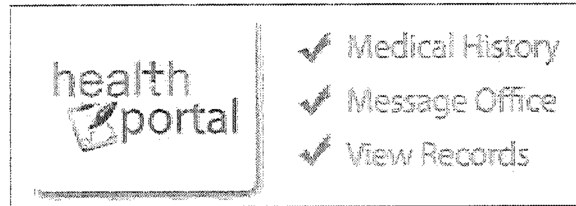
Patient Portal Access



Please provide your email address so that you can have access to:

Request Appointments

Request prescription refills

Ask non emergent medical questions

View medical history/medications

Review lab reports (once reviewed by the Dr.)

Request billing information

Email: ____________________________________

You can also download the Healow App to access the Portal on your mobile device anywhere, anytime!

1	2	3
Download the app	Enter practice code	Enter portal username and password

Practice Code: DGIGCA

Use above practice code to easily link healow app with our practice

Pain Relief Centre
165 Southpark Blvd, Suite C & D
St Augustine, Fl 32086
Patient Registration

Last Name			Primary Care Physician	
First Name		MI	Referring Provider	
Previous Name			Date of Birth (mm/dd/yyyy)	
Address			Gender □ Male □ Female	
City			Marital Status □ Single □ Divorced □ Married □ Widowed	
State	Zip	County	Race : □ American Indian or Alaska Native □ Asian □ Native Hawaiian or Other Pacific □ Black or African American □ White □ Hispanic □ Other □ Refuse to report	
Home Phone	Cell Phone		Ethnicity □ Hispanic or Latino □ Not Hispanic or Latino □ Refuse to report	
Work Phone		Ext.	Social Security Number	
Email Address			Emergency Contact Name & Relation	Emergency Contact Ph #
Preferred Pharmacy			Pharmacy Location	Pharmacy Telephone #

Responsible Party or Guarantor (If under 18 years of age)

Last Name		Relation		
First Name	MI	Address		
Home Phone	Cell Phone	City	State	Zip

Patient Employer Information

☐ Employed ☐ Retired ☐ Full-time Student ☐Part-time Student ☐ Disabled ☐ Unemployed

Employer Name		Occupation		
Address	City	State	Zip	Work Phone

Insurance Information

Primary Insurance Company Name	Subscriber's Name	Subscriber's Date of Birth
Subscriber's Social Security/ID Number	Subscriber's Address	Subscriber's Home Phone
Secondary Insurance Company Name	Subscriber's Name	Subscriber's Date of Birth

In Case of Emergency

Name of local friend or relative	**Relationship:**	**Home #** **Cell #**

Patient Request for Confidential Communications

Patient Name: ____

Patient Date of Birth: ______________________________ Patient SSN: ____________________

This is a request for confidential communications of my protected health information (PHI). When the doctor, nurse or other members of your office want to contact me please use the following guidelines. I understand that you will do your best to adhere to the following requests.

Please check all that apply to this request:

_____ Please do not phone me at home. Use the following alternative phone number to contact me:______________

_____ Please do not phone me at work. Use the following alternative number to contact me:___________________

_____ Please do not contact me by email.

_____ Other request(s) (describe in detail): ____

____

_____ When contacting me by phone it is ok to leave messages and discuss my health information with:

Name:_________________________________Relationship_______________

Name: _________________________________Relationship _______________

________ **(Please initial) I understand that the physician or provider to whom I am making this request will make reasonable efforts to accommodate this request. I further understand that in some emergency situations, my PHI may be released. I authorize my medications from the Pharmacy Data Base be released to this office.**

Advanced Directive Planning

Do you have an Advanced Directive? ☐ Living Will ☐ Power of Attorney ☐ DNR ☐ I do not have an Advanced Directive

Consent for Medical Treatment

I/we voluntarily consent to medical treatment and diagnostic procedures provided by this office and its' associated physicians, clinicians and other personnel. I/we am/are aware that the practice of medicine and surgery is not an exact science and I/we acknowledge that no guarantee has been made as to the result of treatments or examinations.

