Date:

Patient Information

☐ **New Patient** ☐ **Returning Patient**

Last Name	First Name	Middle Initial

Date of Birth MM/DD/YYYY _____/_____/_____	Sex ☐ Male ☐ Female	Social Security #

Address	City	State	Zip Code

Primary Phone Number ☐ Home ☐ Work ☐ Cell	Secondary Phone Number ☐ Home ☐ Work ☐ Cell	Preferred Contact Method ☐ Phone call ☐ Text ☐ Email

Marital Status ☐ Single ☐ Widowed ☐ Divorced ☐ Married ☐ Separated ☐ Partner	Email To be used for provider communication, follow up, patient portal, and practice related material. We DO NOT share email information with other parties. You may choose to remove at any time.	Employment Status ☐ Full time ☐ Part time ☐ Not employed ☐ Student ☐ Homemaker ☐ Retired

Preferred Language ☐ English ☐ Spanish ☐ Other _____	Employer	Job Title

Race ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Other Race ☐ Asian ☐ Black or African American ☐ Unreported ☐ Hispanic ☐ White	Preferred Pharmacy:

Insurance Information

Primary Insurance Company	

Name of Policy Holder ☐ Same as above	Policy Holder's Date of Birth ☐ Same as above ____/_____/_____

Policy Holder's Relationship to Patient ☐ Self ☐ Mother ☐ Father ☐ Other _____	Policy Holder's Social Security # ☐ Same as above

Subscriber Number	Group Number

Secondary Insurance Company ☐ N/A	Name of Policy Holder ☐ Same as above

Secondary Subscriber Number	Secondary Group Number

In Case of Emergency

I hereby give permission to disclose and discuss any information related to my medical condition(s) with the following listed individuals:

Name	Relationship	Phone Number	Yes or No

Reason For Today's Visit

Chief Complaint (please describe symptoms)	

☐ Medical Treatment (list symptoms above) ☐ Work Related Injury – Worker's Compensation ☐ Car Accident or Auto Related Injury ☐ Home Injury	☐ Physical - ☐ School ☐ Work ☐ DOT ☐ Pre-op Medical Clearance ☐ Unknown Cause ☐ Other _____	Onset/Injury Date

Name: Date:

Please report previous treatment received for condition

☐ Emergency Room	☐ Prescribed Medication	☐ Surgery	☐ Ice	☐ Other: _____
☐ Physical Therapy	☐ Over-the-counter Medication	☐ Rest	☐ Heat	☐ Other: _____
☐ Massage	☐ Chiropractic Adjustment	☐ Stretching	☐ Bracing	☐ Other: _____

Current Medications

Medication	Dosage	Condition

Medical History (check all that apply)

☐ ADD/ADHD	☐ Chronic Fatigue Syndrome	☐ Hearing Impairment	☐ Pacemaker
☐ AIDS/HIV	☐ Constipation	☐ Heart Disease	☐ Parkinson's Disease
☐ Allergies	☐ COPD	☐ Heart Murmur	☐ Pinched Nerve
☐ Alzheimer's/Dementia	☐ Depression	☐ Hepatitis	☐ Scoliosis
☐ Anemia	☐ Diabetes: Insulin / Non-insulin	☐ Herniated Disk	☐ Seizure Disorder
☐ Appendicitis	☐ Ear Infections	☐ Herpes/Lesions/Shingles	☐ Sinusitis
☐ Arthritis	☐ Eating Disorder	☐ High Blood Pressure	☐ Sleep Apnea
☐ Asthma	☐ Eczema	☐ High Cholesterol	☐ STD
☐ Autoimmune Condition	☐ Eye Problems	☐ Hypoglycemic	☐ Stroke/ TIA
☐ Back Pain	☐ Fainting /Syncope	☐ Influenza/ Pneumonia	☐ Thyroid Problems
☐ Bleeding Disorder	☐ Fibromyalgia	☐ Joint Pain	☐ Tonsillitis
☐ Bronchitis	☐ Fractures	☐ Kidney Disease/ Stones	☐ Tumors/Growths
☐ Cancer: _____	☐ Gallbladder Disorder	☐ Measles/ Mumps/ Rubella	☐ Ulcers
☐ Cataracts	☐ Glaucoma	☐ Miscarriage	☐ Vaginal Infections
☐ Chest Pain	☐ Gout	☐ Mononucleosis	☐ Vertigo
☐ Chicken Pox	☐ Headaches	☐ Osteoporosis	☐ Other:

