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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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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Assignment of Insurance Benefits

I, _____, hereby assign the benefits under policy/Claim # _____, of _____, otherwise payable to me, but not to exceed the health care provider's reasonable charges, to Elana Kaplove DC.

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

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.

_____
Date

_____
Patient Name

_____
Patient Signature

_____
Witness Name

_____
Witness Signature

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