



Palma **C**eia
Chiropractic & Wellness
Center

*Educating and Empowering Families to
Maximize their Life's Potential*

PATIENT APPLICATION FORM

WELCOME TO OUR OFFICE. We specialize in assisting our patients to achieve their highest level of health through our spinal and postural corrective programs. Our approach is very unique and advanced from other rehabilitative programs. This allows our patients to achieve far superior results compared to most other systems.

Please fill out the following information thoroughly so the doctor can let you know if you are a case we can accept. Please feel free to ask any questions if you need assistance. We look forward to helping you achieve maximum health!

Patient Signature _____

Date: _____

PATIENT APPLICATION SURVEY

Date: _____

Name: _____ Home Phone: _____

Address: _____ Work Phone: _____

City, State, Zip: _____ Cell Phone: _____

Email Address: _____

Would you like to receive our weekly health tips via email? Yes No

Birth Date: _____ Age: _____ SSN: _____ Marital Status: S M D W

Occupation: _____ # of Children: _____ Spouse's Name: _____

How were you referred to our office?: _____

PURPOSE OF THIS VISIT

Reason for this visit - Main Complaint: _____

Is the reason for this visit related to an auto accident/work injury? Yes No If yes; date of accident: _____

When did this condition begin? _____ Did it begin: Gradual Sudden Progressive over time

What activities aggravate your symptoms? _____

Is there anything that has relieved your symptoms? _____

Type of pain: Sharp Dull Ache Burn Throb Spasm Numb Tingling Shooting

Does the pain radiate into your: Arm Leg Does not radiate Is this condition getting worse? Y N

How often do you experience these symptoms throughout the day? 100% 75% 50% 25% 10%

Only With Activity

Does the complaint interfere with: Work Sleep Hobbies Daily Routine Other: _____

Have you experienced this condition before? Yes No If so, please explain: _____

Who have you seen for help with this condition? _____

What treatment did you receive? _____ How did you respond? _____

Please list any other health symptoms or complaints: _____

Please list the medications you are currently taking and their purpose: _____

Please list all past surgeries: _____

Please list all previous accidents and falls: _____

Spinal health is especially important during pregnancy; is there **any chance** that you are pregnant? Yes No

Have you ever been diagnosed with cancer? Yes No Type: _____ Year Diagnosed: _____

HEALTH LIFESTYLE

Do you exercise? Y N How often? 1x 2x 3x 4x 5x per week Other: _____

What activities? _____

Do you smoke? Y N How much? _____

Do you drink alcohol? Y N How much/week? _____

Do you drink coffee? Y N How many cups/day? _____

Do you take any supplements? (vitamins, etc.) _____

HEALTH CONDITIONS: Abnormal postural habits or distortions are the result of trauma or stress to the body that have misaligned the vertebrae in your spine. When these vertebrae are twisted even slightly from their normal position, they will cause stress to the spinal cord and the delicate nerves that pass between the vertebrae. These misalignments are called subluxations. It has been extensively documented that subluxations, causing stress to your nerves, will weaken and distort the overall structure of your spine. This results in a weakened and distorted POSTURE. Postural distortions have many serious and adverse affects on your overall health. The most common and detrimental postural distortion is called Forward Head Syndrome (a "hunched forward" posture starting in the neck and progressively moving down your spine, weakening the entire body).

Please check any health conditions you may be experiencing now, or in the past:

CERVICAL SPINE (NECK):

Postural distortions from subluxations in your neck will weaken the nerves in your arms, hands, and head affecting these parts of your body. Do you experience:

- | | | |
|--|--|---|
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Headaches | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Arm/shoulder/hand pain | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Allergies/hay fever |
| <input type="checkbox"/> Numbness/tingling in arms/hands | <input type="checkbox"/> Visual disturbances | <input type="checkbox"/> Recurrent colds/flu |
| <input type="checkbox"/> Hearing disturbances | <input type="checkbox"/> Coldness in hands | <input type="checkbox"/> Low energy/fatigue |
| <input type="checkbox"/> Weakness in grip | <input type="checkbox"/> Thyroid conditions | <input type="checkbox"/> TMJ/pain/clicking in jaw |
| <input type="checkbox"/> Other _____ | | |

