

**PATIENT NAME:** \_\_\_\_\_ **TODAY'S DATE:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **DATE OF ACCIDENT:** \_\_\_\_/\_\_\_\_/\_\_\_\_

## PATIENT INTAKE – AUTO INJURY

### PERSONAL INFORMATION

First Name: \_\_\_\_\_ M.I. \_\_\_\_\_ Last Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_ Gender: ☐ Male ☐ Female ☐ Unspecified SSN: \_\_\_\_/\_\_\_\_/\_\_\_\_

Primary Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Home Email: \_\_\_\_\_ Work Email: \_\_\_\_\_

*By providing my email address, I authorize my doctor to contact me via the email address(es) provided.*

Which email would you like us to use to communicate with you? (check one) ☐ Home ☐ Work

Contact Method: (check one) ☐ Primary Phone ☐ Cell Phone ☐ Work Phone ☐ Home Email ☐ Work Email

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Drivers License #: \_\_\_\_\_

Spouse/Parents Name: \_\_\_\_\_ Spouse/Parents Occupation: \_\_\_\_\_

Spouse/Parents Employer: \_\_\_\_\_ Spouse/Parents Social Security #: \_\_\_\_\_

Spouse/Parents Work #: \_\_\_\_\_ Spouse/Parents Cell #: \_\_\_\_\_

### EMERGENCY CONTACT

Name: \_\_\_\_\_ Relation to You: \_\_\_\_\_

Home#: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_

### HOW DID YOU HEAR ABOUT US?

*Please be as specific as possible so we can track how our patients FIRST heard about us!*

☐ BrevardChiro.com ☐ BrevardDisc.com ☐ Google ☐ Drive-by ☐ Email Blast ☐ TV Commercial ☐ Radio

☐ Facebook ☐ Yelp ☐ Direct Mailer ☐ YouTube ☐ School ☐ Work ☐ Clinic Employee: \_\_\_\_\_

☐ Magazine Ad: \_\_\_\_\_ ☐ Newspaper: \_\_\_\_\_ ☐ Referred by Friend: \_\_\_\_\_

☐ Current Patient of Physician/NP ☐ Other: \_\_\_\_\_

### ADDITIONAL HEALTH INTERESTS

*Please mark which services and treatments are of interest to you.*

\_\_\_\_ I am interested in Custom Orthotics.

\_\_\_\_ I am interested in Neuropathy Treatment for myself or someone I know.

\_\_\_\_ I am interested in Botox, Dermal Fillers, and/or B12 Injections.

\_\_\_\_ I am interested in Massage Therapy.

\_\_\_\_ I am interested in Treatment for Osteoarthritis.

**MAJOR MEDICAL INSURANCE OR PRIVATE PAY INFORMATION***Please provide insurance card(s) to receptionist.***Auto accident related insurance information will be requested on a separate form.****Type of Insurance:** ☐ Private Ins. ☐ Medicare ☐ Auto Ins. ☐ Worker's Comp ☐ Other \_\_\_\_\_**Primary Insurance Carrier:** \_\_\_\_\_ Phone: \_\_\_\_\_

Policy# \_\_\_\_\_ Group # \_\_\_\_\_ Claim# \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Policy Holder's Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Policy Holder's SSN: \_\_\_\_/\_\_\_\_/\_\_\_\_ Employer: \_\_\_\_\_

Is patient covered by another insurance? ☐ Yes ☐ No**Type of Insurance:** ☐ Private Ins. ☐ Medicare ☐ Auto Ins. ☐ Worker's Comp ☐ Other \_\_\_\_\_**Secondary Insurance Carrier:** \_\_\_\_\_ Phone: \_\_\_\_\_

Policy# \_\_\_\_\_ Group # \_\_\_\_\_ Claim# \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Policy Holder's Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Policy Holder's SSN: \_\_\_\_/\_\_\_\_/\_\_\_\_ Employer: \_\_\_\_\_

Reason for today's visit: \_\_\_\_\_

Is this condition due to an accident? ☐ Yes ☐ No Date of Accident: \_\_\_\_\_Type of Accident ☐ Auto ☐ Work ☐ Home ☐ Other \_\_\_\_\_To whom have you made a report of your accident? ☐ Auto Insurance ☐ Employer ☐ Worker Compensation ☐ Other \_\_\_\_\_**ASSIGNMENT/AUTHORIZATION/RELEASE:**

I certify that I, and/or my dependents, have insurance with the above named insurance company(s) and assign directly to Brevard Chiropractic & Injury Center all benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. I understand that "co pays" are payable at the time of each visit and that I am financially responsible for all charges whether or not paid by insurance. The above named provider's office may use my health care information and may disclose such information to the above named insurance company(s) and their agents for the purpose of obtaining payment for services and determining benefits payable for related services.

