



|                                   |   |     |    |                |
|-----------------------------------|---|-----|----|----------------|
| <b>Past<br/>Health<br/>Events</b> | Previous Surgeries: ___ Eyes/Ears/Nose/Throat ___ Head/Neck ___ Back/Spine<br>___ Chest/ Heart/ Lungs ___ Abdominal ___ Other : _____ |     |    |                |
|                                   | Previous Fractures or Broken Bones?   | YES | NO | Explain: _____ |
|                                   | Previous Falls or Accidents?  | YES | NO | Explain: _____ |
|                                   | Previous Hospitalizations?  | YES | NO | Explain: _____ |
|                                   | Previous Car Accidents?   | YES | NO | Explain: _____ |
|                                   | Do You Workout or Exercise?   | YES | NO | Explain: _____ |
|                                   | Do You Take Any Medications?  | YES | NO | Explain: _____ |
|                                   | Do You Take Any Vitamins/ Herbs?  | YES | NO | Explain: _____ |
| Are You Pregnant?                 | YES   | NO  |    |                |

|                                     |                       |                 |                 |                     |              |
|-------------------------------------|-----------------------|-----------------|-----------------|---------------------|--------------|
| <b>Check All<br/>That<br/>Apply</b> | <b>Health Issues:</b> |                 |                 |                     |              |
|                                     | ___ Polio             | ___ Arthritis   | ___ Diabetes    | ___ Sleeplessness   |              |
|                                     | ___ Cancer            | ___ AIDS or ARC | ___ Heart       | ___ Chronic Fatigue |              |
|                                     | ___ Frequent Illness  | ___ Allergies   | ___ High Stress | ___ Poor Diet       |              |
|                                     | ___ Genetic Disorders | ___ Epilepsy    | ___ Over Weight | ___ Under Weight    |              |
|                                     | ___ Other: _____      |                 |                 |                     |              |
|                                     | <b>Habits:</b>        | <b>None</b>     | <b>Light</b>    | <b>Moderate</b>     | <b>Heavy</b> |
|                                     | Alcohol               | ___             | ___             | ___                 | ___          |
|                                     | Tobacco               | ___             | ___             | ___                 | ___          |
|                                     | Drugs                 | ___             | ___             | ___                 | ___          |
| Pain Relievers                      | ___                   | ___             | ___             | ___                 |              |
| Caffeine                            | ___                   | ___             | ___             | ___                 |              |
| Sleep                               | ___                   | ___             | ___             | ___                 |              |
| Artificial Sweeteners               | ___                   | ___             | ___             | ___                 |              |
| Exercise                            | ___                   | ___             | ___             | ___                 |              |

|  |   |  |  |
|--|---|--|--|
| <b>Check Any<br/>Problem<br/>You Have<br/>Ever<br/>Suffered<br/>From</b> | <input type="checkbox"/> Low Back Pain      | <input type="checkbox"/> Joint Pain/ Stiffness | <input type="checkbox"/> Hearing                 |
|  | <input type="checkbox"/> Heart Rate         | <input type="checkbox"/> Throat/ Voice         | <input type="checkbox"/> Nervousness             |
|  | <input type="checkbox"/> Blood Pressure     | <input type="checkbox"/> Headaches             | <input type="checkbox"/> Forgetfulness           |
|  | <input type="checkbox"/> Eyes/ Vision       | <input type="checkbox"/> Dizziness             | <input type="checkbox"/> Seizures                |
|  | <input type="checkbox"/> Dental/ TMJ        | <input type="checkbox"/> Cold Hands/ Feet      | <input type="checkbox"/> Nausea                  |
|  | <input type="checkbox"/> Muscle Weakness    | <input type="checkbox"/> Poor Appetite         | <input type="checkbox"/> Hemorrhoids             |
|  | <input type="checkbox"/> Fainting           | <input type="checkbox"/> Constipation          | <input type="checkbox"/> Genital Issues          |
|  | <input type="checkbox"/> Shaking/ Tremors   | <input type="checkbox"/> Change in Stools      | <input type="checkbox"/> Weak Stream             |
|  | <input type="checkbox"/> Diarrhea           | <input type="checkbox"/> Infrequent Urination  | <input type="checkbox"/> Lump (Breasts/ Genital) |
|  | <input type="checkbox"/> Heartburn          | <input type="checkbox"/> Fertility Issues      | <input type="checkbox"/> Shoulder/ Arm Pain      |
|  | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Neck Pain             | <input type="checkbox"/> Lungs/ Breathing        |
|  | <input type="checkbox"/> Middle Back Pain   | <input type="checkbox"/> Chest Pain            | <input type="checkbox"/> Sinus Infections        |
|  | <input type="checkbox"/> Hip/ Leg Pain      | <input type="checkbox"/> Sinus Pain            | <input type="checkbox"/> Ear Infections          |

## **AUTHORIZATION AND TERMS OF ACCEPTANCE**

I understand and agree that Health and Accident Insurance policies are an arrangement between an insurance carrier and myself. I also understand that this office will prepare any forms and reports necessary to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care treatment, any fees for professional services rendered to me or my dependent will be immediately due and payable.

I certify that I have read and answered accurately all of the above questions. I authorize Gold Coast Chiropractic and Ronny Bergman, D.C to release any information to any third party payer and/or health practitioners regarding my care. I authorize and request my insurance company to pay directly to Ronny Bergman, D.C. P.C, otherwise payable to me.

X \_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Parent/ Legal Guardian (if minor)

When a patient seeks Chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our Chiropractic method of correction is by specific adjustments of the spine. Health: A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a Chiropractic spinal examination, we encounter non-Chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I have read and fully understand the above statements and I therefore accept Chiropractic care on this basis.

X \_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

**THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

EFFECTIVE: January 1, 2006

In the course of your care as a patient at Gold Coast Chiropractic we may use or disclose personal and health related information about you in the following ways:

- \*Your protected health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- \*Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of services provided to you.
- \*Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

You have a right to request restrictions on our use of your protected health information for treatment, payment and operations purposes. Such requests are not automatic and require the agreement of this office.

Your name, address, telephone number, e-mail address and health records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

If you are not home to receive an appointment reminder or other related information, a message may be left on your answering machine or with a person in your household. You have a right to confidential communications and to request restrictions relative to such contacts. You also have the right to be contacted by alternative means or at alternative locations.

We are permitted and may be required to use or disclose your health information without your authorization in these following circumstances:

- If we provide health care services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization. If you provide an authorization for release of information you have the right to revoke that authorization at a later date.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or, if you would like the information in a specific form please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for as long as the information remains in our files. In addition you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the health protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information. We are further required by law to abide by the terms of this notice while it is in effect.

We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to: RONNY BERGMAN, DC

X \_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date