Klein Chiropractic Center

1906 Clint Moore Rd. Ste 4
Boca Raton, Fl 33496
Phone: (561) 988-1998

Dr. Robert I. Klein

PERSONAL HISTORY

Date _____ Social Security # _____

Name: _____ Address: _____

City: _____ State: _____ Zip _____

Mailing Address: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Sex: _____ Height: _____ Weight: _____

Birthdate: _____ E-mail: _____

Name of Your Employer: _____ Type of Work:

Check If You Are: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Name and Telephone # of Person to Contact In Case of Emergency: _____

Name of Husband or Wife: _____ Spouse's Employer's Phone #: _____

Husband or Wife's Employer: _____

Ages of Your Children: _____

Referred To This Office by: _____

Who Is Responsible For Your Bill? ☐ Self ☐ Husband or Wife ☐ Employer ☐ Insurance ☐ Other: _____

PAST HEALTH HISTORY

PLEASE CHECK APPLICABLE ITEMS:

OPERATIONS:

Appendectomy _____ Rectal _____ Tonsillectomy _____

Gall Bladder _____ Female Organs _____ Hernia _____

Others: _____

ACCIDENTS OR FALLS (Please describe) _____

FRACTURES OR DISLOCATIONS: _____

HABITS:

Sleep (hours) _____ Coffee _____ Tea _____ Alcohol _____

Tobacco _____ Exercise _____ Hobbies _____

Are you now taking any drugs'? (Please name) _____

Have you ever had a nervous breakdown? _____

Have you or any member of your family been treated for a mental disorder? _____

INSURANCE PLAN

You are responsible for meeting the payment requirements of your policy regarding deductibles and co-payments, and also payment for services not covered by your policy. With the above exceptions, in most cases we will accept assignment and payment of benefits of the patient's Insurance benefits, health plans, and third party claims as payment in full for services rendered. Check type of Insurance coverage:

☐ Workman's Compensation ☐ Automobile Insurance Policy
☐ Government Health Plan ☐ Group Policy
☐ Personal Policy ☐ Other

It is hereby agreed by the undersigned that should the balance owed for service become delinquent, that is, thirty (30) days past due from the date of the original invoice, I shall remain liable for any and all collection costs, attorneys fees and/or Interest as a result of collection of the delinquent account.

PATIENT'S SIGNATURE _____

CIRCLE ANY OR THE FOLLOWING DISEASES YOU HAVE HAD;

Appendicitis	Malaria	Chicken Pox	Alcoholism
Scarlet Fever	Tuberculosis	Diabetes	Venereal Infection
Diphtheria	Whooping Cough	Cancer	Arthritis
Typhoid Fever	Anemia	Heart Disease	Epilepsy
Pneumonia	Measles	Goiter	Mental Disorder
Rheumatic fever	Mumps	Influenza	Lumbago
Polio	Small Pox	Pleurisy	Eczema

Please Underline All of the Following Symptoms You Have Had Previously. Please Circle All of the Following Symptoms You Have Now

GENERAL SYMPTOMS

Headache
Fever
Chills
Sweats
Fainting
Dizziness
Convulsions
Loss of Sleep
Fatigue
Nervousness
Loss of Weight
Numbness or pain in arms, hands, or legs Allergy
Wheezing
Neuralgia

E.E.N.T.

Failing vision
Near sightedness
Far sightedness
Crossed eyes
Eye pain
Deafness
Earache
Ear noises
Ear discharge
Nose bleeds
Nasal obstruction
Sore throat
Hoarseness
Asthma
Dental decay
Gum trouble
Frequent colds
Enlarged thyroid
Tonsillitis
Sinus infection
Nasal drainage
Enlarged glands
Hay Fever

SKIN

Skin Eruptions
Itching
Bruises easily
Dryness
Boils
Varicose Veins
Sensitive Skin
Hives or Allergy

RESPIRATORY

Chronic cough
Spitting up phlegm
Spitting up blood
Chest pain
Difficult breathing

CARDIOVASCULAR

Rapid beating heart Slow beating heart High blood pressure Low blood pressure
Pain over heart Previous heart stroke Hardening of arteries
Swelling of ankles Poor circulation Paralytic stroke

MUSCLE & JOINT SYMP.

