Bruce A. Goldberg, D.C., FIAMA
10887 North Military Trail, Suite 4
Palm Beach Gardens, FL 33410

NEW PATIENT FORM

PERSONAL INFORMATION ***CONFIDENTIAL**

Thank you for choosing our practice for your chiropractic needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

Last Name: _____ M.I.: ____ First Name: _____

Home Address: _____ _____ ____ _____
(Street) (City) (State) (Zip)

Cell Phone: _____ Home Phone: _____

E-mail: _____ Date of Birth: ____/____/____

Occupation: _____ Work Phone: _____

Emergency Contact Name: _____ Phone: _____

Sex: M/F Height____Weight____BP____ Pulse____SpO2____PRbmp____BMI____Fat____

Age:_____ SSN: _____ Who should we thank for referring you?_____

Marital Status: _ Single _ Married _ Divorced _ Widowed Number of Children: _____

Primary
Insurance Company: _____ Insurance #: _____

Insurance ID: _____ Group #: _____

Secondary (if applicable)
Insurance Company: _____ Insurance #: _____

Insurance ID: _____ Group #: _____

Automobile Accident / Worker's Compensation (if applicable)
Insurance Company: _____ Policy #: _____

Claim #: _____ Date of Injury: _____

Attorney's Name: _____ Phone #: _____ Contact: _____

Have you received: _ Chiropractic _ Spinal Decompression _ Acupuncture _Cool Laser
When?: _____ With Whom: _____
When?: _____ With Whom: _____

Release & Assignment

I authorize release of any information necessary to process my insurance claims and assign and request payment directly to my physician.

Patient's Signature:_____ Date: ____/____/____

MEDICATIONS

List ALL medications or supplements you are currently taking:

Medications	Dosage	Reason	How Long	Date of Last Check-up

Please indicate any significant illnesses you or a blood relative (grandparent, parent or sibling) have had:

Illness	*You*	*Your Relative*	*Approx. Date*	*Illness*	*You*	*Your Relative*	*Approx. Date*
Cancer	_	_	_____	Diabetes	_	_	_____
Hepatitis B	_	_	_____	Heart Disease	_	_	_____
High Blood Pressure	_	_	_____	Seizures	_	_	_____
Rheumatic Fever	_	_	_____	Emotional Disorders	_	_	_____
Infectious Diseases	_	_	_____	Tuberculosis	_	_	_____

Sexually Transmitted Diseases: _ Gonorrhea _ Syphilis _ AIDS _ HPV _ Chlamydia _ Herpes

DAILY HABITS

Please indicate the use and frequency of the following:

	Yes	No	Amount		Yes	No	Amount
Coffee:	_	_	_____	Tobacco	_	_	_____
Water Intake:	_	_	_____	Alcohol	_	_	_____
Recreational Drugs:	_	_	_____	Soda Pop	_	_	_____
Exercise:	_	_	_____	Fruits/Veg.	_	_	_____

What time do you go to bed? _____ Wake up? _____

When you wake up, do you feel rested? _ Yes _ No or _____%

List any other health problems that you have had: _____

_____

List any allergies, food sensitivities, or food cravings: _____

_____

List any accidents, surgeries, or hospitalizations (include dates): _____

_____

_____

Women ONLY:

Are you pregnant? _ Yes _ No

Amount of Pregnancies: ____ # of live births: ____ # of abortions ____ # of miscarriages: ____

How many days between periods? _____ # of flow days: _____

Do you have clots? _ Yes _ No If yes, what are the size(s): _____

PMS Symptoms (if yes, please indicate): _____

Have you been diagnosed with:

Fibroids **Fibrocystic Breasts** **Endometriosis** **Ovarian Cysts** **PID** **Other:** _____

