Core Health Chiropractic & Wellness

4300 N. University Dr. Suite B104, Sunrise, FL 33351 Office: (954) 636-8414 Fax (954) 252-2497

CHIROPRACTIC PATIENT HISTORY

Date of Birth_____ Social Security Number: _____
Last Name_____ First Name: _____ Email Address _____
Address: _____ Apt # _____
City: _____ STATE: _____ Zip: _____
Phone (H) _____ (W) _____ (Cell) _____
Emergency Contact_____ (Cell) _____
Your Occupation: _____ Employer: _____
Employer Address: _____
Insurance Company _____ Policy Number: _____
Claim Number/Insurer:_____
Have you ever been to another doctor for this problem? Y N Who? _____
Who referred you to this office? _____

WHAT BRINGS YOU TO OUR OFFICE?

FIRST COMPLAINT:_____

- Date when symptom first appeared: _____
- Did it begin: Gradual: _____Sudden: _____Progressive over time: _____
- What makes the symptoms increase? _____
- What relieves the symptoms? _____
- Type of Pain _____ Sharp _____ Dull _____Ache _____ Burn_____ Throb _____
- Does the Pain Radiate into your Arm _____Leg _____ Other_____ Does not radiate _____
- Do you experience Numbness or Tingling? _____Y _____N
- How often do you experience these symptoms? 100%_____ 75%_____ 50% _____ 25% _____ 10% _____
- PAIN INTENSITY: From 1 (Least) to 10 (worst): _____
- Are there any conditions or symptoms you have that may relate to your major symptom? _____

_____

What Makes the problem worse? Sitting __ Standing __ Bending __Coughing __ Lying down ___ Walking __
Sneezing ___ Other _____

OTHER COMPLAINT:_____

- Date when symptom first appeared: _____
- Did it begin: _____ Gradual: _____Sudden: _____Progressive over time: _____
- What makes the symptoms increase? _____
- What relieves the symptoms? _____
- Type of Pain _____ Sharp _____ Dull _____Ache _____ Burn_____ Throb _____
- Does the Pain Radiate into your _____Arm _____Leg _____Does not radiate _____
- Do you experience Numbness or Tingling? _____Y _____N
- How often do you experience these symptoms? 100%_____ 75%_____ 50% _____ 25% _____ 10% _____
- PAIN INTENSITY: From 1 (Least) to 10 (worst): _____
- Are there any conditions or symptoms you have that may relate to your major symptom? _____

_____

What Makes this problem worse? Sitting __ Standing __ Bending __Coughing __ Lying down ___ Walking __
Sneezing ___ Other _____

PATIENT SIGNATURE: _____ DATE: _____

PATIENT HISTORY

Please list all previous treatments for this condition:

Name of treating physician: _____ Date of treatment: _____
Type of treatment or Drugs Prescribed _____

Please list all past surgeries:

Type_____ When_____ Doctor _____
Type_____ When_____ Doctor _____

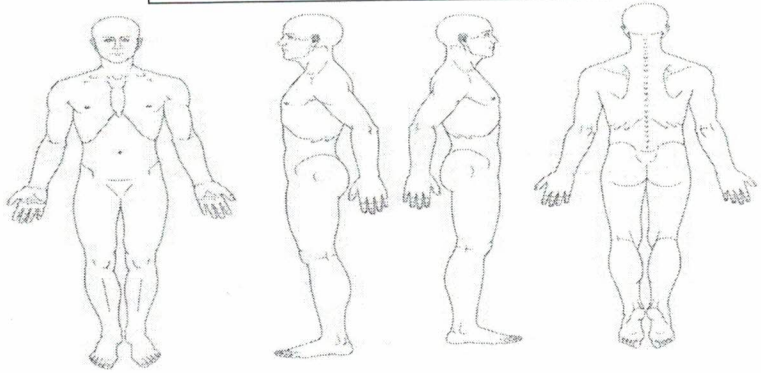
Please list all previous accidents and falls:

What _____ When _____
What _____ When _____

Please list any medications or vitamins you are currently taking:

_____
_____
_____
_____

PAIN LOCATION



Please mark off the areas of your complaint on the diagram above.
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**
CCC	**Where you experience Cramping**