☐ **Private Pay/Cash:** By checking this box, I acknowledge that I do not have insurance and understand that I am financially responsible for all services at the time they are rendered.

\_\_\_\_\_  
Name of Person Responsible For This Account\_\_\_\_\_  
Relationship to Patient

(X)

\_\_\_\_\_  
Responsible Party Signature\_\_\_\_\_  
Date

**Report of Accident**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Date of Accident: \_\_\_\_\_ Time of Accident: \_\_\_\_\_ ☐ A.M. ☐ P.M. City of Accident: \_\_\_\_\_

Street of Accident that your car was on: \_\_\_\_\_ Cross Street (intersection): \_\_\_\_\_

Type of accident: ☐ Head-on ☐ Broadside ☐ Front impact ☐ Rear-ended car in front ☐ Rear impact ☐ Non collision

If a traffic violation was issued, to whom was it issued? \_\_\_\_\_

**Road conditions at the time of incident:** ☐ Wet ☐ Dry ☐ Other**Visibility at time of crash:** ☐ Poor ☐ Fair ☐ Good ☐ Other**Weather conditions:** ☐ Clear ☐ Rainy ☐ Other**Light conditions:** ☐ Sunny/Bright ☐ Overcast/Cloudy ☐ Dusk ☐ Dark**Road Type:** ☐ Concrete ☐ Asphalt ☐ Gravel ☐ Dirt ☐ Other**Were you wearing your seat belt?** ☐ Yes ☐ No**Were shoulder harnesses worn?** ☐ Yes ☐ No**Did the police come to the scene?** ☐ Yes ☐ No**Was an accident report filed?** ☐ Yes ☐ No**Were there any witnesses?** ☐ Yes ☐ No**The following questions pertain to you, the patient, and the vehicle you were in:**

Number of people in accident vehicle: \_\_\_\_\_

Where were you seated? ☐ Mid front ☐ Left front ☐ Right front ☐ Left rear ☐ Mid rear ☐ Right rearWere you: ☐ aware of the approaching collision or ☐ surprised by impact? Did you brace for impact? ☐ Yes ☐ NoWere you rendered unconscious? ☐ Yes ☐ No If yes, for how long? \_\_\_\_\_

At the time of the crash, recall what parts of your head or body struck what parts inside the car: \_\_\_\_\_

In relation to the base of your skull, where was the headrest? ☐ Above ☐ Below ☐ At base of skullHead/Body position at the time of impact: ☐ Head turned left/right ☐ Head looking back ☐ Head straight forward ☐ Body straight in sitting position ☐ Body rotated right/left ☐ Other: \_\_\_\_\_Was this vehicle equipped with airbags? ☐ Yes ☐ No If yes, did it/they inflate? ☐ Yes ☐ No If yes, were you struck? ☐ Yes ☐ NoWhat did your vehicle impact? ☐ Another Vehicle ☐ Other**Vehicle Information & velocity pertaining to the vehicle you were in:**

Who owns the car you were in? \_\_\_\_\_

Vehicle Year: \_\_\_\_\_ Make: \_\_\_\_\_ Model: \_\_\_\_\_ Transmission type ☐ Manual ☐ AutoWas your car ☐ Moving or ☐ Stopped If your car was moving: How fast were you traveling? Approximately \_\_\_\_\_ MPH

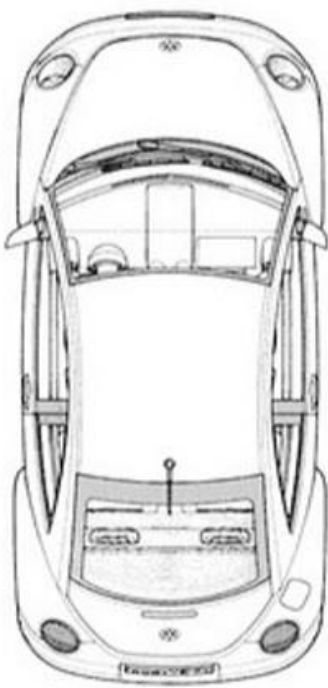
Just before impact, the vehicle you were in was:

☐ Slowing down ☐ Speeding Up ☐ Constant Speed ☐ Stopped

Did the impact to your vehicle come from the:

☐ Front ☐ Rear ☐ Right Side ☐ Left Side ☐ Other \_\_\_\_\_**The following questions pertain to the other vehicle involved in the accident:**Other Vehicle Year: \_\_\_\_\_ Make: \_\_\_\_\_ Model: \_\_\_\_\_ Transmission type ☐ Manual ☐ AutoWhat direction was the other vehicle traveling? ☐ North ☐ South ☐ East ☐ WestWas the other car ☐ Moving or ☐ Stopped If the other car was moving: How fast was it traveling? Approximately \_\_\_\_\_ MPHJust before impact, the other car was: ☐ Slowing down ☐ Speeding Up ☐ Constant Speed

**Report of Accident**

<p><b>Indicate where the initial impact struck your vehicle by marking an "X" on the diagram below:</b></p>	<p>I was traveling N S E W (circle one) on _____ (name of road) when: _____</p> <p>_____</p> <p>_____</p> <p style="text-align: center;"><b><i>Illustrate below how the accident happened:</i></b></p>
	

Were there bleeding cuts caused by the accident? ☐ Yes ☐ No Where: \_\_\_\_\_

Where there any bruises caused by the accident? ☐ Yes ☐ No Where: \_\_\_\_\_

What were the cost of damages to the vehicle you were in? \$ \_\_\_\_\_

Were you wearing a hat or glasses? ☐ Yes ☐ No If yes, still on after crash? ☐ Yes ☐ No

Could you move all parts of your body? ☐ Yes ☐ No If no, what parts couldn't you move and why? \_\_\_\_\_

\_\_\_\_\_

Were you able to get out of the car and walk unaided? ☐ Yes ☐ No If no, why? \_\_\_\_\_

Please describe how you felt:

Immediately after the crash: ☐ Dazed ☐ Confused ☐ Shaken ☐ Uncontrolled feelings ☐ Other

Later that day: ☐ Sore ☐ Stiff ☐ Little pain ☐ Moderate pain ☐ Severe pain

The next day: ☐ Better ☐ Same ☐ Worse ☐ Much worse ☐ Intolerable pain

If you have been involved in previous auto accidents, please list the year of each incident: \_\_\_\_\_

Please list any additional information not covered above that we should know about: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Report of Accident

### Insurance Information

Name of Insurance Company: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Insured's SS #: \_\_\_\_\_

DOB: \_\_\_\_\_ Insured's Employer: \_\_\_\_\_

Policy #: \_\_\_\_\_ Claim #: \_\_\_\_\_

Name of Claim Representative: \_\_\_\_\_ Telephone #: \_\_\_\_\_

### Attorney Information

Attorney's Name: \_\_\_\_\_ Name of Law Firm: \_\_\_\_\_

Attorney's Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Attorney's Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

### Medical Care

Have you gone to a Hospital or seen any other Doctor? ☐ Yes ☐ No When did you go? ☐ Just after accident ☐ Next Day

Mode of Transportation: ☐ Ambulance ☐ Privately transported Other: \_\_\_\_\_

Name of Hospital and/or Attending Doctor: \_\_\_\_\_

Was he/she a: ☐ D.C. ☐ M.D. ☐ D.O. ☐ D.D.S. ☐ P.A.

Were X-Rays taken? ☐ Yes ☐ No If yes, what was X-Rayed: \_\_\_\_\_

Was medication prescribed? ☐ Yes ☐ No Describe any treatment you received: \_\_\_\_\_

### Work

To evaluate the effect that continuing work will have on your recovery please complete the following: Have you been able to work since the injury? ☐ Yes ☐ No Are your work activities restricted as a result of your injuries sustained? ☐ Yes ☐ No

How many hours are in your normal work day? \_\_\_\_\_

What can you do for work with minimum physical effort and for how long? \_\_\_\_\_ ☐ N/A

Prior to the injury were you capable of working on an equal basis with others your age? ☐ Yes ☐ No ☐ N/A

While in recovery, is there any light duty work you could request? ☐ Yes ☐ No ☐ N/A

Please indicate your daily job duties and any activities in which you are occasionally asked to perform:

☐ Standing ☐ Sitting ☐ Walking ☐ Lifting ☐ Driving ☐ Twisting ☐ Crawling ☐ Bending

☐ Operating equipment ☐ Working with arms above head ☐ Typing ☐ Stooping ☐ Other: \_\_\_\_\_