Stiff neck
Backache
Swollen joints
Tremors
Painful tail bone
Foot trouble
Pain between shoulders
Hernia
Spinal curvature
Faulty posture

GENITOURINARY SYMPTOMS

Frequent urination
Painful urination
Blood in urine
Pus in urine
Kidney Infection or Stones
Bed Wetting
Inability to Control Urine
Prostate Trouble

GASTROINTESTINAL * SYMPTOMS

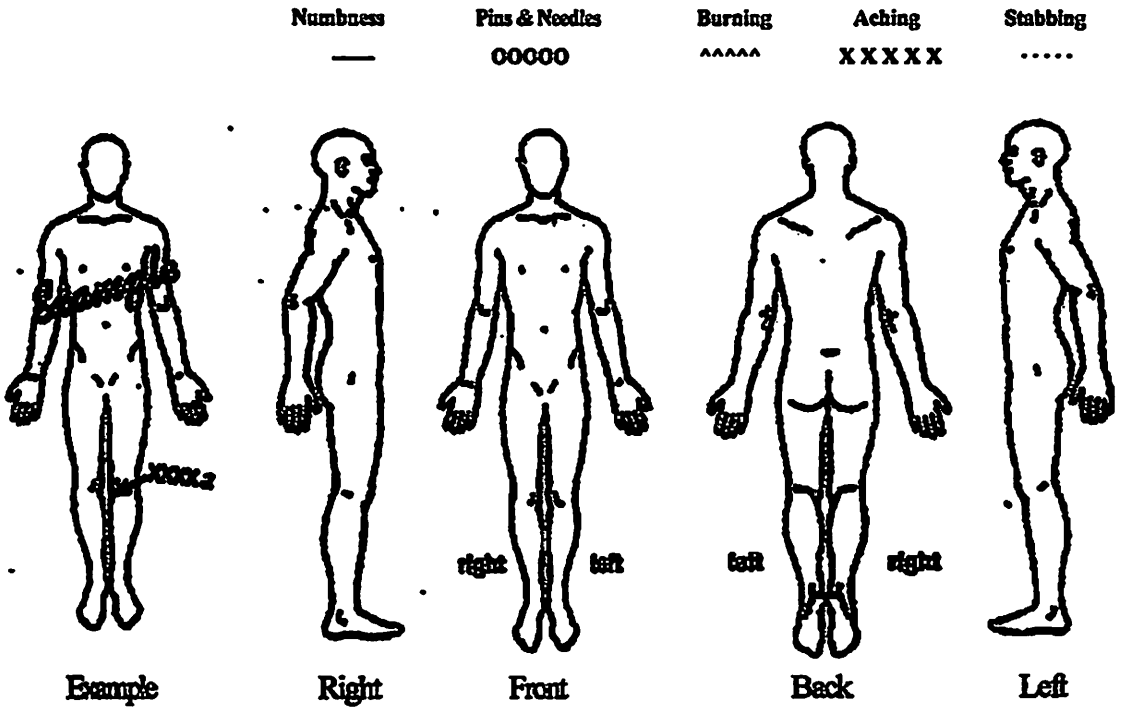
Poor appetite
Difficult digestion
Excessive hunger
Belching or gas
Nausea
Vomiting
Vomiting of blood
Pain over stomach
Distention of abdomen
Constipation
Diarrhea
Colon trouble
Hemorrhoids (Piles)
Intestinal worms
Liver trouble
Gall bladder trouble
Jaundice
Colitis

FOR WOMEN ONLY

Painful menstrual periods
Excessive flow
Hot flashes
Irregular cycle
Cramps or backache
Previous miscarriage
Vaginal discharge
Lumps in breast
Menopausal symptoms
Are you pregnant? ☐ Yes ☐ No

PAIN CHART

PLEASE MARK AREA(S) OF INJURY OR DISCOMFORT AS ILLUSTRATED BELOW.



USING THE SCALE BELOW, PLEASE INDICATE THE DEGREE OF PAIN USING A SCALE OF 1 (MILD DISCOMFORT) TO 10 (EXTREME PAIN)

1 2 3 4 5 6 7 8 9 10 11 12

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for any expenses incurred in collecting your account
- I authorize the staff to perform any necessary services needed during diagnosis and treatment I also authorize the provider *to* release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

Patient Consent for Use and Disclosure of Protected Health Information

Klein Chiropractic Center

I hereby give my consent to Klein Chiropractic Center to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

Klein Chiropractic Center's Notice of Privacy Practice provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Klein Chiropractic Center reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Klein Chiropractic Center 1906 Clint Moore Rd. Ste 4, Boca Raton, Fl 33496

With this consent, Klein Chiropractic Center may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Klein Chiropractic Center may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Klein Chiropractic Center restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Klein Chiropractic Center's use and disclosure of PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Klein Chiropractic Center may decline to provide treatment to me.

