



1 St. Johns Medical Park Drive, St. Augustine, FL 32086 | (904) 217-0542

THIS PACKET MUST BE FULLY COMPLETED BEFORE YOUR CONSULTATION APPOINTMENT CAN BEGIN

How did you hear about us? _____

PATIENT INFORMATION:

FIRST NAME:			LAST NAME:		
DOB:		SSN:		ETHNICITY:	
HEIGHT:		WEIGHT:		GENDER:	
STREET ADDRESS:			CITY:		
STATE:			ZIP CODE:		

INSURANCE INFORMATION: *This is if we refer you for services with St. Augustine Foot, Ankle & Vein*

Primary Insurance:		Policy #:	
Policy Holder Name:		Group #:	
Secondary Insurance:		Policy #:	

PRIMARY CARE PROVIDER INFORMATION:

Primary Care Physician:		Phone #:	
Primary Care Name of Office:		Address:	

EMERGENCY CONTACT:

Full Name:		Home or Work #:	
Relationship to You:		Cell #:	

MEDICAL HISTORY:

CHECK THE BOX NEXT TO THE SYMPTOMS THAT APPLY

- | | | |
|---|--|---|
| ☐ Diabetes | ☐ Neuropathy | ☐ Fibromyalgia |
| ☐ Tumors | ☐ Cancer | ☐ hEDS(Hypermobile Ehlers Danlos) |
| ☐ Epilepsy | ☐ Arthritis | ☐ vEDS (Vascular Ehlers Danlos) |
| ☐ Asthma | ☐ Skin Disorder | ☐ Glaucoma |
| ☐ AIDS (HIV) | ☐ Tuberculosis | ☐ Gout |
| ☐ High Cholesterol | ☐ Blood Pressure Problems | ☐ Anemia Bursitis |
| ☐ Stroke Hepatitis | ☐ Poor Circulation | ☐ Heart Problems |
| ☐ Implants | ☐ Thyroid | ☐ Lung Disease |
| ☐ Sickie Cell | ☐ Osteoporosis | ☐ STD |
| ☐ Colitis | ☐ Rheumatic | ☐ GERD |
| ☐ Gastric Ulcer | ☐ Alcoholism (current) | ☐ Kidney Problems |
| ☐ Limes Disease | ☐ Alcoholism (former) | ☐ Mental Disorder |

Do you smoke? ☐ yes ☐ no

If yes, how many times a day?	
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Do you drink alcohol? ☐ yes ☐ no

If yes, how many times a day?	
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Are you pregnant? ☐ yes ☐ no ☐ not sure

If yes, how far along?	
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Do you have a blood clot(s)? ☐ yes ☐ no ☐ not sure

If yes, provide more info	
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Do you have a cancerous tumor? ☐ yes ☐ no

If yes, provide more info	
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Do you have a pacemaker? ☐ yes ☐ no

If yes, for how long?	
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Do you have a spinal implant? ☐ yes ☐ no

If yes, when was it installed?	
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Do you have a defibrillator? ☐ yes ☐ no

If yes, for how long?	
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Please list any allergies you have:

MEDICAL HISTORY (Continued):

CHECK THE BOX NEXT TO THE SYMPTOMS THAT APPLY

Constitutional:

☐Fever ☐Chills ☐Headache ☐Fatigue ☐Weight Loss/Gain

Eye, Ears, Nose, Mouth, Throat:

☐Blurred Vision ☐Strain/Pain ☐Double Vision ☐Ear Pain Difficulty Swallowing

Heart:

☐Chest Pain ☐Palpitations ☐Difficulty breathing when flat ☐Swelling/Edema ☐Fainting

Lungs:

☐Shortness of Breath ☐Sputum Production ☐Wheezing/Asthma ☐Coughing up Blood

☐Chronic Cough

Gastrointestinal:

☐Abdominal Pain ☐Indigestion Nausea ☐Vomiting ☐Change in Bowel Habit
☐Blood in Stool ☐Loss of Bowel Control

Urinary System/Gynecological:

☐Pain during Urination ☐Blood in Urine ☐Urinary Frequency ☐Urinary Urgency
☐Vaginal/Penile discharge

Neurological:

☐Focal Neurological Deficit ☐Weakness ☐Numbness/Tingling ☐Seizures
☐Stroke ☐Tremors

