance carriers.

I understand this office will require payment from me for any services not covered by my health insurance plan. Any payment due beyond 30 days is subject to late fees, interest at 1.5% per month and collection agency fees. I agree to pay all collection costs associated with collecting said debt, including, but not limited to attorney fees of 25% (twenty-five percent), together with the cost and disbursement of the action.

Assignment of Benefits:

I hereby authorize my insurance benefits to be paid directly to Dr. Francisco Colon and/or Dr. Sebastian Colon.

I have read this document and understand my obligations for payments for care in the absence of insurance coverage.

_____

Signature (Patient, Parent/guardian of patient) Date

Release of Medical Records:

I give my permission for Dr. Colon to request medical information for other medical facilities that may help the doctor to accurately assess and treat my current condition.

_____

Signature (patient, or Parent/guardian of patient) Date

Cordero Family Chiropractic

Auto Accident Report

Date __/__/__ Name: _____ File #_____

Name of Insurance Company: _____

Policy # _____ Claim# _____

Insured SS# ___- __- ____ Insured Date of Birth __ / __ / __

Insured employer _____

Date of Accident __/__/__ Time of Accident _____ AM / PM

If a traffic violation was issued, to whom was it issued to? _____

Did the police come to the accident site? ..... Yes / No

Was a police report filled out? ..... Yes / No

Were there any witnesses? ..... Yes / No

In your own words, please describe the accident: _____

_____

Name the location/street on which you were traveling: _____

In which direction were you traveling? North / South / East / West

Make and model of other vehicle involved:_____

Direction other vehicle was headed? North / South / East / West

Have you gone to a hospital or seen any other doctor after the accident? _____

Did the ambulance take you to the hospital? _____

Name of hospital and/ or doctor seen:_____

Describe any treatments received:_____

Were X-Rays taken? _____ Was medication prescribed? _____

Have you been able to work since the injury? _____

Indicate symptoms that are a result from this accident: _____

Is your condition worsening? _____

In what positions do you experience pain and or discomfort? _____

What is the degree of pain in these positions? _____

Cordero Family Chiropractic

Auto Accident Report

How many hours a day do you work? _____

What daily activities are involved in your work? _____

While you recover, is there any light duty work you could request? _____

Do you work with others who can help you with heavy lifting? _____

What was your position in the vehicle? (Circle one)

Driver Front Passenger Rear Passenger Pedestrian

What vehicle where you driving? (Make, model, and year) _____

What speed were you traveling at time of impact? _____

Who hit who? _____

Where was YOUR vehicle's point of impact? _____

What speed was the OTHER vehicle traveling at? _____

What was the OTHER vehicle point of impact? _____

Were you wearing seat restrain? _____

What position was the head piece on? (Compared to your head) LOW MIDDLE HIGH

Did the air bags deploy? YES / NO

Were you prepared for the impact? (Circle one)

I saw the car coming / I was completely unaware

Which way were you looking at the time of impact? (Circle one)

Forward / Right / Left

What was your mental/ emotional state after the accident? _____

Did the accident render you unconscious? _____For how long? _____

Did you receive medical attention at the scene of the accident? _____

Where did you go immediately after the accident? _____

Have you retained an attorney? _____

If yes, whom: _____ His/ Her phone # _____

Signature:_____ Date: _____

Assignment of Benefits Form

POWER OF ATTORNEY TO ENDORSE CHECKS AND/OR TO SIGN ANY PAPER WHICH WILL ENHANCE OR EXPEDITE PAYMENT TO PROVIDER FOR SERVICE RENDERED, INCLUDING BUT NOT LIMITED TO A RELEASE OF MEDICAL RECORDS AND ASSIGNMENT OF BENEFITS/AUTHORIZATION TO PAY.

Known by all these present that: the undersigned has made, constituted and appointed, and by these presents does hereby make, constitute and appoint CORDERO FAMILY CHIROPRACTIC and any of its duly authorized agents and employees as and to be the undersigned's true and lawful attorney for and in the undersigned's name, place and stead to endorse any and all checks, drafts or money orders which are made payable to the undersigned alone or to the undersigned and CORDERO FAMILY CHIROPRACTIC which checks, drafts or money orders are made payable for services which have been made by CORDERO FAMILY CHIROPRACTIC, at the request of with the knowledge and approval of the undersigned and/or maker of the check, draft or money order.

This assignment includes but is not limited to, all rights to collect benefits directly from my insurance company for services that I have received and all rights to proceed against my insurance company in any action including legal suit if for any reason my insurance company fails to make payments of benefits due to my assignee or me. This assignment also includes any rights to recover attorney's fees and costs for such action brought by the provider as my assignee.

The undersigned by these presents does give and grant CORDERO FAMILY CHIROPRACTIC, as attorney the full power and authority to do and perform all and every act whatsoever requisite and necessary to be done in and about the premises as fully to all intents and purposes as the undersigned might or could do to personally present insofar as the endorsing and cashing of said check and concerned as well as any other document.