### Complaint(s)/Pain Location(s)

<input type="checkbox"/> Dizziness	<input type="checkbox"/> Migraines	<input type="checkbox"/> Shortness of breath
<input type="checkbox"/> Memory Loss	<input type="checkbox"/> Headaches	<input type="checkbox"/> Upper back → <input type="checkbox"/> pain <input type="checkbox"/> stiffness
<input type="checkbox"/> Blurred vision	<input type="checkbox"/> Neck → <input type="checkbox"/> pain <input type="checkbox"/> stiffness	<input type="checkbox"/> Mid back → <input type="checkbox"/> pain <input type="checkbox"/> stiffness
<input type="checkbox"/> Chest pain	<input type="checkbox"/> Jaw problems	<input type="checkbox"/> Lower pain → <input type="checkbox"/> pain <input type="checkbox"/> stiffness
<input type="checkbox"/> Difficulty sleeping	<input type="checkbox"/> Arm pain <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both	<input type="checkbox"/> Leg pain → <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Shoulder pain → <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both	<input type="checkbox"/> Numb Feet/Toes → <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both
<input type="checkbox"/> Irritability	<input type="checkbox"/> Ringing/Buzzing in ear → <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Stomach Upset	<input type="checkbox"/> Shortness of Breath	
<input type="checkbox"/> Tension	<input type="checkbox"/> Nausea	

## Report of Accident

### Patient Current Condition and Pain Form

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Complaint/Pain Location(s) (example: neck, shoulders, upper back, mid-back, low-back, hips, extremities):

What previous care/treatment have you received for your condition?

☐ Physical Therapy ☐ Chiropractic ☐ Medication ☐ Surgery ☐ None ☐ Other \_\_\_\_\_

#### Usual Pain Intensity

No pain 0 1 2 3 4 5 6 7 8 9 10 Severe pain

#### Today's Pain Intensity

No pain 0 1 2 3 4 5 6 7 8 9 10 Severe pain

Please list any recent falls and/or injuries:

What have you tried to help alleviate your condition?

**Please fill out this portion based on your current condition.**

Date of Injury/Onset: \_\_\_\_\_

How would you describe the character of your condition/pain?  
 (please check all that apply)

☐ Sharp ☐ Dull ☐ Tingling ☐ Numb  
☐ Aching ☐ Shooting ☐ Radiating ☐ Burning  
☐ Throbbing ☐ Cramping ☐ Stiffness ☐ Swelling  
☐ Other \_\_\_\_\_

How often do you experience your symptoms?

☐ Constantly (76%-100% of the time)  
☐ Frequently (51%-75% of the time)  
☐ Occasionally (26%-50% of the time)

When do you experience your symptoms?

	Comfortable	Uncomfortable	Painful
Lying down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stretching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Running	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pulling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing from a seated position	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Additional Comments:

## Report of Accident

**A. Date of last:** Spinal Exam: \_\_\_\_\_ Bone Scan: \_\_\_\_\_  
 Spinal X-Ray: \_\_\_\_\_ MRI: \_\_\_\_\_  
 Chest X-Ray: \_\_\_\_\_ CT Scan: \_\_\_\_\_

Medical Doctor: \_\_\_\_\_ Previous Chiropractor: \_\_\_\_\_  
 Physical Therapist: \_\_\_\_\_ Massage Therapist: \_\_\_\_\_

## B. Injuries, Traumas, and Illnesses

Broken Bones/Fractures: \_\_\_\_\_ Head Injuries: \_\_\_\_\_  
 Dislocations: \_\_\_\_\_ Falls: \_\_\_\_\_

**Please check the box to indicate if you have or have had any of the following:**

<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Cancer	<input type="checkbox"/> Gout	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Neuropathy	<input type="checkbox"/> Prosthesis
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Chemical Dependency	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Psychiatric Care
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hernia	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Pace Maker	<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> Asthma	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Herniated Disc	<input type="checkbox"/> Migraines	<input type="checkbox"/> Parkinson's Disease	<input type="checkbox"/> Stroke
<input type="checkbox"/> Bleeding Disorders	<input type="checkbox"/> Goiter	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Pinched Nerve	<input type="checkbox"/> Thyroid Problems

Please list any other illnesses or injuries: \_\_\_\_\_

## C. Surgeries:

Type of Surgery	Date	Surgeon/Hospital

## D. Current Medications: (if certain attributes of your medication(s) are unknown, please write unknown)

Medications or Vitamins/Herbs/Minerals	Dosage (mg)	Frequency	Prescribing Doctor
<input type="checkbox"/> No Current Medications			

## E. Females – Pregnancy:

Are you currently pregnant? ☐ No ☐ Yes Due Date : \_\_\_\_\_

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient/Guardian Printed Name: \_\_\_\_\_

## SYMPTOM DIAGRAM

Name \_\_\_\_\_ Number \_\_\_\_\_ Date \_\_\_\_\_

Please be sure to fill this form out extremely accurately. Mark the area(s) on your body where you feel the described sensation(s). Use the appropriate symbol(s). Mark areas of radiating pain, and include all affected areas. You may draw on the face as well.

