WHITE SANDS INTEGRATIVE MEDICAL
24 BEAL PARKWAY SW, FORT WALTON BEACH, FL 32548
Patient Intake Form

Patient Name_____ Date: _____ Email: _____
SS #/SIN_____ DOB_____ ☐ Male ☐ Female
Home phone_____ Cell Phone _____
Check appropriate Box : ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
Patient's Address _____ City _____ State_____ Zip_____
Employer Name: _____ Spouse or guardian's name: _____
Spouse's Employer_____ Whom may we thank for referring you? _____
Person to contact in case of an emergency_____ Phone_____ In case of a medical emergency, if the patient is of school age 15+, is ok to treat in my absence.

_____ _____
Parent or Guardian Date

Responsible Party
Name of the person responsible for this account: _____ Relationship to patient: _____
Address_____ Home Phone_____
E-Mail_____ Cell Phone _____
Driver's License # _____ Date of Birth: _____ Is the person currently a patient at our office? Yes No
Do you have any Medical insurance? ☐ Yes ☐ No if yes, complete the following:
Name of the insured_____ Relationship to patient_____
Birthdate_____ SS#/SIN_____ Name of Employer_____ Work Phone _____
Address of Employer_____ State _____ Zip_____
Insurance Company_____ Group #_____ Union or local # _____
Ins. Co. Address _____ City _____ State _____ Zip_____

Chief Complaint: _____
History of Present illness:

Location of problem: _____
(Where is the pain/problem?)

Severity: _____
How severe is the pain/problem on a scale of 1-10 with 10 being the most severe? List your range of pain. When is it at its worst and best?

Timing: _____
(Does the pain/problem occur at a specific time?)

What other areas of your body are affected by this problem?
_____
_____
(Ex: ankle problems due to knee problems ...)

Are you on any medications now for this problem? _____

What have you tried in the past to handle your problem? :
_____
(Heat, ice, over the counter medications, prescription medications, rest, exercise, physical therapy, chiropractic adjustments, massage)

Duration: _____
(How long have you had this pain/ problem? When did it start?)

What activities have you given up/changed due to this.
_____ (Example: stopped climbing steps as often)

What activities increase symptoms/makes problems worse: _____

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Health History

Patient Name: _____DOB: _____Date:_____

Past Medical History

(Have you ever had the following: (circle "yes" or "no"/ leave blank if you are uncertain.)

Measles..... NO YES Anemia.....NO YES Back Trouble.....NO YES Hepatitis..... NO YES

Mumps..... NO YES Bladder Infection.....NO YES High Blood Pressure.....NO YES Ulcer.....NO YES

Chicken Pox..... NO YES Epilepsy.....NO YES Low Blood Pressure.....NO YES Kidney Disease.....NO YES

Whooping Cough... NO YES Migraine Headaches. NO YES Hemorrhoids.....NO YES Thyroid Disease.....NO YES

Scarlet Fever..... NO YES Tuberculosis.....NO YES Date of Last Chest X-Ray_____ Bleeding Tendency.....NO YES

Diphtheria..... NO YES Diabetes.....NO YES Asthma.....NO YES Any Other Disease.....NO YES

Smallpox..... NO YES Cancer..... .NO YES Hives of Eczema.....NO YES (**Please List):** _____

Pneumonia..... NO YES Polio..... NO YES AIDS & HIV.....NO YES _____

Rheumatic Fever... NO YES Glaucoma.....NO YES Infectious Mono.....NO YES _____

Arthritis..... NO YES Hernia.....NO YES Bronchitis.....NO YES Stroke.....NO YES

Venereal Disease... NO YES Mitral Valve Prolapse.NO YES Blood or Plasma Transfusion.....NO YES

Previous Hospitalizations/Surgeries/Serious Illnesses	When?	Hospital, City, State
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medication: (include non-prescription)

_____

_____

Primary Care Physician: _____

Have you ever taken Fen-Phen/Redux? NO YES

Are you taking any medications (prescription or over the counter) for acid indigestion?