Patient Signature: _____ Date: _____

ASSIGNMENT OF BENEFITS, AUTHORIZATION TO SETTLE CLAIM AND DIRECTION TO PAY MEDICAL PROVIDER DIRECTLY

Claimant:_____

Insured:_____

Insurer:_____

Claim #:_____

By my signature below, for good and valuable consideration (including but not limited to the extension of credit to me), I hereby assign, transfer and convey to **Core Health Chiropractic & Wellness** (hereinafter "the Provider") all of my rights, title and int in and to medical expense reimbursement in whatever form, including but not limited to any automobile liability medical expens payments or other health benefits indemnification and/or agreement otherwise payable to me. This payment shall not exceed my indebtedness to the above named assignee and I acknowledge that I will timely pay any indebtedness owed by me to the assigne that is not otherwise satisfied by the above-mentioned assigned proceeds. I also acknowledge that any medical expenses not covered under my insurance policy will be my responsibility.

I further authorize the Provider to negotiate, collect and settle any claim with any insurance carrier or other third party payor wit regard to these services, which authorization shall include authority to:
(1) request and receive from any insurer or any other party any and all documentation and records that I am empowered to reque regarding this claim, including, without limitation, a statement of coverage, policy declarations page and insurance policy pursu to Section 627.4137. In addition, the provider has the authority to request and receive any Independent Medical Examination Reports, notices sent to me regarding appointments for Independent Medical Examinations and Examinations Under Oath (inclu proof of mail), Records Review Reports, coverage denial letters, Explanations of Benefits, and Benefit Payment Sheets or Logs (P.I.P. Payout Sheets), without regard as to whether such documentation has already been provided to me and,
(2) to endorse in my name any check issued for payment where benefits were assigned. By way of this assignment and notice, I further instruct you, the insurer, to furnish to Provider copies of all future notices affecting Provider's interest in this claim, including, without limitation, any notices of requested medical examinations or statements.

The Provider hereby objects to any reductions or partial payments. Any partial or reduced payment, regardless of the accompany 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 reduce amount as payment in full.

I further direct my insurer to direct all payments for services rendered by the Provider directly to Provider at the billing address contained on Provider's medical bills.

THIS IS A DIRECT AND IRREVOCABLE ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER MY POLICY OF INSURANCE.

A photocopy of this form shall be considered as effective and valid as the original.

I have read the foregoing and understand and agree to each of the above provisions:

_____ _____

Patient's signature Date

Core Health Chiropractic & Wellness

STANDARD DISCLOSURE AND ACKNOWLEDGMENT FORM

Personal Injury Protection - Initial Treatment or Service Provided

*(an original of this form will be 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 ability 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 $500.00.

The undersigned licensed medical professional affirms the statement numbered #I 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 of Type: _____ Signature: _____ Date: _____

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

NAME (Print of 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), Fl 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.

Core Health Chiropractic & Wellness

Personal Injury/Auto Accident History Form

Important- Please fill out the following in complete detail:

Your Name: _____ Today's Date: _____

Date of Accident: _____ Time of accident: _____am. /pm.

City of Accident: _____ Street of accident: _____

Road conditions at the time of the accident: WET DRY ICY OTHER _____

Did the police come to the accident scene? YES ____ NO____; Is there a report? YES ____NO____

Did you go to a hospital? YES ____ NO ____

If yes, what is the name and city of the hospital? _____

How did you get to the hospital? _____

What parts of your body were X-rayed at the hospital? _____

What did the hospital do for your injuries? _____

How long did you stay at the hospital? _____

What bleeding cuts did you sustain during this accident? _____

What bruises did you sustain during this accident? _____

WHERE were you seated in the vehicle? _____

Were you aware of the approaching collision prior to impact, or did impact catch you be surprise?

AWARE VS SURPRISE

Did you lose consciousness (black out) upon impact? YES ____ NO ____; How long? _____

From the accident, did you become? (Please circle): CONFUSED DISORIENTED LIGHT HEADED
DIZZY NAUSEATED BLURRED VISION RING/BUZZ IN EARS

If you still have any of those symptoms, which ones? _____

Are you currently suffering from any of the following (please circle):

RESTLESSNESS	IRRITABLE
DIFFICULT CONCENTRATING	DIFFICULT WITH MEMORY
SLEEPLESSNESS	FORGETFULNESS
REDUCED TOLERANCE TO HEAT	REDUCED TOLERANCE TO ALCOHOL

How far was the top of the headrest or seatback from the top of your head? _____

Where you wearing a seatbelt? YES ____ NO_____

If yes, check which type. Lap seatbelt_____ or shoulder-lap seatbelt _____.

