Name: ____ Date: ___________________
Address:____
City: ____ State: _________________ Zip: __________
Home Phone: _____________________ E-mail: __________________________________ Y N
Cellular: ________________________ Carrier: ____________________ Text Message Appt Reminders: Y N
DOB: ____________________ Age: ______ SS#: __________________________ Marital Status: S M D W

Occupation: __________________________________ Employer: ____
Employer Address: ____
City: _______________________________ State: _____________ Zip:__________ Phone: __________________

Spouse's Name:____ DOB:_________________________

IN CASE OF EMERGENCY, CONTACT:

Name:____ Relationship: _________________
Address:____________________________________ City:____________________ State:_____ Zip: ___________
Home Phone: _____________________ Cellular Phone: ________________Work Phone:___________________

PRIMARY PHYSICIAN: ____

INSURANCE INFORMATION: (CIRCLE)

SELF PAY CHP BCBS UNITED MEDICARE AUTO WC OTHER: __________________

Primary Insurance:____ Phone: ______________________________
Name of Policy Holder___________________________ DOB _______________ Relationship: Self Spouse Child

ASSIGNMENT AND RELEASE:

I, the undersigned certify that I (or my dependent) have insurance coverage with ______________________ and assign directly to Gene E Jenkins, Jr., D.C., P.A. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Gene E. Jenkins, Jr., D.C. to release all information necessary to secure the payment of benefits.
I authorize the use of this signature on all insurance submissions.

____ _______________________________________

Responsible Party Signature/ Relationship **Date**

I authorize this office to release copies of my medical records to my primary care physician and any other physicians I may be referred to from Dr. Jenkins.

____ _______________________________________

Responsible Party Signature/ Relationship **Date**

Gene E. Jenkins, Jr., DC

1298 Timberlane Road; Tallahassee, FL 32312

PLEASE COMPLETE EVERY SPACE. DO NOT LEAVE ANY BLANK LINES. THANK YOU!

Patient History Form

Patient Name: ___________________________________ DOB: __________________________

Reason for today's visit: ____

Beginning of problem: ________________________________

Do you smoke and if so how frequent: ___________________

Consume alcohol and if so how frequent: ______________________

Are you pregnant: ______

Please list any known medical conditions:
____

____

Please list all medications you currently take: ____
____
____

Do you have any known allergies to any medications?
____

____

Please list all surgeries: ____
____

Please list any known family history of disease (mother, father and siblings):
____
____
____

Patient Signature: _________________________________ Date: __________________________

Gene E. Jenkins, Jr. DC, PA

1298 Timberlane Road

Tallahassee, FL 32312

<u>PLEASE COMPLETE EVERY SPACE. DO NOT LEAVE ANY BLANK LINES. THANK YOU!</u>

Gene E. Jenkins, Jr., DC, PA

1298 Timberlane Rd.
Tallahassee, FL 32312

Dr. Gene E. Jenkins, Jr.
Chiropractic Physician

Board Member
Florida Board of Chiropractic Medicine
(2007 - 2011)

Board Member
Florida Board of Chiropractic Medicine
(1997 - 2005)

Chairman, State of Florida
Board of Chiropractic Medicine
(2000 - 2002)
(2009 - 2010)

Vice Chairman, State of Florida
Board of Chiropractic Medicine
(1999 - 2000)
(2008 - 2009)

Former Consultant, State of Florida
Agency for Healthcare Administration

Former Consultant, State of Florida
Department of Health

Member
Florida Chiropractic Association

Welcome to our office! Following is information of which we feel is important for you to be aware. We appreciate your time and effort in reviewing this information. We believe that a clear definition of our financial policy will allow us to concentrate on the big issue - regaining and maintaining your health. Should you have any questions, please ask for assistance at the front desk.

When arranged in advance, this office will be happy to file charges to the appropriate insurance carrier for you. When special claim forms are required by your carrier, it is your responsibility to supply them to this office with the selection marked "employee" or "insured" completed. Forms that are extensive will result in an office fee. Year end statements can be supplied at a cost of $10.00.

When we agree to take your insurance on assignment, we have to wait for the major portion of payment for services rendered, therefore, you will be requested to pay the portion of your bill not covered by the insurance company upon completion of each visit. If for some reason your insurance claim is denied, you are responsible for the full amount of your bill.

Our office will **NOT** enter into dispute with your insurance company over your claim. This is your responsibility and obligation.

We gladly accept personal checks, cash, Mastercard, and Visa for payment of services rendered. There is a $25.00 service charge for returned checks. Payment is due upon completion of each visit and upon request, we will gladly supply a form adequate for reimbursement from your insurance company.

I, THE UNDERSIGNED (PATIENT OR LEGALLY RESPONSIBLE PARTY), HAVE READ, OR HAD READ TO ME, THE CONTENTS OF THIS INFORMED CONSENT AGREEMENT AND DO UNDERSTAND THE CONTENTS THEREOF. I AUTHORIZE TREATMENT TO BE RENDERED AND DO ASSUME ANY AND ALL FINANCIAL RESPONSIBILITY.

