COVID-19 PRECAUTIONARY QUESTIONS TO BE ANSWERED, BELOW, SO THAT WE MAY KEEP YOU, ALL OTHER PATIENTS, STAFF AND DOCTORS SAFE.

THANK YOU!

- **HAVE YOU RECENTLY TRAVELED TO ANOTHER STATE? DEPENDING ON WHERE YOU HAVE GONE, YOU WILL NEED TO POSSIBLY QUARANTINE FOR 14 DAYS.**

- **HAVE YOU BEEN AROUND ANYONE THAT HAS TESTED POSITIVE FOR COVID-19? IF SO, WHEN?**

- **DO HAVE A FEVER OF ANY FLU LIKE SYMPTOMS; COUGH, SORE THROAT, SHORTNESS OF BREATH?**

- **HAVE YOU TESTED POSITIVE FOR COVID-19? IF SO, YOU NEED TO PROVIDE US WITH VERIFICATION OF YOUR NEGATIVE TEST RESULTS.**

IF YOU HAVE ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, THIS WILL BE DISCUSSED WITH A MEDICAL ADVISOR TO SEE IF YOU MIGHT NEED TO POSTPONE YOUR APPOINTMENT.
PLEASE PRINT YOUR NAME, SIGN AND DATE BELOW.

PRINT: _____

SIGNATURE AND DATE: _____

Russ Tannenbaum, D.C., PA

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PATIENT INTAKE FORM

PLEASE PRINT CLEARLY AND FILL IN COMPLETELY

Date _____

Name _____

Street Address _____ Date Of Birth _____

City _____ State _____ Zip _____ Age _____

Home Phone _____ Work Phone _____

Mobile Phone _____ Email Address _____

Personal & Family History:

Please check: ☐Male ☐Female

☐ Never Married ☐ Divorced ☐ Separated
☐ Married ☐ Widowed ☐ Other

Spouses name _____

Do you have children? Yes / No If yes, how many? _____

Race/Ethnicity/Religion/Language:

☐ American Indian or Alaskan Native ☐ Native Hawaiin or other Pacific Islander ☐ Asian
☐ Black or African American ☐ White ☐ Other

Religion _____ Preferred Language _____ 2nd Language _____

Work/Student Status:

☐Employee ☐Student ☐Other _____

Employer _____ How long? _____

Address _____

Occupation _____

Insurance/PCP/Payment Status:

Insurance Company _____ Phone _____

ID # _____ Plan # _____ Group # _____

Primary Care Physician _____

PCP Phone _____ PCP after hours phone _____

I intend to pay: ☐ Insurance ☐ Cash ☐ Payment Plan ☐ Other _____

Consent to Treat:

I understand and agree that (regardless of my insurance) I am ultimately responsible for the balance on my account for any professional services rendered. I understand that in the event that my account goes into collections, I will be responsible for the balance and will be provided payment options. I am authorizing copies of my medical records to be sent to my insurance company upon request to expedite payment. I have read all the above, completed all information, certifying that all information is true and correct to the best o my knowledge. I will notify you of any changes in my insurance or change of address.

Patient Signature _____

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WHAT BRINGS YOU TO OUR OFFICE

