Chiropractic Center of Lakeland

Patient Intake Forms

PATIENT INFORMATION

Full Name: _____ Birthdate: _____ Date: _____

Address: _____ City: _____ State: _____

ZIP: _____ Primary Phone #: _____ Email: _____

Are you considered a minor? ☐ Yes ☐ No If Yes, who is the responsible payer? _____

Occupation: _____ Employer: _____

Emergency Contact: _____ Phone #: _____

Do you have insurance we will be using? ☐ Yes ☐ No Insurance Company: _____

How did you hear about our office? _____

Race (Circle One): American Indian or Alaska Native / Asian / Black or African American
White (Caucasian) / Hawaiian or Pacific Islander / Decline to Answer

MEDICAL HISTORY

Please mark for **CONDITIONS** you have had or currently have.

Headaches ☐	Arthritis ☐	Cancer ☐	Diabetes ☐
Neck ☐	Asthma ☐	Tumor ☐	Frequent Urination ☐
Upper Back ☐	Sinus Problems ☐	Heart Attack ☐	Fibromyalgia ☐
Mid Back ☐	High Blood Pressure ☐	Stroke ☐	
Low Back ☐		Angina ☐	
Shoulder ☐	Kidney Disorder ☐	Kidney Stones ☐	
Elbow/Arm ☐	Cholesterol ☐	Loss of Bladder Control ☐	
Wrist/Hand ☐	Liver Disorder ☐		
Hip ☐	Fatigue ☐	Abnormal Weight Loss/Gain ☐	
Leg ☐	Allergies ☐		
Knee ☐	Depression ☐	Abominal Pain ☐	
Ankle/Foot ☐	Skin Conditions ☐	Thyroid Disorder ☐	
Jaw ☐	Gall Bladder ☐	Dizziness ☐	

List Medication you are currently taking: _____

_____

List past surgeries: _____

_____

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

☐ Rheumatoid Arthritis ☐ Diabetes ☐ Lupus ☐ Heart Problems

☐ Fibromyalgia ☐ Cancer ☐ Multiple Sclerosis

Women Only: Are you pregnant? ☐ Yes ☐ No How Long? _____ Nursing? ☐ Yes ☐ No

Initial: [ ]

INCIDENT QUESTIONNAIRE

Chiropractic Center of Lakeland

ACCIDENT DETAILS

Full Name: _____ Today's Date: _____ Accident Date: _____

Give a brief description of your accident: _____

_____

_____

_____

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

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

What type was the other vehicle? Compact Car Midsize Car Full Size Car Small Truck

Full Size Truck Small SUV Midsize SUV Large SUV Mini Van Full Size Van

Were you wearing your seatbelt? ❑ Yes ❑ No

*** If yes, any bruising from the seatbelt?** ❑ Yes ❑ No

Did the airbag deploy? ❑ Yes ❑ No

Estimated damage to your vehicle? Minimal Moderate Extensive Totaled Unsure

Were you anticipating the accident? ❑ Yes ❑ No

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

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

How did your head move during the collision?

Forwards then backwards Backwards then forwards Right to Left Left to Right Unsure of motion

Was your body thrown? ❑ Yes ❑ No

*** If yes, in what direction?** Backwards Forwards Left Right Outside the Vehicle

Initial: [ ]

INCIDENT QUESTIONNAIRE

Chiropractic Center of Lakeland

Full Name: _____ Date: _____

Did any part of your body strike anything in the vehicle? ☐ Yes ☐ No

*** If yes, please circle all body parts 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 Normal

Where have you felt pain following the accident? 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 None Other: _____

Have you gone to another medical facility for treatment since the accident? ☐ Yes ☐ No

Where? _____ **When?** _____

*** If yes ...**

How were you transported?

Ambulance Drove self Driven there by friend/family member

Were xrays taken? ☐ Yes ☐ No ☐ Unsure

Was an MRI taken? ☐ Yes ☐ No ☐ Unsure

Was a CT scan taken? ☐ Yes ☐ No ☐ Unsure

Given medication? ☐ Yes ☐ No ☐ Unsure

Did they give you a diagnosis of injury (ex. sprain/strain)? _____

Initial: [ ]

PATIENT COMPLAINT FORM

Chiropractic Center of Lakeland

Full Name: _____ Date: _____

PRIMARY AREA OF COMPLAINT

What brings you into the office today?