THORACIC SPINE (UPPER BACK):

Postural distortions from subluxations in the upper back will weaken the nerves to the heart and lungs and affect these parts of your body. Do you experience:

- | | | |
|---|---|---|
| <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Recurrent lung infections/bronchitis | <input type="checkbox"/> Asthma/wheezing |
| <input type="checkbox"/> Heart murmurs | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Pain when taking a deep breath |
| <input type="checkbox"/> Tachycardia | <input type="checkbox"/> Heart attacks/angina | <input type="checkbox"/> Upper back/shoulder pain |
| <input type="checkbox"/> Other _____ | | |

THORACIC SPINE (MID BACK):

Postural distortions from subluxations in the mid back will weaken the nerves to your ribs/chest and upper digestive tract, and affect these parts of your body. Do you experience:

- | | | |
|---|---|---|
| <input type="checkbox"/> Mid back pain | <input type="checkbox"/> Nausea | <input type="checkbox"/> Ulcers/gastritis |
| <input type="checkbox"/> Pain into ribs/chest | <input type="checkbox"/> Indigestion/heartburn | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Reflux | <input type="checkbox"/> Tired/irritable after eating or when you haven't eaten for a while | |
| <input type="checkbox"/> Other _____ | | |

LUMBAR SPINE (LOW BACK):

Postural distortions from subluxations in the low back will weaken the nerves into your legs/feet and pelvic organs and affect these parts of your body. Do you experience:

- | | | |
|---|--|--|
| <input type="checkbox"/> Pain in hips/legs/feet | <input type="checkbox"/> Weakness/injuries in hips/knees/ankles | <input type="checkbox"/> Low back pain |
| <input type="checkbox"/> Numbness/tingling in legs/feet | <input type="checkbox"/> Recurrent bladder infections | <input type="checkbox"/> Constipation/diarrhea |
| <input type="checkbox"/> Coldness in legs/feet | <input type="checkbox"/> Frequent/difficulty urinating | <input type="checkbox"/> Sexual dysfunction |
| <input type="checkbox"/> Muscle cramps in legs/feet | <input type="checkbox"/> Menstrual irregularities/cramping (females) | |
| <input type="checkbox"/> Other _____ | | |

Please list any health conditions not mentioned: _____

Palma Ceia Chiropractic and Wellness Center

Informed Consent

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Palma Ceia Chiropractic and Wellness Center have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

REGARDING: Chiropractic Scoliosis Treatment (Adjustments, Modalities, and Therapeutic Procedures)

I have been advised of the above as well as the standards associated with scoliosis treatment in regards to watching and waiting, bracing and surgery. I have also been informed of the risks associated with not following those standards. I'm also aware that there is no guarantee or promise of any results and I am aware that the scoliosis can still progress. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care and under my free will choose not to follow the standards associated with scoliosis treatment.

_____ /_____/_____
Patient or Authorized person's Signature Date *Witness Initials*

REGARDING: X-rays/Imaging Studies

FEMALES ONLY → please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.

The first day of my last menstrual cycle was on ____-____-____ Date

I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

MALES/FEMALES: By my signature below, I understand and give consent to be x-rayed if the doctor deems necessary.

_____ /_____/_____
Patient or Authorized person's Signature Date *Witness Initials*

Palma Ceia Chiropractic and Wellness Center

Notice of Privacy Practice

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your Personal Health Information. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as dictated by our office policy, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled 'HIPAA' on tables in the reception. Once you have read this notice, please sign and return to our front desk receptionist. You will get a copy for your records.

PERMITTED DISCLOSURES:

1. Treatment purposes- discussion with other health care providers involved in your care
2. Inadvertent disclosures- open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes- to process a claim or aid in investigation
5. Emergency- in the event of a medical emergency we may notify a family member
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement - to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons -discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders -we may call your home and leave messages regarding a missed appointment or apprise you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice
3. To request mailings to an address different than residence
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain one copy of your records at no charge, when timely notice is provided (72 hours). X-rays are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call Rebecca 813-251-0246. If she is unavailable, you may make an appointment with our receptionist to see [Dr. Alvarez](#) within 72 hours or 3 working days .If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201