Assignment of Benefits and Patient Responsibility

I certify that the information on these forms is true to the best of my knowledge. I accept responsibility for the medical charges incurred by the patient and agree to pay bills at time of service unless other arrangements are made. I authorize my insurance claim to be paid directly to the clinic. I further understand my health care insurance carrier or payor of my health benefits may pay less than the actual bill for services, and all second opinion and pre-admission review requirements are ultimately my responsibility.

Signature of Patient (or patient's personal representative):____

Relationship of representative to patient: ____

Date: ____________________________

Case # ________

PATIENT HEALTH SURVEY

FULL NAME ______________________________ AGE ________ DATE ____________

Have you ever (at any time) experienced any of the following?

Difficulty urinating	Y	N	Claustrophobia (fear of small spaces)	Y	N
Loss of bladder control	Y	N	Spinal surgery	Y	N
Loss of bowel control	Y	N	Common cold/flu	Y	N
Temporary loss of vision, one eye	Y	N	Carotid artery surgery	Y	N
Blood in urine	Y	N	Breast removal	Y	N

Have you ever been diagnosed with or told you have one of the following?

Detached retina	Y	N	Rheumatoid Arthritis	Y	N
Stroke	Y	N	Fractured/broken vertebra	Y	N
Slipped disc	Y	N	Bleeding disorders	Y	N
Herniated disc	Y	N	High blood pressure	Y	N
Osteoporosis	Y	N	Blood in stool	Y	N
TIA's (pin or mini strokes)	Y	N	Cancer	Y	N
Drop attacks (collapsing, but not fainting)	Y	N	AIDS	Y	N
Hardening of the arteries	Y	N	Kidney disease	Y	N
Partial or complete paralysis	Y	N	Prostate disease	Y	N

Do you currently have, or could you be, any of the following?

Pregnant	Y	N
Taking birth control pills	Y	N
Receiving hormone therapy	Y	N
❑ Male ❑ Female		
Receiving chemotherapy	Y	N
Receiving radiation therapy	Y	N
Taking blood thinners	Y	N
A heavy smoker (1 or more packs.day)	Y	N
Surgical/medical implanted devices:		
Aortic clips	Y	N
Brain clips	Y	N
Artificial heart valves	Y	N
Rods, pins, screws	Y	N
IUD	Y	N
Surgical clips/wires	Y	N
Shunt	Y	N
Neurostimulator	Y	N
Dentures	Y	N
Pacemaker	Y	N
Hearing aid	Y	N
Insulin pump	Y	N
Joint replacement	Y	N
Cochlear implants (ear)	Y	N
Other implanted devices:		
Metal fragments (head, eye, skin)	Y	N
Bullets/shrapnel	Y	N
Body piercing	Y	N
Tattoos	Y	N

In the past 14 days (2 weeks), have you experienced any of the following?

Nausea	Y	N
Vomiting	Y	N
Vertigo (spinning)	Y	N
Difficulty walking	Y	N
Incoordination	Y	N
Numbness or other sensory complaints	Y	N
Loss of consciousness	Y	N
Double vision	Y	N
Blurred vision	Y	N
Tinnitus (ringing in ears)	Y	N
Speech problems	Y	N
Clumsiness	Y	N
Memory loss	Y	N
Travel by car/truck	Y	N
Personality changes	Y	N
Fever	Y	N
Recurrent headaches	Y	N
Diarrhea	Y	N
Used a tanning bed/booth	Y	N
Skin rash/infection	Y	N
A major fall	Y	N
A minor fall	Y	N
An auto accident	Y	N
A work injury	Y	N
Loss of strength	Y	N
Pain moving bowels	Y	N
Head trauma	Y	N
Abnormal period	Y	N

