CHIROPRACTIC CENTER OF LAKELAND

New Patient Intake

Name: ______________________________ **Date:** ______________
Address: ____________________ **City:** ______________ **State:** ____ **Zip:** ________
Primary Phone: ____________________ **Work Phone:** ____________________
Birthdate: __________ **SSN:** ______________ **Email:** ____________________
Status: Single Married Divorced Widowed **Children:** Yes No **How Many:** ________
Are you considered a minor? Yes No **If Yes, who is the responsible payer?** ____________
Occupation: ____________________ **Employer:** ____________________
Family Doctor: Yes No **Name of Doctor:** ______________ **Phone:** ____________
Emergency Contact: ____________________ **Phone:** ____________
Do you have insurance we will be using? Yes No **Insurance Company:** ______________
Who referred you to our office: ______________
Rate your overall internal health: Excellent Good Fair Poor **Rate your external health:** Excellent Good Fair Poor

Past Medical History

For the conditions below, place a check in the "past" column if you have had the condition in the past. If you presently have any condition listed below, please place a check in the present column.

Condition	Past	Present
Headaches	☐	☐
Neck Pain	☐	☐
Upper Back Pain	☐	☐
Mid Back Pain	☐	☐
Low Back Pain	☐	☐
Shoulder Pain	☐	☐
Elbow/Arm Pain	☐	☐
Wrist Pain	☐	☐
Hand Pain	☐	☐
Hip Pain	☐	☐
Upper Leg Pain	☐	☐
Knee Pain	☐	☐
Ankle/Foot Pain	☐	☐
Jaw Pain	☐	☐
Joint Pain/ Stiffness	☐	☐
Arthritis	☐	☐
Rheumatoid Arthritis	☐	☐
Cancer	☐	☐
Tumor	☐	☐

Condition	Past	Present
Asthma	☐	☐
Chronic Sinusitis	☐	☐
High Blood Pressure	☐	☐
Heart Attack	☐	☐
Stroke	☐	☐
Angina	☐	☐
Kidney Stones	☐	☐
Kidney Disorders	☐	☐
Bladder Infection	☐	☐
Painful Urination	☐	☐
Loss of Bladder Ctrl	☐	☐
Prostate Problems	☐	☐
Abnormal Wt Loss/Gain	☐	☐
Loss of Appetite	☐	☐
Abdominal Pain	☐	☐
Ulcer	☐	☐
Hepatitis	☐	☐
Liver Disorder	☐	☐
Gall Bladder Disorder	☐	☐

Condition	Past	Present
General Fatigue	☐	☐
Thyroid Disorder	☐	☐
Muscular Incoordination	☐	☐
Visual Disturbances	☐	☐
Dizziness	☐	☐
Diabetes	☐	☐
Excessive Thirst	☐	☐
Frequent Urination	☐	☐
Addiction Drug/Alcohol	☐	☐
Allergies	☐	☐
Depression	☐	☐
Systemic Lupus	☐	☐
Fibromyalgia	☐	☐
Epilepsy	☐	☐
Skin Conditions	☐	☐
HIV/AIDS	☐	☐
For Women:	☐	☐
Birth Control	☐	☐
Hormone Replacement	☐	☐

List Treatments for Past Conditions: ______________________________
List ALL Medications you are Currently Taking: ______________________________
____
List any Allergies: (including food) ______________________________
List any Surgeries: ______________________________

Family Medical History

Please indicate if you have any immediate family members with the following conditions:

☐ Rheumatoid Arthritis
☐ Heart Problems
☐ Diabetes
☐ Cancer
☐ Lupus/Fibromyalgia
☐ Mulitple Sclerosis

Other Family Medical history: ______________________________

Social History

Do you smoke: Yes No **How Much:** __________ **Drink Alcohol:** Yes No **How Much:** ______
For Women Only: Pregnant? Yes No **How Long:** ______________ **Nursing?:** Yes No