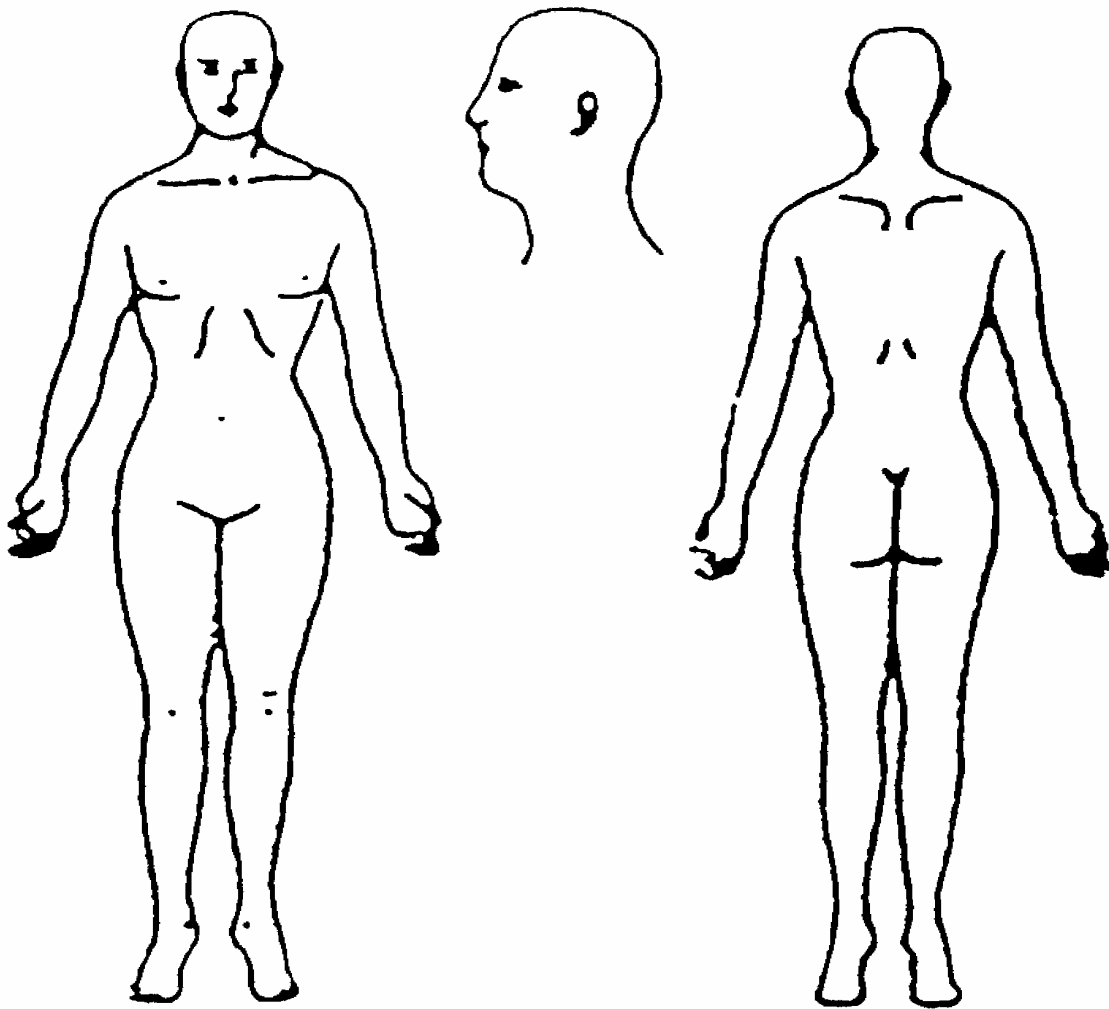
Aches ^^^^

Numbness oooo

Pins/Needles ●●●●

Burning xxxx

Stabbing ///





***Directions:** This questionnaire has been designed to give the doctor information as to how your pain has affected your ability to manage in everyday life. Please check one item in each section that most closely applies to you.*

## **INJURY HISTORY**

### **Section 1. Pain Intensity**

- ☐ I can tolerate the pain I have without using painkillers.
- ☐ The pain is bad but I manage without taking painkiller
- ☐ Painkillers give no relief from pain and I do not use them.
- ☐ Painkillers give complete relief from pain.
- ☐ Painkillers give moderate relief from pain.
- ☐ Painkillers give very little relief from pain.

### **Section 2. Personal care (washing, dressing, etc.)**

- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally but it causes extra pain.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help every day in most aspects of self-care.
- ☐ I do not get dressed, wash with difficulty, and stay in bed.

### **Section 3. Lifting**

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it causes extra pain, but I can manage if they are conveniently positioned (on a table).
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can only lift very light weights.
- ☐ I cannot lift or carry anything at all.