Signature of Patient or Legal Guardian_____ Date _____

Receipt of Notice of Privacy Practices
Written Acknowledgement Form

I,_____, have read a copy of Klein Chiropractic Center's Notice of Privacy Practices.

Signature of Patient or Legal Guardian_____ Date_____

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

PLEASE READ CAREFULLY

Department of Health Duties

The Department of Health is required by law to maintain the privacy of your protected health information. This Notice of Privacy Practices tells you how your protected health information may be used and how the department keeps your information private and confidential. This notice explains the legal duties and practices relating to your protected health information. As part of the department's legal duties this Notice of Privacy Practices must be given to you. The department is required to follow the terms of the Notice of Privacy Practices currently in effect.

The Department of Health may change the terms of its notice. The change, if made, will be effective for all protected health information that it maintains. New or revised notices of privacy practices will be posted on the Department of Health website at **www.myflorida.com** and will be available by email and at all Department of Health buildings.

Uses and Disclosures of your protected health information

Protected health information includes demographic and medical information that concerns the past, present, or future physical or mental health of an individual. Demographic information could include your name, address, telephone number, social security number and any other means of identifying you as a specific person. Protected health information contains specific information that identifies a person or can be used to identify a person.

Protected health information is health information created or received by a health care provider, health plan, employer, or health care clearinghouse. The Department of Health can act as each of the above business types. This medical information is used by the Department of Health in many ways while performing normal business activities.

Your protected health information may be used or disclosed by the Department of Health for purposes of treatment, payment, and health care operations. *Health care professionals use medical information in the clinics or hospital to take care of you. Your protected health information may be shared, with or without your consent, with another health care provider for purposes of your treatment. The Department of Health may use or disclose your health information for case management and services. The Department of Health clinic or hospital may send the medical information to insurance companies, Medicaid, or community agencies to pay for the services provided to you.*

Your information may be used by certain department personnel to improve the department's health care operations. The department also may send you appointment reminders, information about treatment options or other health-related benefits and services.

Some protected health information can be disclosed without your written authorization as allowed by law. Those circumstances include:

- Reporting abuse of children, adults, or disabled persons.
- Investigations related to a missing child.
- Internal investigations and audits by the department's divisions, bureaus, and offices.
- Investigations and audits by the state's Inspector General and Auditor General and the legislature's Office of Program Policy Analysis and Government Accountability.
- Public health purposes including vital statistics, disease reporting, public health surveillance, investigations, interventions and regulation of health professionals.
- District medical examiner investigations.
- Research approved by the department.
- Court orders, warrants, or subpoenas.
- Law enforcement purposes, administrative investigations, and judicial and administrative proceedings.

Other uses and disclosures of your protected health information by the department will require your written authorization. This authorization will have an expiration date that can be revoked by you in writing. These uses and disclosures may be for marketing and for research purposes. Certain uses and disclosure of psychotherapist notes will also require your written authorization.

Individual Rights

You have the right to request the Department of Health to restrict the use and disclosure of your protected health information to carry out treatment, payment, or health care operations. You may also limit disclosures to individuals involved with your care. The department is not required to agree to any restriction.

You have the right to be assured that your information will be kept confidential. The Department of Health may mail or call you with health care appointment reminders. We will make contact with you in the manner and at the address or phone number you select. You may be asked to put your request in writing. If you are responsible to pay for services, you may provide an address other than your residence where you can receive mail and where we may contact you.

You have the right to inspect and receive a copy of your protected health information. Your inspection of information will be supervised at an appointed time and place. You may be denied access as specified by law. If access is denied, you have the right to request a review by a licensed health care professional who was not involved in the decision to deny access. This licensed health care professional will be designated by the department.

You have the right to correct your protected health information. Your request to correct your protected health information must be in writing and provide a reason to support your requested correction. The Department of Health may deny your request, in whole or part, if it finds the protected health information:

- Was not created by the department,
- Is not protected health information,
- Is by law not available for your inspection, or
- Is accurate and complete.

If your correction is accepted, the department will make the correction and tell you and others who need to know about the correction. If your request is denied, you may send a letter detailing the reason you disagree with the decision. The department will respond to your letter in writing. You also may file a complaint, as described below in the section titled Complaints.