Musculoskeletal:

☐Joint Pain/Spasms ☐Joint Swelling ☐Joint Stiffness ☐Weakness

Integumentary:

☐Rashes ☐Loss of Hair ☐Itching

Psychosocial:

☐Depression ☐Anxiety ☐Insomnia
☐Recent Stressors Recent Lifestyle Change

Endocrine:

☐Excessive Thirst ☐Excessive Swelling

Blood and Lymphatic Systems:

☐Bleeding Problems ☐Swollen Glands

Allergic/Immunologic:

☐Allergy Symptoms ☐Allergic Reactions

SURGICAL HISTORY

Provide any surgical history for the past 7 years

Procedure:		Date of Surgery:	
Complications (if any):			
Procedure:		Date of Surgery:	
Complications (if any):			
Procedure:		Date of Surgery:	
Complications (if any):			

FAMILY HISTORY

Check the boxes that apply

	Father	Mother	Brother	Sister
Diabetes	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐
Thyroid	☐	☐	☐	☐
Cancer	☐	☐	☐	☐

MEDICATIONS

List all medications (Please bring a list of medications if you need more room)

Medication:		Dosage:		Frequency:	
Medication:		Dosage:		Frequency:	
Medication:		Dosage:		Frequency:	
Medication:		Dosage:		Frequency:	
Medication:		Dosage:		Frequency:	
Medication:		Dosage:		Frequency:	

Do I Need a Test for PVD?

Peripheral Vascular Disease (PVD) is a serious circulatory problem in which the blood vessels outside of your heart and brain to narrow, block, or spasm. It affects over 3 Million Americans in a year, most over the age of 50. It may result in leg discomfort with walking, poor healing leg sores/ulcers. People with PVD are at significantly increased risk of stroke and heart attack.

Answers to these questions will determine if you are at risk for PVD and if a vascular exam will help us better assess your vascular health status.

Click the box next to the symptom that applies

Do you have foot, calf, buttock, hip or thigh discomfort when you walk which is relieved by rest?	☐ yes	☐ no
Do you experience foot or toe pain that often disturbs your sleep?	☐ yes	☐ no
Do you have skin wounds or ulcers on your feet or toes that are slow to heal?	☐ yes	☐ no
Have you suffered a severe injury to the leg(s) or feet?	☐ yes	☐ no
Do you have an infection of the leg(s) or feet that may be gangrenous (black skin tissue)?	☐ yes	☐ no

NEUROPATHY SYMPTOMS ASSESSMENT

Check the box next to the symptom that applies

☐ Numbness

☐ Tingling / Pins & Needles

☐ Pain

☐ Shooting shocks

☐ Burning

☐ Aching

Where on your body do you experience these symptoms?			
How long have you suffered with these symptoms?			
Were you diagnosed with neuropathy? If so, when?			
How was the diagnosis made?			
Please provide the name of your Neurologist (if applicable)			
Have you had an EMG/NCS test done?		Date of Study:	

Are you Diabetic?

☐ yes

☐ no

☐ I've been told I'm pre-diabetic

If you are Diabetic, please complete the following questions:

Who treats your diabetes? (please provide full doctor's name)	
When were you diagnosed?	
What are your fasting blood sugars?	
Current hemoglobin A1C:	

Have you been diagnosed with Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)?

☐ yes

☐ no

If you have been diagnosed with CIDP, please answer the following questions:

Who treats your CIDP? (please provide doctor's name)	
When were you diagnosed?	

**PATIENT AUTHORIZATION FOR DISCLOSURE OF TREATMENT INFORMATION
RELEASE OF MEDICAL INFORMATION**

I GIVE MY PERMISSION FOR OUR PROVIDERS AT THE NEUROPATHY AND HEALING CENTER TO OBTAIN MEDICAL RECORDS FROM ANOTHER PHYSICIAN AS DEEMED NECESSARY FOR MY CARE AND TREATMENT.

I GIVE MY PERMISSION FOR OUR PROVIDERS WITH THEIR STAFF TO SPEAK WITH AND/OR RELEASE MY MEDICAL RECORDS TO:

Full Name:		Relationship:		Phone #:	
Full Name:		Relationship:		Phone #:	

I understand that this authorization permits The Neuropathy & Healing Center to share details regarding my medical condition, treatment progress, and any other information related to my treatment program as necessary.