Allergies

Medication Allergies:	Reaction:
Supplement Allergies:	Reaction:
Food Allergies:	Reaction:
Other:	Reaction:

Name: Date:

Surgical History (check all that apply)

☐ Angioplasty	☐ Debridement	☐ Lumpectomy
☐ Arthroscopy	☐ Dilation and Curettage	☐ Mastectomy
☐ Appendectomy	☐ Ear Tubes	☐ Pacemaker/Defibrillator
☐ Biopsy (site):	☐ Eye Surgery (specify):	☐ Skin Lesion Removal
☐ Bunionectomy	☐ Gallbladder Removal	☐ Spinal Surgery (type):
☐ Cardiac Surgery (type):	☐ Gastric Bypass	☐ Thyroid Surgery
☐ Carpal Tunnel	☐ Hernia	☐ Tonsillectomy
☐ Cesarean Section	☐ Hysterectomy	☐ Tubal Ligation
☐ Colostomy	☐ Joint Replacement	☐ Vasectomy
☐ Cosmetic (type):	☐ Kidney Surgery	☐ Other:

Family History

Check all that apply. Please indicate family member associated with condition: M-Mother, F- Father, S-Sister, B- Brother, MG- Maternal Grandmother, MF- Maternal Grandfather, MA- Maternal Aunt, MU- Maternal Uncle, PG- Paternal Grandmother, PF- Paternal Grandfather, PA- Paternal Aunt, PU- Paternal Uncle, C- Child

Condition	Family Member	Condition	Family Member	Condition	Family Member
☐ ADD/ADHD		☐ Diabetes		☐ Obesity	
☐ Alcoholism/Substance Abuse		☐ Eczema/Psoriasis		☐ Parkinson's Disease	
☐ Alzheimer's/Dementia		☐ Heart Disease		☐ Psychiatric Disorder	
☐ Arthritis		☐ Hemodialysis		☐ Seizure Disorder	
☐ Asthma		☐ Hepatitis		☐ Stomach or GI problems	
☐ Auto Immune Disease (ex: Lupus)		☐ High Blood Pressure		☐ Stroke/TIA	
☐ Cancer (type):		☐ High Cholesterol		☐ Thyroid Problems	
☐ COPD		☐ Kidney Disease		☐ Other:	

Social History

Exercise Habits: ☐ Daily ☐ Minimal ☐ 3-4 x per week ☐ None ☐ 1-2 x per week ☐ None Due to Injury/Illness	Tobacco Use: ☐ Never Smoked ☐ Smokeless Tobacco ☐ Current Smoker ☐ Vaporizer ☐ Former Smoker Amt/Day _____ # of years _____	Alcohol Use: _____ Drinks Per Week Caffeine Use: _____ Cups Per Day
Drug Use: ☐ No history of recreational drug use ☐ Former use of recreational drugs ☐ Current use of recreational drugs	Work Habits: ☐ N/A Average # of hours per week _____ Mostly- ☐ Sitting ☐ Standing ☐ Walking Labor- ☐ Sedentary ☐ Light ☐ Moderate ☐ Heavy Environment- ☐ Difficult ☐ Stressful ☐ Relaxed ☐ Enjoyable	

Review of Systems (check all that apply)

Name: Date:

