UPPER CERVICAL
CENTER OF BRANDON

Dear Future Patient,

Welcome to Upper Cervical Health Care, the most revolutionary health care procedure on the planet today. We have had the privilege of seeing thousands of patient's lives changed by this procedure. Upper Cervical Health Care originated in 1923 and there is an estimated only 2000 practicing Upper Cervical Doctors throughout the world. Upper Cervical Health Centers ® is a professional network of Doctors providing Upper Cervical Health Care to thousands across the United States and several other nations.

Upper Cervical Health Care is a unique form of Chiropractic that focuses on the upper two bones in the neck. The brainstem extends down from your head into these two bones and is responsible for controlling and regulating every function in your body. So, if one of those two top bones get slightly misaligned it can reduce or completely cut off the nerve supply from your brain to any one or several different parts of your body causing that area to malfunction or possibly even shut down resulting in a wide range of health problems. This misalignment can cause so many different problems that it would be impossible to even begin to list them in this letter. That is why we offer everyone and their entire family a COMPLIMENTARY CONSULTATION followed by a precise Upper Cervical examination. If the Doctor determines you have an Upper Cervical misalignment, you will receive an explanation of what steps will be needed to correct your misalignment and return your body to better health.

Thank you for caring enough about your health of your family to consider Upper Cervical Health Centers ® for your healthcare needs. We sincerely hope that we can help you and your whole family by improving your health so that you may have a healthier, happier, and better quality of life. We are looking forward to seeing you at your upcoming appointment.

Sincerely,

The Doctors and Staff

9280 Bay Plaza Blvd. Suite 725, Tampa, FL 33619 ~ (813) 644-7190
www.ucbrandon.com

UPPER CERVICAL
CENTER OF BRANDON

Confidential Patient Information

The following information is needed to better serve you. Please complete all questions. If you need help, please don't hesitate to ask. **PLEASE PRINT**.

Today's Date _____

Name _____ Phone _____□ Home □ Cell

Address _____ City _____ State___ Zip _____

Age____ Birthdate _____ Marital Status M S W D How many Children ____

Referred By _____ E-mail address _____

Would you like to receive text message reminders of your appointment? □ Yes □ No

If Yes, please provide: Your cell phone number _____

Your cell phone company _____
(This is needed to ensure the text message can be sent)

Your Employer _____ Occupation_____

Spouse's Name _____

Do you have Medicare? _____ (**If yes, please take the Medicare card/s to the front desk**).

Is your condition due to an accident? □ Yes □ No Date of Accident _____

Type of accident □ Auto □ Work/Job □ At Home □ Other _____

Describe the major complaints that bring you to our office _____

_____

_____

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Health History

Name: _____ Date: _____

List all current health problems: _____

_____

List any other doctors see, treatments and results obtained: _____

_____

Your current physician(s)/therapist(s): _____

_____

List all surgeries and their dates: _____

_____

List any medications you are taking: _____

_____

List any traumas and their dates: _____

_____

Please Check the Conditions You Have or Had

( ) AIDS
( ) Anemia
( ) Arthritis
( ) Cancer
( ) Chronic Fatigue
( ) Depression
( ) Diabetes
( ) Epilepsy
( ) Fibromyalgia
( ) Hypoglycemia
( ) Multiple Sclerosis
( ) Parkinson's Disease
( ) Polio
( ) Rheumatic Fever
( ) Rheumatoid Arthritis
( ) Tuberculosis
( ) Venereal Disease

Please Check All Present Symptoms

Cardiovascular

( ) General Swelling
( ) Swelling in Legs
( ) Swelling in Face
( ) Swelling Around Eyes
( ) Chest Pain
( ) Pounding Heart
( ) Rapid Heart Beat
( ) Irregular Heart Beat
( ) Blue or Purple Skin
( ) Blue or Purple Nail Beds
( ) Cold Hands/Feet

