GOLDSMITH
CHIROPRACTIC & ACUPUNCTURE CENTER
1219 S. East Ave., Ste. 206
Sarasota, Florida 34237
Office (941)953-3030 Fax (941) 953-3044

Currently, in healthcare, if a health detail is not documented on paper, it just doesn't exist. This is extremely important if you are wanting to use your insurance.

The following is GCAC Office Policy for your intake forms:

- **As these are medical necessary forms for documentation of your past and current health, it is important that all questions are completely filled in. This will give Dr. Goldsmith the valuable information she will need to move forward with your examination.**
- **Please put *N/A* (not applicable) on the line if question does not apply to you.**
- **We understand that you may not be able to answer a question because you just don't remember. In that case, write "don't remember" or IDK.**
- **If any question is left blank, our staff will highlight the blanks and have you fill them in before your consultation and examination with Dr. Goldsmith.**

Instructions for Symptom Reports:

You may be visiting our office with 1 or multiple problems (complaints) that you would like addressed. You will see Symptom Reports for up to 6 areas. For each area of complaint, you must fill out a Symptom Report.

Example: You have left side neck, left side upper back and general low back pain. The pain from your neck and upper back is shooting into your left shoulder.

Fill out a Symptom Report combining the neck and upper back and since the shoulder pain seems to be coming from your neck, you won't need an additional report for shoulder.

Fill out a separate Symptom Report for the lower back.

As above, if you don't document the complaint on the intake paperwork Symptom Report, it will not be addressed (even though we do know the song "Dem Bones" and use it as a teachable moment).

You may not know whether your symptom is associated with the neck, mid back or low back when you are feeling it in your upper or lower extremities. Please fill out a separate Symptom Report if that is the case as you can have a neck problem separate from a shoulder rotator cuff problem or a hip problem separate from a low back problem, etc.

For your convenience, we have included 0-10 Scale of Pain Severity Cheat Sheet.

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Patient Survey

Name: _____

Date: _____

Services Interested In:

- o Chiropractic
- o Acupuncture
- o Neuromuscular Therapy
- o Stress Management

Additional Comments:_____

_____

_____

_____

_____

_____

X_____ _____

Patient Signature (or guardian, if patient is a minor) **Date**

Doctor's Initials_____

0-10 SCALE OF PAIN SEVERITY

Severity		Description of Experience
10	Unable to Move	I am in bed and can't move due to my pain. I need someone to take me to the emergency room to get help for my pain.
9	Severe	My pain is all that I can think about. I can barely talk or move because of the pain.
8	Intense	My pain is so severe that it is hard to think of anything else. Talking and listening are difficult.
7	Unmanageable	I am in pain all the time. It keeps me from doing most activities.
6	Distressing	I think about my pain all of the time. I give up many activities because of my pain.
5	Distracting	I think about my pain most of the time. I cannot do some of the activities I need to do each day because of the pain.
4	Moderate	I am constantly aware of my pain but I can continue most activities.
3	Uncomfortable	My pain bothers me but I can ignore it most of the time.
2	Mild	I have a low level of pain. I am aware of my pain only when I pay attention to it.
1	Minimal	My pain is hardly noticeable.
0	No Pain	I have no pain.

SYMPTOMS

Please fill out separate symptom forms for each problem in the order of the worst first. Only documented problem areas will be evaluated.

SYMPTOM 1

Symptom :_____

Have you had this before?: (circle one) **Y N IDK Any new symptoms from this problem?**

Pain rating (1-10, with 10 being worst imaginable):
❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10

Main impaired activity made more difficult by above symptom:

Pain Quality:
❑Aching
❑Burning
❑Cramping
❑Deep
❑Diffuse
❑Dull
❑Numbness
❑Radiating
❑Sharp
❑Shooting
❑Stiffness
❑Tight
❑Tingling

Pain Frequency:
❑Constant-There all the time
❑Frequent-Daily & Often
❑Intermittent-Off & on daily
❑Occasional week to week
❑Seldom less than 1 per month
❑Varies due to flare-ups
❑Only with certain movements