O yes O no if yes what type: _____

Do you have a sulfa allergy? NO YES

Allergies/Medication Allergies:

_____

_____

CLINICIAN SIGNATURE: _____ **DATE REVIEWED:**_____

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Patient Social History

Name: _____ DOB: _____ Date: _____

Marital Status Single: _____ Married: _____ Separated: _____ Divorced: _____ Widowed: _____

Use of Alcohol Never: _____ Rarely: _____ Moderate: _____ Daily: _____
Use of Tobacco Never: _____ Rarely: _____ Moderate: _____ Daily: _____
Use of Drugs Never: _____ Type/Frequency: _____

Health History

Patient Name: _____ DOB: _____ Date: _____

Excessive Exposure At home or work: Fumes: _____ Dust: _____ Solvents: _____ Airborne Particles: _____ Noise: _____

Family Medical History:

	Age	Disease	If Deceased, Cause of Death
Father			
Mother			
Siblings			
Spouse:			
Children:			

Indicate which of the below you have experienced in the last 1-2 months
1=Never; 2=Rarely; 3=Occasionally; 4=Frequently; 5=Constantly

Muscular/Skeletal		**Neurological:**		**General:**	
Muscle Aches	1 2 3 4 5	Headaches	1 2 3 4 5	Fatigue	1 2 3 4 5
Fibromyalgia	1 2 3 4 5	Migraines	1 2 3 4 5	Malaise	1 2 3 4 5
Arthritis	1 2 3 4 5	Dizziness	1 2 3 4 5	Weakness, tiredness	1 2 3 4 5
Joint Pain	1 2 3 4 5	Numbness	1 2 3 4 5	Lightheadedness	1 2 3 4 5
Low Back Pain	1 2 3 4 5	Tingling in hands or feet	1 2 3 4 5	Irritability	1 2 3 4 5
Neck Pain	1 2 3 4 5	Pins/needles in hands or feet	1 2 3 4 5	Constipation	1 2 3 4 5
Wrist/Hand Pain	1 2 3 4 5	Burning in hands or feet	1 2 3 4 5	Diarrhea	1 2 3 4 5
Elbow Pain	1 2 3 4 5	Hypersensitivity	1 2 3 4 5	Feeling foggy	1 2 3 4 5
Shoulder Pain	1 2 3 4 5	Difficulty with Balance	1 2 3 4 5	Forgetfulness	1 2 3 4 5
Hip Pain	1 2 3 4 5	Knee Pain	1 2 3 4 5	Ankle/Foot Pain	1 2 3 4 5
Pain b/t shoulder blades	1 2 3 4 5				

Do you have a Living will?.....NO YES Do you have a DNR? (DO NOT RESUSCITATE) .....NO YES

IF YES PLEASE PROVIDE THE OFFICE WITH A COPY FOR YOUR FILE.

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____ _____
Signature of the Patient, Parent or Guardian Date

_____ _____ _____
Doctor's Review Signature of Doctor Date

White Sands Integrative Medical Office Policies

Please Read and Initial beside each paragraph

____**AUTHORIZATION FOR TREATMENT**: I hereby authorize the Physician/Nurse Practitioner at White Sands Integrative Medical to perform diagnostic tests and render care considered therapeutically necessary based on findings during my examination. I give the Physician/Nurse Practitioner permission and authority to administer care as discussed and agreed upon and in accordance with diagnostic tests, diagnosis, and analysis. The Physician/Nurse Practitioner will not give any treatment or health care if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through health care procedures whatever he/she may be suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the Physician/Nurse Practitioner. The Physician/Nurse Practitioner provides individualized health care service is in accordance with examination findings. Your Physician/Nurse Practitioner is professionally licensed according to State and Federal Laws for Florida and is available to work with other types of providers in your health care regimen. I am authorizing the Physician/Nurse Practitioner, to proceed with any treatment that may be necessary. Furthermore, any risk involved, will be explained to me upon my request. As of the date stated below, I have the legal right to select and authorize health care services for the patient named below. If my authority to select and authorize this care should be revoked or modified in any way, it is known that it is my responsibility to immediately notify White Sands Integrative Medical.

_____ **CHIROPRACTIC CARE:** The chiropractic adjustments combined with other clinical procedures are frequently beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. It is the patient's responsibility to report any underlying conditions that may not be known to the acting provider. Adjustments/Spinal Manipulations are frequently provided in an **"open adjusting area."** I understand that an **"open adjusting area"** means that multiple patients/clients may be present at any given time exposing my care to other patients/clients receiving care at White Sands Integrative Medical. Also, that verbal care discussions may potentially be overheard by other patients/clients in the room. I understand that it is my responsibility to notify my Physician/Nurse Practitioner if I have concerns regarding the **"open adjusting area"** policy.

____ **CONSENT FOR TREATMENT AND X-RAY**: I acknowledge and understand that the Physician/Nurse Practitioner will provide a history and examination today and this MAY include NECESSARY x-rays. The Physician/Nurse Practitioner is hereby authorized to complete this examination and treatment.

