Dr. Jennifer Brandon
730 SW 4th Street
Cape Coral, FL

Welcome. In order to best serve you, please fill out this and any other forms thoroughly, and then return to receptionist. Thank you for choosing our office.

LAST NAME_____FIRST_____M.I._____Soc.Sec. #_____

DATE OF BIRTH_____TELEPHONE (C)_____(& CELL PROVIDER)_____

ADDRESS_____CITY_____STATE_____ZIP_____

EMPLOYER_____E MAIL _____

NAME OF SPOUSE/PARTNER_____CHILDREN_____

INSURANCE INFORMATION PLEASE HAND INSURANCE CARD TO THE RECEPTIONIST & SIGN INSURANCE FORMS

PATIENT HISTORY

What would you like to see the chiropractic doctor for?_____When did it start?_____

Ever had this/these problems before? Y/N If so when?_____

Wellness check up_____No symptoms, I would like to be checked for vertebral subluxations.

How did you hear about our office?_____

Previous Illnesses _____Present illnesses_____

Recent accident?_____Auto accident? _____Recent fall?_____

Presently on any medication_____Date of recent medical examination_____

Name of doctor?_____Any health problems? _____

Previous chiropractic care? Y/N Name of doctor _____When was your last adjustment?_____

Findings _____

Present weight _____ Any recent gains or loss?_____Height _____

Parental consent to examine and give chiropractic care to a minor X_____Date _____

ARE YOU THE LEGAL CUSTODIAL PARENT? YES OR NO

Please Answer each question:

OCCUPATIONAL INFORMATION

What is your occupation?

How many hours a week do you work? _____

OR attend school _____

what do you do? _____

Do you spend time sitting?_____Hours_____

Standing?Hours. Walking?_____Hours _____

Any problems doing your work due to your health?_____

FAMILY HISTORY

Do you have a family history of:

Heart trouble_____

Cancer _____

Nervous conditions _____

Inherited disease?

_____

_____

LIFESTYLE INFORMATION

Are you breast-feeding? _____

What is your favorite food?

_____

What foods do you dislike?____

_____

How much water do you drink a day?

_____

How many times a week do you exercise? _____

I give permission to have chiropractic care with Dr. Jennifer Brandon, Chiropractor

Signed:_____ Date: _____

Comprehensive Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US. PLEASE READ.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted by law. We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time.

Uses And Disclosures Of Protected Health Information Based Upon Your Written Consent

You will be asked by your chiropractor to sign this consent/acknowledgment form. By signing the consent/acknowledgment form, your chiropractor, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you may also use and disclose your protected health information to pay your health care bills and to support the operation of the chiropractor's office. **Following are examples of the types of uses and disclosures of your protected health care information that the chiropractor's office is permitted to make once you have signed this consent/acknowledgment form:**

CHIROPRACTIC CARE: We will use and disclose your protected health information to provide, coordinate, or manage your chiropractic care and any related services. This includes the coordination or management of your chiropractic care with a third party that has already obtained your permission to have access to your protected health information.

PAYMENT: Your protected chiropractic information will be used, as needed, for your chiropractic services. This may include certain activities that your insurance plan may undertake before it approves or pays for the chiropractic services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

In addition: We may call you by name in the waiting or adjusting area. We may use your personal contact information to call you to remind you of, cancel or re-schedule an appointment. We may leave a message on your answering machine, voice mail or by text message. Most office visits are performed in an open area where complete privacy of your name and health information will be respected but cannot be guaranteed. Special appointment times are available by request for discussion of any private or confidential matters. We may mail appointment reminders, announcements or greeting cards to your home. Your private information will be used when we bill insurance claims for you or need to collect an outstanding balance using an outside collection agency. We will disclose your health information to your primary care physician unless you specifically request in advance for us not to. We may share your protected health information with third party "business associates" that perform various activities (e.g. electronic billing or transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that

contains terms that will protect the privacy of your protected health information. We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services. Your name and address may be used to send you a newsletter about our practice and services we offer.
Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. **You may revoke this authorization, at any time, in writing, except to the extent that your chiropractor or the chiropractic practice has taken an action in reliance on the use or disclosure indicated in the authorization.**

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend, (or another person you specifically identify) your protected health information that directly relates to that person's involvement in your chiropractic care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify a family member, personal representative or any other person that is responsible for your care, of your location, general condition or death.

Emergencies: We may use or disclose your protected health information in an emergency treatment situation.

Communication Barriers: We may use and disclose your protected health information if your chiropractor or staff member in the practice attempts to obtain consent from you but is unable to do so due to substantial communication barriers and the chiropractor or staff member determines, using professional judgment, that you intend to consent to use or disclosure under the circumstances.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. Please make this request in writing to our Privacy Contact. You may have the right to have your chiropractor amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint. The terms of this Notice may change. If the terms do change you may receive a revised Notice by contacting our Privacy Contact.

PATIENT SIGNATURE_____ DATE _____

Privacy Contact:

Dr. Jennifer Brandon Chiropractor. 618 SW 3rd St. Cape Coral, FL 33991 239-329-8987

Dr. Jennifer Brandon, Chiropractor
730 SW 4th St.
Cape Coral, FL 33991
239-329-8987

Consent to Treat/Bill & Privacy Information Form

Dr. Jennifer Brandon, Chiropractor 730 SW 4th St. Cape Coral, Fl 33991

Thank you for choosing Dr. Jennifer Brandon, Chiropractor. Please review the form below so we can provide the optimal care for you, bill appropriately, and share your information securely.

