

## Dodd Chiropractic Clinic

2025 Park Street, Jacksonville, FL 32204 • (904) 388-1811 • Fax (904) 387-6091

APRIL A. DODD, D.C.

RILEY S. DODD, D.C.

DANIEL A. DODD, D.C.

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Social Security # \_\_\_\_\_ Birth Date: \_\_\_\_\_ Sex: M / F

Cell # (\_\_\_\_) \_\_\_\_\_ Work # (\_\_\_\_) \_\_\_\_\_

Email: \_\_\_\_\_

Have you ever had Chiropractic Care before? Y / N If yes, When: \_\_\_\_\_ Where: \_\_\_\_\_

What is your major complaint/cause of injury? \_\_\_\_\_

### APPOINTMENT POLICY:

We schedule multiple appointments at one time. This is for your convenience to minimize waiting and incorporating these appointments into your weekly routine. If you are unable to keep an appointment for any reason, we ask that you call immediately to reschedule your visit. **It is the doctor's recommendation that you make up a missed appointment within 7 days of any cancellation.** No shows and cancellations inconvenience our patients and staff. Consideration is expected and appreciated. You will receive text messages and emails for reminder purposes.

### FINANCIAL POLICY

1. This office reserves the right to charge **\$100** for new patient appointments and **\$25** for established patient appointments not cancelled 24 hours prior to the appointment time.
2. All payments are expected at the time of service. All co-pays are due at sign-in time. Please sign in by full legal name.
3. All insurance assignment patients must pay their deductible and/or the co-insurance at the time of service.
4. I understand that certain treatment recommendations may not be covered by my insurance plan, and that there will be an **additional charge** for those services when provided. I also understand that a list of these charges will be provided to me upon request.
5. I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment of all services.
6. I understand that there may be an additional charge of **\$25.00** for the completion of any FMLA, Short-term disability, or other medical reports I request.

I will be paying today by: CASH ( ) CHECK ( ) MASTER CARD ( ) VISA ( ) DISCOVER ( )

Patient OR Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Dodd Chiropractic Clinic

## REVIEW OF SYSTEMS

Patient Name: \_\_\_\_\_

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

Do you have any of the following? (**Please circle Y/N for each number.** If you answer yes, please explain.)

### I. Integumentary (skin) conditions

1. Rash or Itching Y / N ? \_\_\_\_\_
2. Change in skin color Y / N ? \_\_\_\_\_
3. Breast Lump Y / N ? \_\_\_\_\_
4. Varicose Veins Y / N ? \_\_\_\_\_
5. Breast Discharge Y / N ? \_\_\_\_\_
6. Change in hair or nails Y / N ? \_\_\_\_\_

### II. Neurologic

1. Headaches/Migraine Y / N ? \_\_\_\_\_
2. Seizures Y / N ? \_\_\_\_\_
3. Tremors Y / N ? \_\_\_\_\_
4. Numbness or Tingling Y / N ? \_\_\_\_\_
5. Fainting Y / N ? \_\_\_\_\_
6. Paralysis Y / N ? \_\_\_\_\_
7. Stroke Y / N ? \_\_\_\_\_

### III. Eyes

1. Loss of Vision Y / N ? \_\_\_\_\_
2. Double Vision Y / N ? \_\_\_\_\_
3. Light Sensitive Y / N ? \_\_\_\_\_
4. Eye Pain Y / N ? \_\_\_\_\_
5. Eye infections Y / N ? \_\_\_\_\_
6. Eye Diseases Y / N ? \_\_\_\_\_

### IV. Ears, Nose, Mouth, Throat

1. Allergies Y / N ? \_\_\_\_\_
2. Hay Fever Y / N ? \_\_\_\_\_
3. Sinus Congestion Y / N ? \_\_\_\_\_
4. Runny Nose Y / N ? \_\_\_\_\_
5. Nose Bleeds Y / N ? \_\_\_\_\_
6. Ear Aches/Infection Y / N ? \_\_\_\_\_
7. Ringing in ears Y / N ? \_\_\_\_\_
8. Bleeding Gums Y / N ? \_\_\_\_\_
9. Mouth Sores Y / N ? \_\_\_\_\_
10. Difficulty Swallowing Y / N ? \_\_\_\_\_

### V. Respiratory

1. Asthma Y / N ? \_\_\_\_\_
2. Chronic Bronchitis Y / N ? \_\_\_\_\_
3. Emphysema Y / N ? \_\_\_\_\_
4. Frequent Coughing Y / N ? \_\_\_\_\_