Primary Complaint: ☐Work ☐Sports ☐Auto ☐Trauma ☐Chronic

Please explain: _____

Describe pain in detail: _____

When did the condition begin: _____

Is this condition getting worse? ☐Yes ☐No ☐Constant ☐Intermittent

If yes, please explain: _____

Type of Pain: ☐ Sharp ☐ Dull ☐ Ache ☐ Burn ☐ Throb

Does the Pain radiate anywhere? ☐Yes ☐No If yes, ☐ Arm ☐ Leg ☐ Head

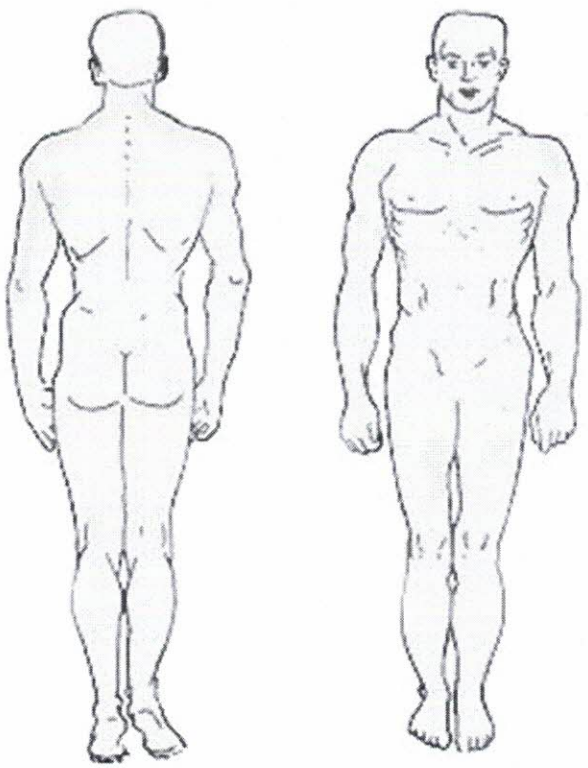
Do you experience numbness or tingling? ☐Yes ☐No

Have you had this or similar conditions in the past? ☐Yes ☐No

If yes, please explain: _____

Have you been treated by a Medical Physician for this condition? ☐Yes ☐No

If yes, where? _____



PAIN LOCATION

Please use the following symbols on the pain diagram to accurately describe your condition.

PPP Where you experience Pain
NNN Where you experience Numbness
TTT Where you experience Tingling
BBB Where you experience Burning

Chiropractic History

Have you ever been to a Chiropractor before? ☐Yes ☐No

Doctor's Name_____
Date of last chiropractic visit_____
Reason for care_____
Date of last chiropractic x-rays_____
How long were you under care? _____
Are other family members under chiropractic care?
☐Yes ☐No Who? _____

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Health History:

List any Allergies: _____

List medications you are currently taking and dosages:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

List any past surgeries & dates: _____

List any past accidents & dates: _____

List any x-rays you've had in the past 2 years: _____

Family medical history: _____

Do you have or have you ever had any of the following conditions or diseases?

☐Unexplained weight loss
☐Cancer Type:_____
☐Chemotherapy
☐Double Vision
☐Glaucoma
☐Pain looking at bright lights
☐Ringing in ears
☐Decreased hearing
☐Vertigo ☐Loss of balance
☐Dizziness
☐Sinus Problems
☐Loss of smell
☐Difficulty swallowing
☐Lumps in Neck
☐Neck Pain ☐Stiffness
☐Chest pain ☐Tightness
☐Heart attack
☐Heart murmur
☐Mitral valve prolapse
☐Heart surgery ☐Pacemaker
☐Congenital heart defect
☐Edema
☐Light headed episodes
☐High ☐ Low blood pressure
☐Cough
☐Dyspnea/difficult breathing
☐Flu like symptoms
☐SOB walking 2 blocks
☐Asthma
☐Chest congestion
☐Nausea ☐Vomiting
☐Abdominal pain
☐Excess Gas ☐Heartburn

☐Constipation
☐Inguinal pain
☐Ulcers ☐Colitis
☐Breast Problems
☐Gynecological problems
☐Mood Swings (PMS)
☐Heavy Periods
☐Painful periods
☐Frequent periods
☐Breast tenderness
☐Acne
☐Bone loss
☐Thinning skin
☐Hair loss
☐Memory lapses
☐Neck pain
☐TMJ
☐Shoulder Problems
☐Elbow pain
☐Leg problems
☐Knee problems
☐Foot problems
☐Disc problems
☐Scoliosis
☐Artificial bones/joints
☐Arthritis
☐Urinary problems
☐Flank pain
☐Prostate problems
☐Headaches ☐Migraine
☐Fainting ☐Seizures
☐Tremors ☐Paralysis
☐Numbness ☐Stroke

☐Tingling ☐Falls
☐Unsteady Gait
☐Clumsiness of hands
☐Peripheral neuropathy
☐Epilepsy
☐Psychiatric problems
☐Depression ☐Anxiety
☐Poor concentration
☐Poor memory
☐Fatigue
☐Insomnia
☐Increased thirst
☐Weight change
☐Hot flashes ☐Night Sweats
☐Diabetes
☐Hyper ☐Hypo Thyroid
☐Easy bruising
☐Prolonged bleeding
☐Swelling of legs
☐Blood clots
☐Anemia
☐Enlarged ☐Painful Glands
☐Environmental allergies
☐Eczema
☐HIV+/AIDS
☐Hepatitis
☐Tuberculosis
☐Shingles
☐Kidney problems
☐Alcohol/drug abuse
☐Ear, nose, throat problems
☐Alcohol/drug abuse
☐Other(s) _____