☐ Regional Pain ☐ Recent Injury ☐ Wellness Care (Skip the rest of this form)

Select **ONE** (the primary) region below where you feel the complaint (**for additional complaints use next page**)

☐ Neck and/or Upper Back ☐ Mid-Back ☐ Low Back/ Pelvis ☐ Extremity: _____

The complaint is (Pick **ONE**):

☐ New *** WHEN**: _____

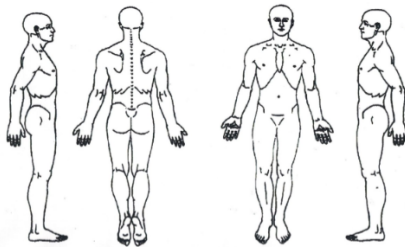
☐ Comes and Goes *** INITIAL START**: _____

*** MOST RECENT**: _____

☐ Chronic *** WHEN**: _____

What caused the complaint you are experiencing today?

_____



Please indicate where you feel the complaint:

The symptom is getting:

☐ Better ☐ Worse ☐ Staying the same

How often do you feel the symptom?

☐ Occasional ☐ Intermittent ☐ Frequent ☐ Constant

___ / 10 * Please rate the intensity of your symptom TODAY from 0-10, with 10 being the worst possible.

How would you describe the feeling of your symptom? (Check all that apply):

☐ Ache ☐ Tightness ☐ Burning ☐ Sharp ☐ Tingling ☐ Stabbing

☐ Shooting ☐ Throbbing ☐ Pulling ☐ Dull ☐ Stiffness ☐ Spasm

What makes the complaint worse? _____

What helps relieve the complaint? _____

Does the **PAIN** travel into your arms or legs? ☐ Yes ☐ No

** If yes, Where:* _____

Have you had **NEW NUMBNESS or TINGLING** in your arms or legs since this started? ☐ Yes ☐ No

** If yes, Where:* _____

What lifestyle activities does this interfere with? (Check all that apply)

☐ Personal Care (washing, dressing, etc...) ☐ Prolonged Standing ☐ Traveling ☐ Sleeping

☐ Social/Recreational Activities ☐ Prolonged Sitting ☐ Walking ☐ Bending

☐ Lifting ☐ Other: _____

Are you currently or have you previously been treated for this problem? ☐ Yes ☐ No

** If yes, type of treatment:* _____

Have you had any testing for this condition? ☐ Yes ☐ No

** If yes...* ☐ X - ray ☐ MRI ☐ CT Scan ☐ Other: _____

Doctor's Notes: _____

_____

_____

Initial: [ ]

Full Name: _____

ADDITIONAL AREA OF COMPLAINT (SKIP IF YOU HAVE NO 2ND COMPLAINT)

Type of issue?

☐ Regional Pain ☐ Recent Injury

Select **ONE ADDITIONAL** region below where you feel a complaint.

☐ Neck and/or Upper Back ☐ Mid-Back ☐ Low Back/ Pelvis ☐ Extremity: _____

The complaint is (Pick **ONE**):

☐ New *** WHEN**: _____

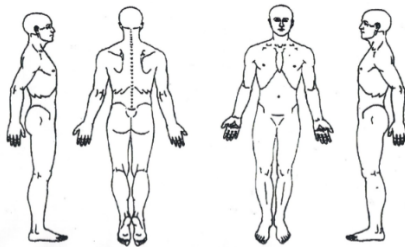
☐ Comes and Goes *** INITIAL START:** _____

*** MOST RECENT:** _____

☐ Chronic *** WHEN**: _____

What caused the complaint you are experiencing today?

_____



Please indicate where you feel the complaint:

The symptom is getting:

☐ Better ☐ Worse ☐ Staying the same

How often do you feel the symptom?