Vertebrobasilar

( ) Double Vision
( ) Loss of Coordination
( ) Loss of Memory
( ) Ringing in Ears
( ) Heart Attack
( ) High Blood Pressure
( ) Muscle Weakness
( ) Dizziness
( ) Blurred Vision
( ) Stroke
( ) Hypertension
( ) Inability
( ) Burning Sensations
( ) Blindness
( ) Previous Head Injury
( ) Previous Neck Injury
( ) Taking Birth Control
( ) Family History of Stroke
( ) Blood Vessel Disease
( ) Check If You Smoke
( ) Fainting
( ) Area of Numbness

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Health Review

Please Check All Present Symptoms

Skin, Hair, Nails
( ) Eczema
( ) Itchy Skin
( ) Rough, Scaly Skin
( ) Dry Skin
( ) Oily Skin
( ) Yellow Skin
( ) Bruise Easily
( ) Baldness
( ) Paper Thin Nails
( ) Nail Biting

Eyes
( ) Blurred Vision
( ) Double Vision
( ) Eye Fatigue
( ) Excessive Tearing
( ) Lack of Tearing
( ) Light Bothers Eyes
( ) Excessive Itching
( ) Pain in Eyeball

Ears
( ) Loss of Hearing
( ) Hearing Not Sufficient
( ) Pain in Ears
( ) Discharge from Ears
( ) Vertigo
( ) Ringing in Ears

Nose & Sinuses
( ) Nose Bleeds
( ) Pressure Over Eyes
( ) Nose Obstruction
( ) Frequent Colds
( ) Sinusitis
( ) Loss of Smell
( ) Allergies

Mouth & Throat
( ) Pain in Throat
( ) Bleeding Gums
( ) Abscessed Teeth
( ) Dentures
( ) Difficulty Swallowing

Respiratory
( ) Shortness of Breath
( ) Dry Cough
( ) Coughing Up Blood
( ) Wheezing
( ) Productive Cough

Gastrointestinal
( ) Poor Appetite
( ) Constant Nibbling
( ) Difficulty Swallowing
( ) Indigestion
( ) Nausea & Vomiting
( ) Abdominal Pain
( ) Change in Bowel Habits
( ) Diarrhea
( ) Constipation
( ) Hemorrhoids

Genitourinary

Urination Is
( ) Frequent
( ) Not Sufficient

The Amount Is
( ) High
( ) Moderate
( ) Low
( ) Frequent Urination at Night
( ) Intense Desire to Urinate
( ) Difficulty Urinating
( ) Lack of Control
( ) Pain with Urination
( ) Dribbling
( ) Bloody Urine
( ) Cloudy Urine

Venereal Disease
( ) Syphilis
( ) Gonorrhea
( ) Other

Women Only
( ) Painful Periods
( ) Spotting
( ) Premenstrual Symptoms
( ) Irregular Periods
( ) Lumps in Breast
( ) Vaginal Discharge
# of Pregnancies _____
# of Deliveries _____

Social History
( ) Smoking
( ) Other Tobacco Use
( ) Alcohol Use
( ) Drink Coffee of Tea

Diet Is
( ) Balanced
( ) Not Balanced

Rest Is
( ) Sufficient
( ) Not Sufficient

Recreation Is
( ) Sufficient
( ) Not Sufficient

Family Stress Is
( ) Severe
( ) High
( ) Moderate
( ) Minimal
( ) None

My Job Stress Is
( ) Severe
( ) Moderate
( ) Minimal
( ) None

( ) Nervousness
( ) Irritability
( ) Fatigue
( ) Depression
( ) Panic Attacks
( ) Problems Sleeping
( ) Feeling Run-down

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Musculoskeletal System

Please Check All Present Symptoms

Head
( ) Frequent Headaches
( ) Severe Headaches
( ) Head Feels Heavy
( ) Vertigo
( ) Dizziness
( ) Light Headedness
( ) Loss of Taste
( ) Loss of Smell
( ) Loss of Hearing
( ) Loss of Balance

Neck
( ) Pain in Neck
( ) Pain with Movement
( ) Swelling in Neck
( ) Stiffness in Neck
( ) Pinched Nerve in Neck
( ) Neck Feels Out of Place
( ) Muscle Spasms in Neck
( ) Grinding Sounds in Neck
( ) Popping Sounds in Neck
( ) Limited Neck Movement