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Do you take Supplements or Vitamins? ☐Yes ☐No
Do you Exercise? ☐Yes ☐No
Do you Smoke? ☐Yes ☐No How much? _____ How long? _____

For Women Only

Are you taking Birth Control? ☐Yes ☐No
Are you Pregnant? ☐Yes ☐No If yes, how long? _____

Do you suffer from PMS, Peri-menopausal, or Menopausal Symptoms? ☐Yes ☐No

Emergency Contact

Name: _____ Relationship _____

Contact number _____ Mobile/Alternate number_____

Wellness Interests

Are you interested in a Comprehensive Analysis which includes:

Emotional Stressors
Circulatory Disturbances
Digestive Maladies
Nutritional Assessment
Immune Disorders
Food Sensitivity Analysis
Dental Disturbances
Environmental Sensitivity Profile
Metabolic Disturbances
Sleep Disturbances
Bacteria, Fungi
Cell Salts
Parasites, Protozoa
Chemical Toxins, Heavy Metals

Please Fill In Any Other Health Information You Feel We Might Need For Your Care.

_____

_____

Thank you for being complete and thorough

_____ Date: _____
Patients Signature

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PATIENT CONSENT FORM

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such NOTICE OF PRIVACY PRACTICES prior to signing this consent. I understand that this organization has the right to change its NOTICE OF PRIVACY PRACTICES from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the NOTICE OF PRIVACY PRACTICES.

I understand that I may request in writing that you restrict how my private information is used or disclosed to cay out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

PROTECTED HEALTH INFORMATION MAY BE LEFT ON MY ANSWERING MACHINE OR WITH A SPOUSE OR OTHER PERSONS RESIDING WITH ME. YES NO (please circle)

Patient name: _____

Patient Signature: _____ Date: _____

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Receipt of Notice of Privacy Practices

Written Acknowledgement Form

I, _____ have read a copy of the

Notice of Patient Privacy Practices for the office of:

Russ Tannenbaum, D.C., P.A.
5800 Colonial Drive, Suite 305
Margate, FL 33063

_____ _____

Signature of Patient of Parent or Legal Guardian Date

Russ Tannenbaum, D.C., PA

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ASYRA Bioresonance
Electro dermal Acupuncture/Homeopathic Evaluation and Treatment

Patient Consent

The Asyra is a FDA registered EAV (Electro Acupuncture according to VOLL) device that noninvasively, and at no risk to you, screens for energetic imbalances that reflect imbalances in your physiology, and/or the presence of toxicity. The manufacturer's description of the device is available below.

In Asyra testing, you are energetically connected with the Asyra software as you grasp two metal bars. Thousands of individual frequencies, corresponding to physiologic conditions or toxins, rapidly course through your body. If an applied frequency encounters a molecule that shares its frequency, then "resonance" occurs, such that the return signal of that frequency will register as a voltage drop. This signifies that the entity "looked for" by the specific frequency is present in your body. The Asyra software sends in signals that cause the body's meridian networks to "work together", allowing toxic foci to be identified.

This concept, which combines concepts of Homeopathy, Physiology, and Quantum Physics, is new to this medical practice, but it is not new. The Asyra is the culmination of decades of research and experience, building upon the work of Dr. Voll over half a century ago. Practitioners who I respect have found the Asyra to be quite helpful, and I anticipate that utilization of the Asyra concept will elevate the outcomes of our patients beyond that available with our current best practices.

The Asyra will register frequency imbalances corresponding to physiologic abnormalities, and will then suggest therapies, pharmacologic or nutritional, that will "balance" the problems identified. These frequencies can be imprinted into a homeopathic carrier medium, which will then take as sublingual drops. There is the potential for a detox reaction with intake of the sublingual drops.

Your insurer will not cover the cost of the Asyra evaluation or the imprinted drops that are generated. Payment will be your responsibility and is requested at or before the time of service.