### **Section 4. Walking**

- ☐ Pain does not prevent me from walking any distance.
- ☐ Pain prevents me from walking more than one mile.
- ☐ Pain prevents me from walking more than ½ mile.
- ☐ Pain prevents me from walking more than ¼ mile.
- ☐ I can only walk using a cane or crutches.
- ☐ I am in bed most of the time and have to crawl to the toilet.

### **Section 5. Sitting**

- ☐ I can sit in any chair as long as I like.
- ☐ I can only sit in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting for more than one hour.
- ☐ Pain prevents me from sitting for more than 30 minutes.
- ☐ Pain prevents me from sitting for more than 10 minutes.
- ☐ Pain prevents me from sitting at all.

### **Section 6. Standing**

- ☐ I can stand as long as I like without extra pain.
- ☐ I can stand as long as I want but it causes extra pain.
- ☐ Pain prevents me from standing for more than one hour.
- ☐ Pain prevents me from standing for more than 30 minutes.
- ☐ Pain prevents me from standing for more than 10 minutes.
- ☐ Pain prevents me from standing at all.

### **Section 7. Sleeping**

- ☐ Pain does not prevent me from sleeping well.
- ☐ I can sleep well only by using tablets.
- ☐ Even when I take tablets I have less than 6 hours sleep.
- ☐ Even when I take tablets I have less than 4 hours sleep.
- ☐ Even when I take tablets I have less than 2 hours sleep.
- ☐ Pain prevents me from sleeping at all.

### **Section 8. Sex Life**

- ☐ My sex life is normal and causes no extra pain.
- ☐ My sex life is normal and causes some extra pain.
- ☐ My sex life is nearly normal but is very painful.
- ☐ My sex life is severely restricted by pain.
- ☐ My sex life is nearly absent because of pain.
- ☐ Pain prevents any sex life at all.

### **Section 9. Social Life**

- ☐ My social life is normal and gives me no extra pain.
- ☐ My social life is normal but increase the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests.
- ☐ Pain has restricted my social life and I do not go out as often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have no social life because of pain.

### **Section 10. Traveling**

- ☐ I can travel anywhere without extra pain.
- ☐ I can travel anywhere but it gives me extra pain.
- ☐ Pain is bad but I manage journeys over 2 hours.
- ☐ Pain restricts me to journeys of less than one hour.
- ☐ Pain restricts me to short necessary trips under a half hour.
- ☐ Pain restricts me from traveling except to the doctor or hospital.

## **Informed Consent to Chiropractic Adjustments and Care**

I have been informed that it is not uncommon for patients to have some increased discomfort after an adjustment. If that happens, I will apply ice to the area and rest it. If I am concerned about the discomfort or develop any new symptoms, I can call the office and speak to the staff. If I am out of town or unable to contact the doctor, I can present myself to the emergency room.

If any test were performed outside of this office (laboratory or other diagnostic procedures) I understand the doctor will notify me of the results at my next scheduled appointment or when the reports are available.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various methods of physical therapy and if necessary, diagnostic x-rays, on me by the doctor of chiropractic in this office and or anyone working in this clinic authorized by the doctor of chiropractic.

I further understand and have been informed that, as in all health care, in the practice of chiropractic there are some very slight risks to treatment, including, but not limited to muscle strains and sprains. I do not expect the doctor to be able to anticipate and explain all the risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time based upon the facts then known, is in my best interests.

I have read the above consent, and by signing below, I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition for which I seek treatment.

\_\_\_\_\_  
Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

### **X-RAY/MEDICAL RELEASE/INSURANCE INFORMATION:**

I hereby authorize that all medical records, x-rays and any other pertinent medical information be released to Brevard Chiropractic & Injury Center. Also to disclose all insurance coverage for treatment provided herein.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Social Security #

**Brevard Chiropractic & Injury Center**

Timothy Bortz, D.C.

3260 Murrell Road, Suite 101

Rockledge, FL. 32955

(321) 631-1100



Dr. Timothy Bortz, DC  
3260 Murrell Rd., Suite 101  
Rockledge, FL. 32955  
321-631-1100  
www.BrevardChiro.com

## IRREVOCABLE DOCTORS LIEN

**To: Attorney or Insurance Carrier** \_\_\_\_\_

**My Patient/Your Client:** \_\_\_\_\_

**Date of Accident:** \_\_\_\_\_

I hereby authorize Brevard Chiropractic & Injury Center to furnish you, my attorney/insurance carrier, with a full report of their 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/insurance carrier to pay directly to said doctor such sums as may be due and owing him/her office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately 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 therewith. In the event that a dispute may arise out of the terms of agreement and requires BCIC to hire an attorney, the patient shall be responsible for payment of all attorneys' fees and all costs that are incurred in enforcing the agreement.**

I fully understand that I am directly responsible to said doctor for all professional bills submitted by him/her for services rendered to me and that this agreement is made solely for said doctor's additional protection and in consideration of him/her awaiting payment.