CHIROPRACTIC CENTER OF LAKELAND

Auto Accident Questionnaire

Patient Name: ____________________________ Today's Date: ___________ Accident Date: ____________

Please give a brief description of your accident: (Where, What, When & How)

Where did it happen? ____

What happened? ____

____

____

____

Where were you in the vehicle? Driver Passenger Rear Right Passenger Rear Left Passenger

What type of vehicle were YOU in? Compact Car Midsize Car Full Size Car Small Truck Full Size Truck
Small SUV Midsize SUV Large SUV Mini Van Full Size Van Motorcycle

What type of vehicle collided with you? Compact Car Midsize Car Full Size Car Small Truck Full Size Truck
Small SUV Midsize SUV Large SUV Mini Van Full Size Van Motorcycle

How fast were you traveling? _________ MPH How fast was the other vehicle traveling? _________MPH

Where was the impact on your vehicle? Front Rear Driver Side Passenger Side
Front Driver Side Rear Driver Side Front Passenger Side Rear Passenger Side

Were you wearing your seatbelt? Yes No Did the Airbag deploy? Yes No

Estimate the damage to your vehicle: Minimal Moderate Extensive Totaled Unsure

Were you anticipating the accident? Expecting the collision Completely Unexpected

What position were you sitting? Straight ahead Rotated Right Rotated Left Unsure

What position was your head? Straight ahead Rotated Right Rotated Left Unsure

Was your body thrown? Yes No In what direction? Backwards Forwards Left Right Outside the vehicle

How did your head move during the collision? Forwards then backwards Backward then Forwards
Right to Left Left to Right Unsure of motion

Did any part of your body strike anything in the vehicle? Yes No If Yes, please circle all body part involved:

Head Upper Back Mid Back Lower Back Chest Left Shoulder Right Shoulder Left Arm Right Arm

Left Elbow Right Elbow Left Leg Right Leg Left Knee Right Knee Left Shin Right Shin

How did you feel immediately following the accident? Dazed Disoriented Headache Pain Unconscious None

CHIROPRACTIC CENTER OF LAKELAND

Auto Accident Questionnaire

<u>Where did you feel pain immediately following the accident</u>? None Head Neck Upper Back Mid Back Lower Back Chest Left Shoulder Right Shoulder Left Arm Right Arm Left Elbow Right Elbow Left Leg Right Leg Left Knee Right Knee Left Shin Right Shin Other: ___________________________

<u>Did you go to the hospital immediately following the accident</u>? Yes No <u>Where</u>? ________________________

<u>How were transported to the hospital</u>? Ambulance Drove self Driven there by friend/family member

<u>Were you admitted to the hospital</u>? Yes No How many days in the hospital? _______________________

<u>What was done at hospital</u>? <u>Xrays</u>? Yes No <u>Xrays of what</u>? Neck Mid back Low back Other: ________

<u>MRI</u>? Yes No <u>MRI of what</u>? Neck Mid back Low back Other: ________

<u>CT scan</u>? Yes No <u>CT of what</u>? Neck Mid back Low back Other: ________

<u>Given Medication</u>? Yes No <u>What Medication</u>? ___________________________

<u>Later after the accident, where did you feel pain</u>? None Head Neck Upper Back Mid Back Lower Back Chest Left Shoulder Right Shoulder Left Arm Right Arm Left Elbow Right Elbow Left Leg Right Leg Left Knee Right Knee Left Shin Right Shin Other: ____________________________________

<u>Are you feeling numbness or tingling anywhere</u>? Yes No <u>Where</u>? ____

____

<u>Has the accident affected your sleep</u>? Yes No <u>How much sleep do you lose a night</u>? ___________hours of sleep.

