George Tabib, D.C.
13630 W. Hillsborough Ave. Tampa, FL. 33635
P: 813.749.6654 F: 813.320.0585
contact@BSPchiro.com

ADULT INTAKE FORM

Welcome to Bayside Spine and Performance!

- Patient information contained within this form is considered strictly confidential. Your responses are important to help us better understand health issues you face and ensure the delivery of the best possible treatment.
- For any questions that do not apply to you, simple respond "N/A" for Not Applicable.

Today's Date: _____

Have you ever received chiropractic care? ☐ No ☐ Yes

Name of Last Chiropractor: _____

Last Chiropractic Treatment: _____

Primary Care Physician Name: _____ **Primary Care Physician Phone:** _____

How did you hear about us? ☐ Existing Patient ☐ Google Search ☐ Social Media ☐ Website

Who can we thank for referring you to our office? _____

Personal Information

Full Name: _____ **Date of Birth:** ____/_____/____ **Age:** _____ **Sex:** ☐ M ☐ F
First MI Last

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

Social Security Number: _____ **Email Address:** _____

Cell Phone: _____ **Home Phone:** _____ **Work Phone:** _____

Emergency Contact: _____ **Contact Number:** _____ **Relationship:** _____

Occupation: _____ **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed

What type of care are you interested in? ☐ Chiropractic Care ☐ Sports Recovery ☐ Massage Therapy ☐ Wellness

What is your long-term goal from treatment? (Ex. play a round of golf) _____

Is this visit due to a work related injury? ☐ No ☐ Yes **Is this visit related to an auto accident?** ☐ No ☐ Yes

Date of Injury: _____/_____/_____

(If you answered yes to either question above, call office or check with receptionist. Additional information is needed.)

Patient Signature: _____

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Health Questionnaire

Would you say your health is (check one): ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

For Women: Are you pregnant or nursing? ☐ Yes ☐ No **If yes, How many weeks?** _____

Do you wear? ☐ Heel Lift ☐ Prescription Orthotics ☐ Arch Supports

Past Health History

Do you have any known allergies? ☐ **No** ☐ **Yes** **List:** _____

Do you take any medications and/or supplements? ☐ **No** ☐ **Yes List:** _____

Do you have a history of cancer? ☐ **Yes** ☐ **No** **Explain:** _____

Do you have a history of any autoimmune condition? ☐ **Yes** ☐ **No** **Explain:** _____

Have you ever had a stroke or issues with blood clotting? ☐ **Yes** ☐ **No**

Have you recently experienced dizziness, unexplained fatigue, weight loss, or blood loss? ☐ **Yes** ☐ **No**

Have you ever had any major illnesses, broken bones, hospitalizations, accidents, or surgeries? ☐ **Yes** ☐ **No**

Date	Injury/Fracture/ Illness/Surgery	Treatment	Result

Social Health History

Do you exercise? **Yes** ☐ **No** ☐ _____ **Times per week**

Do you smoke? **Yes** ☐ **No** ☐ _____ **Packs per day** **Years of use:** _____

Do you consume alcohol? **Yes** ☐ **No** ☐ _____ **Drinks per week**

Recreational drug use? **Yes** ☐ **No** ☐ **If yes, explain:** _____

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Family Health History

Have any of your family members been diagnosed with any of the following? If so, indicate relationship.

☐ **Heart Disease:** _____ ☐ **Cancer:** _____

☐ **Diabetes:** _____ ☐ **Arthritis:** _____

☐ **Autoimmune:** _____ ☐ **Other:** _____

Chief Complaint

Has the present problem for which you are consulting us been an issue in the past? ☐ **Yes** ☐ **No**

If yes, when?: _____ **Was treatment provided?:** ☐ **Yes** ☐ **No** **If yes, by whom?:** _____

When did symptoms begin?: ☐ **Today** ☐ **Days Ago** ☐ **Weeks Ago** ☐ **Months Ago** ☐ **Years Ago**

Was the onset: ☐ **Gradual** ☐ **Sudden** **Since its onset has it gotten:** ☐ **Better** ☐ **Worse**

Describe what caused the pain: _____

Have you detected any possible relationship between your current complaint and any of the following?