CONSENT FOR TREATMENT By signing this form, I consent to and authorize my provider(s) at Dr. Jennifer Brandon, Chiropractor. to treat me or my dependent. I understand this could include lab tests, x-rays, and/or administration, education. I understand that my provider is available to explain the treatment and I have the right to refuse treatment. I understand that this consent will be valid and remain in effect if I attend any of the clinics at Dr. Jennifer Brandon, Chiropractor.

CONSENT FOR THE USE AND DISCLOSURE OF HEALTH INFORMATION I hereby authorize Dr. Jennifer Brandon, Chiropractor. release any information acquired during my examination and treatment to any authorized agent for the purposes of healthcare, treatment, and payment. I authorize the release of medical health information to my insurers as necessary for determination and payment of benefits; to utilization review and professional standards review organizations, companies, and community resources that assist me with my healthcare needs.

CONSENT TO BILL, ASSIGNMENT OF BENEFITS, AND PAYMENT I authorize Dr. Jennifer Brandon, Chiropractor. to file a claim with my insurance carrier for services rendered. I authorize Dr. Jennifer Brandon, Chiropractor. payment of benefits directly to Dr. Jennifer Brandon, Chiropractor. for services provided to my dependent or me. I understand that I am responsible for any part of the charges that are not covered/paid by my insurance, and I will be billed directly for those services. If you are uninsured, please note that your account is your responsibility. No patient will be denied services due to his/her inability to pay. Discounts for essential services are offered dependent on income and household size as compared to the current federal poverty guidelines. Please inquire for more details. The parent or legal guardian of a minor patient (under 18 years of age) is responsible for payment on the minor's account.

ACKNOWLEDGEMENT OF PERSONAL PROPERTY I understand that Dr. Jennifer Brandon, Chiropractor. shall not be liable for loss or damages of any personal property.

LIMITS OF CONFIDENTIALITY We are permitted or required, under specific circumstances, to use or disclose protected health information without your written authorization: suicidal urges (being a danger to yourself), homicidal urges (being a danger to others), court order/subpoena, child abuse/neglect, and elder or vulnerable adult abuse/neglect. I understand that I may revoke this consent in writing; however, my revocation will not apply to information already used or released in reliance on this consent. I agree that a copy of this consent may be used in place of the original. I also understand that by refusing to sign this consent or revoking this consent, this organization may not be able to provide services to me. My signature below indicates that I understand and accept the content of this form.

_____ Date _____

Signature Patient or Patient Representative

(Print Name) _____

If not the patient: Relationship to patient: _____

AUTHORIZATION TO RELEASE OR OBTAIN PROTECTED HEALTH INFORMATION

PATIENT NAME: _____ **DOB**_____

MAILING ADDRESS: _____

This will authorize _____

to allow Dr. Jennifer Brandon to **obtain a copy of my x-rays and related reports** in your file, **that are dated since 2020**. In addtion I want you to send Dr. Jennifer Brandon:

_____ Hospital and physician office records and daily notes. **Dated after 2020**

I understand that I have the right to inspect and request a copy of information to be disclosed, and that I may withdraw this authorization at any time, except to the extent that action has been taken based on this authorization.

I hereby authorize _____, to release/obtain records of my treatment, including drug, alcohol, depression, mental illness/psychiatric, HIV/AIDS, hepatitis or other sexually transmitted disease, unless specified below.

I do not want the following information released /obtained:

_____

I understand that this authorization shall expire, without my express revocation, one year from the date written below.

I will pick my records up. ☐
Please call me when records are ready at:

_____
(Telephone Number)

Please mail records to the address above. ☐
Or: Please mail to the following address: ☐

_____

_____

_____ _____
Date **Signature of the patient; parent; guardian**

Dr. Jennifer Brandon 730 SW 4th ST. Cape Coral FL 33991 239-329-8987

Cancelation and Missed Appointment Policy

We want to be your partner not only in Chiropractic care, but in excellent overall health for many years to come. Any missed appointment may have a direct impact on

your health.

We respectfully ask that you give us 24 Hours' notice if you are unable to make your appointment so that we may reschedule as soon as possible. When you schedule your appointment, it is a "Promise to Appear" that we take very literally and seriously. Any "missed" appointment is one that you do not keep, or one that is not cancelled or rescheduled within 24 hours' notice.

A missed appointment has negative consequences both for your progress and our practice by creating stress and inconvenience to other patients who requested an appointment at that time. *Therefore, if you miss an appointment, you will be charged a fee of $50.00.*

We realize that rare circumstances do arise that are beyond your control that may prevent you from keeping your appointment. Please let us know if there is anything we can do to help you keep your appointment

I have read and understand the "Cancellation and Missed Appointment Policy" as set forth by Dr. Jennifer Brandon and agree to abide by it.

Signature: _____ Date: _____

Print Name: _____

730 SW 4th St, Cape Coral, FL 33991 (239)329-8987