ONE GREAT PLACE TO GET WELL

Dr. Mel Youngs, D.C.
Chiropractic Physician and Associates
(239) 542-1422 FAX: (239) 542-9688 www.dryoungs.com

DOCTOR MEL'S Wellness Spa SERVICES

Today's Date

TELL US ABOUT YOURSELF

Patient Name: _____ _____ ____ Nickname: _____ ◯Male ◯Female
Last First MI

Birthdate: Age:___ SS#: _____ Primary Phone#: _____ Alt. Phone#: _____

Mailing Address:_____ _____ _____ Email Address:_____
City State Zip

Employer:_____ Occupation:_____

Employer Address:_____ _____ _____ Referred By: _____
City State Zip

Status: ◯Minor ◯Single ◯Married ◯Divorced ◯Separated ◯Widowed ◯Significant Other

Race/Ethnicity: ◯White ◯Black/African American ◯Hispanic/Latino ◯Asian ◯American Indian/Alaska Native ◯Native Hawaiian/Pacific Islander

Spouse's Name:_____ Do you have children? ◯Yes ◯No How many? _____

ACCOUNT INFORMATION

☐SAME AS ABOVE Name of Person Ultimately Responsible for Account_____

Billing Address:_____ _____ _____ Email Address:_____
City State Zip

SS# _____ Drivers License #: _____ Payment Method: ◯Cash ◯Check

◯Credit Card_____ Name on Credit Card_____ Exp. Date

IN THE EVENT OF AN EMERGENCY

Name of whom we should contact:_____ Relationship: _____

Primary Phone #:_____ Medical Doctor:_____ Phone #: _____

IRREVOCABLE AGREEMENT FOR PAYMENT

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 or treatment that any fees for professional services rendered to me will be immediately due and payable. I understand and agree that if charges are to be filed with an insurance carrier and unpaid/denied, I am responsible for payment. Furthermore, I understand that DR. MEL YOUNGS, D.C., P.A. will prepare any necessary forms to assist me in making collection from my insurance carrier and that any amount authorized will be paid directly to DR. MEL YOUNGS, D.C., P.A. and will be credited to my account upon receipt. I understand that DR. MEL YOUNGS, D.C., P.A. is acting solely as an agent for me in filing to my insurance carrier for benefits assigned to me and authorize release of any information required to support my claim. However, DR. MEL YOUNGS, D.C., P.A. can assume no responsibility for guaranteeing payment of covered services. I understand that I am financially responsible for all charges whether or not paid by my insurance carrier as well as any attorney fees and costs incurred to collect for these services.

_____ Initials

CONSENT FOR TREATMENT

I understand that if I am accepted as a patient of DR. MEL YOUNGS, D.C., P.A., I authorize DR. MEL YOUNGS, D.C., P.A. and her staff to proceed with any treatment that may be medically necessary. Furthermore, any risk associated with Chiropractic treatment will be explained to me upon my request.

_____ Initials

I**f under 18:** I hereby authorize Dr. Mel Youngs, D.C., P.A. to administer treatment without my being present at the time of treatment.

_____ Initials

ASSIGNMENT OF BENEFITS

I hereby authorize (Name of Insurance Carrier)_____to pay and mail directly to DR. MEL YOUNGS, D.C., P.A. the benefits otherwise payable to me or for my dependent for their services, but not to exceed the charges for those services. I hereby irrevocably assign to DR. MEL YOUNGS, D.C., P.A., any benefits under any policy medical of insurance, indemnity agreement, or any other collateral source as defined in Florida Statutes for any services and charges provided DR. MEL YOUNGS, D.C., P.A."

_____ Initials

Check out our monthly spa specials at Dryoungs.com ~ Email your paperwork to office@dryoungs.com

REASON FOR TODAY'S VISIT

◯Emergency ◯New Injury ◯Old Injury ◯Chronic Pain ◯Wellness Are you in pain: ◯Yes ◯No

Rate your pain with the following scale: mild (1)(2)(3)(4)(5)(6)(7)(8)(9)(10) intense

Did your injury occur during: ◯Work ◯Sports/play ◯Auto Accident

When did your condition/accident occur: __ ___ ___ Please explain what happened: _____

Is your condition getting worse? ◯Yes ◯No ◯Constant ◯Comes and goes Has this ever happened before? ◯Yes ◯No

Have you ever been treated by a Medical Physician for this condition? ◯Yes ◯No

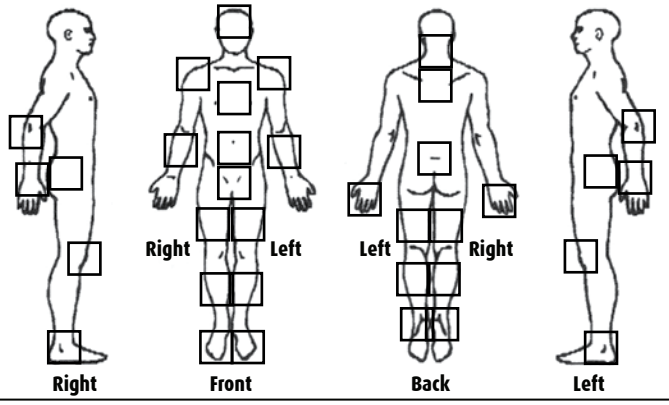
Have you ever been adjusted by a Chiropractor in the past? ◯Yes ◯No Who? _____

Do you feel overall healthy? ◯Yes ◯No

Do you have or have you had any of the following diseases, medical conditions or procedures?