☐ Occasional ☐ Intermittent ☐ Frequent ☐ Constant

___ / 10 * Please rate the intensity of your symptom TODAY from 0-10, with 10 being the worst possible.

How would you describe the feeling of your symptom? (Check all that apply):

☐ Ache ☐ Tightness ☐ Burning ☐ Sharp ☐ Tingling ☐ Stabbing

☐ Shooting ☐ Throbbing ☐ Pulling ☐ Dull ☐ Stiffness ☐ Spasm

What makes the complaint worse? _____

What helps relieve the complaint? _____

Does the **PAIN** travel into your arms or legs? ☐ Yes ☐ No

** If yes, Where:* _____

Have you had **NEW NUMBNESS or TINGLING** in your arms or legs since this started? ☐ Yes ☐ No

** If yes, Where:* _____

What lifestyle activities does this interfere with? (Check all that apply)

☐ Personal Care (washing, dressing, etc...) ☐ Prolonged Standing ☐ Traveling ☐ Sleeping

☐ Social/Recreational Activities ☐ Prolonged Sitting ☐ Walking ☐ Bending

☐ Lifting ☐ Other: _____

Are you currently or have you previously been treated for this problem? ☐ Yes ☐ No

** If yes, type of treatment:* _____

Have you had any testing for this condition? ☐ Yes ☐ No

** If yes...* ☐ X - ray ☐ MRI ☐ CT Scan ☐ Other: _____

Doctor's Notes: _____

_____

_____

Initial: [ ]

PLEASE READ AND INITIAL EACH SECTION

Initial: [ ]

Thank you for choosing us as your chiropractic healthcare provider. To help us provide timely care for all patients, we ask that you give at least **24 hours' notice** if you need to cancel or reschedule an appointment. Your appointment time is reserved specifically for you, and advance notice allows us to offer that time to another patient in need of care. Our office **does not** charge for missed or cancelled chiropractic appointments; however, we appreciate your effort to keep your scheduled time whenever possible.

PLEASE NOTE : massage appointments require at least **24 hours' notice** to cancel or reschedule. A **$25 cancellation fee** may apply for late cancellations or missed massage appointments.

Initial: [ ]

When you begin care at The Chiropractic Center of Lakeland, our goal is to help improve spinal function and reduce interference caused by spinal joint restrictions or misalignments. Chiropractic care focuses on the evaluation and correction of spinal subluxations, which are areas of the spine that may not be moving or functioning properly. Corrections are performed through chiropractic adjustments, either by hand or with a mechanical instrument, depending on the patient's needs.

Our office does not diagnose or treat diseases or conditions outside the scope of chiropractic care. If we find anything during your examination that appears unusual or may require care from another type of healthcare provider, we will recommend that you seek the appropriate evaluation.

Initial: [ ]

The claims for treatment for my current condition which the doctor will diagnose with an onset date of _____ , is **NOT** related to an automobile accident, workers compensation claim, or any other accident involving a third party or payor.

(Today's Date)

Patient Signature: _____ Date: _____

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 or treatment 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.
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.

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

_____	_____	_____
Name *(PRINT or TYPE)*	Signature	Date

The undersigned licensed medical professional or medical director, if applicable, 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. The treatment or services rendered were explained 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(14) and (15), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Licensed Medical Professional Rendering Treatment/Services or Medical Director, if applicable *(Signature by his/ 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.

ASSIGNMENT OF BENEFITS, LIENS, DIRECT PAYMENT AUTHORIZATION, AUTHORIZATION TO RELEASE INSURANCE INFORMATION, AND AUTHORIZATION TO ESCROW UNPAID MEDICAL & PIP BENEFITS

Chiropractic Center of Lakeland, Inc.

INSURANCE CARRIER: _____ POLICY NUMBER: _____ DATE OF LOSS: _____

For and in consideration of Chiropractic Center of Lakeland, Inc. agreeing to pursue the responsible automobile insurance carrier for payment of benefits due and not requiring prepayment for services, I hereby irrevocably assign all rights and benefits to Chiropractic Center of Lakeland, Inc. for Personal Injury Protection, extended Personal Injury Protection, Medical Payment Coverage, and other benefits which I may have in accordance with Florida Statute §627.736. This includes any benefits from my insurance company and any other entity which may be responsible for medical expenses incurred. I further authorize Chiropractic Center of Lakeland, Inc. to collect payments & prosecute any necessary actions to collect payment for services as they see fit and allowable by law and contract. THIS DOCUMENT CONSTITUTES AN ASSIGNMENT OF RIGHTS AND BENEFITS.