Mid-Back
( ) Mid-Back Pain
( ) Pain Between Shoulder Blades
( ) Sharp Stabbing Pain
( ) Dull Ache
( ) Pain from Front to Back
( ) Pain Over Kidney Area
( ) Muscle Spasms

Lower Back
( ) Lower Back Pain
( ) Lower Back Feels Out of Place
( ) Muscle Spasms

Shoulders
( ) Pain in Shoulders
( ) Pain Across Shoulders
( ) Muscle Spasms
( ) Can't Raise Arm
( ) Above Shoulder
( ) Above Head

Arms & Hands
( ) Pain in Upper Arm
( ) Pain in Forearm
( ) Pain in Hands
( ) Pain in Fingers
( ) Pins & Needles
( ) In Arms
( ) In Fingers
( ) Fingers Go To Sleep
( ) Cold Hands
( ) Swollen Fingers
( ) Loss of Grip Strength

Hips, Legs & Feet
( ) Pain in Buttocks
( ) Pain in Hip
( ) Pain Down Leg
( ) Knee Pain
( ) Leg Cramps
( ) Pins & Needles in Legs
( ) Numbness in Legs
( ) Numbness in Toes
( ) Cold Feet
( ) Swollen Ankles
( ) Swollen Feet

Patient Consent for Use and Disclosure of Protected Health Information

With my consent, Upper Cervical Center of Brandon (UCCB) may use and disclose protected health information (PHI) to carry out treatment, payment and healthcare options (TPO). Please refer to Upper Cervical Center of Brandon Notice of Privacy for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. UCCB reserves the right to revise its Notice of Privacy Rights at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to UCCB.

With my consent, UCCB may call my home or other designated location and leave a message on voice mail or in person in reference to any item that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my chiropractic care.

With my consent, UCCB may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

By signing this form, I am consenting to Upper Cervical Center of Brandon's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Upper Cervical Center of Brandon may decline to provide treatment to me.

_____ _____

Signature of Patient or Legal Guardian | Print Name of Patient or Legal Guardian

Authorization *to Pay Doctor/Clinic*

I authorize and direct payment of any medical expense benefits allowable to the doctor/clinic named below as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to the doctor/clinic. I agree that a photo static copy of this agreement shall serve as the original.

_____ _____

Signature | Date

Authorization to Pay/Release is Granted to: Upper Cervical Center of Brandon

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www.ucbrandon.com

Financial Policy Agreement

Health Insurance:
The providers of Upper Cervical Center of Brandon do not participate in any network; therefore your health insurance is a contract between you and the insurance company. Upon request, our staff will provide a "Super Receipt" in a timely manner that provides **accurate and complete** information in the event you desire to submit it to your insurance company for review. Despite our efforts, there is no guarantee of benefits or reimbursement, nor does Upper Cervical Center of Brandon promise that an insurance company will or should pay the fees charged and paid at the time of service.

As a patient, it is your responsibility to pay all fees at the time the services are rendered and for your convenience; Upper Cervical Center of Brandon accepts all major credit cards and personal checks. If you feel that you need some assistance from a family member or a parent with making a decision about your care, it is advisable that you bring them with you on your second visit when the plan of care is discussed with you.

Concerning Your Scheduled Appointments:
If you change, forget or cancel an appointment less than 48 hours notice for a New Patient appointment or less than 24 hours notice for an Established Patient appointment, there will be a fee of $25 up to the full visit fee depending on the length of the appointment that is broken.

We try to confirm appointments with an e-mail (48 hours) and/or a text reminder (24 hours) before your scheduled appointment, please make sure that we have your correct e-mail address, cell phone number and cell phone carrier to ensure that all efforts are available for confirmation. **As a reminder, check your SPAM folder!**

Guaranty of Payment:
By signing below, I accept personal responsibility for the payment in full of my account.

_____ _____

Signature Date

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Medical Information

Name: _____ **Date of Birth** ____/____/____

Release of Information

☐ I authorize the release of information including the appointment date and time, ledger information (charges, payments, and balance) and any information that is pertaining to my treatment (diagnosis, office notes and radiology images). This information may be released to:

Name: _____ **Date of Birth** ____/____/____

Name: _____ **Date of Birth** ____/____/____

Name: _____ **Date of Birth** ____/____/____

Name: _____ **Date of Birth** ____/____/____

Name: _____ **Date of Birth** ____/____/____

Name: _____ **Date of Birth** ____/____/____

☐ Information ***IS NOT*** to be released to anyone.

