Do you have access to our Patient Portal?

Please provide your email address so that you can have access to:

Request Appointments

Request prescription refills

Ask non emergent medical questions

View medical history/medications

Review lab reports (once reviewed by the Dr.)

Request billing information

Email Address (Please Print Clearly): _____

You can also download the Healow App to access the Portal on your mobile device anywhere, anytime!

Practice Code: DGIGCA

Use above practice code to easily link healow app with our practice

How Did You Hear About Us?

THANK YOU FOR CHOOSING FM MEDICAL CENTERS, WE WOULD APPRECIATE YOU TAKING THE TIME TO COMPLETE THIS FORM.

PLEASE SELECT ONE OF THE FOLLOWING:

Did you hear about us in one of the following ways?

- Newspaper Advertisement ____
- Drove by _____
- Facebook ____
- Attorney ____
- Television Advertisement ___
- Internet Search/Web site ___
- Yellow Pages ___
- Employer/Friend/Insurance ___
- Another Physician ____ Who: _____
- Other _____

Your Name (please print): _____

Pain Relief Centre
165 Southpark Blvd, Suite C & D
St Augustine, Fl 32086
Patient Registration

Last Name			Primary Care Physician/Referring Physician
First Name		MI	Social Security Number
Previous Name			Date of Birth (mm/dd/yyyy)
Address			Gender □ Male □ Female
City			Marital Status □ Single □ Divorced □ Married □ Widowed
State	Zip	County	Race : □ American Indian or Alaska Native □ Asian □ Native Hawaiian or Other Pacific □ Black or African American □ White □ Hispanic □ Other □ Refuse to report
Home Phone	Cell Phone		Ethnicity □ Hispanic or Latino □ Not Hispanic or Latino □ Refuse to report
Work Phone Ext.			Email Address

Responsible Party or Guarantor (If under 18 years of age)

Last Name		Relation		
First Name	MI	Address		
Home Phone Cell Phone		City	State	Zip

Patient Employer Information

□ Employed □ Retired □ Full-time Student □Part-time Student □ Disabled □ Unemployed				
Employer Name		Occupation		
Address	City	State	Zip	Work Phone

Insurance Information

Primary Insurance Company Name	Subscriber's Name	Subscriber's Date of Birth
Subscriber's Social Security/ID Number	Subscriber's Address	Subscriber's Home Phone
Secondary Insurance Company Name	Subscriber's Name	Subscriber's Date of Birth

In Case of Emergency

Name of local friend or relative	**Relationship:**	**Home #** **Cell #**

Patient Request for Confidential Communications

Patient Name: _____

Patient Date of Birth: _____ Patient SSN: _____

This is a request for confidential communications of my protected health information (PHI). When the doctor, nurse or other members of your office want to contact me please use the following guidelines. I understand that you will do your best to adhere to the following requests.

Please check all that apply to this request:

_____ Please do not phone me at home. Use the following alternative phone number to contact me:_____

_____ Please do not phone me at work. Use the following alternative number to contact me:_____

_____ Please do not contact me by email.

_____ Other request(s) (describe in detail): _____

_____

_____ When contacting me by phone it is ok to leave messages and discuss my health information with:

Name:_____Relationship_____

Name: _____Relationship _____

_____ **(Please initial) I understand that the physician or provider to whom I am making this request will make reasonable efforts to accommodate this request. I further understand that in some emergency situations, my PHI may be released. I authorize my medications from the Pharmacy Database be released to this office.**

Advanced Directive Planning

Do you have an Advanced Directive? ☐ Living Will ☐ Power of Attorney ☐ DNR ☐ I do not have an Advanced Directive

Consent for Medical Treatment

I/we voluntarily consent to medical treatment and diagnostic procedures provided by this office and its' associated physicians, clinicians and other personnel. I/we am/are aware that the practice of medicine and surgery is not an exact science and I/we acknowledge that no guarantee has been made as to the result of treatments or examinations.