You have the right to receive a summary of certain disclosures the Department of Health may have made of your protected health information. This summary does not include:

- Disclosures made to you.
- Disclosures to individuals involved with your care.
- Disclosures authorized by you.
- Disclosures made to carry out treatment, payment, and health care operations.
- Disclosures for public health.
- Disclosures for health professional regulatory purposes.
- Disclosures to report abuse of children, adults, or disabled.
- Disclosures prior to April 14, 2003.

This summary does include disclosures made for:

- Purposes of research, other than those you authorized in writing.
- Responses to court orders, subpoenas, or warrants.

You may request a summary for not more than a 6-year period from the date of your request.

If you received this Notice of Privacy Practices electronically, you have the right to a paper copy upon request.

For Further Information

Requests for further information about the matters covered by this notice may be directed to the person who gave you the notice, to the director or administrator of the Department of Health facility where you received the notice, or to the Department of Health, Inspector General at 4052 Bald Cypress Way, BIN A03/ Tallahassee, FL 32399-1704/ telephone 850-245-4141.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with the: Department of Health's Inspector General at 4052 Bald Cypress Way, BIN A03/ Tallahassee, FL 32399-1704/ telephone 850-245-4141 and with the Secretary of the U.S. Department of Health and Human Services at 200 Independence Avenue, S.W./ Washington, D.C. 20201/ telephone 202-619-0257 or toll free 877-696-6775. The complaint must be in writing, describe the acts or omissions that you believe violate your privacy rights, and be filed within 180 days of when you knew or should have known that the act or omission occurred. The Department of Health will not retaliate against you for filing a complaint.

Effective Date

This Notice of Privacy Practices is effective beginning April 14, 2003, and shall be in effect until a new Notice of Privacy Practices is approved and posted.

References

"Standards for the Privacy of Individually Identifiable Health Information; Final Rule." 45 CFR Parts 160 through 164. *Federal Register*, Vol. 65, No. 250 (December 28, 2000).

"Standards for the Privacy of Individually Identifiable Health Information; Final Rule." 45 CFR Parts 160 through 164. *Federal Register*, Vol. 67, No. 157 (August 14, 2002).

DH 150-741, 4/03; Stock Number: 6720-741-0150-0

Florida Department of Health
Office of the Inspector General
4052 Bald Cypress Way, BIN A-03
Tallahassee FL 32399-1704

A Medicare Approved
Comprehensive Outpatient Rehabilitation Facility

INSURANCE ASSIGNMENT FORM

Patients Name:_____ Patients Insurance ID #: _____

Instructions: Please read this form carefully, check the applied spaces, and sign at bottom.

Insurance authorization-Patient release and authorization
____ I hereby authorize payment directly to _____ __«_ for the benefits due to me in my pending claim and/or Major Medical Benefits otherwise payable to me, but not to exceed the physicians and/or the Corporation's regular charges for therapy for this treatment period.
____ I further authorize the release of any medical information required by the insurance carriers).
____I understand that I am financially responsible for charges not covered by this authorization- A copy of this authorization may be used in lieu of the original.

Medicare Authorization -Patient Release and Authorization
____I verify that the information given by me in applying for payment under title XVIH of the Social Security Act is covered.
____*I* authorize any holder of medical or other information about me to release to the Social Security Administration or it's intermediaries or carries any information to be used in place of the original and releases payment of medical insurance benefits either to myself or the party who excepts assignment.

Notice: Anyone who misrepresents or falsifies confidential infoimation reported by this form may upon conviction be subject to fine and imprisonment under federal law.

Medicare Acknowledgment- Rehabilitation Services billing and Reimbursement
____ I am aware that Medicare and/or insurance will not reimburse some costs of my rehabilitation.
____ I am aware that Medicare Law requires._____ to make me aware that I will be billed for these non-reimbursement services.
____ I am aware that these procedures are integral to my rehabilitation and cannot be __ therefore, I may expect to be billed for any difference between the final bill and allowable charges. Please contact this office to make financial arrangements.
____ I have read the above and understand that I am financially responsible for paying any and all charges incurred in the rehabilitation program not reimbursed.

Date: _____ Patient: _____

Witness:_____ For Patient

Advance Beneficiary Notice of Non-coverage (ABN)

Dr. Robert Klein

- Klein Chiropractic Center &
- Physical Therapy Center

B. Patient Name: **C. Identification Number:**

NOTE: If Medicare doesn't pay for **D.** items below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** items below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
Examinations	Non – Covered procedures	$50.00
X-rays	Non – Covered procedures	$60.00 - $90.00
Modalities / Therapy	Non – Covered procedures	$25.00 - $60.00

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** _____ listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D. Items** listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D. items** listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the **D. items** listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date: