RICHARD R. SHAKER, D.C., C.C.S.P., R.T.P., A.C.R.B.

Chiropractic: ☐ Trigenics: ☐ Auto Accident: ☐

Name: ______________________ DOB: ____________
S.S. #: ____________ Email: ____________________
Address: ______________________________City__________
State: ________ Zip code ______________
Home Telephone:________________ Work Telephone:______________
Employer Name: ______________________________
Employer Address: ______________________________
Emergency Contact(s): (Name) (Relationship) (Telephone)
1. ______________________________
2. ______________________________

Marital Status: Single ☐ Married ☐ Divorced ☐ Separated ☐

If auto related please fill out the following

Claim Number:________________ Policy number: ______________
Adjustor Name & Contact #: ______________________
Assigned Attorney(s): ______________________
Date of accident: ______________________
Location of accident: ______________________
Description of MVA ______________________
Please list any injuries sustained due to this accident
____
____

Spouse Information

Name: ______________________ S.S.#: ______________
Address: ______________________________
Home Telephone:______________ Work Telephone:______________
Employer Name: ______________________________
Employer Address: ______________________________

Referred By: Internet/Website ☐ Patient ☐ Other ☐ ______________
Have you been seen or treated by any other physicians ______________

Please Note all payments are due at the time services are rendered

Shaker Spine & Sport Institute accepts cash, all major credit cards & "in state" personal checks. If payment made by check is returned for "NSF" patient will be responsible for original check amount and an additional 25.00 service charge. By signing below, you agree to accept all financial responsibility as the patient who is receiving medical services or as the responsible party for a minor patient. Your signature verified that you have reviewed the above disclosure statement and understand your responsibility and agree to these terms.

Patient Signature: ______________________ Date: ______________

3314 Henderson Blvd. Ste. 203 Tampa, Fl 33609 (B) 813-876-9552 (F) 813-877-1558

RICHARD R. SHAKER, D.C., C.C.S.P., R.T.P., A.C.R.B.

SHAKER
SPINE • SPORT • INSTITUTE

PATIENT REGISTRATION

What treatment have you already received for your condition?
__ Medications__ Surgery __Physical Therapy __Chiropractic Services __ None__
Other:______________________________
IF AUTO: Did you go to the hospital due to the accident? __Yes __No
If yes, What is the name of the hospital ______________________
Please mark to indicate if you have had/ currently have any of the following:

__ AIDS/HIV
__ Alcoholism
__ Allergy Shots
__ Anemia
__ Anorexia
__ Appendicitis
__Arthritis
__Asthma
__ Bleeding Disorders
__ Breast Lump
__ Bronchitis
__Bulimia
__ Cancer
__ Cataracts
__ Chemical Dependency
__ Rheumatoid Arthritis
__ Stroke
__ Tonsillitis
__ Ulcers
__ Whooping Cough
__ Chicken Pox
__ Diabetes
__Emphysema
__ Epilepsy
__ Fractures
__ Glaucoma
__ Goiter
__ Gonorrhea
__ Gout
__ Heart Disease
__ Hepatitis
__ Hernia
__ Herniated Disc
__ Herpes
__ High Cholesterol
__ Rheumatic Fever
__ Suicide Attempt
__ Tumors, Growths
__ Vaginal Infections
Other: ______________________
__ Liver Disease
__ Measles
__ Migraine/ Headaches
__ Miscarriage
__ Mononucleosis
__ Multiple Sclerosis
__ Mumps
__ Osteoporosis
__ Pacemaker
__ Parkinson's Disease
__ Pinched Nerve
__ Pneumonia
__ Polio
__ Prostate Problem
__ Prosthesis
__ Scarlet Fever
__ Thyroid Problems
__ Typhoid Fever
__ Venereal Disease

EXERCISE
__ None
__ Moderate
__ Daily
__ Heavy

WORK ACTIVITY
__ Sitting
__ Standing
__ Light Labor
__ Heavy Labor

HABITS
__ Smoking
__ Alcohol
__ Coffee/ Caffeine Drinks
__ High Stress Level

INJURIES/ SURGERIES YOU HAVE HAD
Falls ______________________ Date__________
Head Injuries______________________ Date __________
Broken Bones ______________________ Date __________
Dislocations ______________________ Date __________
Surgeries ______________________ Date __________

3314 Henderson Blvd. Ste. 203 Tampa, Fl 33609 (B) 813-876-9552 (F) 813-877-1558

RICHARD R. SHAKER, D.C., C.C.S.P., R.T.P., A.C.R.B.

SHAKER
SPINE · SPORT · INSTITUTE

RELEASE OF PATIENT RECORDS AUTHORIZATION

Certified:
Chiropractic
Sports Physician

Registered
Trigenics
Physician

American
Chiropractic
Rehab Board

Member:
American Chiropractic
Association

Florida
Chiropractic
Association

Hillsborough County
Chiropractic
Association

FCA Council
Sports Injuries

ACA Council
Sports Injuries

American Chiropractic
Board of Sports
Physicians

I hereby authorize ______________________
To release a copy of my patient records, x-rays or MRI's
containing protected health information to

Shaker Spine & Sport Institute
3314 Henderson Blvd Suite #203
Tampa, FL 33609

This authorization is given pursuant to Florida Statute 456.057 and HIPAA regulations. I understand that Florida Statute 456.057 (10) makes clear that any third party to whom records are disclosed is prohibited from further disclosing any information in the medical record without the expressed written consent of the patient or the patients legal representatives.