At any time after Insurer fails to render the applicable payment within 30 days upon receipt of Health Care Providers medical bills got any date of service, this agreement may be revoked. Health Care Provider's said revocation will be effective on the thirty first (31) day after Insurer has received Health Care Provider medical bill(s) that Insurer has denied, withdrawn, reduced, or failed to pay in accordance with Florida Statutes 627.736. Said revocation shall include any and all dates of services subsequent to the thirty-first (31) day after Insurer has received Health Care Provider medical bills that Insurer has denied, withdrawn, reduced, or failed to pay in accordance with Florida Statute 627.736.

A photocopy of this document shall be as binding as an original signature page.

The undersigned does hereby ratify and confirm any and all actions taken by the said attorney in accordance with this special power and which they said attorney shall do cause to be done by virtue of these presents.

ASSIGNMENT OF BENEFITS

I,_____, hereby authorize _____
(name of insured) (name of insurance company)

to pay to and mail directly to CORDERO FAMILY CHIROPRACTIC, the medical benefits otherwise payable to me for their services, but not to exceed the charges of those services. I hereby irrevocably assign to CORDERO FAMILY CHIROPRACTIC and benefits under any policy of insurance, indemnity agreement, or any other collateral source as defined in Florida Statutes for any services and charges provided by CORDERO FAMILY CHIROPRACTIC.

_____ _____ _____
PATIENT'S SIGNATURE PATIENT'S NAME DATE

CORDERO FAMILY CHIROPRACTIC

Dr. Francisco Colon & Dr. Sebastian Colon

3208 Lantana Rd.

Lantana , Fl , 33462

Phone (561) 533 – 3884

Fax (561) 439 – 7349

HIPPA Compliant Medical Release Form

Date: _____

To : _____

(Doctor / Hospital)

Patient Name : _____

Patient Address : _____

Birth Date :_____ S S # _____

Purpose of Release of all medical records / PHI : continuing medical care with Dr. Francisco Colon / Dr. Sebastian Colon .

Limited Power of Attorney : In the event that your institution requires a site specific authorization for release of protected health information , I grant Dr. Colon the ability to use this medical release form I signed with him along with his signature on your form to release my PHI . I do appreciate the fact that you are lolling after my PHI privacy . I hope you understand that I have the right to have my medical records/PHI sent to Dr. colon in a timely fashion to ensure the proper documents are made available to him for my continuing medical care and well being . I have read his HIPPA policy that can be found on line at : www.cordero chiropractic .com. If you have any concerns about releasing my medical records to Dr. Colon , please call me at (561) 533 – 3884.

X_____

(Patient Signature)

Cordero Family Chiropractic

Dr. Francisco Colón & Dr. Sebastián Colón
3208 Lantana rd.
Lantana Fl, 33462
(561) 439-7349
Fax (561) 439-7348

TO: Attorney _____

_____

_____

RE: Health Reports and Doctor's Lien

I (_____) hereby authorize the above doctor to furnish you, my attorney/insurance carrier, with a full report of his examination, diagnosis treatment, prognosis, etc., of myself in regards to the accident/illness which occurred/began on _____.

I hereby give and direct you, my attorney, to pay directly to the said doctor such sums as may be due and owing him for professional services rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment or verdict as may be necessary adequately to protect the said doctor, I hereby future give a lien on my case to said doctor against any and all proceeds of any settlement, judgment or verdict which may be paid to you attorney, or myself as a result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all professional bills submitted by him for services rendered me and that this agreements is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

Dated:_____ Patients Signature:_____

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums for any settlement, judgment or verdict as may be necessary adequately to protect the said doctors named above.

Dated:_____ Attorney's Signature:_____

Attorney: Please date, sign and return one copy to doctor's office at once.
Reply envelope attached.
Keep one copy for your records.

CORDERO FAMILY CHIROPRACTIC

Dr. Francisco M. Colón and Dr. Sebastian J. Colón

3208 Lantana Rd. Lantana, FL. 33462

Certified Mail Receipt # _____

Date: _____

INSURANCE COMPANY AND ADDRESS:

Name: _____

Address: _____

_____

City: _____ State: _____ Zip: _____

NOTICE OF INITIATION OF TREATMENT

Patient: _____

Insured: _____

Date of Loss: _____

Claim #: _____

Policy #: _____

To whom it may concern:

Please be advised that I have been consulted by and have commenced rendering medical services to the patient referenced above. The first day of treatment was on _____.

Also enclosed please find a direction to pay by which the patient has directed you to send the check for payment for services rendered to the undersigned. The patient has granted us a lien on the benefits.

In accordance with 627.736(5)(b), I will be timely submitting the bills. We expect you govern yourself accordingly.

Sincerely,

Francisco Colon, DC and Sebastian Colon, DC

AUTHORIZED REPRESENTATIVE: _____