I have received a copy of Palma Ceia Chiropractic and Wellness Center's Patient Privacy Notice. I understand my rights as well as the practices duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this 'Notice of Privacy Practice" at any time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

Patient's Name _____

DOB _____

Patient Signature _____

Date _____

Witness _____

Date _____

Palma Ceia Chiropractic and Wellness Center

Office Policies

As a potential new patient, we feel it is important that you understand our office policies regarding, how patients of this practice are cared for, and the various methods we offer to facilitate payment for that care. Please read each policy carefully so there is no misunderstanding as to what you can expect as a patient of this practice, and what we expect in return. Once you have read "Our Office Policies", if you have any questions or any of these policies are unclear to you, and you would like further explanation before submitting your Application for Care, please let our front desk know and a member of our staff will be happy to discuss them with you further. We believe it is in everyone's best interests to provide potential new patients as much information as possible about how the doctors at this office practice chiropractic so that an informed decision can be made as to whether they wish to become a patient.

Over time, individuals who are accepted, as patients at this office, gain a greater understanding as to the purpose of chiropractic. Since the majority of patient care occurs in an open bay area, patients have a unique opportunity to observe firsthand the positive results that are achieved and the benefits derived from being under chiropractic care. This knowledge and awareness reaps a positive environment that promotes healing and encourages families to maintain good health. We want your experience with us to be an exceptional one, so help us to help you and together we can make affirmative changes in your life and the lives of those you care about.

❑ PATIENT PRIVACY - Since the majority of patient care takes place in an open bay area it is important to understand that any conversations you have with the doctor can be overheard by other patients. In order to maintain patient privacy it is the policy of this practice to refrain from discussing any confidential matters with patients during treating hours while patients are being adjusted. If you have a confidential matter you wish to discuss please let us know and we will schedule time for you to speak to the doctor in a private consultation room. These consultations must be scheduled in advance.

❑ YOUR CARE - When a patient seeks chiropractic health care and we agree to provide that care, it is essential for the patient and the doctor to be working toward the same objective. Chiropractic care at Palma Ceia Chiropractic and Wellness Center is rendered primarily to minimize and reduce misalignments in the spine, which are a major interference to the body's ability to heal properly. The doctors use a myriad of techniques to accomplish this goal, including but not limited to the latest techniques for spinal correction. It is important that you understand both the objective and the method(s) so there is no confusion or disappointment. Tremendous progress has been made in the rehabilitating and correction of spinal problems. Where in the past, chronic spinal structural problems could not be reversed or corrected, today they can. Your doctor will outline a course of treatment that will take you beyond simple pain relief, through two distinct phases of care to make a structural correction to your spine that will enable your central nervous system to function optimally, thereby improving your overall health.

❑ FIRST THINGS FIRST- Prior to receiving chiropractic care at this office, a health history and examination will be completed. Imaging studies as well as any other necessary diagnostics may also be ordered, to confirm the true nature of your condition and exact location of the spinal misalignments. The results of these procedures will aid in assessing your presenting problem, your overall health and, in particular, the condition of your spine. They will also assist the doctor in determining the type and amount of care you will need. All relevant findings will be reported to you along with care plan recommendations so that you can make the best possible decision regarding your health care needs. Our gold standard for care is to ensure the reduction of spinal misalignments while teaching patients what they need to do in addition to being adjusted to maintain their health for a lifetime.

❑ PATIENT'S REPORT OF FINDINGS - To enhance your understanding of the chiropractic approach that will be used to manage your health, immediately following your first adjustment, you will be scheduled for a 'Doctors Report of Findings'. The information you receive at this appointment will be both informative and clinically relevant to your case, therefore attendance is required for individuals who wish to become new patients of this practice. Because the results of your x-rays and all examinations as well as the doctors' recommendations for care, will be discussed at that time, we strongly urge new patients to invite their spouse or significant other to attend. We know from experience that when a patient's family understands the goals and objectives of chiropractic care and how restoring and maintaining good health can affect their lives as well, they become infinitely supportive and helpful in making important decisions concerning treatment options.

I hereby acknowledge receiving a copy of the practices 'Office Policies' that I have read and retained. This signature page will be retained by the practice as evidence of my receiving and understanding this 'Notice'. I further acknowledge that any concerns regarding these 'Policies' as well as all my questions have been answered by a qualified member of the staff to my complete satisfaction.