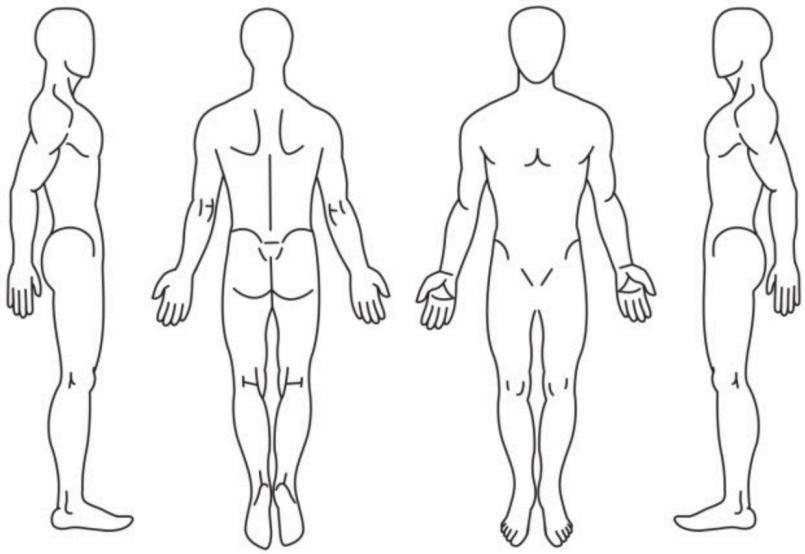
☐ **Muscle Weakness** ☐ **Bowel/Bladder** ☐ **Digestion** ☐ **Cardiac/Respiratory** ☐ **Other** _____

Have you tried any self-treatment or taken any medication (over the counter or prescription)? ☐ **Yes** ☐ **No**

If yes, explain: _____ **Results:** ☐ **Alleviated** ☐ **No change** ☐ **Worsened**

Are you currently taking anti-coagulant or blood thinning medications? ☐ **Yes** ☐ **No**

In the diagram to the right, mark the figures in relation to where you experience symptoms on your body. Use the symbols below to show what type of discomfort you are experiencing.



+++ **Burning**

- - - **Sharp/Stabbing**

000 **Dull/Achy**

******** **Numb/Tingling**

Patient Signature: _____

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Health Insurance Portability & Accountability Act (HIPAA)
Consent for Purposes of Treatment, Payment, and Health Care Operations

This document is meant to obtain acknowledgement of your understanding of your rights to privacy and the practices rights and responsibility to information disclosure under the Health Insurance Portability and Accountability Act.

I consent to George Tabib DC PA d/b/a Bayside Spine and Performance (the "Practice") use and disclosure of my Protected Health Information for the purpose of providing treatment to me, for purposes relating to the payment of services rendered to me, and for the Practice's general health care operations purposes. Health care operations shall include, but are not limited to, quality assessment activities, credentialing, business managements, and other general operation activities. I understand that the Practice's diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

For purposes of this Consent, "Protected Health Information" means any information, including my demographic information, created or received by the Practice, that relates to my past, present, or future physical or mental health or condition; the provision of health care to me; or the past, present, or future payment for the provision of health care services to me; and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me.

I understand that I have the right to request a restriction on the use and the disclosure of my Protected Health Information for the purposes of treatment, payment, or health care operations of the Practice, but the Practice is not required to agree to these restrictions. However, if the Practice agrees to a restriction that I request, the restriction is binding on the Practice.

I understand that I have a right to review the Practice's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes my rights and the Practice's duties regarding the types of uses and disclosures of my Protected Health Information.

By signing this document, I acknowledge that I have received, reviewed, understand, and agree to the Notice of Privacy Practices of the Practice, which describes the Practice's policies and procedures regarding the use and disclosure of my Protected Health Information created, received, or maintained by the Practice.