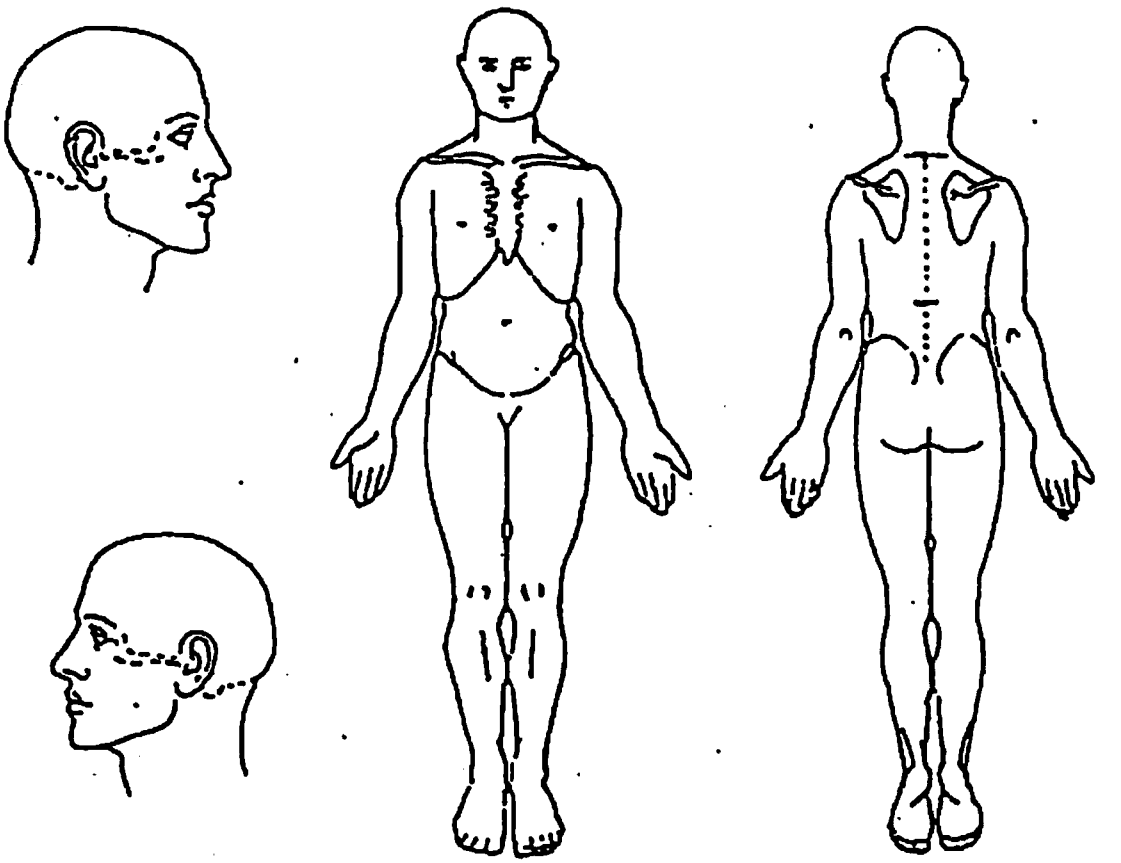
Symptom Survey (for everyone)

The following is a list of symptoms that you may or may not have experienced.

Please indicate as follows:
No Mark = Never Experienced Check Mark (√) = Sometimes Experienced
Plus sign (+) = Frequently Experienced

__lack of appetite	__abdominal pain	__eye problems	__fatigue
__excessive appetite	__chest pain	__jaundice	__edema
__loose stool or diarrhea	__sciatic pain	__asthma	__gall stones
__blood in stool	__indigestion	__allergies	__vomiting
__pain or coldness in the genital area	__difficulty digesting oily foods	__jaundice (yellowish in eyes or skin)	__black tarry stools
__urinary problems	__recent use of antibiotics	__decreased sex drive	__headaches
__easily bruised	__belching, burping	__bloated after eating	__cough
__light colored stool	__heartburn/reflux	__soft or brittle nails	__ear ringing
__feeling the retention of food in the stomach	__difficulty in making plans or decisions	__tendency to become obsessive with work	__intolerance to weather
__laughing for no apparent reason	__spasms or twitching of muscles	__insomnia, difficulty sleeping	__tendency to faint easily
__shortness of breath	__easily angered or agitated	__catch colds	__nightmares
__nasal problems	__dizziness	__hay fever	__weight gain
__skin problems	__knee problems	__weight loss	__bronchitis
__insomnia, difficulty	__claustrophobia	__low back pain	__allergies
__heart palpitations	__colitis or	__hearing impairment	__hair loss
__cold hands and feet	__diverticulitis	__mentally restles	_anigna pains
__high cholesterol	__kidney stones	__hemorrhoids	__constipation
__decreased sex drive			

