RICHARD R. SHAKER, D.C., C.C.S.P., R.T.P., A.C.R.B.

Chiropractic: ☐ Trigenics: ☐ Auto Accident: ☐

Client Information

Name: _____ DOB: _____

S.S. #: _____ Email: _____

Address: _____ City _____

State: _____ Zip code _____

Home Telephone: _____ Work Telephone: _____

Employer Name: _____

Employer Address: _____

Emergency Contact(s): (Name) (Relationship) (Telephone)

1. _____

2. _____

Marital Status: Single ☐ Married ☐ Divorced ☐ Separated ☐

If auto related please fill out the following

Claim Number: _____ Policy number: _____

Adjustor Name & Contact #: _____

Assigned Attorney(s): _____

Date of accident: _____

Location of accident: _____

Description of MVA _____

Please list any injuries sustained due to this accident

_____

_____

Spouse Information

Name: _____ S.S.#: _____

Address: _____

Home Telephone: _____ Work Telephone: _____

Employer Name: _____

Employer Address: _____

Referred By: Internet/Website ☐ Patient ☐ Other ☐ _____

Have you been seen or treated by any other physicians _____

Please Note all payments are due at the time services are rendered

Shaker Spine & Sport Institute accepts cash, all major credit cards & "in state" personal checks. If payment made by check is returned for "NSF" patient will be responsible for original check amount and an additional 25.00 service charge. By signing below, you agree to accept all financial responsibility as the patient who is receiving medical services or as the responsible party for a minor patient. Your signature verified that you have reviewed the above disclosure statement and understand your responsibility and agree to these terms.

Patient Signature: _____ Date: _____

3314 Henderson Blvd. Ste. 203 Tampa, Fl 33609 (B) 813-876-9552 (F) 813-877-1558

SHAKER SPINE & SPORT INSTITU
RICHARD R. SHAKER DC, CCSP*, RTP*, ACRB*

PATIENT REGISTRATION (PAGE 3)

What treatment have you already received for you condition?
___Medications ___Surgery ___Physical Therapy ___ Chiropractic Services ___None
OTHER:_____

IF AUTO: Did you go to the hospital due to the accident? ___Yes ___No
If yes, What is the name of the hospital _____

Please mark to indicate if you have had/ currently have any of the following:

___ AIDS/HIV	___Chicken Pox	___Liver Disease
___Alcoholism	___Diabetes	___Measles
___Allergy Shots	___Emphysema	___Migraine/Headaches
___Anemia	___Epilepsy	___Miscarriage
___Anorexia	___Fractures	___Mononucleosis
___Appendicitis	___Glaucoma	___Multiple Sclerosis
___Arthritis	___Goiter	___Mumps
___Asthma	___Gonorrhea	___Osteoporosis
___Bleeding Disorders	___Gout	___Pacemaker
___Breast lump	___Heart Disease	___Parkinson's Disease
___Bronchitis	___Hepatitis	___Pinched Nerve
___Bulimia	___Hernia	___Pneumonia
___Cancer	___Herniated Disc	___Polio
___Cataracts	___Herpes	___Prostate Problem
___Chemical Dependency	___High Cholesterol	___Prosthesis
___Rheumatoid Arthritis	___Rheumatic Fever	___Scarlet Fever
___Stroke	___Suicide Attempt	___Thyroid Problems
___Tonsillitis	___Tumors, Growths	___Typhoid Fever
___Ulcers	___Vaginal Infections	___Venereal Disease
___Whooping Cough	Other: _____	

EXERCISE	WORK ACTIVITY	HABITS
___None	___Sitting	___Smoking
___Moderate	___Standing	___Alcohol
___Daily	___Light Labor	___Coffee/Caffeine Drinks
___Heavy	___Heavy Labor	___High Stress Level

INJURIES/SUGERIES YOU HAVE HAD

Falls _____	Date _____
Head Injuries _____	Date _____
Broken Bones _____	Date _____
Dislocations _____	Date _____
Surgeries _____	Date _____
_____	Date _____
_____	Date _____

SHAKER
SPINE · SPORT · INSTITUTE

RICHARD R. SHAKER, D.C., C.C.S.P., R.T.P., A.C.R.B.

RELEASE OF PATIENT RECORDS AUTHORIZATION

I hereby authorize_____
To release a copy of my patient records, x-rays or MRI's containing protected health information to

Shaker Spine & Sport Institute
3314 Henderson Blvd Suite #203
Tampa, FL 33609

Certified:
Chiropractic
Sports Physician

Registered
Trigenics
Physician

American
Chiropractic
Rehab Board

Member:
American Chiropractic
Association

Florida
Chiropractic
Association

Hillsborough County
Chiropractic
Association

FCA Council
Sports Injuries

ACA Council
Sports Injuries

American Chiropractic
Board of Sports
Physicians

This authorization is given pursuant to Florida Statute 456.057 and HIPAA regulations. I understand that Florida Statute 456.057 (10) makes clear that any third party to whom records are disclosed is prohibited from further disclosing any information in the medical record without the expressed written consent of the patient or the patient's legal representatives.