I have the right to revoke this consent, in writing, at any time, except to the extent that the Physician of the Practice has acted in reliance on this consent.

The Practice reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of the privacy practices by calling the office and requesting a revised copy be administered at the time of my next appointment.

_____ _____

Name of Patient/Personal Representative (print) **Date**

_____

Signature of Patient/Personal Representative

_____

Description of Personal Rep's Authority

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Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events per one million persons per year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every conceivable complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date: _____

Parent/Guardian: _____ Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date: _____

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Patient: _____

AUTHORIZATIONS AND RELEASES

Consent to Professional Treatment

I certify that all information provided to this practice is true and correct, to the best of my knowledge. I hereby give consent to this practice and its health care providers, consultants, assistants, or designees to render care and treatment to me as they deem necessary. I recognize that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made as to the result of evaluation and treatment. If the patient is a minor child, under the age of eighteen (18) at the date of treatment, I hereby stipulate that I am the legal guardian of the child and grant my consent for the treatment of the child as provided for herein. I acknowledge that may refuse treatment at any time.

Initials: _____

Patient Health Information and Privacy Policy

This policy outlines the way Patient Health Information (PHI) will be used in this office and the patient's rights concerning those records. You must read and consent to this policy before receiving services. For more information about Health Information Portability and Accountability Act (HIPAA) and health information privacy visit: hhs.gov - Understanding Health Information Privacy

- The patient understands and agrees to allow this office to use their PHI for the purpose of treatment, payment, health care operations and coordination of care. The patient agrees to allow this office to submit requested PHI to the payor(s) named by the patient for the purpose of payment. This office will limit the release of all PHI to the minimum necessary to receive payment.
- The patient has the right to examine and obtain a copy of their health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. This office is not obligated to agree to those restrictions.
- The patient's written consent shall remain in effect for as long as the patient receives care at this office, regardless of the passage of time, unless the patient provides written notice to revoke their consent. A revocation of consent will not apply to any prior care or services.
- This office is committed to protecting your PHI and meeting its HIPAA obligations: Staff have been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures.
- Patients have the right to file a formal complaint with our privacy official about any suspected violations.
- This office has the right to refuse treatment if the patient does not accept the terms of this policy.

Initials: _____

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Financial Obligation and Appointment Policy

I hereby accept full financial responsibility for services rendered by this practice. I accept full responsibility for any fees incurred, regardless of insurance coverage. I understand that George Tabib DC PA d/b/a Bayside Spine and Performance is an out-of-network provider, and the patient is self-pay, for a flat rate fee that is not an insurance discount. This fee must be paid before services are rendered. Should the account be referred to an attorney or collection agency for collection, I shall pay all fees, including but not limited to legal fees, collection agency fees, and any and all other expenses incurred in the collection of past due accounts. Balances beyond 90 days overdue may be subject to a billing fee of 5% per month and may require the involvement of a collections agency. A returned check from our financial institution is subject to a returned check fee of $35 per returned check. The practice reserves the right to change without notices the flat rate fees and fee schedule. We require a 24-hour notice of any cancellation or rescheduled appointment. Failure to comply may result in a financial penalty.

You may direct any questions regarding this financial obligation to the clinic manager or physician.

Initials: _____

Assignment of Benefits and Release of Records

I hereby assign to this practice all of my medical and procedure benefits to which I am entitled, including major medical benefits. I hereby authorize and direct my insurance carrier(s), including Medicare and other government sponsored programs if applicable, private insurance and any other health plans to issue payment directly to this practice for medical services rendered. This assignment is irrevocable. I hereby authorize this practice to release any medical or other information required by third party payors, including government agencies, insurance carriers, or any other entities necessary to determine insurance benefits or benefits payable for related services and supplies provided to me by the practice.