List the year, make and model of the vehicle you were in:

Year _____ Make _____ Model_____

What is the year, make and model of the other vehicle?

Year _____ Make _____ Model_____

Personal Injury/Auto Accident History (Continued)

Was your car stopped at the time of impact? YES____ NO ____
If no, then estimate the speed of the vehicle you were in: _____ mph.

On what part of the automobile did your following body parts hit? _____

Did you receive any injury from the seat belt? YES ____ NO ____
If Yes, then describe: _____

What is the estimated cost in damage to the vehicle you were in $ _____

Was your head pointed straight forward? YES____ NO ____; If No, what direction was it turned and by how much? _____

Was the other vehicle moving at the time of the collision? YES____ NO ____
If yes, what was its approximate speed? _____mph

Please describe, to the best of your knowledge, what happened during this accident:

_____
_____
_____
_____
_____

Was any other doctor consulted after your accident? _____
If yes, what was the doctor's name? _____

What care was given? _____

Have you been unable to work due to this accident? _____
If yes, give dates_____

Have you returned to work? _____ If yes, when? _____
If you have not returned to work, when do you expect to return? _____

Have you had any surgeries? _____
If yes, what and when? _____

Have you had any accidents or injuries prior to this injury? _____
If yes, explain_____
Is your injury covered by insurance? _____
If yes, name of insurance company and adjuster_____
_____
Have you retained an attorney? _____If yes, his name and address _____
_____

Signed: _____ Date: _____

Core Health Chiropractic & Wellness

OFFICE POLICIES

Patient-Doctor Agreements
The purpose of these agreements is to allow us to more completely serve you and to get the best result in the shortest amount of time. It is our experience that those who adhere to the following agreements get the best results,

Signing In
When you arrive, please sign in at the front desk. You will be called and assigned a treatment room in the order you signed in. Other patients may be called before you because of the particular services being received that day or their doctor may be available before yours. When you go to the assigned treatment room, rest, relax and the doctor will be in as soon as possible.

New Injuries
In the event you sustain a new injury. Please let the front desk know as soon as possible. There may be additional paper work to be filed out.

Appointments
After your treatment, please be sure to stop at the front desk to take care of any co-pays or balances, and be sure to make your next appointment.

Payment of Bills
We will expect that you honor all financial agreements made with our office. If you find that you cannot fulfill your financial obligation, notify our financial manager immediately so that new arrangements can be made. Our policy is that patients maintain a zero personal balance. Insurance companies are expected to pay their portion within 45 days of claim submission. If they do not, we expect the patient to call the insurance company on our behalf to help get the claim paid. If an insurance company sends a check to your home, it should be brought or sent to our office as soon as possible unless told specifically this is not the case. Please also bring in the attached explanation of benefits (EOB).

Rescheduling Appointments
We have set up a specific course of treatment for you. A certain number of treatments in a set amount of time are required for us to get the results we both desire. If you need to change this time, please reschedule your appointment for another time on the same day if possible. If the same day is not possible, be sure to make up the missed appointment within one week. **For our massage therapy patients and counseling patients, a 24-hour advance notice phone call is required, so that we may fill that slot. If 24 hours notice is not given a cancellation fee will be charged to your account.**

Progress Evaluations and Re-Examinations
Progress evaluations and re-examinations will be performed periodically to determine your rate of progress and future course of treatment. A special time will be set up for your re-evaluation appointments.

Upsets
We are here to serve YOU. Please speak with the staff or doctor about anything that could be upsetting you (i.e. long waits, staff insensitivity, treatment confusion etc.). We see your comments as helping us to help you and others.