Purpose of Disclosure

The purpose of this disclosure is to allow the authorized recipient(s) to stay informed of my treatment progress and assist with my care as needed. I understand that this information may include details about my diagnosis, treatment plan, response to treatment, and any adjustments made by my healthcare providers.

Acknowledgment & Rights

- I understand that I have the right to revoke this authorization at any time by providing a written request to The Neuropathy & Healing Center. However, any disclosures made before the revocation date will remain valid.
- I understand that The Neuropathy & Healing Center cannot guarantee that the recipient(s) of my health information will not disclose it to others.
- I acknowledge that signing this form is voluntary, and I am not required to authorize the release of my information.
- I understand that this authorization will remain in effect until (select one):

☐ A specific date: _____

☐ The end of my treatment program

☐ I revoke it in writing

Signature Agreement

By signing my name below, I acknowledge, agree and confirm that I have provided accurate information regarding my medical history to the best of ability and consent to the terms outlined in this document.

Patient Signature:		Date:	
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The Neuropathy & Healing Center Consent Form

HIPAA

The undersigned does hereby acknowledge that he/she/they has/have received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersigned does hereby consent to the use of his/her/their health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

INFORMED CONSENT

I hereby request and consent to the performance of chiropractic examinations, adjustments, and any other associated procedures on me.

I understand, as with any health care procedures, that there are certain complications which may arise during chiropractic treatments. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Ehler's Danlos Syndrome, Horner's Syndrome, diaphragmatic paralysis, cervical myelopathy, and costovertebral strains and separations

I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgement during the course of the procedure(s) which the doctor and/or physical therapist feels at the time, based upon the facts then known, that are in my best interest.

I have had an opportunity to discuss the nature, purpose, and risks of chiropractic care and other recommended procedures. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed.

If there is any dispute about my care, I agree to a resolution by binding arbitration according to the American Arbitration Association guidelines. I have read (or have had read to me) the above explanation of the chiropractic treatments. I state that I have been informed and weighed the risks involved in chiropractic treatment at this health care office. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

X-RAY and/or MRI RELEASE AND CONSENT

It is not unusual for our office to order an X-Ray and/or MRI in the process of determining how we can best help you. Please select from the following:

☐ Yes, please do whatever you feel is necessary to come up with the best care plan for me (and, NO, I am certainly NOT pregnant).

☐ No thanks! I'll pass for now, as I am pregnant or have another medical condition which contradicts me being exposed to x-ray.

Signature Agreement

By signing my name below, I acknowledge, agree and confirm that I have reviewed, understood, and consent to the terms outlined in this document. I attest that the information on this form, and those preceding, is true and accurate to the best of my knowledge.

Patient Signature:		Date:	
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If signing on behalf of a minor or patient unable to sign:

Printed Name of Authorized Representative:	
Relationship with the Patient:	
Authorized Representative Signature:	