Initials: _____

Signature: _____ Date: _____

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CONSENT TO TREAT MINOR

I hereby request and authorize George Tabib DC PA d/b/a Bayside Spine and Performance, and whomever he/she may designate as his/her assistant or authorized representative, to administer healthcare, as he/she deems necessary to my dependent minor child. This authorization also extends to include diagnostic imaging, laboratory and other testing at the doctor's discretion.

As of today's date, I have the legal right to select and authorize health care service for the minor child named above. If applicable, under the terms and conditions of a divorce/separation or other legal authorization, the consent of a spouse, former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

_____ _____
Patient Printed Name Date

_____ _____ _____
Legal Guardian Name Legal Guardian Signature Relationship to Patient

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PATIENT PHOTOGRAPH, VIDEO & WRITTEN TESTIMONIAL CONSENT AND RELEASE FORM

Purpose of Release: The purpose of this Release is to give your permission to George Tabib DC PA d/b/a Bayside Spine and Performance (hereinafter referred to as the practice) to use your information (photograph/video/testimonial) for the practices own advertising, publicity, educational, and promotional purposes.

You agree to the following:

1. Your Photograph/Video/Written Testimonial: This includes all items and/or information you provide to and/or let the practice record (for example, quotes attributable to you, your voice, video footage, photos, etc.).
2. You understand and agree that the practice has the unrestricted right to:
   (a) Reproduce, copy, modify, create derivatives of, or use the photograph/video/testimonial, and
   (b) Use your name in connection with the photograph/video/testimonial as the practice may choose, and
   (c) Display, distribute, send or broadcast the photograph/video/testimonial by any means or method.

You give the practice your permission to use your photograph/video/testimonial for the purpose of creating, publishing and distributing promotional, educational, advertising and publicity materials. The practice shall be the copyright owner of all published materials, and you give the practice, absolutely and forever, the copyright and the right to secure copyright of the published materials and all extensions and renewals of such copyright. You agree that no promotional idea or document containing the use of the published material needs to be submitted to you for approval.

3. The terms of this permission shall begin on the date you have signed below.
4. You agree to waive all rights and release the practice from, and shall not sue the practice or take any other legal against the practice for, any claim or cause of action, whether now known or unknown, including without limitation, for defamation, invasion of right to privacy, publicity or personality, commercial misappropriation of name or likeness or any similar matter, or based upon or relating to the use and exploitation of the photograph/video/testimonial.

Authorization to use and disclose health information for marketing purposes:

I authorize the practice and/or its related entities to use and disclose my health information for marketing purposes as follows:

1. Description of health information that may be used and/or disclosed: I authorize the practice to use and disclose my protected health information; specifically, information about the condition for which the practice treated me and the outcomes of that treatment, and all information described above.
2. Authorized recipients of my health information and purposes for which my health information may be disclosed: I authorize the practice to use my health information for the practices own advertising, publicity, educational, and promotional purposes, and to disclose my health information to any recipients of the practices advertising, publicity, educational, or promotional material.
3. I understand that I have the right to revoke this authorization prior to the expiration date shown below. I may revoke this authorization by writing to the practice's privacy officer at the following email address: George Tabib, Contact@BSPchiro.com.
4. I understand that information disclosed under this authorization may potentially be re-disclosed by the recipients. The federal privacy rules do not protect my health information from re-disclosure by recipients under this authorization.
5. I understand that I may decline to sign this authorization. The practice may not refuse to treat me if I do not sign this authorization.
6. This authorization shall expire 10 years from the date of your last visit with this practice.
   I have read this release, understand it, and am signing it voluntarily. I understand that any consideration received is full and fair for purposes described above for the use of the photograph/video/testimonial. By my signature, I represent that I am at least eighteen years of age or the guardian of a minor and am competent to execute this release and that by doing so am not violating any other contractual restrictions that would preclude me from executing this release. By signing below, I acknowledge that I have read and that I understand this release and authorization form. I am authorized to execute this authorization and agree to permit the disclosures permitted by this authorization.

_____	_____	_____
Patient Printed Name	Patient Signature	Date