I, _____, wish to be evaluated with the Asyra technology and be treated with imprinted homeopathic frequencies generated by the device. I have been given the opportunity to ask questions and understand that my insurer will not cover the costs involved and that payment is my responsibility.

_____ _____

Signature Date

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ACUPUNCTURE CONSENT FORM

Acupuncture is the insertion of a thin needle into the surface of the body. A patient may feel a slight pricking sensation and/or electrical impulse near the needle. Patients usually report little or no pain during an acupuncture treatment. On occasion, there may be slight bruising to the area where the needle was inserted. The duration of an acupuncture treatment is usually 15 minutes. Although no outcome of treatment can be guaranteed, it is understood that every patient is unique and that each treatment is designed specifically for the conditions of the patient.

I UNDERSTAND THAT I HAVE THE RIGHT TO CONSENT TO, OR REFUSE TREATMENT.

Patient Consent:

_____
Print Name

_____ _____
Signature Date

Parent or Guardian Consent to Treat a Minor:

I, _____ as the parent or guardian of _____,
Print Name Name of Minor

authorize treatment of above named minor by Dr. Russ Tannenbaum D.C., P.A..

_____ _____
Signature Date

Payment Policy:
I understand that regardless of my insurance status, I am ultimately responsible for any charges for professional services rendered by Dr. Russ Tannenbaum D.C., P.A..

_____ _____
Signature Date

Russ Tannenbaum, D.C., PA

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MASSAGE THERAPY, MANUAL THERAPY, NEURO MUSCULAR RE-EDUCATION, PROPRIOCEPTIVE NEUROMUSCLAR FACILITATION CANCELLATION OR "NO-SHOW" POLICY

Any patient who has a scheduled massage appointment and needs to cancel MUST do so at least 24 hours prior to the appointment. Failure to do so will result in a $30.00 cancellation fee. We reserve the right to the above charge if we are not notified of a cancellation in advance or if the patient misses the scheduled appointment.

I understand that regardless of my insurance status, I am ultimately responsible for the $30.00 cancellation or missed massage appointment fee if the office is not notified within 24 hours.

I HAVE READ AND AGREE TO THE MASSAGE APPOINTMENT CANCELLATION POLICY.

Patient Consent:

_____
Print Name

_____ _____
Signature Date

Parent or Guardian of a Minor:

I, _____ as the parent or guardian of _____,
Print Name Name of Minor

I HAVE READ AND AGREE TO THE APPOINTMENT CANCELLATION POLICY.

_____ _____
Signature Date

_____ _____
Signature Date

Russ Tannenbaum D.C., P.A
5800 COLONIAL DRIVE, SUITE 305
MARGATE, FL 33063

ASSIGNMENT OF INSURANCE BENEFITS, RELEASE, & DEMAND

Insurer and Patient Please Read the Following in its Entirety Carefully!

I, the undersigned patient/insured knowingly, voluntarily and intentionally assign the rights and benefits of my automobile Insurance, a/k/a Personal Injury Protection (hereinafter PIP), Uninsured Motorist, and Medical Payments policy of insurance to the above health care provider. I understand it is the intention of the provider to accept this assignment of benefits in lieu of demanding payment at the time services are rendered. I understand this document will allow the provider to file suit against an insurer for payment of the insurance benefits or an explanation of benefits and to seek §627.428 damages from the insurer. If the provider's bills are applied to a deductible, I agree this will serve as a benefit to me. This assignment of benefits includes the cost of transportation, medications, supplies, over due interest and any potential claim for common law or statutory bad faith/unfair claims handling. If the insurer disputes the validity of this assignment of benefits then the insurer is instructed to notify the provider in writing within five days of receipt of this document. Failure to inform the provider shall result in a waiver by the insurer to contest the validity of this document. The undersigned directs the insurer to pay the health care provider the maximum amount directly without any reductions & without including the patient's name on the check. To the extent the PIP insurer contends there is a material misrepresentation on the application for insurance resulting in the policy of insurance is declared voided, rescinded, or canceled, I, as the named insured under said policy of insurance, hereby assign the right to receive the premiums paid for my PIP insurance to this provider and to file suit for recovery of the premiums. The insurer is directed to issue such a refund check payable to this provider only. Should the medical bills not exceed the premium refunded, then the provider is directed to mail the patient/named insured a check which represents the difference between the medical bills and the premiums paid.