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

Messages

Please call ☐ My home _____ ☐ My work _____

☐ My cell _____ ☐ Other _____

If unable to reach me:

☐ You may leave a detailed message

☐ Please leave a message asking me to return your call

Signed: _____ Date: ____/____/____

Witness: _____ Date: ____/____/____

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UPPER CERVICAL
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Medical Information Release Form

Name: _____ **Date of Birth** ____/____/____

Release of Information to Providers

☐ I authorize the release of any information that is pertaining to my treatment (diagnosis, office notes, and radiology images and reports) to be used when contacting the providers listed below. This information may be used for co-management of care, and/or sharing of this information so that the providers will have a better understanding of what care is being rendered, why the care is being rendered and how receiving the care is providing a better quality of life for me.

Name: _____ **PH#** _____

Specialty: _____

Name: _____ **PH#** _____

Specialty: _____

Name: _____ **PH#** _____

Specialty: _____

Name: _____ **PH#** _____

Specialty: _____

Name: _____ **PH#** _____

Specialty: _____

☐ Information ***IS NOT*** to be released to anyone.

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

Signed: _____ Date: ____/____/____

Witness: _____ Date: ____/____/____

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Informed Consent

We encourage and support a **shared decision-making process** between us regarding your health needs. As a part of that process you have a right to be informed about the condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether to undergo such care with full knowledge of the known risks. This information is intended to make you better informed in order that you can knowledgably give or withhold your consent.

Chiropractic is based on the science which concerns itself with the relationship between structures (primarily the spine; especially the cranio-cervical junction) and function (primarily of the nervous system) and how this relationship can affect the restoration and preservation of health.

Adjustments are made by chiropractors to correct or reduce spinal and extremity joint subluxations. **Vertebral subluxation** is a disturbance to the nervous system and is a condition where one or more vertebra in the spine is misaligned and/or does not move properly causing interference and/or irritation to the nervous system. The primary goal in chiropractic care is the removal and/or reduction of nerve interference caused by vertebral subluxation.

A chiropractic examination will be performed which may include spinal and physical examination, orthopedic and neurological testing, palpation, specialized instrumentation, radiological examination (x-rays), and laboratory testing.

The chiropractic adjustment is the application of a precise movement and/or force into the spine to reduce or correct vertebral subluxation(s). There are several different methods or techniques by which the chiropractic adjustment can be accomplished. Some may require the use of an instrument or other specialized equipment. In addition, physiotherapy or rehabilitative procedures may be included in the management protocol. Among other things, chiropractic care may reduce pain, increase mobility and improve quality of life.

In addition to the benefits of chiropractic care and treatment, one should also be aware of the existence of some risks and limitations of this care. The risks are seldom high enough to contraindicate care and all health care procedures have some risk associated with them.

Risks associated with some chiropractic treatment may include soreness, musculoskeletal sprain/strain, and fracture. Risks associated with physiotherapy may include the preceding as well as allergic reaction and muscle and/or joint pain.

I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.

I have read the above paragraph. I understand the information provided. All questions I have about this information have been answered to my satisfaction. Having this knowledge, I knowingly authorize the doctors of the Upper Cervical Center of Brandon to proceed with Chiropractic care and treatment.

Dated this _____ day of _____, 20____.

_____

Patient / Guardian Signature

Parental Consent for Treatment of a Minor Patient:

Patient Name: _____

Patient age: _____ Date of Birth: _____

Printed name of person legally authorized to sign for Patient: _____

Signature: _____

Relationship to Patient: _____

In addition, by signing below, I give permission for the above-named minor patient to be managed by the doctor even when I am not present to observe such care.

Please print the name(s) of the person(s) legally authorized to sign for the minor patient.

_____

Name Relationship

_____

Name Relationship

_____

Name Relationship

_____

Parent / Guardian Signature