<u>What other symptoms are you feeling now</u>? Nervousness Irritability General Fatigue Depression Cramping Unintentional Twitching Difficult Urination

<u>Have you experienced any weight changes</u>? Yes No Gain of _____ pounds Loss of _______pounds

<u>Has this affected your daily quality of life</u>? Yes No <u>How much</u>? None Minimally Moderately Severely

Please write down any other information that you feel is important for us to know: ___________________________

____

____

____

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Patient Signature: ____ Date: __________________________________

CCL

Chiropractic Center of Lakeland

Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Name of Patient Date

CCL

Chiropractic Center of Lakeland

Term of Acceptance

When a patient care at the Chiropractic Center of Lakeland and we accept a patient for such care, it is essential for both to be working toward a common goal.

Chiropractic has only one goal: to eliminate misalignments within the spinal column which interferes with the expression of the body's innate wisdom. It is important all patients understand both the objective and the method used to attain our goal. The following definitions will help to educate each patient.

Health: Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

Adjustment: A specific application of forces to facilitate the body's correction of the spinal Subluxation. Our method of correction is performed by mechanical device as well as by hand.

Spinal Subluxation: A misalignment of one or more of the 24 vertebrae in the Spinal Column which causes alteration and interference with the transmission of information from the brain to all systems of the body, thus having a positive effect on the body's organs and systems, even down to the cellular level.

We do not offer to diagnose or treat any disease or condition other than vertebral Subluxation. However if during the course of chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will recommend our patients seek care fro a health care provider who specializes in that area. Regardless of the specific condition we cannot provide care of give advice on the care provided by other practitioners.

Our Practice objective is to eliminate major interference to the expression of the body's innate wisdom.

All questions regarding the doctor's objectives pertaining to my care in this office have been fully answered.

____

Print Name

____________________________________ ______________________

Sign Name Date

CCL

Chiropractic Center of Lakeland

DOCTOR'S LIEN

To: Attorney____

____

____

RE:____

I hereby authorize the above doctor to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him for professional services rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment or verdict as may be necessary adequately to protect said doctor. I hereby further give a lien on my case to said doctor against any and all proceeds of any settlement, judgment or verdict which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated or injuries in connection herewith.

I fully understand that I am directly and fully responsible to said doctor for all professional bills submitted by him for service rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

Dated________________________________ Patient's Signature______________________________

Address_________________________________

____

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary adequately to protect the said doctor named above.

Dated____________________________ Attorney's Signature______________________________

Attorney: Please date, sign and return on copy to doctor's office at once. Reply envelope attached. Keep a copy for your records.

OFFICE OF INSURANCE REGULATION

Bureau of Property & Casualty Forms and Rates

Standard Disclosure and Acknowledgement Form
Personal Injury Protection - Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

1. The services set forth below were **actually rendered.** This means that those services have **already been provided.**
2. I have the right and the **duty to confirm** that the services have already been provided.
3. I was **not solicited** by any person to seek any services from the medical provider of the services described above. This means that no person has initiated contact with me and/or persuaded me to use the doctor or licensed professional, clinic, or medical institution that provided the services.
4. The medical provider has **explained** the services to me for which payment is being claimed.
5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to $500.

The undersigned licensed medical professional affirms the statement numbered 1 above and also:

A. I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.

B. I have **explained** the services rendered to the insured person, or his or her guardian, **sufficiently** for that person to sign this form with informed consent.

C. The accompanying statement or bill is **properly completed** in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to **truthfully, accurately**, and in a **substantially complete** manner.

D. The coding of procedures on the accompanying statement or bill is proper. This means that **no service has been upcoded, unbundled**, or constitutes an invalid **or not medically necessary diagnostic test** as defined by Section 627.732 (15) and (16), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Insured Person (patient receiving treatment) or Guardian of Insured Person:

Name *(PRINT or TYPE)*	Signature	Date

Licensed Medical Professional Rendering Treatment *(Signature by his or her **own hand**)*:

Name *(PRINT or TYPE)*	Signature	Date

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of Claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234(1)(b), Florida Statutes.

Note: The **original** of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may **not** be electronically furnished. Failure to furnish this form may result in non-payment of the claim.