I hereby further give a lien to Chiropractic Center of Lakeland, Inc. against any and all insurance benefits named herein, and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by Chiropractic Center of Lakeland, Inc. as a result of the above stated loss date. This document acts as an irrevocable absolute assignment of my rights and benefits to the extent of the charges for services provided. I agree to cooperate with Chiropractic Center of Lakeland, Inc. and their attorney's (at their choosing), and to do all things reasonable to effect payment of the bills by the insurance company or other entity to Chiropractic Center of Lakeland, Inc. including, but not limited to, disclosing my medical condition, being available for factual discovery or other cooperation.

This assignment concerns only the bills for Chiropractic Center of Lakeland, Inc. and those costs including, but not limited to, attorney's fees, other costs, and interest necessary in procuring payment from the above-named insurance company and/or other entities. This assignment is not intended to assign any other causes of action that may belong to the undersigned patient. I agree to pay any applicable deductible or co-payment not covered by any policy of insurance cited above. I understand that as a benefit and convenience to me, Chiropractic Center of Lakeland, Inc. will bill and pursue collection against the insurance company or other responsible entity on my behalf. I hereby instruct and direct my insurance company to pay my benefits directly to Chiropractic Center of Lakeland, Inc. at the address provided on the bill. If my current policy prohibits direct payment to doctors, then I hereby instruct and direct my insurance company or other responsible entity to make the check payable to me and mail it to Chiropractic Center of Lakeland, Inc. at the address on the bill. Chiropractic Center of Lakeland, Inc.'s medical care is being provided for a reasonable fee for treatment causally related to the above loss date and is medically necessary. I instruct my insurance carrier or other responsible entity to pay these bills to the full extent of my available benefits under the insurance policy and Florida law. If any portion of the charge for these services is either reduced or denied in whole or in part, my insurance company or other entity is to place funds equal to the amount of the reduced or denied charges into escrow and hold the escrowed funds until agreement or resolution of legal action by Chiropractic Center of Lakeland, Inc.. I further instruct my insurance company to make payment for charges submitted by Chiropractic Center of Lakeland, Inc. in priority to any other requests to escrow benefits, including a request by myself to reserve benefits for pending disability claims. I hereby give Chiropractic Center of Lakeland, Inc. limited power of attorney to endorse and sign my name on any draft for payment to either Chiropractic Center of Lakeland, Inc. or myself if said draft represents payment for charges related to services rendered by Chiropractic Center of Lakeland, Inc..

I further direct my insurance carrier or responsible other entity to provide information to Chiropractic Center of Lakeland, Inc. which is otherwise available to me including but not limited to a copy of any applicable insurance policy, declaration page, all applicable endorsements, transcripts and/or copies of any recorded statements, examinations under oath and requests for same, independent medical evaluations and requests for same, peer review reports, and a listing of all PIP benefits paid to date which shall include when claims were made, when the claims were received, the payment or denial of each claim, the amount of the deductible and the claims applied thereto, and whether benefits have been exhausted and the amount of PIP benefits available, commonly known as a "PIP log". This request includes the name of other medical providers to whom payments have been under my policy of insurance. This agreement is intended to serve as an assignment of rights and benefits under my policy of insurance in favor of Chiropractic Center of Lakeland, Inc.. If any language within this agreement has the effect of invalidating this agreement, that language shall be deemed void and the remainder of the assignment shall maintain full force and effect. A photocopy of this assignment shall be considered as effective and valid as the original.

Patient Signature	Date	Patient Name

If patient is incapacitated or under the age of 18, please indicate the patient name, guardian name and relation to patient, and obtain guardian signature.

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Name: _____ Date: _____

Print Patient's Name

The undersigned does hereby acknowledge that he or she has received a copy of this office's Note of Privacy Practices Pursuant to HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersigned does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, Sate law and Federal Law.

Dated this _____ day of _____ , 20 _____

By _____

Patient's Signature

If patient is a minor or under a guardianship order as deined by State law:

By _____

Signature of Parent/Guardian (Circle One)