### VI. Vascular

1. High Blood Pressure Y / N ? \_\_\_\_\_
2. Vascular Disease Y / N ? \_\_\_\_\_
3. Chest Pains Y / N ? \_\_\_\_\_
4. Irregular Heart Beat Y / N ? \_\_\_\_\_
5. History of Heart Murmur Y / N ? \_\_\_\_\_
6. Swelling of Feet / Ankles Y / N ? \_\_\_\_\_

### VII. Gastrointestinal

1. Diarrhea Y / N ? \_\_\_\_\_
2. Constipation Y / N ? \_\_\_\_\_
3. Bloody Stool Y / N ? \_\_\_\_\_
4. Stomach Pain Y / N ? \_\_\_\_\_
5. Hepatitis Y / N ? \_\_\_\_\_
6. Ulcer Y / N ? \_\_\_\_\_
7. Loss of Appetite Y / N ? \_\_\_\_\_

### VIII. Genitourinary

1. Kidney Stones Y / N ? \_\_\_\_\_
2. Kidney/Bladder Infection Y / N ? \_\_\_\_\_
3. Frequent Urination Y / N ? \_\_\_\_\_
4. Blood in Urine Y / N ? \_\_\_\_\_
5. Loss of Bladder Control Y / N ? \_\_\_\_\_
6. Female - Pain with periods Y / N ? \_\_\_\_\_
7. Female - # of pregnancies Y / N ? \_\_\_\_\_
8. Female - # of miscarriages Y / N ? \_\_\_\_\_
9. Male - Testicular Pain Y / N ? \_\_\_\_\_

### IX. Musculoskeletal

1. Rheumatoid Arthritis Y / N ? \_\_\_\_\_
2. Joint Pain or Weakness Y / N ? \_\_\_\_\_
3. Muscle Pain or Weakness Y / N ? \_\_\_\_\_
4. Leg Pain Y / N ? \_\_\_\_\_
5. Cold or Burning Extremity Y / N ? \_\_\_\_\_
6. Joint Stiffness or Swelling Y / N ? \_\_\_\_\_

### X. Lymphatic/Hematological

1. Anemia Y / N ? \_\_\_\_\_
2. Bleeding Problems Y / N ? \_\_\_\_\_
3. Easily Bruise Y / N ? \_\_\_\_\_
4. Past Blood Transfusion Y / N ? \_\_\_\_\_
5. Slow to heal after cuts Y / N ? \_\_\_\_\_

### XI. Endocrine

1. Diabetes Y / N ? \_\_\_\_\_
2. Thyroid/other Y / N ? \_\_\_\_\_
3. Hypoglycemic Y / N ? \_\_\_\_\_
4. Excessive Thirst / Urination Y / N ? \_\_\_\_\_

### XII. Psychiatric

1. Anxiety/ depression Y / N ? \_\_\_\_\_
2. Sleep Disorders Y / N ? \_\_\_\_\_
3. Memory Loss Y / N ? \_\_\_\_\_

### XIII. Constitutional

1. Fever Y / N ? \_\_\_\_\_
2. Recent weight change Y / N ? \_\_\_\_\_
3. Fatigue Y / N ? \_\_\_\_\_

**Dodd Chiropractic Clinic**

**Jacksonville, FL 32204  
(904) 388-1811 FAX (904) 387-6091**

**REQUEST FOR MEDICAL RECORDS**

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

Patient's Name: \_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

I hereby request that all medical records and reports, including all x-rays, be released to:

**Dodd Chiropractic Clinic  
2025 Park Street  
Jacksonville, Florida 32204  
(904) 388-1811**

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

Riley Dodd D.C.

## Dodd Chiropractic Clinic

### CONSENT TO X-RAY – FEMALE ONLY

*Patient Name:* \_\_\_\_\_

*Date:* \_\_\_\_\_

I understand that if I am pregnant and have x-rays taken which expose my lower torso to radiation, it is possible to injure the fetus.

I have been advised that the 10 days following onset of menstrual period are generally considered to be safe for x-ray exams.

With those factors in mind, I am advising my doctor that:

	Yes	No	Don't Know
I am pregnant			
I could be pregnant			
I am late with my menstrual period			
I am taking oral contraceptives			
I have an IUD			
I have had a tubal ligation			
I have had a hysterectomy			
I have irregular menstrual periods			

My last menstrual period began on: \_\_\_\_\_

With fuller understanding of the above, and believing that I am not currently at risk, I consent to have an x-ray performed if clinically indicated.