Pain radiates into:

❑Left Hand	❑Right Hand
❑Left Wrist	❑Right Wrist
❑Left Arm	❑Right Arm
❑Lt Shoulder	❑Rt Shoulder
❑Lt Scapula	❑Rt Scapula
❑Lt Foot	❑Rt Foot
❑Lt Ankle	❑Rt Ankle
❑Lt Leg	❑Rt Leg
❑Lt Knee	❑Rt Knee
❑Lt Thigh	❑Rt Thigh
❑Lt Hip	❑Rt Hip
❑Lt Glut	❑Rt Glut

Pain Cause:
❑A Fall
❑Work Injury
❑Auto Accident
❑Illness (RA, Lupus, etc)
❑Lifting Injury
❑Unknown
❑Gradual Onset
❑Overuse

Pain Pattern:
❑Better in Morning
❑Better in Afternoon
❑Better in Evening
❑Worse in Morning
❑Worse in Afternoon
❑Worse in Evening
❑Consistent doesn't vary
❑Too Soon to Tell

What has been done before to treat this symptom? (does not apply to a new accident)
❑Acupuncture
❑Prescription medicine ❑ Chiropractic
❑Massage
❑Surgery
❑OTC Medicines
❑Physical Therapy
❑Nothing

Pain Duration:
❑_____Day(s)
❑_____Week(s)
❑_____Month(s)
❑_____Year(s)

If problem is over 3 months (chronic), is it worsening?: Y N

Pain aggravated by:
❑Bending ____
❑Driving for ___ mins
❑Getting up/down
❑Increased Activity
❑Looking down
❑Overhead activities
❑Reaching
❑Sitting for ___ mins
❑Standing for ___ mins
❑Typing for ____ mins
❑Coughing
❑Exercising
❑Housework
❑Lifting ___lbs
❑Lying down
❑Preparing food
❑Resting
❑Sneezing
❑Twisting
❑Walking for__mins

Pain relieved by:
❑Exercise
❑Ibuprofen
❑Knees Bent Up
❑Lying Down
❑No Movement
❑Resting
❑Standing
❑Support
❑Walking
❑Chiropractic
❑Heat
❑Ice
❑Lifting
❑Medication
❑Reaching
❑Sitting
❑Stretching
❑Turning Head
❑Acupuncture
❑Nothing Yet
❑Massage
❑Other _____

For Doctor's Use Only:
What restrictions relate to the main impaired activity for this symptom?

CA: _____ DR: _____

Patient Name:_____ Date:_____

SYMPTOMS

Please fill out separate symptom forms for each problem in the order of the worst first. Only documented problem areas will be evaluated.

SYMPTOM 2

Symptom :_____

Have you had this before?: (circle one) **Y N IDK Any new symptoms from this problem?**

Pain rating (1-10, with 10 being worst imaginable):
☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Main impaired activity made more difficult by above symptom:

Pain Quality:
- ☐Aching
- ☐Burning
- ☐Cramping
- ☐Deep
- ☐Diffuse
- ☐Dull
- ☐Numbness
- ☐Radiating
- ☐Sharp
- ☐Shooting
- ☐Stiffness
- ☐Tight
- ☐Tingling

Pain Frequency:
- ☐Constant-There all the time
- ☐Frequent-Daily & Often
- ☐Intermittent-Off & on daily
- ☐Occasional week to week
- ☐Seldom less than 1 per month
- ☐Varies due to flare-ups
- ☐Only with certain movements

Pain radiates into:
- ☐Left Hand ☐Right Hand
- ☐Left Wrist ☐Right Wrist
- ☐Left Arm ☐Right Arm
- ☐Lt Shoulder ☐Rt Shoulder
- ☐Lt Scapula ☐Rt Scapula
- ☐Lt Foot ☐Rt Foot
- ☐Lt Ankle ☐Rt Ankle
- ☐Lt Leg ☐Rt Leg
- ☐Lt Knee ☐Rt Knee
- ☐Lt Thigh ☐Rt Thigh
- ☐Lt Hip ☐Rt Hip
- ☐Lt Glut ☐Rt Glut