Body Chart
Mark painful areas of the body with an "X"



Symptoms

Reason for visit: _____

When did you first notice the symptom(s)?: _____

How did it start?: _____

Is this condition getting progressively worse?: _____

Where specifically is the problem(s) located?: _____

Which activities make it worse? ☐Sitting ☐Standing ☐Walking ☐Bending ☐Lying Down ☐Other

Type of Pain: __ Sharp __ Cramping __ Dull __ Throbbing __Numb __ Aching
__Shooting __ Tingling __ Stiff __Swollen __Other: _____

Rate the severity of your pain (1, mild pain or discomfort, to 10, severe pain):

1 2 3 4 5 6 7 8 9 10

Is the pain constant or does it come and go?: _____

GOLDBERG WELLNESS & ACUPUNCTURE CENTER

Dr. Bruce A. Goldberg, D.C., FIAMA
10887 North Military Trail, Suite 4
Palm Beach Gardens, FL 33410
Office Phone: 561.624.5070/ Office Fax: 561.469.9706
GoldbergWellness.com

ASSIGNMENT OF BENEFITS, AUTHORIZATION TO SETTLE CLAIM AND DIRECTION TO PAY MEDICAL PROVIDER DIRECTLY

By my signature below, for good and valuable consideration (including but not limited to the extension of credit to me), I hereby assign, transfer and convey to **Goldberg Wellness & Acupuncture Center** (hereinafter "the Provider") all of my rights, title and interest in and to medical expense reimbursement in whatever form, including but not limited to any automobile liability medical expense payments or other health benefits indemnification and/or agreement otherwise payable to me. This payment shall not exceed my indebtedness to the above named assignee and I acknowledge that I will timely pay any indebtedness owed by me to the assignee that is not otherwise satisfied by the above-mentioned assigned proceeds. I also acknowledge that any medical expenses not covered under my insurance policy will be my responsibility.

I further authorize the Provider to negotiate, collect and settle any claim with any insurance carrier or other third party payor with regard to these services, which authorization shall include authority to: (1) request and receive from any insurer or any other party any and all documentation and records that I am empowered to request regarding this claim, including, without limitation, a statement of coverage, policy declarations page and insurance policy pursuant to Section 627.4137. In addition, the Provider has the authority to request and receive any Independent Medical Examination Reports, notices sent to me regarding appointments for Independent Medical Examinations and Examinations under oath (including proof of mail) Records Review Reports, coverage denile letters, Explanations of Benefits, and Benefit Payment Sheets or Logs (P.I.P. Payout Sheets), without regard as to whether such documentation has already been provided to me and, (2) to endorse in my name any check issued for payment where benefits were assigned. By way of this assignment and notice, I further instruct you, the insurer, to furnish to Provider copies of all future notices affecting Provider's intrest in this claim, including, without limitation, any notices of requested medical examinations or statements.

The Provider hereby objects to any reductions or partial payments. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by the provider shall be done so under protest, at the riskof the insurer, and the deposit shall not be deemed a waiver, accord, satisfaction, discharge, settlement or agreement by the provider to accept a reduced amount as payment in full.

I further direct my insurer to direct all payments for services rendered by the Provider directly to Provider at the billing address contained on Provider's medical bills.

THIS IS A DIRECT AND IRREVOCABLE ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER MY POLICY OF INSURANCE.

A photocopy of this form shall be considered as effective and valid as the original.