Patient Signature: \_\_\_\_\_

Guardian Signature: \_\_\_\_\_  
(If practical)

## Dodd Chiropractic Clinic

DODD CHIROPRACTIC CLINIC  
2025 PARK STREET  
JACKSONVILLE, FL 32204

### 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.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

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

See next pages for Privacy Practices

# Dodd Chiropractic Clinic

## NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to that information.

### PLEASE REVIEW THIS NOTICE CAREFULLY

Dodd Chiropractic Clinic, known as the "practice" from this point forward, is committed to maintaining the privacy of your protected health information (PHI), which includes the information about your health condition and the care and treatment you receive from this practice. The creation of a record detailing the care and services you receive helps this office to provide you with quality health care. This notice details how your PHI may be used and disclosed to third parties. This notice also details your rights regarding your PHI. The privacy of PHI in patient files will be protected when the files are taken to and from the practice by placing the files in a box or briefcase, and kept within the custody of a doctor or employee of the practice authorized to remove the files from the practice's office. It may be necessary to take patient files to a facility where a patient is confined or to a patient's home where the patient is to be examined or treated.

### NO CONSENT REQUIRED

The practice may use or disclose your PHI for the purposes of:

- **Treatment** – In order to provide you with the health care you require, the practice will provide your PHI to those health care professionals, whether on the practice's staff or not, directly involved in your care so that they may understand your health condition and needs. For example, a physician treating you for a condition or disease may need to know the results of your latest physician examination by this office.
- **Payment** – In order to get paid for services provided to you, the practice will provide your PHI directly or through a billing service, to appropriate third party payors, pursuant to their billing and payment requirements. For example, the practice may need to provide the Medicare program with information about health care services that you received from the practice so that the practice can be properly reimbursed. The practice may also need to tell your insurance plan about treatment you are going to receive so that it can determine whether or not it will cover the treatment expense.
- **Health Care Operations** – In order for the practice to operate in accordance with applicable law and insurance requirements and in order for the practice to continue to provide quality and efficient care, it may be necessary for the practice to compile, use and/or disclose your PHI. For example, the practice may use your PHI in order to evaluate the performance of the practice's personnel in providing care to you.

The practice may use or disclose your PHI, without written consent from you, in the following additional instances:

- **De-identified information** – Information that does not identify you and, even without your name, cannot be used to identify you
- **Business Associate** – To a business associate if the practice obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI. A business associate is an entity that assists the practice in undertaking some essential function, such as a billing company that assists in the office in submitting claims for payment to insurance companies or other payer's.
- **Personal Representative** – To a person who, under applicable law, has the authority to represent you in making decisions related to your health care.
- **Emergency Situations** –
  1. for the purpose of obtaining or rendering emergency treatment to you provided that the practice attempts to obtain your consent as soon as possible; or
  2. to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating your care with such entities in an emergency situation.
- **Communication Barriers** – If, due to substantial communication barriers or inability to communicate, the practice has been unable to obtain your consent and the practice determines, in the exercise of its professional judgment, that your consent to receive treatment is clearly inferred for the circumstances.
- **Public Health Activities** – Such activities include, for example, information collected by a public health authority, as authorized by law, to prevent or control disease and that does not identify you and, even without your name, cannot be used to identify you.
- **Abuse, Neglect, or Domestic Violence** – To a government authority if the practice is required by law to make such disclosure; if the practice is authorized by law to make such a disclosure, it will do so if it believes that the disclosure is necessary to prevent serious harm.
- **Health Oversight Activities** – Such activities, which must be required by law, involve government agencies and may include, for example, criminal investigations, disciplinary actions, or general oversight activities relating to the community's health care system.
- **Judicial and Administrative Proceeding** – For example, the practice may be required to disclose your PHI in response to a court order or a lawfully issued subpoena.
- **Law Enforcement Purposes** – In certain instances, your PHI may have to be disclosed to a law enforcement official. For example, your PHI may be the subject of a grand jury subpoena. Or the practice may disclose your PHI if the practice believes that your death was the result of criminal misconduct.
- **Coroner or Medical Examiner** – The practice may disclose your PHI to a coroner or medical examiner for the purpose of identifying you or determining your cause of death.
- **Organ, Eye, or Tissue Donation** – If you are an organ donor, the practice may disclose your PHI to the entity to whom you have agreed to donate your organs.
- **Research** – If the practice is involved in research activities, your PHI may be used, but such use is subject to numerous governmental requirements intended to protect the privacy of your PHI and that does not identify you and even without your name, cannot be used to identify you.
- **Avert a Threat or Health Safety** – The practice may disclose your PHI if it believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public, and the disclosure is to an individual who is reasonably able to prevent or lessen the threat.
- **Worker's Compensation** – If you are involved in a Worker's Compensation claim, the practice may be required to disclose your PHI to an individual or entity that is part of the Worker's Compensation system.