CONSTITUTIONAL	ENDOCRINE	HEMATOLOGY/LYMPH	CARDIOVASCULAR
☐ Weight Loss ☐ Fatigue ☐ Fever	☐ Loss of Hair ☐ Heat/Cold Intolerance	☐ Bruising ☐ Gums Bleed Easily	☐ Murmur ☐ Chest Pain ☐ Palpitations ☐ Dizziness ☐ Fainting Spells ☐ Shortness of Breath ☐ Difficulty Lying Flat ☐ Swelling Ankles
EYES	**GASTROINTESTINAL**	**MUSKULOSKELETAL**	
☐ Glasses/Contacts ☐ Eye Pain ☐ Double Vision ☐ Cataracts	☐ Heartburn/Reflux ☐ Nausea/Vomiting ☐ Constipation ☐ Change in bowel movements	☐ Joint Pain Swelling ☐ Stiffness ☐ Muscle Pain ☐ Back Pain	
EAR, NOSE, THROAT	**GENITOURINARY**	**NEUROLOGICAL**	
☐ Difficulty Hearing ☐ Ringing in the Ears ☐ Vertigo ☐ Sinus Trouble ☐ Nasal Stiffness ☐ Frequent Sore Throat	☐ Burning/Frequency ☐ Night Time ☐ Blood in Urine ☐ Erectile Dysfunction ☐ Abnormal Discharge ☐ Bladder Leakage	☐ Loss of Strength ☐ Numbness ☐ Headaches ☐ Tremors ☐ Memory Loss	
RESPIRATORY	**PSYCHIATRIC**	**SKIN**	
☐ Cough Easy ☐ Wheezing ☐ Chills	☐ Anxiety/Depression ☐ Mood Swings ☐ Difficulty Sleeping	☐ Rash/Sores ☐ Lesions ☐ Itching/Burning	

ACCESS 365 URGENT CARE/BACK IN ACTION MEDICAL CENTER

Medical Information Release Form
(HIPAA Release Form)

Name: _____ Date of Birth: _____

Release of Information

[ ] I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be release to:

- [ ] Spouse _____
- [ ] Child(ren) _____
- [ ] Other _____

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call my: [ ] cell [ ] home [ ] work

If unable to reach me:

- [ ] you may leave a detailed message
- [ ] please leave a message asking me to return your call
- [ ] Other _____

The best time to reach me is (day) _____ between (time) _____

Signed: _____ Date: _____

Witness: _____ Date: _____

Ownership Notice to Patients

Because of concerns that there may be a conflict of interest when a physician refers a patient to a health care facility in which the physician has an ownership interest, Florida passed a law (the "Patient Self-Referral Act of1992," FL Statute Section 455.654).

Under this law, I must disclose my ownership in this facility and tell you about alternative places where you may go to obtain these services. This disclosure is intended to help you make a fully informed decision about your health care. You have the right to obtain healthcare items or services at a location or from a provider or supplier of your choice, including the facility in which I am owner. I assure you that you will not be treated differently if you do not choose the facility listed below in which I have an ownership interest.

Dr. Robert McLaughlin has an ownership in: Back In Action Medical Center, LLC, Proactive Health and Wellness, DBA Back In Action Chiropractic, and Access 365 Urgent Care.

Alternative Medical facilities in which we do not have ownership:

1. Jensen Beach Urgent Care
2. Med Stat Urgent Care
3. Martin County Department of Health

Alternative Chiropractic facilities in which we do not have ownership:

1. Complete Care Chiropractic
2. Life Chiropractic
3. Vital Wellness Center

Patient Name _____

Signature _____

Date _____

If not patient, name of legal guardian:_____Relationship_____

ACCESS 365 URGENT CARE LLC / BACK IN ACTION MEDICAL CENTER LLC

PRIVACY & BILLING PROCEDURES
AUTHORIZATION & ACKNOWLEDGEMENT

These authorizations, acknowledgements and waivers cover all services rendered to the above patient for today and all future dates of service. You may submit written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any events that occurred before you notified us of your decision to revoke.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Access 365 Urgent Care, LLC (A365UC) and Back In Action Medical Center, LLC (BIAM)reserve the right to modify the privacy practices outlined in the Notice of Privacy Practices. I have had the opportunity to read or have received a copy of the Notice of Privacy Practices for the patient outlined above.