**Patient Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

## ASSIGNMENT OF NO-FAULT INSURANCE BENEFITS

I hereby authorize, direct and demand that my personal injury protection insurance pay directly to my assignee **Brevard Chiropractic & Injury Center 3260 Murrell Road, Suite 101 Rockledge, FL. 32955** such sums as may be due and owing in this office for services rendered to me, both by reason of accident or illness and by reason of any other bills that are due this office, and to withhold such sums from any disability benefits, medical payment benefits, no-fault benefits, health and accident benefits, worker's compensation benefits, or any other insurance benefits obligated to reimburse me or from any settlement, judgment or verdict on my behalf as may be necessary to adequately protect said office. I hereby further give a lien to said office 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 said office. This is to act as an assignment of all my rights, benefiting and privileges under my insurance policy to my assignees for any and all amounts owed.

I hereby assign and transfer to this my assignee/health care provider any and all causes of action that I may have or that might exist in my favor against my insurance company and authorize this office to prosecute said cause of action either in my name or in the office's name, and further I authorize this office to compromise, settle or otherwise resolve said claim or cause of action as they see fit.

I authorize the office to release pursuant to Privacy Rule, 45C.F.R. parts 160 and 164 promulgated pursuant to the HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 ("HIPAA"), Pub. L. No. 104-191, 110 Stat. 1936 (1996), any information including, but not limited to, medical records, insurance information or documents otherwise pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under this assignment.

**Patient Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

## **DIRECT PAYMENT AUTHORIZATION WITHOUT ASSIGNMENT OF BENEFITS**

By way of original or a copy hereof, I \_\_\_\_\_, the undersigned patient, hereby direct my applicable personal injury protection and/or medical payments insurance carrier to make payment directly to the undersigned medical provider for services and/or supplies rendered to me by said medical provider which were necessitated by a motor vehicle accident occurring on \_\_\_\_\_.

Additionally, I hereby authorize and direct my applicable personal injury protection and/or medical payments insurance carrier to make any and all checks or drafts payable to the undersigned medical provider only and to forward same to the undersigned medical provider's place of business.

This authorization for direct payment should not be deemed as assignment of benefits in that I, the patient, retain all rights to enforce my applicable insurance contract. Furthermore, this Direct Payment Authorization without Assignment of Benefits transfers no right, title, or interest in said contract other than the right to receive direct payment as specified hereinabove.

Prior authorizations for payment or assignments for PIP benefits to the undersigned medical provider, if any, are hereby cancelled and replaced by the Direct Payment Authorization without Assignment of Benefits as of the date shown above.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Medical Provider

\_\_\_\_\_  
Date

**Brevard Chiropractic & Injury Center**  
Timothy Bortz, D.C.  
3260 Murrell Road, Suite 101  
Rockledge, FL. 32955  
(321) 631-1100

**HIPAA NOTICE OF PRIVACY PRACTICES - FINANCIAL POLICY – MINOR CONSENT**  
**Brevard Chiropractic & Injury Center**

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), commonly known as "HIPAA" is a Federal program that requires all medical records and other individually identifiable health information used or disclosed by us, in any form, whether electrically, on paper or orally, is kept properly confidential. The act gives you, the patient, significant rights and control over your health information. This notice describe certain obligations we have regarding ways in which we may use and disclose health information about you, it also outlines your rights to the health information we keep about you.

We understand that information about you and your health is personal and are committed to your privacy. We create a record of the care and services you receive. We need this record to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of the records of your care generated by this office, whether made by your personal doctor, others working in the office, or associates processing billing and your insurance claims.

**We are required by law to:**

- Make sure that health information that identifies you is kept private.
- Give you this Notice of our legal duties and privacy practices with respect to health information about you.
- Follow the terms of the Notice that is currently in effect.

**A partial list of how we may use and disclose Health Information about you:**

- For Treatment, payment, health care and business operations of this office.
- As required by Law, Law enforcement, lawsuits and disputes; protect public safety or assist apprehending criminals.
- Military or Veteran's and Workers Compensation.
- Public Health Risks; Coroners, health examiners and funeral directors.
- To government authorities to prevent child abuse or domestic violence; to avert a serious threat to health and safety
- National security and intelligence activities.
- Security Officials for Inmates:
- To government agencies for audits, investigations and other oversight activities.
- For certain limited research purposes.
- The practice maintains patient sign-in sheets that are visible and accessible to patients, staff and others who may enter this office.