(Y)(N) Heart Attack/Stroke
(Y)(N) Artificial Valves
(Y)(N) Shingles
(Y)(N) Emphysema / Asthma
(Y)(N) Ulcers/ Colitis
(Y)(N) Cancer
(Y)(N) Chemotherapy
(Y)(N) Hepatitis
(Y)(N) High/Low Blood Pressure
(Y)(N) Alcohol / Drug Abuse
(Y)(N) Psychiatric Problems
(Y)(N) Fainting/Seizures/ Epilepsy
(Y)(N) Tuberculosis
(Y)(N) Venereal Disease
(Y)(N) Rheumatic Fever
(Y)(N) Glaucoma
(Y)(N) Frequent Neck Pain
(Y)(N) Frequent Low Back Pain
(Y)(N) Heart Murmur
(Y)(N) Arthritis
(Y)(N) Sinus Problems
(Y)(N) Congenital Heart Defect
(Y)(N) High Cholesterol

PLEASE CIRCLE ALL THE AFFECTED AREAS



Please list any surgeries with dates and/or any other serious medical condition(s) not listed above:

_____

List any past accidents with dates: _____

Please list anything that you may be allergic to: _____

List medications: _____

Do you take any Supplements or Vitamins? ◯Yes ◯No Do you exercise? ◯Yes ◯No _____hours per week

Do you smoke? ◯Yes ◯No How much? _____ How long? _____

For women: Are you taking Birth Control? ◯Yes ◯No Are you Nursing? ◯Yes ◯No Are you pregnant? ◯Yes ◯No

We invite you to discuss with us any questions regarding our services.
The best health services are based on a friendly, mutual understanding between provider and patient.

OUR POLICY

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account. **I understand that it is my responsibility to inform the office of any changes to my account.**

I understand that Dr. Mel Youngs, D.C., P.A. has a No-Show Policy for Massage Therapy. The office requires a 24 hour notice prior to cancelling an appointment. **If there is not a 24 hr notice given I will be charged a $25 cancellation fee. I understand this charge is my responsibility and will not be passed on to my insurance company.**

Signature _____ Date:

Dr. Mel Youngs, D.C., P.A.
916 E. Cape Coral Pkwy
Cape Coral, Fl 33904
(239) 542-1422
Fax: (239) 542-9688

Records Request Authorization

PATIENT INFORMATION

Patient Name _____

Patient Date of Birth _____

Social Security Number _____

CONSENT FOR RELEASE OF INFORMATION

I, _____ authorize _____
(Name and/or facility)

_____
(Address, City, State, Zip) (Phone and Fax Number)

to disclose the following healthcare information for treatment on these dates _____.

The information released will be used for the following purpose:

I specifically authorize the following for release:

☐ Entire record ☐ Only those items listed below:

☐ Visit/Progress Notes
☐ X-ray / MRI Reports
☐ X-ray Films
☐ Range of Motion
☐ Lab Results
☐ Other

I authorize disclosure of the above mentioned medical records for the purposes stated above. I also am aware that I am not giving permission for any disclosure other that what is described above. I understand that I can revoke this authorization at any time, except to the extent actions have already taken place.

This release is effective for 180 days from the date signed unless other specifications follow:

I understand that the parties in receipt of my healthcare information may not further disclose my information unless another authorization is obtained from me or unless disclosure is specifically required or permitted by law.

_____ _____
Signature of Patient or Legal Representative Date

Dr. Mel Youngs D.C., PA & Associates

916 E. Cape Coral Pkwy
Cape Coral, FL 33904
(239) 542-1422

PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

THIS CONSENT FORM ENSURES PRIVACY OF YOUR PROTECTED HEALTH INFORMATION

I, _____, hereby state that by signing the Consent, I acknowledge and agree as follows:

1. The Practice's Privacy Notice has been provided to me prior to this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information (PHI) necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out is health care operations. The Practice explained to me that the Privacy Notice would be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.
4. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.
Protected Health Information and Account Information may be released to: Name_____
Relationship:_____ Phone Number:_____
5. I understand that this Consent is valid and will remain in effect until I revoke it. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.
6. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.
7. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.
8. I understand that my name will be visible on a sign in sheet to other patients, and that this office is an open treatment facility.

Consent to Email or Text Usage for Appointment Reminders and Other Healthcare Communications:
Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information.

If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from the Practice.

_____ (**Patient initials**) I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing (revocation available upon request).

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

_____ _____
Signature **Date**

_____
Signature of Legal Representative Relationship