Assignment of Benefits and Patient Responsibility

I certify that the information on these forms is true to the best of my knowledge. I accept responsibility for the medical charges incurred by the patient and agree to pay bills at time of service unless other arrangements are made. I authorize my insurance claim to be paid directly to the clinic. I further understand my health care insurance carrier or payor of my health benefits may pay less than the actual bill for services, and all second opinion and pre-admission review requirements are ultimately my responsibility.

Signature of Patient (or patient's personal representative):_____

Relationship of representative to patient: _____

Date: _____

APPOINTMENT CANCELLATION POLICY

Dear Patient,

We strive to provide excellent medical care to you, our valued patient. "No-shows" and cancellations take valuable appointment slots away from individuals who need access to medical care in a timely manner. In an effort to increase access, we have implemented a Cancellation Policy.

Our policy is as follows:

1. We request a 24- hour notice to reschedule your appointment.

2. If a 24 hour notice is not given, the following fees will apply: Massage appointments-$35. Ultrasound/Nerve Conduction Studies-$50. For appointments with Dr. Spooner there will be a charge of $125. All other appointments are charged @ a fee of $25. This fee will be billed to you directly, is not covered by your insurance, and is due at your next appointment.

3. If you are up to 15 minutes late for an appointment, we will attempt to fit you in as the schedule allows. If you are over 15 minutes late and have not called ahead, a cancellation fee will be applied.

4. We are pleased to provide you our patient portal. There you will receive email reminders and access to a convenient way to reschedule. If you would like more information regarding the patient portal, please see a receptionist.

We thank you for trusting FM Medical Centers with your medical care.

I have read and understand the Appointment Cancellation Policy and agree to the terms of this policy.

_____ _____

Signature Date

_____

Printed Name

INFORMED CONSENT

Patient Name: _____ Date: _____

Every type of health care is associated with some risk of a potential problem. This includes chiropractic health care. Pain Relief Centre and whomever he/she may designate as his/her assistant wants to inform you about potential problems associated with chiropractic health care before consenting to treatment. This is called informed consent.

Analysis/Examination/Treatment
As a part of the analysis, examination, and treatment, you are consenting to the following procedures:

 spinal manipulative therapy palpation vital signs range of motion testing flexion/distraction electrical muscle stimulation
 orthopedic testing basic neurological testing muscle strength training
 ultrasound hot/cold therapy cervical/lumbar traction
 radiographic studies

_____

By signing this document below the patient agrees to the modalities suggested by the physician.

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: Those listed below. Some patients will feel some stiffness and soreness following the first few days of treatment. In this office we use trained staff personnel to assist the doctor with portions of your consultation, examination, x-ray taking, physical therapy application, traction, massage therapy, exercise instruction, etc. Occasionally when your doctor is unavailable, another clinic doctor will treat you on that day. I will make every reasonable effort during the 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.

Chiropractic adjustments are the moving of bones with the doctor's hands or with the use of a machine. Frequently adjustments create a "pop" or "click" sounds/sensation in the area being treated.

SORENESS: It is common for chiropractic adjustments, traction, massage therapy, exercise, etc. to result in a temporary increase in soreness in the region being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic changes. It is not dangerous, but please do tell your doctor about it.

SOFT TISSUE INJURY: Soft tissue primarily refers to muscles and ligaments. Muscles move bones, and ligaments limit joint movement. Rarely a chiropractic adjustment, traction, massage therapy, etc., may tear some muscle of ligament fibers. The result is a temporary increase in pain and necessary treatments for resolution, but there are no long term effects for the patient. These problems occur so rarely that there are no available statistics to quantify their probability.

PHYSICAL THERAPY BURNS: Some of the machines we use generate heat. We also use both heat and ice, and recommend them for home care on occasion. Everyone's skin has different sensitivity to these modalities and rarely, either heat or ice can burn or irritate the skin. The result is a temporary increase in skin pain, and there may even be some blistering of the skin. These problems occur so rarely that there are no available statistics to quantify their probability.