Disputes: The insurer is directed by the provider and the undersigned to not issue any checks or drafts in partial settlement of a claim that contain or are accompanied by language releasing the insurer or its insured/patient from liability unless there has been a prior written settlement agreed to by the health provider (specifically the office manager) and the insurer as to the amount payable under the insurance policy. The insured and the provider hereby contests and objects to any reductions or partial payments. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by the provider shall be done so under protest, at the risk of the insurer, and the deposit shall not be deemed a waiver, accord, satisfaction, discharge, settlement or agreement by the provider to accept a reduced amount as payment in full. The insurer is hereby placed on notice that this provider reserves the right to seek the full amount of the bills submitted. If the PIP insurer states it can pay claims at 200% of Medicare then the insurer is instructed & directed to provide this provider with a copy of the policy of insurance within 10 days. **Any effort by the insurer to pay a disputed debt as full satisfaction must be mailed to the address above, after speaking with the office manager, and mailed to the specific attention of the Office Manager. See Fla. Stat. §673.3111.**

EUOs and IMEs: If the insurer schedules a defense examination or examination under oath (hereinafter "EUO") the insurer is hereby INSTRUCTED to send a copy of said notification to this provider. The provider or the provider's attorney is expressly authorized to appear at any EUO or IME set by the insurer. The health care provider is not the agent of the insurer or the patient for any purpose. This assignment applies to both past and future medical expenses and is valid even if undated. A photocopy of this assignment is to be considered as valid as the original. I agree to pay any applicable deductible, co-payments, for services rendered after the policy of insurance exhausts and for any other services unrelated to the automobile accident. The health care provider is given the power of attorney to: endorse my name on any check for services rendered by the above provider; and to request and obtain a copy of any statements or examinations under oath given by patient.

Release of information: I authorize this provider to: furnish an insurer, an insurer's intermediary, the patient's other medical providers, and the patient's attorney via mail, fax, or email, with any and all information that may be contained in the medical records; to obtain insurance coverage information (declaration sheet & policy of insurance) in writing and telephonically from the insurer; request from any insurer all explanation of benefits (EOBs) for all providers and non-redacted PIP payout sheets; obtain any written and verbal statements the patient or anyone else provided to the insurer; obtain copies of the entire claim file, the property damage file, and all medical records, including but not limited to, documents, reports, scans, notes, bills, opinions, X-rays, IMEs, and MRIs, from any other medical provider or any insurer. The provider is permitted to produce my medical records to its attorney in connection with any pending lawsuits. The insurer is directed to keep the patient's medical records from this provider private and confidential. The insurer is not authorized to provide these medical records to anyone without the patient's and the provider's prior express written permission.

Demand: Demand is hereby made for the insurer to pay all bills within 30 days without reductions and to mail the latest non-redacted PIP payout sheet and the insurance coverage declaration sheet to the above provider within 15 days. The insurer is directed to pay the bills in the order they are received. However, if a bill from this provider and a claim from anyone else is received by the insurer on the same day the insurer is directed to not apply this provider's bill to the deductible. If a bill from this provider and claim from anyone else is received by the insurer on the same day then the insurer is directed to pay this provider first before the policy is exhausted. In the event the provider's medical bills are disputed or reduced by the insurer for any reason, or amount, the insurer is to: set aside the entire amount disputed or reduced; escrow the full amount at issue; and not pay the disputed amount to anyone or any entity, including myself, until the dispute is resolved by a Court. Do not exhaust the policy. The insurer is instructed to inform, in writing, the provider of any dispute.

Certification: I certify that: I have read and agree to the above; I have not been solicited or promised anything in exchange for receiving health care; I have not received any promises or guarantees from anyone as to the results that may be obtained by any treatment or service; and I agree the provider's prices for medical services, treatment and supplies are reasonable, usual and customary.

Caution: Please read before signing. If you do not completely understand this document please ask us to explain it to you. If you sign below we will assume you understand and agree to the above.

Patient's Name _____ Patient's Signature _____
(Please Print) (If patient is a minor, signature of parent/guardian)

Date _____

Updated: 09/11/2015