____
Patient or Patient Legal Representative Signature

____
Patient's Printed Name

____________________ ____________________
Patient's Date of Birth **Date Signed**

Specific description of information to be disclose:
____
____
____

CONFIDENTIAL TRANSMISSION CONTAINS PERSONAL HEALTH INFORMATION THAT YOU ARE REQUIRED BY LAW TO MAINTAIN IN A SECURED AND CONFIDENTIAL MANNER. RE-DISCLOSURE IS PROHIBITED. FAILURE TO MAINTAIN CONFIDENTIALITY OR RE-DISCLOSURE WITHOUT AUTHORIZATION COULD RESULT IN PENALTIES.

FAMILY · ATHLETIC · PERSONAL

HENDERSON POINTE BUILDING
3314 HENDERSON BLVD., #203
TAMPA, FL 33609
813-876-9552 / FAX 813-877-1558
www.drshaker.com

SHAKER
SPINE · SPORT · INSTITUTE

RICHARD R. SHAKER, D.C., C.C.S.P., R.T.P., A.C.R.B.

HIPPA ACKNOWLEDGEMENT AND PRIVACY PREFERENCES

You may be contacted by our office to remind you of appointments, healthcare treatment options or other health services that may be of interest to you. In order to maintain your privacy, please answer the following:

May we contact you at home? ___ YES ___ NO Ok to leave message? ___ YES ___ NO
May we contact you at work? ___ YES ___ NO Ok to leave message? ___ YES ___ NO
May we contact you via cell? ___ YES ___ NO Ok to leave message? ___ YES ___ NO

Is it ok to leave a message that includes:
Practice name and phone number only? ___ YES ___ NO
Detailed or specific message? ___ YES ___ NO

Would you like to authorize someone else to schedule, confirm, or change appointments? __ YES __NO
If so, please provide:
Name ______________________ Phone ______________________
Would you like to authorize someone else to receive medical information on your behalf? ___YES___NO
For the purpose of marketing, advertising, special events and offers, may we contact you via email and/or newsletter? ___ YES ___ NO

HOW DID YOU HEAR ABOUT US?
___ Friend or Family Member (Name) ______________________
___ Website: ___ Drshaker.com __ Yelp ___Google ___Instagram ___Facebook Other: ___________
___ Newspaper/ Newsletter or Mailer ______________________
___ An article or advertisement in: ______________________
___ Other: ______________________

Richard R. Shaker, DC, has posted my rights as a patient under the HIPAA (Health Insurance Portability and Accountability Act) on his website www.DrShaker.com. I have had the opportunity to read and understand my rights. I understand I can request a written copy at any time. I have been provided the opportunity to ask questions regarding my rights and received answers to my satisfaction.

3314 Henderson Blvd. Ste. 203 Tampa, Fl 33609 (B) 813-876-9552 (F) 813-877-1558

RICHARD R. SHAKER, D.C., C.C.S.P., R.T.P., A.C.R.B.

PATIENT CONSENT FORM (HIPAA)

Regarding the Use & Disclosure of Protected Health Information ("Consent Form")

For the purposes of this Consent Form, "Office" shall refer to: Shaker Spine & Sport. I understand that some of my health information may be used and/or disclosed by the Office to carry out treatment, payment, or health care operations, and that for more complete description of such uses and disclosures I should refer to the Office's privacy notice entitled, "Our Privacy Practices." I understand that I may review this privacy notice at any time prior signing this form.

I understand that over time the Office's privacy practices may need to change in accordance with law and that if I wish to obtain a copy of the notice as revised, I can call the Office to request such copy.

I understand that I may request restrictions on how my information is used or disclosed to carry out treatment, payment, or health care operations, and that I can also revoke this Consent in, but only to the extent that the Office has not taken action in reliance thereon and also provided that I do so in writing.

I understand that for my protection, any requests to amend my health information or to access my medical records must be made in writing.

Patient Name (please print): ____

Signature: ___________________________________ Date: ___/___/_____

RICHARD R. SHAKER, D.C., C.C.S.P., R.T.P., A.C.R.B.

SHAKER
SPINE • SPORT • INSTITUTE

The patient or responsible party listed above hereby acknowledge and agree that the examination fee is $150.00 for services rendered regardless of the purchase of a Trigenics Treatment. The patient and the responsible party herby acknowledge, understand, and agree that they are financially responsible for payment for such professional services.

I, the undersigned, understand and agree to the above information.

Patient Name:______________________________

Signature: ________________________________

Date:_____________________________________

Witness Name:_____________________________

Signature:_________________________________

Date:_____________________________________

3314 Henderson Blvd. Ste. 203 Tampa, Fl 33609 (B) 813-876-9552 (F) 813-877-1558

RICHARD R. SHAKER, D.C., C.C.S.P., R.T.P., A.C.R.B.

Attention Patients

Due to an increasing number of "No Show" appointments, we have implemented a **strict** office policy:

You MUST call or leave a voicemail 24 hours in advance to cancel your appointment or you will be charged a **"NO SHOW FEE"**

The fees include:

- **Chiropractic Treatments $50**
- **Auto & Commercial Insurance $50**
- **Trigenics Treatments $100**

THANK YOU FOR YOUR COOPERATION!

Patients Name (Please print) ______________________________

Signature ___________________________________**Date:**__/__/__

3314 Henderson Blvd. Ste. 203 Tampa, Fl 33609 (B) 813-876-9552 (F) 813-877-1558