# Dodd Chiropractic Clinic

## APPOINTMENT REMINDER

The practice may, from time to time, contact you to provide appointment reminders or information about treatment alternatives or health-related benefits and services that may be of interest to you. The following appointment reminders are used by the practice:

1. a postcard mailed to you at the address you provided to us
2. a telephone call to your home and leaving a message on an answering service or with an individual who answers the phone
3. a telephone call to your place of employment and leaving a message on an answering service or with an individual who answers the phone
4. an email to the email address provided by you.

## SIGN IN LOG

The practice maintains a sign in log for individuals seeking care and treatment in the office. The sign in log is located in a position where staff can readily see who is seeking care in the office, as well as the individual's located within the practice's office suite. This information may be seen by and is accessible to others who are seeking care or services in the practice's office.

## FAMILY/FRIENDS

The practice may disclose to your family member, other relative, a close personal friend, or any other person identified by you, your PHI directly relevant to such person's involvement with your care or the payment for your care. The practice may also use or disclose your PHI to notify or assist in the notification (including identifying or locating) a family member, a personal representative, or another person responsible for your care, of your location, general condition or death. However, in both cases, the following conditions apply:

1. If you are present at or prior to the use or disclosure of your PHI, the practice may use or disclose your PHI if you agree, or if the practice can reasonably infer from the circumstances, based on the exercise of its professional judgment, that you do not object to the use or disclosure.
2. If you are not present, the practice will, in the exercise of professional judgment, determine whether the use or disclosure is in your best interests and, if so, disclose only the PHI that is directly relevant to the person's involvement with your care.

## AUTHORIZATION

Use and/or disclosures, other than those described above, will be made only with your written authorization.

## YOUR RIGHTS

You have the right to:

1. Revoke and Authorization and or consent, in writing, at any time and to request a revocation, you must submit a written request to the practice's Compliance Officer.
2. Request restrictions on certain use and/or disclosure of your PHI as provided by law, however, the practice is not obligated to agree to any requested restrictions. To request restrictions, you must submit a written request to the practice's Compliance Officer. In your written request, you must inform the practice of what information you want to limit, whether you want to limit the practice's use or disclosure, or both, and to whom you want the limits to apply. If you practice agrees to your request, the practice will comply with your request unless the information is needed in order to provide you with emergency treatment.
3. Receive confidential communications or PHI by alternative means or at alternative locations; you must make your request in writing to the practice's Compliance Officer. The practice will accommodate all reasonable requests.
4. Inspect and obtain a copy your PHI as provided by law. To inspect and copy your PHI, you are requested to submit a written request to the practice's Compliance Officer. The practice can charge you a fee for the cost of copying, mailing or other supplies associated with your request.
5. Amend your PHI as provided by law. To request an amendment, you must submit a written request to the practice's Compliance Officer. You must provide a reason that supports your request. The practice may deny your request if it is not in writing, if you do not provide a reason in support of your request, if the information to be amended was not created by the practice (unless the individual or entity that created the information is no longer available), if the information is not part of your PHI maintained by the practice, if the information is not part of the information you would be permitted to inspect and copy, and/or if the information is accurate and complete. If you disagree with the practice's denial, you will have the right to submit a written statement of disagreement.
6. Receive an accounting of disclosures of your PHI as provided by law. The request should indicate in what form you want the list (such as a paper or electronic copy)
7. Receive a paper copy of this Privacy Notice from the practice upon request to the practice's Compliance Officer.
8. Complain to the practice or to the Office of Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20201, 202/619-0257, email: [ocrmail@hhs.gov](mailto:ocrmail@hhs.gov) or to the Florida Attorney General, Office of the Attorney General, PL-01 The Capitol, Tallahassee, FL 32399-1050, 850/414-3300, if you believe your privacy rights have been violated. To file a complaint with the practice, you must contact the practice's Compliance Officer. All complaints must be in writing.
9. To obtain more information on, or have your questions about your rights answered; you may contact the practice's Compliance Officer, April Dodd, D.C at (904)388-1811.