NOTICE OF PRIVACY PRACTICES

We maintain protocols to ensure the security and confidentiality of your personal information. We have physical security in our building, passwords to protect our databases, compliance audits, and virus/intrusion detection software. Within our practice, access to your information is limited to those who need it to perform their jobs. At this office, we are committed to treating and using protected health information about you responsibly. This notice of Privacy Policy describes the personal information we collect, how, and when we use or disclose this information. This notice is effective April 14, 2003, and applies to all protected health information as defined by federal regulations. Each time you visit, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment and plan for future care or treatment. This information, often referred to as your health or medical record, serves as a: Basis for planning your care and treatment; means of communication among the many health professionals who contribute to your care; legal documentation describing the care you received; means by which you or a third party payer can verify that services billed were actually provided; tool in educating health professionals; source of data for our research; source information for public health officials charged to improve the health of the state and nation; source of data for our planning and marketing; tool by which we assess and continually work to improve the care we render and outcomes we achieve. Although your health record is the physical property of this office, the information belongs to you. You have the right to: obtain a paper copy of this notice of privacy policies upon request; inspect and obtain a copy of your health record as provided by 45 CFR 164.524 (reasonable copy fees apply in accordance with state law); amend your health record as provided by 45 CFR 164.526; obtain an accounting of disclosures of your health information as provided by 45 CFR 164.528; request confidential communications of your health information as provided by 45 CFR 164.522(B) request restrictions on certain uses and disclosures of your information as provided by 45 CFR 164.522(A) – (however, we are not required by law to agree to a requested restriction.) Our practice is required to: maintain the privacy policy of your health information; provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you; abide by the terms of this notice; notify you if we are unable to agree to a requested restriction; accommodate reasonable requests you may have to communicate your health information. We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. We will keep a posted copy of the most current notice in our facility containing the effective date in the top righthand corner. In addition, each time you visit our facility for treatment, you may obtain a copy of the current notice in effect upon request. We will not disclose your health information in a manner other than described in the section regarding Examples of Disclosure for Treatment; Payment and Health Operations, without your written authorization, which you may revoke as provided by 45 CFR 164.508(B)(5), except to the extent that action has already taken. Examples of Disclosure for Treatment, Payment & Health Operations: we will use your health information for treatment. We may provide medical information about you to healthcare providers, our practice personnel, or third parties who are involved in the provision, management, or coordination of your care. We will use your health information for payment. We may disclose your information so that we can collect or make payment for the health services you receive. We may disclose your health information for our routine operations. These uses are necessary for certain administrative, financial, legal and quality improvement activities that are necessary to run our practice and support the core functions. Consistent with applicable law, we may disclose medical information to the following: to provide appointment reminders, to coroner, medical examiner or funeral directors; workers' compensation or other similar programs established by law; to public health or legal authorities charged with preventing or controlling disease, injury or disability; to researcher when their research has obtained a required waiver from the Institutional Review Board/Privacy Board, who has reviewed the research proposal; to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of organs for the purpose of donation and transplant; as required by law for reporting a crime, responding to a court order, grand jury subpoena, warrant, discovery request, or other legal process or complying with the health oversight activities such as audits, investigations, and inspections necessary to ensure compliance with government regulations and civil rights laws; for military and veterans affairs or national security and intelligence activities; for services provided in our organization through contacts with business associates (i.e. transcription services) due to the nature of business associates' services, they must receive your health information in order to perform the jobs we've asked them to do and protect our health information we require the business associate to appropriately safeguard your information; to the FDA health information relative to adverse events with respect to food, supplements, product and product defects or post marketing surveillance information to health related benefits that may be of interest to you; to your personal representative or personal legally responsible for your care and authorized to act on your behalf in making decisions related to your care; when we believe in good faith that your information is necessary to prevent a serious threat to your safety or that of another person (i.e. abuse, neglect, or domestic violence); to family member or close personal friend health information relevant to that person's involvement in your care or payment related to your care, we may notify these individuals of your location/general condition; to an organization assisting in a disaster relief effort. For all non-routine operations, we will obtain your written authorization before disclosing your personal information. In addition, we take great care to safeguard your information in every way that we can to minimize any incidental disclosures.

Acknowledgment of Notice of Privacy Practices Policy

I acknowledge that I have received, reviewed, and understand the Notice of Privacy Practices and Financial Policy of The Neuropathy and Healing Center. I understand that these policies outline how my medical information may be used and disclosed, as well as my financial responsibilities related to the services provided. I understand that:

- The Notice of Privacy Practices describes how my protected health information (PHI) may be used and disclosed for treatment, payment, and healthcare operations.
- I have the right to request a copy of these policies for my records.
- I may contact the office if I have any questions regarding these policies.

Signature Agreement

By signing my name below, I acknowledge, agree and confirm that I have reviewed, understood, and consent to the terms outlined in this document.

Patient Signature:		Date:	
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If signing on behalf of a minor or patient unable to sign:

Printed Name of Authorized Representative:	
Relationship with the Patient:	
Authorized Representative Signature:	

NOTICE OF FINANCIAL & ATTENDANCE POLICIES

Welcome to our office. We are committed to providing you with the highest quality of care and appreciate the trust you have placed in us.

We accept cash, checks, and all major credit cards. We also partner with Affirm and CareCredit for patients who prefer to finance their treatment through a payment plan.

To help ensure the best possible treatment outcomes, please take a few moments to review the following policies, which apply once you enroll in a treatment program.