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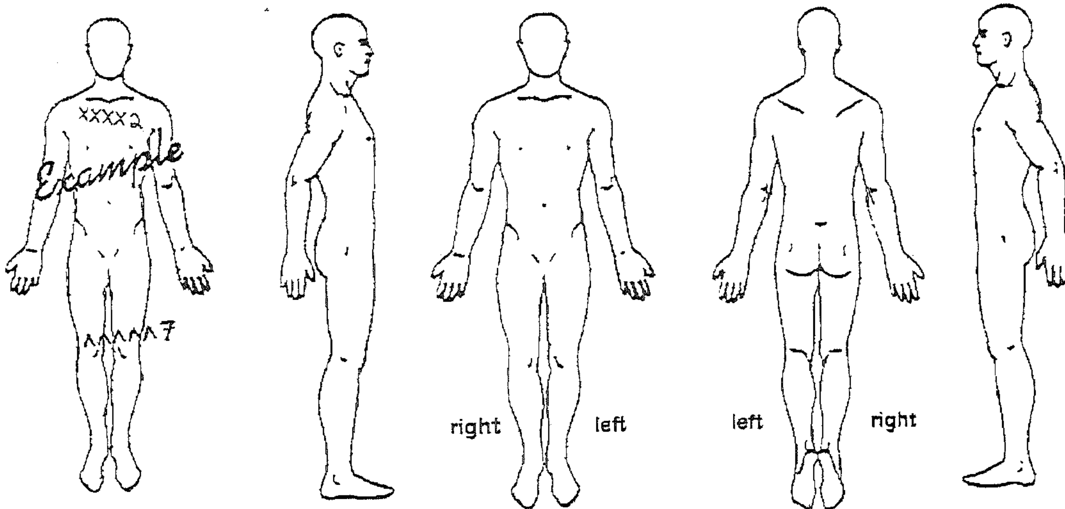
rev. 08/04

SHOW US WHERE IT HURTS

Case#__________ Name______________________________ Date____________

Please mark area(s) of injury or discomfort as shown in the example below.
Mark all areas with the appropriate symbols and indicate the degree of pain using a scale from 1 (discomfort) to 10 (extreme pain).

Description:	Numbness	Pins & Needles	Burning	Aching	Stabbing	Dull
Symbol	NNN	PPP	BBB	AAA	SSS	DDD



Pain Relief Centre

www.painreliefcentre.net

PALATKA
700 Reid Street
Suite A
Palatka, FL 32177
Ph: 386-328-4043
Fax: 386-328-4141

Scott Fechter D.C.
Juliana Farrell D.C.
Santina Whited D.C., DABCN

ST. AUGUSTINE
165 Southpark Boulevard
Suites C and D
St. Augustine, FL 32086
Ph: 904-823-8833
Fax: 904-823-9394

Consent for Release of Medical Records

To: ____

Doctor or Hospital or Other

I understand that all patient information is confidential and privileged, that the confidentiality of my medical records is protected by federal and state law, and that your delivery of copies to the above individual in response to my directions is mandated by law. I agree to hold Pain Relief Centre harmless for any loss of confidentiality of identifiable patient information that may result from compliance with my directions or for use or disclosures made by those receiving my medical records as directed. I further understand that as part of my medical record, the following information, if presented in my record, will be released unless stricken: Sexual abuse Information, Information about Sexually Transmitted Diseases, Drug, Alcohol and Other Substance Abuse Information, Child Abuse and Neglect Information, and Mental Health.

Please send the following records:

____

____

____

____

____

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. I hereby, authorize and certify the release of any medical forms and or other information necessary to process insurance claims. I authorize payment of medical benefits to St. Augustine Chiropractic dba Pain Relief Centre.

I hereby authorize and request you to release to:

Scott Fechter D.C.
Juliana Farrell D.C.
165 SouthPark Blvd
St. Augustine, Fl. 32086
Ph. 904.823-8833
Fax. 904.823-9394

Santina Whited D.C., DABCN
700 Reid Street
Palatka, FL 32177
Ph. 386-328-4043
Fax 386-328-4141

The complete medical records in your possession concerning my illness and/or treatment.