I have read the foregoing and understand and agree to each of the above provisions:

_____ Date_____
Patient/Guardian/Insured Printed Name

_____
Patient/Guardian/Insured Signature

Date of Loss/Accident _____

FINANCIAL POLICY AGREEMENT

We are committed to providing you with the best possible care. If you have medical insurance, we are eager to help you receive the maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

Payment for services due at the time rendered unless our staff has approved payment arrangements in advance. We accept CASH, CHECK, MASTER, DISCOVER, AMERICAN EXPRESS, or VISA CARDS. We will be happy to help you process your insurance claim form for your reimbursement.

Returned checks and balances older than 30 days may be subject to additional fees and interest charges of 1.5% per month. We will gladly discuss your proposed treatment and answer any questions relating to your insurance.

You must realize, however that:

1. Your insurance is a contract between you, your employer, and the insurance company. We are not a party on the contract.
2. Our fees are generally considered to fall within the acceptable range by most companies and therefore are covered up to the maximum allowable determined by each carrier. This applies only up to companies that pay a percentage (50% or 80%) of the "U.C.R." "U.C.R." is defined as usual, customary and reasonable. This statement does not apply to companies who reimburse on an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area.
3. **Not all services are a covered health benefit** in all contacts. Some insurance companies arbitrarily select certain services they will not cover.

We must emphasize that as medical providers, our relationship is with you and not with your insurance company. While filing of insurances claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment on your account. If some problems do arise, we encourage you to contact us promptly for assistance in management of your account.

If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE do not hesitate to ask us. We are here to help you.

PATIENTS/INSURED SIGNATURE: _____

PRINT NAME: _____

INSURANCE COMPANY: _____

DATE: _____

DATE OF ACCIDENT: _____
(if applicable)

PRIVACY PRACTICES ACKNOWLEDGEMENT

Posted on Lobby Wall

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy practices and I have been provided an opportunity to review it.
(If you WOULD like a copy of the HIPAA Privacy regulations)

Name: _____ **DOB:** _____

Signature: _____ **Date:** _____

WAIVER

I acknowledge that I was given the opportunity to accept the Notice of Privacy Practices and have chosen not to receive that Notice or have it explained to me.
(If you WOULD NOT like a copy of the HIPAA Privacy regulations)

Name: _____ **DOB:** _____

Signature: _____ **Date:** _____

RELEASE OF RECORDS

Date:_____

To:

_____

(Doctor or Hospital)

Address:

_____

_____

I hereby authorize and request you to release my complete medical records, concerning my illness and/or treatment during the period of _____ to _____.

To: Bruce Goldberg, D.C., P.A.
10887 North Military Trail, Suite 4
Palm Beach Gardens, FL 33410
Office Phone: 561.624.5070/Office Fax: 561.469.9706

Name: _____

DOB: _____

Date: _____

Signed: _____

PATIENT CONSENT FORM

I hereby indicate my wish to be a participant in the rehabilitation program offered by:

Bruce A. Goldberg, D.C., FIAMA

I understand that the purpose of this program is to enhance my recovery from an injury or illness. I further understand that there exists the possibility that certain changes may occur during treatment. I have been informed of the procedures and methods of treatment that will be administered to my _____, and I fully understand what is required for me as a patient.

I verify that my participation is fully voluntary, no coercion of any sort has been used to obtain my participation and I may withdraw from treatment at any time.

I understand that the facility administrator maintains an open door policy and encourages patients to participate or any reason.

SIGNATURE: _____

PRINT NAME: _____

DATE: _____

Goldberg Wellness & Acupuncture Center
10887 North Military Trail, Suite 4
Palm Beach Gardens, FL 33410

(561)624-5070

Patient Text Message Consent Form

Patient Name: _____

Mobile Number: _____

I hereby give my consent for Goldberg Wellness & Acupuncture Center to send Text Messages reminders to my mobile telephone (as per the above number). These messages will be a reminder of my previously booked appointment date and time, or a notification that I need to schedule an appointment.

Should I not be able to keep my appointment I will call the office to cancel/reschedule.

Signature : _____ Date: _____

All patients have the right to change their minds and have this service stopped. If you no longer wish to receive these text reminders, please notify reception(by phone or in writing – please note we cannot accept incoming text messages.

If you change your mobile number please inform us so that we can update our records.