____**HIPAA/PRIVACY**: The patient understands and agrees to allow White Sands Integrative Medical to use their Patient Health Information for the sole purpose of treatment, payments, healthcare operations, and coordination of care. We want you to know your Patient Health Information is going to be used in this office and your rights concerning these records. If you would like to have a more detailed account of our policies and procedures concerning Patient Health Information, we encourage you to read the HIPAA NOTICE that is displayed at the intake window before signing this consent. No entities or persons are ever provided patient health information (PHI) without written consent of the patient/guardian.

____**FINANCIAL POLICY**: It is the policy of White Sands Integrative Medical that all balances will be paid in full at time of service unless other arrangements have been made. We accept cash, check, MasterCard, Visa, Discover and American Express. Remote Credit Card Payments will incur an additional $2.50 processing fee.

____**GROUP/INDIVIDUAL INSURANCE**: Your insurance is an agreement between you and your insurance company, not between your insurance company and our office. We offer a complimentary coverage verification, however, the benefits quoted to us by your insurance company are not a guarantee of payment. As a courtesy to you, our office will complete and file any necessary insurance forms at no additional charge. It is to be understood and agreed that any service rendered are charged to you directly

White Sands Integrative Medical Office Policies

Please Read and Initial beside each paragraph

and you are responsible for payment of any non-covered services, deductibles, or co-pays. If your insurance does not respond within 60 days, or if you suspend or terminate care, any fees for services will be due immediately. You may also pay the full amount due each visit. You may then submit the bill to your insurance carrier for reimbursement.

_____**ASSIGNMENT AND RELEASE**: I assign directly to White Sands Integrative Medical all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether paid by insurance or not. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic. Furthermore, I authorize the release of my medical records to secure payment/and or to receive medical information pertaining to my case in the facility with/to my Major Medical Provider.

I hereby certify that I understand and agree to the policies set forth by White Sands Chiropractic, Inc.

Patient or Parent/Legal Guardian (Print) **Signature** **Date**

____ ***FEMALES RECEIVING X-RAYS***: To the Best of my knowledge, I am not pregnant, neither confirmed nor suspected.

Date of last menstrual cycle: _____ Method of birth control: _____

Patient/Parent or Legal Guardian (Print Signature Date

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Authorization for Release of Health Information for Highly/Easily Contracted Infectious Diseases/Illness or Disorders

This form authorizes release of health information pertaining to any and all highly infectious diagnosis you may have received or been exposed to. Your information will be protected as mandated by Federal and State Privacy Law's.

Please list any and all Highly Infectious Disease that you have been diagnosed with or exposed to.

If none, please state none. You must answer to the best of your ability.

_____

_____

_____

_____

_____

_____

I certify that all of the information above is true and accurate.

Name (Print)_____ Date_____

Name (Signature)_____

WHITE SANDS INTEGRATIVE MEDICAL
24 BEAL PARKWAY S.W.
FT. WALTON BEACH, FL 32548
Dr. Erik Persiani, D.C.

PH: (850) 226-6728
FAX: (850) 226-6729

MISSED RESERVATION POLICY

By signing I am stating that I understand that I will be charged $25.00 for failure to notify White Sands Chiropractic Clinic that I will be unable to honor any scheduled appointment(s) time(s).

Signature: _____ **Date:** _____

Print name: _____

APPOINTMENT REMINDERS

We would like your permission to send you appointment reminder's via text messaging and or via email. Please fill out the appropriate area's below concerning how you prefer to be reminded.

EMAIL ADDRESS: _____

CELL PHONE NUMBER: _____

CELL PHONE CARRIER: _____

SIGNATURE: _____ **DATE:** _____

PRINTED NAME: _____

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PROVIDER STATEMENT OF PATIENT/CLIENT RIGHTS AND RESPONSIBILITIES

PATIENTS/CLIENTS HAVE THE RIGHT TO:

- Be treated with dignity and respect.
- Fair treatment, regardless of race, ethnicity, creed, religious belief, sexual orientation, gender, age, health status, or source of payment for care.
- Their treatment and other patient information kept private and only released upon signed consent.
- Access to care easily and in a timely fashion.
- A candid discussion of treatment options/choices and financial obligations.
- participate in the development of their plan of care.
- The delivery of services in a culturally competent manner.
- Information about WSIM, its providers, services available, and their role in the treatment process.
- Clinical guidelines used in providing and managing their care.
- Freely and without adverse consequences, file a complaint, grievance, or appeal.