_____
Patient or Patient Legal Representative Signature

_____
Patient's Printed Name

_____ _____
Patient's Date of Birth **Date Signed**

Specific description of information to be disclose:

_____
_____
_____

CONFIDENTIAL TRANSMISSION CONTAINS PERSONAL HEALTH INFORMATION THAT YOU ARE REQUIRED BY LAW TO MAINTAIN IN A SECURED AND CONFIDENTAIL MANNER. RE-DISCLOSURE IS PROHIBITED. FAILURE TO MAINTAIN CONFIDENTIALITY OR RE-DISCLOSURE WITHOUT AUTHORIZATION COULD RESULT IN PENALTIES.

HENDERSON POINTE BUILDING
3314 HENDERSON BLVD., #203
TAMPA, FL 33609
813-876-9552 / FAX 813-877-1558
www.drshaker.com

FAMILY · ATHLETIC · PERSONAL

SHAKER SPINE & SPORT INSTITUTE

RICHARD R. SHAKER DC, CCSP, RTP*, ACRB**

HIPAA ACKNOWLEDGEMENT AND PRIVACY PREFERENCES

You may be contacted by our office to remind you of appointments, healthcare treatment options or other health services that may be of interest to you. In order to maintain your privacy, please answer the following:

May we contact you at home? ___YES___NO Ok to leave message? ___YES___NO
May we contact you at work? ___YES___NO Ok to leave message?___YES___NO
May we contact you via cell? ___YES___NO Ok to leave message?___YES___NO

Is it ok to leave a message that includes:
Practice name and phone number only? ___YES ___NO
Detailed or specific message? ___YES ___NO

Would you like to authorize someone else to schedule, confirm, or change appointments? ___YES___NO
If so, please provide:
Name_____ Phone_____

Would you like to authorize someone else to receive medical information on your behalf?___YES___NO

For the purpose of marketing, advertising, special events and offers, may we contact you via email and/or newsletter? ___YES___NO

HOW DID YOU HEAR ABOUT US?

____Friend or Family Member (Name)_____
____Website: ____Drshaker.com ___Healthgrades ___Google Other:_____
____Newspaper/Newsletter or Mailer _____
____An article or advertisement in:_____
____Other: _____

Richard R. Shaker, DC, has posted my rights as a patient under the HIPAA (Health Insurance Portability and Accountability Act) on his website www.DrShaker.com. I have had the opportunity to read and understand my rights. I understand I can request a written copy at any time. I have been provided the opportunity to ask questions regarding my rights and received answers to my satisfaction.

SHAKER SPINE & SPORT INSTITUTE

RICHARD R. SHAKER DC, CCSP, RTP*, ACRB**

PATIENT CONSENT FORM (HIPAA)

Regarding the Use & Disclosure of Protected Health Information
("Consent Form")

For the purposes of this Consent Form, "Office" shall refer to: Shaker Spine & Sport. I understand that some of my health information may be used and/or disclosed by the Office to carry out treatment, payment, or health care operations, and that for a more complete description of such uses and disclosures I should refer to the Office's privacy notice entitled, "Our Privacy Practices." I understand that I may review this privacy notice at any time prior signing this form.

I understand that over time the Office's privacy practices may need to change in accordance with law and that if I wish to obtain a copy of the notice as revised, I can call the Office to request such copy.

I understand that I may request restrictions on how my information is used or disclosed to carry out treatment, payment, or health care operations, and that I can also revoke this Consent in, but only to the extent that the Office has not taken action in reliance thereon and also provided that I do so in writing.

I understand that for my protection, any requests to amend my health information or to access my medical records must be made in writing.

Patient Name (please print):_____

Signature:_____ Date: ___/___/__

Attention Patients

We have implemented a new office policy: You must call to cancel your appointment within 24 hours or you will be charged a **"No Show Fee"**

Fees include:

- Chiropractic treatment - $50
- Chiropractic Initial Exam - $125
- Trigenics Treatment - $150
- Trigenics Initial Exam - $250
- Auto Patients & Commercial Insurance Patients are subjected to a $100 No Show Fee (Out of pocket expense)

Thank you for your cooperation!

Patient Name (please print) _____

Signature: _____ Date: __/__/__