AUTHORIZATION TO TREAT & BILL

I give consent and authorization to A365UC and/or BIAM to examine and provide all routine medical care, diagnostic procedures, disposing of any specimens or tissue taken from my body, and provide treatment in the judgment of the medical provider, necessary or beneficial to my health and well-being with no guarantees expressed regarding the results of examination and treatment by aforementioned facility.

I authorize the release of any medical and demographic information necessary to process all claims. I authorize payment of medical benefits to A365UC and/or BIAM for all services performed.

I understand that I am responsible for all charges incurred at the time of service unless other arrangements were made prior to being treated. I will pay any deductible, co-payments, and any amounts denied or not covered by insurance. I understand it is my responsibility to check with my insurance carrier prior to my visit for covered and non-covered benefits and also whether or not A365UC and/or BIAM visit will be paid with my in-network or out-of-network benefits billed as urgent care place of service (POS 20).

I understand that if I do not provide complete and accurate billing/insurance information at the time of service and this lack of information prevents A365UC and/or BIAM from collecting from my insurance company, I will be responsible for the full charges. If a referral or additional forms are required by my insurance company, I understand I am responsible for providing A365UC and/or BIAM with a referral within 48 hours of my visit and/or complete all insurance required forms in a timely manner, or I may be responsible for all charges.

Collection Fees: If payment is not made as agreed upon, the account will be turned over for collection. The patient and/or guarantor, shall be responsible for and agree to pay all reasonable cost of collection including, but not limited to, reasonable collection agency fees, attorneys fees, and court costs.

Jurisdiction and venue: If any suit must be filed to collect an unpaid balance on an account, patient, and/or guarantor, agrees that such suit may be brought in courts of Martin County, Florida, and waives any objection to jurisdiction or venue.

Assignment & Release: I hear by request and assign directly to A365UC and/or BIAM all medical benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, including collection fees and/or interest that may accrue, whether or not paid by insurance. I hereby authorize the provider to release all information necessary to secure the payment of benefits unless written notice is given to revoke this authorization. I authorize the use of a copy of this signature is as valid as the original signature on all of my insurance submissions. Co-pays and Quick Pay fees are due at the time of service. All account balances will be the patient's and/or guarantor's responsibility after processing of insurance, if applicable, and may be assessed and $15.00 statement fee per invoice. Full balance is due within 15 days or upon receipt of the first invoice.

PLEASE SIGN HERE: PATIENT, GUARDIAN OR PERSONAL REPRESENTATIVE: _____ DATE:_____

OUTSIDE LABORATORY AND RADIOLOGISTS

It is my understanding that A365UC and/or BIAM may send lab specimens to an outside laboratory or send x-rays taken by A365UC and/or BIAM to an outside radiologist for over reading. I give permission for those outside laboratories and radiologists to bill my insurance for their services. I understand that I may incur additional chargers as a a result of those outside laboratory tests or radiologists. I understand that A365UC and/or BIAM is not responsible for payment to those laboratories and/or radiologist.

PLEASE SIGN HERE: PATIENT, GUARDIAN OR PERSONAL REPRESENTATIVE**:** _____DATE: _____

NON-COVERED SERVICES

It is my understanding that my insurance company may deem my visit to A365UC and/or BIAM as a non-covered service and may make me fully responsible for payment of all charges for these services.

PLEASE SIGN HERE: PATIENT, GUARDIAN OR PERSONAL REPRESENTATIVE: _____DATE: _____