PATIENTS/CLIENTS HAVE THE RESPONSIBILTY TO:

- Treat service providers with dignity and respect; and not to take actions that may harm others.
- Provide service providers with information needed to provide the best possible care.
- Make inquires regarding care being recommended/provided.
- Help develop and adhere to recommendations/treatment plans (including medicinal regimens), and to notify service providers when the plan no longer works for them.
- Tell provider about medication changes, including medications given to them by others.
- Keep all agreed upon appointments; notifying the service provider(s) as soon as possible of any needed changes.
- Provide accurate information regarding Insurance Coverage changes.
- Discuss any financial issues that may prevent them from adhering to treatment plan contracts.
- Report suspected fraud and abuse whether physical, financial, or otherwise.
- Openly report concerns about the quality of care being provided.
- Ensure that the facility has accurate contact information (name, address, phone…).

Patient Name (print) _____

Patient Signature _____ Date _____

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NOTICE TO PATIENTS

To maintain compliance with various state and federal regulations, managed care and preferred provider agreements, as well as billing and coding guidelines, we have adopted the following financial policies.

1. Our clinic has established a single fee schedule that applies to all patients for each service provided.
2. You may be entitled to a contractual discount under the following circumstances:
   a. We are a participating provider in your health plan.
   b. You are covered by a State or Federal program with a mandated fee schedule.
   c. Patients who are uninsured, or underinsured can rightfully per Florida Law contract individually, an agreed upon plan of care including an individually agreed upon payment/financial obligation with White Sands Integrative Medical.
   d. Patients who meet state and or federal poverty guidelines or other special circumstances outlined in our "Hardship/Indigent Policy" may be offered a discount for a specified period of time as determined by the clinic. Verification of financial hardship may be required.
3. As part of our compliance plan, as of 04/24/2014 our office will be unable to extend any type of discounts other than those listed above.
4. Credit balances are **non-refundable** and **non-transferable**; credit balances can be used towards future treatments offered by White Sands Integrative Medical.
5. Reasonable efforts to acquire payment from a third party payor will be performed by WSIM on your behalf; in the event that your auto insurance, major medical insurance, workers' compensation or law suit does not provide payment **you will be responsible for all balances due.**

Acknowledged By: _____

Date: _____

Revised 11/16/2020

Your Information. Your Rights. Our Responsibilities.
This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights
When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you. You can get an electronic or paper copy of your medical record:

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information. We may charge a reasonable, cost-based fee.

ASK US TO CORRECT YOUR MEDICAL RECORD
- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days

REQUEST CONFIDENTIAL COMMUNICATIONS
- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

ASK US TO LIMIT WHAT WE USE OR SHARE
- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

GET A LIST OF THOSE WITH WHOM WE'VE SHARED INFORMATION
- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

GET A COPY OF THIS PRIVACY NOTICE
- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

CHOOSE SOMEONE TO ACT FOR YOU
- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

FILE A COMPLAINT IF YOU FEEL YOUR RIGHTS ARE VIOLATED
- You can complain if you feel we have violated your rights by contacting us at 850-226-6728.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints
- We will not retaliate against you for filing a complaint.

Your Choices
For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

HOW DO WE TYPICALLY USE OR SHARE YOUR HEALTH INFORMATION?

We typically use or share your health information in the following ways:

TREAT YOU

We can use your health information and share it with other professionals who are treating you.
Example: A doctor treating you for an injury asks another doctor about your overall health condition.

RUN OUR ORGANIZATION

We can use and share your health information to run our practice, improve your care, and contact you when necessary.
Example: We use health information about you to manage your treatment and services.

BILL FOR YOUR SERVICES

We can use and share your health information to bill and get payment from health plans or other entities.
Example: We give information about you to your health insurance plan so it will pay for your services.

HOW ELSE CAN WE USE OR SHARE YOUR HEALTH INFORMATION?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

HELP WITH PUBLIC HEALTH AND SAFETY ISSUES

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

DO RESEARCH

We can use or share your information for health research.

COMPLY WITH THE LAW

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

RESPOND TO ORGAN AND TISSUE DONATION REQUESTS

We can share health information about you with organ procurement organizations.

WORK WITH A MEDICAL EXAMINER OR FUNERAL DIRECTOR

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

ADDRESS WORKERS' COMPENSATION, LAW ENFORCEMENT, AND OTHER GOVERNMENT REQUESTS

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

RESPOND TO LAWSUITS AND LEGAL ACTIONS

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

FOR MORE INFORMATION SEE:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

CHANGES TO THE TERMS OF THIS NOTICE

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.