# Dodd Chiropractic Clinic

## PRACTICE'S REQUIREMENTS

The Practice:

1. Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the practice's legal duties and privacy practices with respect to your PHI.
2. Is required by State law to maintain a higher level of confidentiality with respect to certain portions of your medical information that is provided for under federal law. In particular, the practice is required to comply with the following State statutes:  
  
Section 381.004 relating to HIV testing, Chapter 384 relating to sexually transmitted diseases and Section 456.057 relating to patient records ownership, control and disclosure.
3. Is required to abide by the terms of this Privacy Notice.
4. Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your PHI that it maintains.
5. Will distribute any revised Privacy Notice to you prior to implementation.
6. Will not retaliate against you for filing a complaint.

## QUESTIONS AND COMPLAINTS

You may obtain additional information about our privacy practices or express concerns or complaints to the person identified below who is the Compliance Officer and Contact person appointed for this practice. The Compliance Officer is April Dodd, D.C.

You may file a complaint with the Compliance Officer if you believe that your privacy rights have been violated relating to release of your protected health information. You may, also, submit a complaint to the Department of Health and Human Services the address of which will be provided to you by the Compliance Officer. We will not retaliate against you in any way if you file a complaint.

## EFFECTIVE DATE

This Notice is in effect as \_\_\_\_\_



## Dodd Chiropractic Clinic

### NON-COVERED SERVICES, PRODUCT AND SUPPLIES

Your health insurance plan requires you to be responsible for co-payments, co-insurance and deductibles for covered services. You are also financially responsible for all non-covered services, products and supplies (e.g., vitamins, durable medical equipment, laser therapy, maintenance care, services that exceed your insurance coverage limits).

The services, products and supplies listed below are not covered according to your health insurance plan. **We will not charge these items or services to you without your permission. Your acknowledgement below indicates that you have been advised of this information and that you agree to pay this office for the below listed products, services or supplies.**

**Services:** \_\_\_\_\_ Wellness Care                      4 visits per month                      Package: \$160.00 / 4 visits  
Adjustment Only/ No Therapies  
(Must have approval from Dr. for wellness care)  
(Must be used within 30 days of purchase)

**Services:** \_\_\_\_\_ Non-Insurance (Cash) Visit                      Amount: \$60.00 / single                      Package 1: \$300.00/6 visits  
Package 2: \$540.00/12 visits  
\*PACKAGES MUST BE USED  
WITHIN 12 MONTHS FROM  
DATE OF PURCHASE

**Services:** \_\_\_\_\_ Massage Therapy                      Amount: \$60 / 30 mins                      Package: \$300.00 / 6 visits

**Services:** \_\_\_\_\_ Laser Therapy                      Amount: \$20.00 / single                      Package: \$100.00 / 6 visits

**Services:** \_\_\_\_\_ Decompression Therapy                      Amount: \$60.00 / single                      Package: \$300.00 / 6 visits

**Services:** \_\_\_\_\_ Rehab/EMS or Intersegmental Therapy                      Amount: \$20.00 / single                      Package: \$ N/A

**Services:** \_\_\_\_\_ Non-Covered X-Rays                      Amount: Depends on Amount                      Package: \$ N/A  
of Views: 50\$ or 75\$

**Products:**                      Orthotics                      Amount: \$318.00 Foot levelers / \$60.00 Powersteps

#### **Patient Acknowledgement:**

I <FIRST NAME> <LAST NAME> acknowledge that I have been told in advance by this office

that the services, products and supplies listed above are not covered by my health insurance plan and I agree

to pay for these non-covered services, products and supplies at the time the service, supply or product is provided.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Dodd Chiropractic Clinic**  
**DODD CHIROPRACTIC CLINIC**  
**2025 PARK STREET**  
**JACKSONVILLE, FL 32204**

**INFORMED CONSENT FOR CHIROPRACTIC TREATMENTS AND CARE**

I voluntarily consent to treatment which may include, medical evaluation, emergency services, diagnostic procedures, massage therapy, spinal manipulation, and other chiropractic procedures including various modes of physical therapy by the physicians named below, his/her assistants, or his/her designees, and/or other licensed doctors who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctors named below as is necessary in his/her judgment. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of services, procedures, treatments or examinations at Dodd Chiropractic Clinic.

I understand that I will have the 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 that are recommended to me upon evaluation. 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, disk injuries, strokes, dislocations and sprains. I do not expect the doctor 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 interests.

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 for any future condition(s) for which I seek treatment.

**TO BE COMPLETED BY THE PATIENT or GUARDIAN**

Patient Name: \_\_\_\_\_

Signature of Patient or Guardian: \_\_\_\_\_

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

Name of physician(s) employed at the time of consent:  
April A. Dodd, DC, Daniel A. Dodd, DC, Riley S. Dodd, DC