Print Name________________________________ Date of Birth__/__/__

Address____________________________________ SS#________________

City_________________________ State _________Zip_____________

Signature_________________________ Witness_________________ Date___________________

(If relative, state relationship)

INFORMED CONSENT

Patient Name ______________________________ Date_________________________

Every type of health care is associated with some risk of a potential problem. This includes chiropractic health care. Pain Relief Centre and whomever he/she may designate as his/her assistant wants to inform you about potential problems associated with chiropractic health care before consenting to treatment. This is called informed consent.

Analysis/Examination/Treatment
As a part of the analysis, examination, and treatment, you are consenting to the following procedures:

_x_ spinal manipulative therapy
_x_ range of motion testing
_x_ muscle strength testing
_x_ ultrasound
_x_ radiographic studies
_x_ palpation
_x_ orthopedic testing
_x_ flexion/distraction
_x_ hot/cold therapy
_x_ vital signs
_x_ basic neurological testing
_x_ electric muscle stimulation
_x_ cervical/lumbar traction

By signing this document below the patient agrees to the modalities suggested by the physician.

The material risks inherent in chiropractic adjustment.
As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: Those listed below. Some patients will feel some stiffness and soreness following the first few days of treatment. In this office we use trained staff personnel to assist the doctor with portions of your consultation, examination, x-ray taking, physical therapy application, traction, massage therapy, exercise instruction, etc. Occasionally when your doctor is unavailable, another clinic doctor will treat you on that day. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

Chiropractic adjustments are the moving of bones with the doctor's hands or with the use of a machine. Frequently adjustments create a "pop" or "click" sounds/sensation in the area being treated.

SORENESS: It is common for chiropractic adjustments, traction, massage therapy, exercise, etc. to result in a temporary increase in soreness in the region being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic changes. It is not dangerous, but please do tell your doctor about it.

SOFT TISSUE INJURY: Soft tissue primarily refers to muscles and ligaments. Muscles move bones, and ligaments limit joint movement. Rarely a chiropractic adjustment, traction, massage therapy, etc., may tear some muscle or ligament fibers. The result is a temporary increase in pain and necessary treatments for resolution, but there are no long term effects for the patient. These problems occur so rarely that there are no available statistics to quantify their probability.

PHYSICAL THERAPY BURNS: Some of the machines we use generate heat. We also use both heat and ice, and recommend them for home care on occasion. Everyone's skin has different sensitivity to these modalities, and rarely, either heat or ice can burn or irritate the skin. The result is a temporary increase in skin pain, and there may even be some blistering of the skin. These problems occur so rarely that there are no available statistics to quantify their probability.

RIB FRACTURES: The ribs are found only in the thoracic spine or middle back. They extend from your back to your front chest area. Rarely a chiropractic adjustment will crack a rib bone, and this is referred to as a fracture. This occurs only on patients that have weakened bones from such things as osteoporosis. Osteoporosis can be noted on your x-rays. We adjust all patient very carefully, and especially those who have osteoporosis on their x-rays. These problems occur so rarely that there are no available statistics to quantify their probability.

DISC HERNIATIONS: Disc herniations that create pressure on the spinal nerve or on the spinal cord are frequently successfully treated by chiropractors and chiropractic adjustments, traction, etc. This includes both in the neck and back. According to the article, Reviews of the Literature: Side Posture Manipulation for Lumbar Intervertebral Disk Herniation by: J. David Cassidy, D.C., the treatment of lumbar intervertebral disk herniation by side posture manipulation is both safe and effective: although, some herniations require surgery. (Journal of Manipulative and Physiological Therapeutics. Volume 16: Number 2 February 1993).