Attendance & Cancellation Policy

Your treatment plan has been carefully designed by your provider to give you the best opportunity for improvement.

Consistency is one of the most important factors in achieving successful results. Missing or frequently rescheduling appointments may reduce the effectiveness of your treatment, and we cannot guarantee that canceled appointments will be available to reschedule.

To help us provide timely care for all patients, we kindly request at least 24 hours' notice if you need to cancel or reschedule an appointment.

As a one-time courtesy, the cancellation fee will be waived if you cancel with less than 24 hours' notice. However, repeated late cancellations may, at our discretion, result in a \$50 cancellation fee. Appointments missed without prior notice ("no-shows") will be charged a \$50 no-show fee.

If you are unable to attend your appointments consistently, you may be discharged from your current course of therapy.

Should you wish to resume treatment at a later date, an additional office visit at \$49.00 with your provider may be required to establish a new treatment plan.

Treatment sessions that have already been used are considered completed services and cannot be refunded or repeated.

Our team is committed to helping you achieve the best possible outcome and improve your quality of life. If you are experiencing challenges that may prevent you from attending your appointments consistently, please let us know. We are happy to work with you whenever possible to help you stay on track with your care.

Returned Checks

Any check returned by your financial institution for non-sufficient funds (NSF) will be subject to a \$55 returned check fee.

Thank you for taking the time to review these policies. We appreciate the opportunity to participate in your care. If you have any questions, please don't hesitate to ask. We are here to help.

Signature Agreement

By signing my name below, I acknowledge, agree and confirm that I have reviewed, understood, and consent to the financial and attendance terms outlined in this document.

Patient Signature:		Date:	
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Notice of Non-Refundable Consultation Fee and Attendance Policies

Thank you for choosing The Neuropathy & Healing Center. We appreciate the opportunity to care for you.

Because your Neuropathy Consultation is a dedicated **60-minute appointment**, we reserve this time exclusively for you. As a result, we are often unable to offer that appointment to another patient once it has been reserved.

To help ensure appointment availability and reduce missed appointments, the following policy applies to all Neuropathy Consultations.

Consultation Fee

A non-refundable consultation fee of \$102.45 is required at the time your appointment is scheduled.

This amount includes:

- \$99.00 Consultation Fee
- \$3.45 Merchant Processing Fee (3.49%)

Appointments are not confirmed until payment has been received. Consultation fees must be paid by credit or with debit card at the time of scheduling. Cash payments are not accepted for consultation reservations.

Rescheduling

We understand that unexpected situations can arise. As a one-time courtesy, you may reschedule your consultation one time at no additional charge, provided you notify our office at least 48 hours before your scheduled appointment.

Cancellations, No-Shows & Additional Reschedules

A new non-refundable consultation fee of \$102.45 will be required before another appointment can be scheduled if:

- You cancel with less than 48 hours' notice
- You do not arrive for your scheduled consultation (no-show)
- You need to reschedule your consultation a second time

The new consultation fee will be charged to the credit or debit card on file.

Acknowledgment

By scheduling your Neuropathy Consultation, you acknowledge that you have read, understand, and agree to this Non-Refundable Consultation Fee Policy. We appreciate your understanding and cooperation. This policy helps us provide timely access to care for all patients while protecting the dedicated appointment times reserved for each individual.

Thank you for choosing The Neuropathy & Healing Center. We look forward to partnering with you on your journey toward better nerve health and healing.

Signature Agreement

By signing my name below, I acknowledge, agree and confirm that I have reviewed, understood, and consent to the non-refundable consultation fee and attendance policies outlined in this document.

Patient Signature:		Date:	
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Acknowledgment of Financial, Attendance and Non-Refundable Policies

I acknowledge that I have received, reviewed, and understand the Notice of Financial, Attendance and Non-Refundable Policies at The Neuropathy and Healing Center.

- The Financial Policy outlines my financial obligations with The Neuropathy & Healing Center.
- I have the right to request a copy of these policies for my records.
- I may contact the office if I have any questions regarding these policies at (904) 217-0542.

Signature Agreement

By signing my name below, I acknowledge, agree and confirm that I have reviewed, understood, and consent to the terms outlined in this document.

Patient Signature:		Date:	
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