RIB FRACTURES: The ribs are found only in the thoracic spine or middle back. They extend from your back to your front chest area. Rarely a chiropractic adjustment will crack a rib bone, and this is referred to as a fracture. This occurs only on patients that have weakened bones from such things as osteoporosis. Osteoporosis can be noted on your x rays. We adjust all patients very carefully, and especially those who have osteoporosis on their x rays. These problems occur so rarely that there are no available statistics to quantify their probability.

DISC HERNIATIONS: Disc herniations that create pressure on the spinal nerve or on the spinal cord are frequently successfully treated by chiropractors and chiropractic adjustments, traction, etc. This includes both in the neck and back. According to the article, Reviews of the Literature: Side Posture Manipulation for Lumbar Intervertebral Disk Herniation by: J. David Cassidy, D.C., the treatment of lumbar intervertebral disc herniation by side posture manipulation is both safe and effective: although, some herniations require surgery. (Journal of Manipulative and Physiological Therapeutics. Volume 16: Number 2 February 1993).

STROKE: Stroke is the most serious problem associated with chiropractic adjustments. Stoke means that a portion of the brain does not receive enough oxygen from the bloodstream. The results can be temporary or permanent dysfunction of the brain, with a very rare complication of death. Chiropractic adjustments have been associated with strokes that arise from the vertebral artery only; this is because the vertebral artery is actually

found inside the neck vertebrae. The adjustment is related to vertebral artery stroke is called the “extension-rotation-thrust atlas adjustment”. We do not do this type of adjustment on patients. Other types of neck adjustments may also potentially be related to vertebral artery strokes., but no one is certain. (The most recent studies (Journal of the CCA, Vol. 37 No 2. June 1993) estimate that the incident of this type of stroke is 1 per every 3,000,000 upper neck adjustments. This means that an average chiropractor would have to be in practice for hundreds of year before they would statistically be associated with a single patient stroke.)

OTHER PROBLEMS: There may be other problems or complications that might arise from chiropractic treatment other than those noted above. These other problems or complications occur so rarely that it is not possible to anticipate and/or explain them all in advance of treatment..

Chiropractic is a system of health care delivery, and, therefore, as with any health care delivery system we cannot promise a cure for any system, disease, or condition as a result of treatment in this clinic. We will always give you our best care, and if results are not acceptable, we will refer you to another provider who we feel will assist your situation.

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 incidence of stroke are exceedingly rare and are estimated to occur between one in one million and one in one five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatments.
Other treatment options for your condition may include:
*Self-administered, over-the-counter analgesics and rest
*Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and painkillers
*Hospitalization
*Surgery
If you choose to use one of the above noted “other treatment” options, you should be aware that there are more risks and benefits of such options and you may wish to discuss these with your primary care physician.

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.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTOOD THE ABOVE.
PLEASE CHECK THE APPROPRIATE BOX AND SIGN BELOW

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed treatment options, indications, contraindications and risks with my physician and have had my questions answered to my satisfaction. 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 options, indications, contraindications and risks, I hereby give my consent to that treatment.

Can we send our findings from today and future visits to your primary care doctor? [ ] Yes [ ] No
[ ] I don’t have one, but I’d like to schedule an appointment with a doctor from FM Medical..

If so, please list your primary doctors name and phone # : _____

_____ _____
Patient’s Printed Name Date

_____ _____
Patient’s Signature Parent or Guardian Signature for Minor

_____ _____
Witness Signature Date

SHOW US WHERE IT HURTS

Please mark area(s) of injury or discomfort as shown in the example below. Mark all areas with the appropriate symbols and indicate the degree of pain using a scale from 1 (discomfort) to 10 (extreme pain)

Description:	Numbness	Pins & Needles	Burning	Aching	Stabbing	Dull
Symbol:	NNN	PPP	BBB	AAA	SSS	DDD