Patient's Name

DOB

Patient Signature

Date

Witness

Date

**Palma Ceia
Chiropractic & Wellness
Center**
NOTICE OF PRIVACY PRACTICES
Dex T. Alvarez, D.C.

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED
AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY AND SIGN.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted by law.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time.

Uses and Disclosures Of Protected Health Information Based Upon Your Written Consent

You will be asked by your chiropractor to sign this consent/acknowledgment form. By signing the consent/acknowledgment form, your chiropractor, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you may also use and disclose your protected health information to pay your health care bills and to support the operation of the chiropractor's office.

Following are examples of the types of uses and disclosures of your protected health care information that the chiropractor's office is permitted to make once you have signed this consent/acknowledgment form:

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your chiropractic care and any related services. This includes the coordination or management of your chiropractic care with a third party that has already obtained your permission to have access to your protected health information.

Payment: Your protected chiropractic information will be used, as needed, for your chiropractic services. This may include certain activities that your chiropractic insurance plan may undertake before it approves or pays for the chiropractic services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your chiropractor's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of chiropractic students, substitute chiropractors, doctors who observe our practice, licensing, marketing, fundraising activities, and conducting or arranging for other business activities.

In addition we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting or adjusting room. We may use your health information to call you to remind you of, cancel, or reschedule an appointment. We may leave a message on your answering machine or voice mail. To promote a less stressful, family friendly and time efficient environment, most office visits are performed in an open area where complete privacy of your name and health information will be respected but cannot be guaranteed. Special appointment times are available by request for discussion of private or confidential matters. We may mail appointment reminders, announcement or greeting cards to your home. Your name or picture may be used on a "Thank You for Referring", "Welcome to Our Office," or office bulletin board unless you specifically request us not to do so. Your private information will be used when we bill insurance claims for you or need to collect an outstanding balance using an outside collection agency.

We may share your protected health information with third party "business associates" that perform various activities (e.g., billing transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Contact to request that these materials not be sent to you.

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that your chiropractor or the chiropractic practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object

We may use and disclose your protected health care information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your chiropractor may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

NOTICE OF PRIVACY PRACTICES

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your chiropractic care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Emergencies: We may use or disclose your protected health information in an emergency treatment situation. If this happens, your chiropractor shall try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If your chiropractor or another chiropractor in the practice is required by law to treat you, and the chiropractor has attempted to obtain your consent, but is unable to obtain your consent, he or she may still use or disclose your protected health information to treat you.

Communication Barriers: We may use and disclose your protected health information if your chiropractor or staff member in the practice attempts to obtain consent from you but is unable to do so due to substantial communication barriers and the chiropractor or staff member determines, using professional judgment, that you intend to consent to use or disclosure under the circumstances.

We may use or disclose your protected health information in the following situations without your consent or authorization:
When required By Law, Public Health, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration, Legal Proceedings, Law Enforcement, Funeral Directors, and Organ Donation, Criminal Activity, Military Activity, Inmates and National Security.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance.

You have the right to inspect and copy your protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, health operations or additional uses listed above in paragraph 8. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your chiropractor is not required to agree to a restriction that you request. If your chiropractor believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your chiropractor does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for this request. Please make this request in writing to our Privacy Contact.

You may have the right to have your chiropractor amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint. The terms of this Notice may change. If the terms do change you may receive a revised Notice by contacting our Privacy Contact.

Privacy Contact Phone: 813-251-0246

Address: 1502 S. MacDill Ave • Tampa, FL •33629

I have received a copy of this office's Notice of Privacy Practices and consent to the use and disclosure of protected health information by Dr. Dex T. Alvarez, D.C., staff and business associates for treatment, payment, health care operations and additional uses listed above. I have reviewed, acknowledge, and understand the content of the Notice of Privacy Practices.

"You May Refuse To Sign This." THIS NOTICE WAS PUBLISHED AND BECOMES EFFECTIVE ON APRIL 14, 2003.

Printed Patient Name _____

Date _____

Signature _____

Printed Name of Parent/Guardian _____

Signature of Parent/Guardian _____