Pain Cause:
- ☐A Fall
- ☐Work Injury
- ☐Auto Accident
- ☐Illness (RA, Lupus, etc)
- ☐Lifting Injury
- ☐Unknown
- ☐Gradual Onset
- ☐Overuse

Pain Pattern:
- ☐Better in Morning
- ☐Better in Afternoon
- ☐Better in Evening
- ☐Worse in Morning
- ☐Worse in Afternoon
- ☐Worse in Evening
- ☐Consistent doesn't vary
- ☐Too Soon to Tell

What has been done before to treat this symptom? (does not apply to a new accident)
- ☐Acupuncture
- ☐Prescription medicine
- ☐Chiropractic
- ☐Massage
- ☐Surgery
- ☐OTC Medicines
- ☐Physical Therapy
- ☐Nothing

Pain Duration:
- ☐_____Day(s)
- ☐_____Week(s)
- ☐_____Month(s)
- ☐_____Year(s)

If problem is over 3 months (chronic), is it worsening?: Y N

Pain aggravated by:
- ☐Bending ____
- ☐Driving for ___ mins
- ☐Getting up/down
- ☐Increased Activity
- ☐Looking down
- ☐Overhead activities
- ☐Reaching
- ☐Sitting for ___ mins
- ☐Standing for ___ mins
- ☐Typing for ____ mins
- ☐Coughing
- ☐Exercising
- ☐Housework
- ☐Lifting ___lbs
- ☐Lying down
- ☐Preparing food
- ☐Resting
- ☐Sneezing
- ☐Twisting
- ☐Walking for__mins

Pain relieved by:
- ☐Exercise
- ☐Ibuprofen
- ☐Knees Bent Up
- ☐Lying Down
- ☐No Movement
- ☐Resting
- ☐Standing
- ☐Support
- ☐Walking
- ☐Chiropractic
- ☐Heat
- ☐Ice
- ☐Lifting
- ☐Medication
- ☐Reaching
- ☐Sitting
- ☐Stretching
- ☐Turning Head
- ☐Acupuncture
- ☐Nothing Yet
- ☐Massage
- ☐Other _____

For Doctor's Use Only:
What restrictions relate to the main impaired activity for this symptom?

CA: ____ DR: ____

Patient Name: _____ Date:_____

SYMPTOMS

Please fill out separate symptom forms for each problem in the order of the worst first. Only documented problem areas will be evaluated.

SYMPTOM 3

Symptom : _____

Have you had this before?: (circle one) Y N IDK **Any new symptoms from this problem?**

Pain rating (1-10, with 10 being worst imaginable):
❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10

Main impaired activity made more difficult by above symptom:

Pain Quality:
❑Aching
❑Burning
❑Cramping
❑Deep
❑Diffuse
❑Dull
❑Numbness
❑Radiating
❑Sharp
❑Shooting
❑Stiffness
❑Tight
❑Tingling

Pain Frequency:
❑Constant-there all the time
❑Frequent-daily & often
❑Intermittent-off & on daily
❑Occasional week to week
❑Seldom less than 1 per month
❑Varies due to flare-ups
❑Only with certain movements

Pain radiates into:

❑Left Hand	❑Right Hand
❑Left Wrist	❑Right Wrist
❑Left Arm	❑Right Arm
❑Lt Shoulder	❑Rt Shoulder
❑Lt Scapula	❑Rt Scapula
❑Lt Foot	❑Rt Foot
❑Lt Ankle	❑Rt Ankle
❑Lt Leg	❑Rt Leg
❑Lt Knee	❑Rt Knee
❑Lt Thigh	❑Rt Thigh
❑Lt Hip	❑Rt Hip
❑Lt Glut	❑Rt Glut

Pain Cause:
❑A Fall
❑Work Injury
❑Auto Accident
❑Illness (RA, Lupus, etc.)
❑Lifting Injury
❑Unknown Origin
❑Gradual Onset
❑Overuse

