3305 Rice Street Coconut Grove FL, 33133

Phone: 305-792-8393 / Fax: 305-444-1523

Email: JaguarTherapy@gmail.com

Web: www.JaguarTherapy.com

Patient Profile

(PLEASE PRINT CLEARLY)

Personal Information

Full Name: ____ Jr / Sr
Last First M.I.

Address: ____
Street Address Apartment/ Unit #

____
City State ZIP Code

Cell Phone: ___________________ Alternate Phone: _____________

Birth Date: ____/____/_____ Gender: ☐ Male ☐ Female Height________ Weight___________

Emergency Contact: ____________________ Emergency Contact Phone: _______________

Health Insurance? ☐ Yes ☐ No Referred By: ______________________________

Is visit due to a car accident? ☐Yes ☐ No Is visit due to a Slip or Fall? ☐ Yes ☐ No

Your present complaint/symtoms:____

Are you taking any Medications? ☐ Yes ☐ No Medication List:________________________

Are you taking any Supplements ☐ Yes ☐ No Supplement List:_________________________

Allergies: ____

Email:____________________________

Facebook:_________________________

Twitter:__________________________

Instagram:________________________

Physician Form (if known)

Physician Information

Type of Physician ☐ Chiropractic ☐ Family ☐ Specialist

Physician Name: ____

Address: ____
Street Address Apartment/ Unit #

____
City State ZIP Code

Phone: __________________ Ext. ______ Fax: ____________________

Email Address: ________________________________ (Please Print Clearly)

Patient: ________________________________

Authorization and Releases

Authorization and Releases

Patient Health Information and Privacy Policy

This policy outline the way Patient Health Information (PHI) will be used in this office and the patient's right concerning those records. You must read and consent to this policy before receiving services. A complete copy of the Health Information Portability and Accountability Act (HIPAA) is available here: http://www.cms.hhs.gov/SecurityStandard/Downloads/securityproposedrule.pdf

1. The patient understands and agrees to allow this office to use their PHI for the purpose of treatment, payment, health care operations and coordination of care. The patient agrees to allow this office to submit requested PHI to the payor(s) named by the patient for the purpose of payment. This office will limit the release of all PHI to the minimum necessary to receive payment.
2. The patient has the right to examine and obtain a copy of their health records at ant rime and request corrections. The patient may request to know what disclosures have been made, and submit in writing ant further restrictions on the use of their PHI. This office is not obligated to agree to those restrictions.
3. The patient's written consent shall remain in effect for as long as the patient receives care at this office, regardless of the passage of time, unless the patient provides written notice to revoke their consent. A revocation of consent will not apply to any prior care or services.
4. This office is committed to protecting your PHI and meeting its HIPAA obligations: Staff have been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures.
5. Patients have the right to file a formal complaint with our privacy official about any suspected violations.
6. This office has the right to refuse treatment if the patient does not accept the terms of this policy.

Initial _________

Consent to Professional Treatment The patient certifies that all information provided to this office is true and correct, to the best of their knowledge. The patient grants their consent to this office and its staff to render treatment as deemed necessary by the attending physician. If the patient is a minor child, under the age of eighteen (18) at the date of treatment, I hereby stipulate that I am the legal guardian of the child, and grant my consent for the treatment of the child as provided for herein. The patient may refuse treatment at any time.

Initial _________

Assignment of Benefit and Release of Records

The patient hereby assigns benefits to be paid directly to this provider by all of their third party payors. This assignment is irrevocable. Failure to fulfill this obligation will be considered a breach of contract between the patient and this offices.

The patient authorizes this office to release any information required by a third party payor necessary for reimbursement of charges incurred.

Initial _________

Signature: ______________________________ Date: __________