Patient Signature_____ Date: _____

Core Health Chiropractic & Wellness

Informed Disclosure and Consent:
Chiropractic Spinal Adjustment Procedures and Physical Modalities

You have the right as a patient to be informed about your injuries and/or condition, as well as the doctor's recommended procedures and any necessary referrals to be utilized to evaluate and treat your complaints. There are potential risks and benefits in all forms of commonly used treatment, including deciding on non-treatment in the hope that the pain and/or lack of ability to perform normal activities will eventually go away. Evaluations at this office consist of a thorough regional examination of your complaints and any necessary diagnostic X-rays. If you are a female of child bearing age, you must inform the physician if there is even the slightest possibility that you may be pregnant (you must be sexually active and have missed a menstrual period), as X-rays can have harmful effects on a fetus. The physician will perform various Range of Motion and Orthopedic Stress Tests to determine the most likely cause of your pain and most appropriate course of treatment for each of your complaints. Your non-surgical spinal-related complaints will be treated with specific chiropractic spinal adjustment procedures using the hands or a mechanical instrument. You may feel joint movement and hear joint noises during the procedure. Minor temporary soreness may occur, particularly early in the treatment, or during periods of flare-up with your return to normal activities; this is also true of massage therapy and physical therapy. More significant risks (for example, fractures, sprains/strains, strokes and disc injuries) are rare. Chiropractors, or D.C.'s, have the lowest medical malpractice insurance claims of all primary care physicians in the USA, including M.D., D.O., D.D.S., D.V.M. and D.P.M. practitioners. The for-profit malpractice insurance industry has determined there is less risk involved in chiropractic spinal adjustment procedures and the adjunct therapies than in the prescribing of medication and surgery (both of which, however, may be necessary for a patient's recovery). I do not expect the doctor to be able to anticipate and explain all potential risks and complications, and I wish to rely on the doctor's education, training and experience to exercise judgment during the course of treatment, based on the facts then known, to do what is in my best interest. I further acknowledge that treatment may worsen or fail to relieve all of my spinal-related pain and that no guarantee of a "new spine" or complete cure have been given. I have had the opportunity to ask questions, and all my questions have been answered fully and satisfactorily. By signing below, I consent to the prescribed treatment plan and intend for this consent form to cover the entire course of treatment for my current complaints and for future conditions for which I seek treatment for my current complaints and/or therapists working at this office (or for the minor patient named below for whom I am the custodial parent or legal guardian).

Signature: _____ Date: _____

Printed Name: _____

If a minor (less than 18 years old), Parent or Guardian's name: _____

Parent or Guardian's signature: _____

Core Health Chiropractic & Wellness

Release of Records / Payment Agreement And Assignment of Benefits

Patient to sign prior to any medical treatment to be performed

Patient: _____ Date: _____

I hereby authorize: Core Health Chiropractic & Wellness, my Health Care Provider/Facility, **to release any and all medical information** to the above named insurance carrier(s), or to my designated attorney, now or in the future, and/or to my physician(s), if necessary, for the purposes of payment of my medically related outstanding debts, administration and evaluation, utilization review and financial audit. This, authorization remains valid and effective from the date of this signing until revoked in writing, to both my insurance carrier and to this provider of services. 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 records are without the expressed written consent of the patient or the patient's legal representatives.

Payment Agreement: All charges are due at the time of service, unless other arrangements have been made in advance. All professional services rendered are charged to the patient and the patient is responsible for all fees, regardless of insurance coverage. I understand I am responsible to the above -mentioned facility/provider, for charges not covered by this assignment, including deductibles & co-payment requirements by my insurance policy or certificate. I further agree that in the event of non-payment, I will bear the expenses of collection and /or court costs, and reasonable legal fees, should this be required. I understand if my commercial insurance has not paid the bill within 60 days of my visit(s), for my services received by my provider /facility, I am responsible, and I will then make whatever arrangements are necessary & available to me to pay all unpaid charges.

Assignment of Benefits: I hereby assign to Core Health Chiropractic & Wellness Center my health Care Provider /Facility, all money to which I am entitled for medically related expenses, received at, or through the above mentioned facility. The payment shall not exceed my indebtedness. Any payment that facility/health care provider, received by the insurance company, beyond my indebtedness shall be refunded to me, when my outstanding bill(s) with them are paid.

I understand I may request a copy of any or all of my medical records for a reasonable fee or a fee allowed by State Statute or Workers' Compensation Statute. Any copy of this document shall be as valid as if it were the original. I have read the above authorization to release medical records, assignment of benefits, and payment agreement, and hereby acknowledge that I understand it. The payment agreement portion of this instrument may not be revoked in writing or otherwise.

Signed: _____ Date: _____

Witness: _____ Date: _____

Core Health Chiropractic & Wellness

ACKNOWLEDGEMENT 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.

Patient Name (Please Print)_____ Date:_____

_____
Parent, Guardian, or Patient's legal representative

_____
Signature

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.