Pain Pattern:
❑Better in Morning
❑Better in Afternoon
❑Better in Evening
❑Worse in Morning
❑Worse in Afternoon
❑Worse in Evening
❑Consistent doesn't vary
❑Too Soon to Tell

What has been done before to treat this symptom? (does not apply to a new accident)
❑Acupuncture
❑Prescription medicine
❑Chiropractic
❑Massage
❑Surgery
❑OTC Medicines
❑Physical Therapy
❑Nothing

Pain Duration:
❑_____Day(s)
❑_____Week(s)
❑_____Month(s)
❑_____Year(s)

If problem is over 3 months (chronic), is it worsening?: Y N

Pain aggravated by:
❑Bending _____
❑Driving for ___ mins
❑Getting up/down
❑Increased Activity
❑Looking down
❑Overhead activities
❑Reaching
❑Sitting for ___ mins
❑Standing for ___ mins
❑Typing for _____ mins
❑Coughing
❑Exercising
❑Housework
❑Lifting ___lbs.
❑Lying down
❑Preparing food
❑Resting
❑Sneezing
❑Twisting
❑Walking ___mins

Pain relieved by:
❑Exercise
❑Ibuprofen
❑Knees Bent Up
❑Lying Down
❑No Movement
❑Resting
❑Standing
❑Support
❑Walking
❑Chiropractic
❑Heat
❑Ice
❑Lifting
❑Medication
❑Reaching
❑Sitting
❑Stretching
❑Turning Head
❑Acupuncture
❑Nothing Yet
❑Massage
❑Other _____

For Doctor's Use Only:
What restrictions relate to the main impaired activity for this symptom?

CA: _____ DR: _____

Patient Name: _____ Date: _____

Pain Drawing

Name: _____ **Date:** _____

TELL US WHERE AND HOW YOU HURT.

Please read carefully:

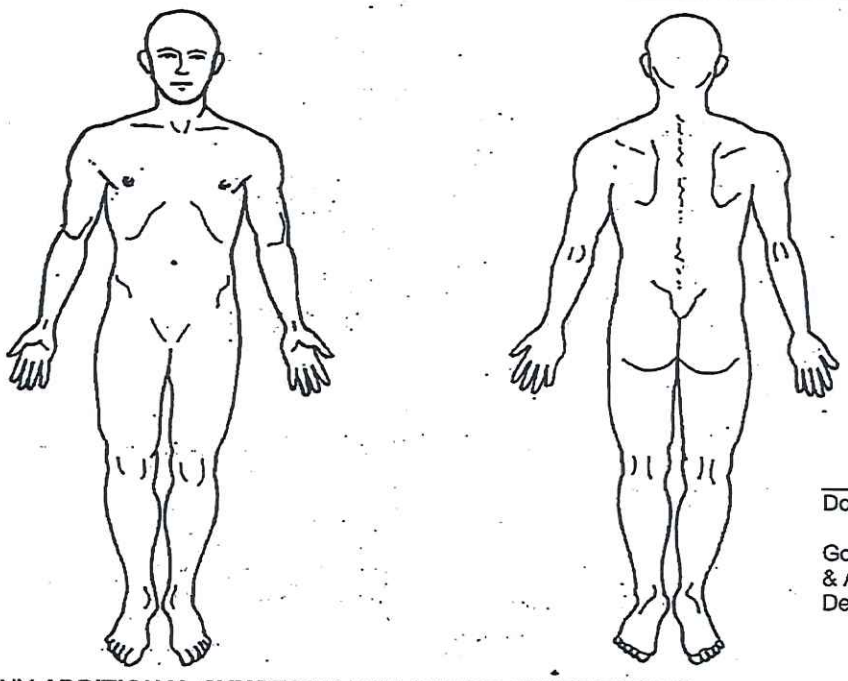
Mark the areas on your body where you feel your pain. Include all affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where it start to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbol(s) listed below.

