

**WELCOME**  
**THANK YOU FOR CHOOSING US AS YOUR HEALTH PROVIDERS**

PLEASE PROVIDE ALL INFORMATION TO THE BEST OF YOUR ABILITY SO THAT WE MAY BETTER SERVE YOU  
*ALL INFORMATION IS STRICTLY PROTECTED*

Patient Name \_\_\_\_\_  
Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
Address \_\_\_\_\_  
City/ State/ Zip \_\_\_\_\_  
SS# \_\_\_\_\_  
Gender { M } { F }    Marital Status    S    M    D    W  
Cell \_\_\_\_\_  
Home Phone \_\_\_\_\_  
Email \_\_\_\_\_@\_\_\_\_\_  
Occupation \_\_\_\_\_  
Spouse \_\_\_\_\_  
Send Statement to:  Patient or \_\_\_\_\_  
Address \_\_\_\_\_  
City/State/Zip \_\_\_\_\_

Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**INSURANCE:**

Policy Holder's Name \_\_\_\_\_  
Address \_\_\_\_\_  
City/State/Zip \_\_\_\_\_  
SS# \_\_\_\_\_  
Gender: { M } { F }    DOB \_\_\_\_/\_\_\_\_/\_\_\_\_  
Insurance Company: \_\_\_\_\_  
Group Name \_\_\_\_\_ Group # \_\_\_\_\_

**CASE**

Were you in an Auto Accident?    YES    NO    Date: \_\_\_\_\_  
If Yes, Do you have an attorney? Name: \_\_\_\_\_  
Were you injured at work?    YES    NO    Date: \_\_\_\_\_  
Did one of our patients refer you to us?    YES    NO  
If Yes, who?  
\_\_\_\_\_

**CONDITION AND HISTORY**

What complaint or condition(s) brings you to our office?  
\_\_\_\_\_  
\_\_\_\_\_  
How long have you had condition(s)?  
\_\_\_\_\_  
Have you seen anyone else for this condition?  
If Yes, whom?  
M.D.    CHIROPRACTOR    MASSAGE    ACUPUNCTURE  
Primary Care Physician: \_\_\_\_\_

**Patient or Guardian Please Initial Below:**

\_\_\_\_ YES I will pay my portion (co-pay) at the time of service.  
\_\_\_\_ YES This office has permission to copy my driver's license or photo ID for the purposes of verification and identification only  
\_\_\_\_ YES I have read and understand the "advised consent" Form

**AUTHORIZATION AND ASSIGNMENT OF BENEFITS**

I authorize Dr. Pearsall, Dr Brandon Nevel, and their staff to perform services needed for diagnosis and treatment of my condition  
I authorize the release of personal information, properly protected, to process and pay any claims relating to my care.  
I authorize payment directly to:  
**Dr. Don S. Pearsall, Dr. Brandon Nevel**, of health benefits, Medical and/or Government benefits otherwise payable to me relative to services rendered. I understand this office only accepts benefit assignment when Insurance Company pays directly to us.

→ \_\_\_\_\_  
**PATIENT/GUARDIAN SIGNATURE**

**Doctor's Notes:**

How would you describe your symptom(s)?  
 Sharp  Sore  Throbbing  Tingling  Dull  Stiff  Spasm  Ache  Numbness  
 Weakness  Burning

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Please Rate the intensity of your pain (Circle one number)

0 1 2 3 4 5 6 7 8 9 10  
(No pain) (Moderate pain) (Severe pain)

How often is the pain present?  
 Constant (81-100%)  Frequent (51-80%)  Occasional (26-50%)  Intermittent (25% or less)

Is your pain getting.....  worse  better  Staying the same  Comes and Goes

What makes your pain better?

Nothing  Walking  Rest  Moving/exercise  Medication \_\_\_\_\_

What makes your pain worse?

Nothing  Walking  Sitting  Moving/exercise  Lying/rest

Are you taking any medication? Please list \_\_\_\_\_

Do you exercise? What? \_\_\_\_\_ How Often? \_\_\_\_\_

Is your condition affecting your ability to perform routine daily activities?

No effect  Some restriction  Cannot work  Not sleeping well  Need help with daily activities

**History:**

Have you ever had lung, heart, bowel or bladder problems? If yes please describe.

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Ever been in the Hospital? If yes describe.

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Are you pregnant?  Yes  No  Maybe last menstrual cycle? \_\_\_\_\_

Do you smoke cigarettes? If yes, how long and how many per day? \_\_\_\_\_

Is there any other information you feel is important for us to know regarding your treatment?

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Doctor's Notes:

# INFORMED CONSENT FOR CHIROPRACTIC TREATMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustment and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or the patient named below, for whom I am legally responsible) by the doctor or chiropractor named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with, or serving as back-up for the doctor or chiropractor named below, including those working at the clinic or office listed below, or any office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to, fractures, disc injuries, vertebral artery dissection, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interest.

I have read or have had read to me, the above consent. I have also had the opportunity to ask questions about its content, and by signing below, I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and any other condition(s) for which I seek treatment.

### To be completed by the patient:

Patient's Name: \_\_\_\_\_ Signature of Patient: \_\_\_\_\_  
Date Signed: \_\_\_\_/\_\_\_\_/\_\_\_\_ Witness' Signature: \_\_\_\_\_

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### To be completed by patient's representative if patient is a minor or physically or legally incapacitated:

Patient's name: \_\_\_\_\_ Signature of Patient: \_\_\_\_\_  
Date Signed: \_\_\_\_/\_\_\_\_/\_\_\_\_ Signature of Representative: \_\_\_\_\_  
Relationship or Authority of patient's representative: \_\_\_\_\_  
Translated By: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

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Don Pearsall, D.C. / Brandon Nevel, D.C. /

**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 chart and maintained for six years.

\_\_\_\_\_  
Patient Name (please print)

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_  
Parent, Guardian or Patient's legal representative

\_\_\_\_\_  
Signature

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

**Don Pearsall, D.C.**  
**Brandon Nevel, D.C.**

275 Toney Penna Drive, Ste. 12  
Jupiter, FL 33458

Phone (561)746-4242  
Fax (561)746-7405

**FINANCIAL POLICY:**

*All professional fees are due at the time of service unless previous arrangements are made.*

- Services are rendered to the patient, not the insurance company.
- You are required to pay your co-payments at the time of your visit.
- For unpaid claims over 45 days, it is your responsibility to follow up with your insurance carrier and the balance due is considered due and payable.
- Account balances over 60 days from date of service will be charged a monthly late fee and interest on a monthly basis at a rate of 18% annually or the maximum annual interest rate permitted, which ever is lower.
- If the account becomes delinquent, the patient is responsible for all collection costs and/or attorneys fees.
- Confidentiality is waived if Dr. Pearsall reports unpaid services to various agencies/companies including credit reporting agencies
- It is your responsibility to notify our front desk staff of any insurance or address changes.
- You will be responsible for any charges that occur if we are not notified.

I, \_\_\_\_\_ have read and understand the above listed information.  
(Print Name)

\_\_\_\_\_  
Signature

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Today's Date