_____________________________ _____________________________

Patient/Responsible Party Date Witness Date

Telephone 850-668-4057 • Fax 850-668-3594

GENE T. JENKINS, JR., DC, PA.
1238 TIMBERLANE RD.
TALLAHASSEE, FL. 32312
850-668-4057

INFORMED CONSENT

Dear Patient:

Every type of health care is associated with some risk of a potential problem. This includes chiropractic health care. We want you to be informed about potential problems associated with chiropractic health care before consenting to treatment. This is called informed consent.

Chiropractic adjustments are the moving of bones with the doctor's hands or with the use of a machine. Frequently adjustments create a "pop" or "click" sound/sensation in the area being treated.

In this office we use trained staff personnel to assist the doctor with portions of your consultation, examination, x-ray taking, physical therapy application, exercise instruction, etc.

Stroke: Stroke is the most serious problem associated with chiropractic adjustments. Stroke means that a portion of the brain does not receive enough oxygen from the blood stream. The results can be temporary or permanent dysfunction of the brain, with a very rare complication of death. Chiropractic adjustments have been associated with strokes that arise from the vertebral artery only; this is because of the vertebral artery is actually found inside the neck vertebrae. The adjustment that is related to vertebral artery stroke is called the "extension-rotation-thrust atlas adjustment". ***We do not do this type adjustment on patients.*** Other types of neck adjustments may also potentially be related to vertebral artery strokes, but no one is certain. The most recent studies (Journal of the CCA, Vol. 37 No., June, 1993) estimate that the incident of this type of stroke is 1 per every 3,000,000 upper neck adjustments. This means that an average chiropractor would have to be in practice for hundreds of years before they would statistically be associated with a single patient stroke.

Disc Herniations: Disc herniations that create pressure on the spinal nerve or on the spinal cord are frequently successfully treated by chiropractors and chiropractic adjustments, traction, etc. This includes both in the neck and back. Yet, occasionally chiropractic treatment (adjustments, traction, etc.) will aggravate the problem and rarely surgery may become necessary for correction. Rarely chiropractic adjustments may also cause a disc problem if the disc is in a weakened condition. These problems occur so rarely that there are no available statistics to quantify their probability.

Soft Tissue Injury: Soft tissues primarily refer to muscles and ligaments. Muscles move bones and ligaments limit joint movement. Rarely a chiropractic adjustment, traction, massage therapy, etc., may tear some muscle or ligament fibers. The result is a temporary increase in pain and necessary treatments of resolution, but there are no long term affects for the patient. These problems occur so rarely that there are no available statistics to quantify their probability.

Rib Fractures: The ribs are found only in the thoracic spine or middle back. They extend from your back to your front chest area. Rarely a chiropractic adjustment will crack a rib bones, and this is referred to as a fracture. This occurs only on patients that have weakened bones from such things as osteoporosis. Osteoporosis can be noted on your x-rays. We adjust all patients very carefully, and especially those who have osteoporosis on their x-rays. These problems occur so rarely that there are no available statistics to quantify their probability.

Physical Therapy Burns: Some of the machines we use generate heat. We also use both heat and ice, and recommend them for home care on occasion. Everyone's skin has different sensitivity to these modalities, and rarely, either heat or ice can burn or irritate the skin. The result is a temporary increase in skin pain, and there may even be some blistering of the skin. These problems occur so rarely that there are no available statistics to quantify their probability.

Soreness: It is common for chiropractic adjustments, traction, massage therapy, exercises, etc. to result in a temporary increase in soreness in the region being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic change. It is not dangerous, but please do tell your doctor about it.

Other Problems: There may be other problems or complications that might arise from chiropractic treatment other than those noted above. These other problems or complications occur so rarely that it is not possible to anticipate and/or explain them all in advance of treatment.

Chiropractic is a system of health care delivery, and, therefore, as with any health care delivery system we cannot promise a cure for any symptom, disease, or condition as a result of treatment in this clinic. We will always give you our best care, and if results are not acceptable, we will refer you to another provider who we feel will assist your situation.

If you have any questions on the above, please ask your doctor. When you have a full understanding, please sign and date below.

______________________________	______________________
Patient's Name Printed	*Today's Date*
______________________________	______________________
Patient's Signature	*Parent or Guardian Signature for Minor*

DID YOU READ THIS FORM BEFORE YOU SIGNED IT?

Witness: ______________________________ **Date:** ________________

ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

By checking the lines below I authorize being contacted for practice reminders by:
Mail _______;
Email_______; at email address ____;
Telephone numbers________;
____;
By voice mail ____________;
By text message _________;

By checking this checking the lines below I authorize the doctor to personally discuss with me products that may benefit my health or condition. _______

________________________________ ____________________
Patient Name (please print) Date

____
Name of Parent, Guardian or Patient's legal representative

____
Signature of Patient, Parent, Guardian or Patient's legal representative

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.

List below the names and relationship of people to whom you authorize the Practice to release PHI.

Name:	Relationship to Patient:
______________________________	________________________________
______________________________	________________________________
______________________________	________________________________

Gene E. Jenkins Jr., D.C., P.A.
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Tallahassee, FL 32312
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