Ache > > > > > Numbness = = = = = = Pins & Needles o o o o

Burning x x x x Stabbing / / / / / Throbbing ~ ~ ~ ~ ~ ~

Stiffness^^^^^^^ Cramps CCCC Sharp IIII Shooting →→→

Other_____



_____
Doctors Initials

Goldsmith Chiropractic
& Acupuncture Center
Deborah Goldsmith, DC, AP, DOM

PLEASE CHECK ANY **ADDITIONAL SYMPTOMS** YOU MAY BE EXPERIENCING:

❑blurred vision	❑dizziness	❑light bothers eyes	❑pins and needles in legs
❑buzzing in ears	❑face flushed	❑loss of balance	❑ringing in ears
❑cold hands	❑fatigue	❑loss of smell	❑shortness of breath
❑cold feet	❑fainting	❑low resistance to colds	❑stiff neck
❑cold sweats	❑fever	❑muscle jerking	❑stomach upset
❑concentration loss /confusion	❑headaches	❑numbness in fingers	
❑depression/weeping spells	❑head seems too heavy	❑numbness in toes	
❑diarrhea	❑insomnia	❑pins & needles in arms	

Patient's Signature: X _____ **Date:** _____

Guardian's Signature Authorizing Care: _____ Date: _____

Activities that are affected by my current health problems

Name: _____ Date: _____

0 = No affect
1 = I am aware of my problem when I do this activity (Mild)
2 = I don't want to do this activity because of my problem (Moderate)
3 = I can't do this activity at all. (Severe)

Basic

_____ Bending
_____ Climbing Stairs
_____ Falling Asleep
_____ Kneeling
_____ Lifting and How Many Pounds
_____ Looking Over Shoulder
_____ Lying Down
_____ Rising Out of Chair
_____ Sitting and How Many Minutes
_____ Standing and How Many Minutes
_____ Staying Asleep
_____ Walking and How Far

Daily Living

_____ Caring for Infirm Family Member
_____ Child Care
_____ Computer Use and How Many Minutes
_____ Concentrating
_____ Driving
_____ Housework
_____ Lifting Children
_____ Lifting/Carrying Groceries
_____ Pet Care
_____ Reading
_____ Sexual Activity
_____ Yard Work

Occupational Duties

_____ Computer Work and How Many Minutes
_____ Desk Work and How Many Minutes
_____ Driving (at work)
_____ Lifting (at work)
_____ Using the Telephone

Personal Care

_____ Bathing
_____ Dressing
_____ Hair Care
_____ Shaving

Recreational Activities

_____ Cycling
_____ Drawing
_____ Exercise
_____ Golf
_____ Needle Work
_____ Piano
_____ Running
_____ Softball
_____ Swimming
_____ Tennis

Name: _____ Date: _____

Review of Systems

Do you have any ongoing or current symptoms listed below? Check either "Yes" or "No" for each.