STROKE: Stroke is the most serious problem associated with chiropractic adjustments. Stroke means that a portion of the brain does not receive enough oxygen from the blood stream. The results can be temporary or permanent dysfunction of the brain, with a very rare complication of death. Chiropractic adjustments have been associated with strokes that arise from the vertebral artery only; this is because the vertebral artery is actually found inside the neck vertebrae.

The adjustment is related to vertebral artery stroke is called the "extension-rotation-thrust atlas adjustment". We do not do this type adjustment on patients. Other types of neck adjustments may also potentially be related to vertebral artery strokes, but no one is certain. (The most recent studies (Journal of the CCA, Vol. 37 No. 2, June, 1993) estimate that the incident of this type of stroke is 1 per every 3,000,000 upper neck adjustments. This means that an average chiropractor would have to be in practice for hundreds of years before they would statistically be associated with a single patient stroke.)

OTHER PROBLEMS: There may be other problems or complications that might arise from chiropractic treatment other than those noted above. These other problems or complications occur so rarely that it is not possible to anticipate and/or explain them all in advance of treatment.

Chiropractic is a system of health care delivery, and, therefore, as with any health care delivery system we cannot promise a cure for any system, disease, or condition as a result of treatment in this clinic. We will always give you our best care, and if results are not acceptable, we will refer you to another provider who we feel will assist your situation.

The probability of those risks occurring.
Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options.
Other treatment options for your condition may include:
*Self-administered, over-the-counter analgesics and rest
*Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
*Hospitalization
*Surgery
If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated.
Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.
PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed treatment options, indications, contraindications and risks with my physician and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the options, indications, contraindications and risks, I hereby give my consent to that treatment.

______________________	______________________
PATIENT'S NAME PRINTED	DATE
PATIENT'S SIGNATURE	PARENT OR GUARDIAN SIGNATURE FOR MINOR
WITNESS SIGNATURE	DATE

PAIN DISABILITY QUESTIONNAIRE

Patient Name ______________________________ Date ________________

Instructions: These questions ask your views about how your pain now affects how you function in everyday activities. Please answer every question and mark the ONE number on EACH scale that best describes how you feel.

1. Does your pain interfere with your normal work inside and outside the home?
Work normally — Unable to work at all
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

2. Does your pain interfere with personal care (such as washing, dressing, etc.)?
Take care of myself completely — Need help with all my personal care
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

3. Does your pain interfere with your traveling?
Travel anywhere I like — Only travel to see doctors
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

4. Does your pain affect your ability to sit or stand?
No problems — Can not sit/stand at all
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

5. Does your pain affect your ability to lift overhead, grasp objects, or reach for things?
No problems — Can not do at all
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

6. Does your pain affect your ability to lift objects off the floor, bend, stoop, or squat?
No problems — Can not do at all
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

7. Does your pain affect your ability to walk or run?
No problems — Can not walk/run at all
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

8. Has your income declined since your pain began?
No decline — Lost all income
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

9. Do you have to take pain medication every day to control your pain?
No medication needed — On pain medication throughout the day
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

10. Does your pain force your to see doctors much more often than before your pain began?
Never see doctors — See doctors weekly
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

11. Does your pain interfere with your ability to see the people who are important to you as much as you would like?
No problem — Never see them
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

12. Does your pain interfere with recreational activities and hobbies that are important to you?
No interference — Total interference
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

13. Do you need the help of your family and friends to complete everyday tasks (including both work outside the home and housework) because of your pain?
Never need help — Need help all the time
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

14. Do you now feel more depressed, tense, or anxious than before your pain began?
No depression/tension — Severe depression/tension
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

15. Are there emotional problems caused by your pain that interfere with your family, social and or work activities?
No problems — Severe problems
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

____
Examiner

OTHER COMMENTS:

____

With Permission from: Anagnostis C et al: The Pain Disability Questionnaire: A New Psychometrically Sound Measure for Chronic Musculoskeletal Disorders. *Spine* 2004; 29 (20): 2290-2302.