Constitutional		**Genitourinary**	
Weight Loss or Gain	☐ Yes ☐ No	Blood in your urine	☐ Yes ☐ No
Appetite changes (increased or decreased)	☐ Yes ☐ No	Menstrual changes	☐ Yes ☐ No
Fatigue, profound and impairs daily function	☐ Yes ☐ No	Urinating that is painful or difficult	☐ Yes ☐ No
Fever or chills	☐ Yes ☐ No	Erection problems	☐ Yes ☐ No
Shakes/sweats from lack of alcohol or drug	☐ Yes ☐ No	Vaginal discharge or bleeding	☐ Yes ☐ No
Eyes		**Musculoskeletal**	
Eye pain or drainage	☐ Yes ☐ No	Broken bones	☐ Yes ☐ No
Visual changes	☐ Yes ☐ No	Joint pain or swelling	☐ Yes ☐ No
Dry, irritated eyes	☐ Yes ☐ No	Muscle aches	☐ Yes ☐ No
ENT/Mouth		Muscle weakness	☐ Yes ☐ No
Ear pain or drainage	☐ Yes ☐ No	Back pain	☐ Yes ☐ No
Frequent sinus infections	☐ Yes ☐ No	**Skin/Breasts**	
Hearing changes or loss	☐ Yes ☐ No	Masses or lumps	☐ Yes ☐ No
Nosebleeds	☐ Yes ☐ No	Nipple discharge	☐ Yes ☐ No
Dizziness	☐ Yes ☐ No	Rashes or nonhealing ulcers	☐ Yes ☐ No
Respiratory		**Neurologic**	
Blood in your sputum	☐ Yes ☐ No	Seizures	☐ Yes ☐ No
Chest tightness	☐ Yes ☐ No	Coughing or choking with	☐ Yes ☐ No
Cough lasting >1 month (productive or not)	☐ Yes ☐ No	Excessive daytime sleepiness	☐ Yes ☐ No
Shortness of breath	☐ Yes ☐ No	Extremity pain or burning	☐ Yes ☐ No
Wheezing	☐ Yes ☐ No	Hallucinations	☐ Yes ☐ No
Chest pain with inhalation or coughing	☐ Yes ☐ No	Numbness or tingling	☐ Yes ☐ No
Cardiovascular		Difficulty falling asleep, staying	☐ Yes ☐ No
Chest pain or heaviness	☐ Yes ☐ No	**Endocrinologic**	
Palpitations	☐ Yes ☐ No	Hair loss	☐ Yes ☐ No
Fainting or near fainting spells	☐ Yes ☐ No	Frequent urination	☐ Yes ☐ No
Swelling of feet or legs	☐ Yes ☐ No	Increased thirst	☐ Yes ☐ No
Shortness of breath lying flat in bed	☐ Yes ☐ No	Heat or cold intolerance	☐ Yes ☐ No
Gastrointestinal		Hot flashes or night sweats	☐ Yes ☐ No
Abdominal pain	☐ Yes ☐ No	**Heme/Lymph**	
Blood in your stool	☐ Yes ☐ No	Bleeding from gums or nose	☐ Yes ☐ No
Constipation	☐ Yes ☐ No	Unexplained bruising	☐ Yes ☐ No
Diarrhea or Food Intolerance	☐ Yes ☐ No	Swollen, painful lymph nodes	☐ Yes ☐ No
Heartburn or Indigestion	☐ Yes ☐ No	**Allergy/Immun**	
Vomiting or nausea lasting for >1 day	☐ Yes ☐ No	Watery eyes	☐ Yes ☐ No
Swallowing difficulty	☐ Yes ☐ No	Runny nose	☐ Yes ☐ No
Psych		Food intolerance	☐ Yes ☐ No
Anxiety without clear explanation	☐ Yes ☐ No	Frequent skin sores	☐ Yes ☐ No
Sadness lasting for days or weeks	☐ Yes ☐ No	**Other**	
Hearing voices	☐ Yes ☐ No	Do you exercise	☐ Yes ☐ No
Thoughts of hurting yourself	☐ Yes ☐ No	Do you eat red meat	☐ Yes ☐ No
Thought of hurting others	☐ Yes ☐ No	Do you take supplements	☐ Yes ☐ No
Fear of people, places or things	☐ Yes ☐ No	If yes, have supplements changed	☐ Yes ☐ No

The information above was reviewed with the patient. Physician: _____

GOLDSMITH
CHIROPRACTIC & ACUPUNCTURE CENTER

2801 Fruitville Road, Suite 140
Sarasota, Florida 34237
Office (941)953-3030 Fax (941) 953-3044

Authorization for the Release of Medical Records

Patient Name: _____ Date of Birth: _____
(Also list maiden name/other names used)

I hereby request and authorize: Dr. Deborah Goldsmith and agents of her clinic

_____ **To Disclose Information to:** _____ **To Receive Information from:**

Doctor/s): _____

Address:_____City/State/Zip: _____

Office Phone:_____Fax:_____

FOR GCAC STAFF ONLY:

Information to be disclosed includes copies of:
_____ Labs
_____ Recent Physical Exam
_____ X-ray Reports
_____ X-ray Films
_____MRI Reports
_____ Other (Specify) : _____

Purpose for disclosure: Treatment and/or Payment

This authorization will be effective for six months after the date signed, unless cancelled in writing. I understand that the cancellation will have no effect on information released prior to receiving the cancellation. A copy of this authorization is as valid as the original.

X_____ Date: _____
Signature of Patient

OR

_____ Date: _____
Signature of Legal Representative/Relationship

If signature for a minor patient, I hereby state that my parental rights have not been revoked by a court of law.

Notice to recipient of information: This information has been disclosed to you from confidential records, which are protected by law. Unless you have further authorization, laws may prohibit you from making any further disclosures of this information without the specific written consent of the patient or legal representative.

GOLDSMITH
CHIROPRACTIC & ACUPUNCTURE CENTER

Office (941)953-3030 Fax (941) 953-3044

Patient Consent Form for Chiropractic Care And Chinese Medicine

I hereby request and consent to the performance of Chiropractic Adjustments, Acupuncture and/or other procedures, including various modes of Physical Therapy and Diagnostic X-rays, on me or on the patient named below, for whom I am legally responsible by Dr. Deborah Goldsmith.

I understand that, as in the practice of medicine, in the practice of Chiropractic there are some risks to treatment, including but not limited to; Fractures, Disc Injuries, Strokes, Dislocations and Sprains. I do not expect the Doctor to be able to anticipate and explain all risks and complications. I wish to rely on the Doctor to exercise judgment during the course of the procedure which the Doctor feels at the time, based on the facts then known, and is in my best interests.

I understand that the Acupuncture treatment typically may have certain side effects. These could include, but are not limited to, some local bruising, minor bleeding, fainting, temporary pain or treatment. I also understand that the Herbal Dietary Supplements may have certain side effects, such as diarrhea, nausea, vomiting, and allergic reactions.

ALL FEMALE PATIENTS, PLEASE COMPLETE

In order to protect you, the patient, we need to be assured that, if the Doctor orders x-rays, there is no possibility of pregnancy.

I hereby release you and your staff from any responsibility for injury or complications to my fetus or myself should I be pregnant on this date.

___ There is a possibility of my being pregnant.
___ There is NO possibility of my being pregnant.

I have read, or have had read to me, the above consent. By signing below, I agree to the above named procedures, I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Patient's name (please print): X _____ Date: _____

X _____

Signature of patient (or guardian, if patient is a minor)

GOLDSMITH
CHIROPRACTIC & ACUPUNCTURE CENTER

1219 S. East Ave., Ste. 206
Sarasota, Florida 34237
Office (941)953-3030 Fax (941) 953-3044

Patient Health Information

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own 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. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and healthcare operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Patient's name (please print): X _____ Date: _____

X _____

Signature of patient (or guardian, if patient is a minor)

GOLDSMITH
CHIROPRACTIC & ACUPUNCTURE CENTER

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Office (941)953-3030 Fax (941) 953-3044

Patient Consent to Receive Mail/Or Telephone Messages

We respect your privacy and it is important that you carefully list anyone that you wish to have access to your information.

Understand, it is your responsibility to inform us of any changes to this consent form.

Patient Name: _____ Date: _____

Preferred telephone number to reach you? #_____ ☐ cell ☐ home ☐ work

DO WE HAVE YOUR PERMISSION TO?

Send an appointment reminder to your home? Yes _____ No _____

Send test results to your home? Yes _____ No _____

Preferred mailing address? _____ State: ____ Zip: _____

Leave the following information on your preferred telephone number answering machine/voicemail?

Appointment information? Yes _____ No _____
Billing information? Yes _____ No _____
Medical information? Yes _____ No _____

I give permission to share the following information with the person(s) named below:

Name: _____

Appointment information? Yes _____ No _____
Billing information? Yes _____ No _____
Medical information? Yes _____ No _____

Name: _____

Appointment information? Yes _____ No _____
Billing information? Yes _____ No _____
Medical information? Yes _____ No _____

Name: _____

Appointment information? Yes _____ No _____
Billing information? Yes _____ No _____
Medical information? Yes _____ No _____

X_____ **Date:** _____
Signature of patient (or guardian, if patient is a minor)