**As our patient, your rights regarding Health Information about you:**

- Right to Inspect and copy.
- Right to Amend.
- Right to Request Restrictions.
- Right to Request Confidential Communication.
- Right to Accounting Disclosures.
- Right to a Paper copy of this Notice (full Notice is available upon request)

**Changes to this Notice:** We reserve the right to change this Notice. We will post a copy of a current notice in our facility with the current effective date on the first page.

**Complaints:** If you believe that your privacy rights have been violates, you may file a complaint with us. All complaints must be in writing. Please contact the administrator at the location where you were treated to file a complaint.

**Acknowledgement of Receipt of HIPPA Notice of Privacy Practices:**

I acknowledge that I was provided a copy of the Notice of Privacy Practices and have read (or had the opportunity to read if I chose) and understood the Notice. This notice is considered effective dates signed, and shall remain effective for a minimum of 6 years, unless otherwise revoked, in writing, by patient.

Unless you request otherwise, we may use or disclose health information to a family member or other personal representative to the extent necessary to help you with your healthcare or payment for your health care. In addition, we may use your confidential information to remind you of appointments, phone, email, postal service or other method requested by you.

**Additional Disclosure Authority:** In addition to the allowable disclosures described in the State of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to persons indicated as follows:

Name	Relationship

Name	Relationship

**HIPAA NOTICE OF PRIVACY PRACTICES - FINANCIAL POLICY – MINOR CONSENT**  
**Brevard Chiropractic & Injury Center**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Financial Policy:**

Full payment is expected at the time of service. Payments accepted are cash, check or credit card.

If you have insurance, we will make a copy of your card and collect any co-pay or co-insurance that is due. As a courtesy, our office will contact your insurance company to obtain a benefit quote. If there is a balance after your insurance processes the claim, we will forward you a statement. Insurance coverage varies greatly, if you have questions, feel free to contact our office and we will do our best to assist you. Please be aware that some insurance plans require pre-certification for care. Care will commence once approval has been obtained.

As a courtesy to our patients we will provide a copy of your medical records at a cost according to Florida Statutes and per written request. Additionally, should you or your insurance company require forms or information, this office reserves the right to charge for time spent in preparation of those forms or requested medical information. It is your responsibility to make sure your insurance company is paying this office. Although this office may bill your insurance carrier for services rendered, all charges for services rendered are the patients' responsibility.

We will notify you as soon as we know of any difficulties we are having collecting monies from your insurance carrier. Should difficulties arise, you may need to contact your insurance company. If our office determines that your insurance carrier will reimburse you directly and not pay our office, you will be required to pay in full for all services at the time they are rendered. Our office makes every attempt to correspond with insurance carriers to assist them in correctly paying your claims.

All patients who have insurance, no matter the type it is, are required to pay co-payments, deductibles and/or percentages required each visit. If our office is a non-participating provider with the insurance company you have, we will gladly file those claims for you but you will be responsible for payment at the time service is rendered. If you are a Medicaid enrollee, your eligibility status must be verified each month. If your eligibility is terminated, you become responsible for services rendered. If you have been injured on the job, you must have authorization for care from the Worker's Compensation Insurance Company before an appointment or treatment can be rendered by our office. Your employer will assist you in securing that information.

Brevard Chiropractic & Injury Center also accepts Personal Injury Protection claims resulting from motor vehicle accidents and Workers Compensation claims to treat injured workers. Prior approval must be obtained with these cases before care can commence. You will also be required to complete an "Accident Form" in addition to the regular "Intake Forms" Brevard Chiropractic & Injury is also a provider for Medicare. You will be required to read and sign the separate Medicare policy documentation.

**By signing below, I agree to the following:** "I have read and understand "HIPPA Notice of Privacy Practices" & "Financial Policy" I understand that health and accident insurance policies are an agreement between and insurance carrier and me. I authorize payment from my insurance carrier directly to this office and with the understanding that all monies be credited to my account upon receipt. I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. We will require you to honor the financial agreements you make with our office. If you find that you cannot fulfill the agreement you have made with us, please advise our financial department immediately so new arrangements can be made. Any insurance checks sent to your home should be brought or sent to our office within three (3) days with Explanation of Benefits (stub/statement) to indicate which services were paid.

**\*\*Our office will submit your insurance claims for you as a courtesy. However, your insurance is an agreement between you and your carrier, not between your insurance company and this office.**

Patients without insurance are expected to pay in full at the time services are rendered, unless other arrangements have been made with our financial department

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Consent to Treatment of Minors:**

By my signature below, I consent to any x-ray, examination, and chiropractic or rehabilitative diagnosis or treatment, which is deemed advisable by a licensed chiropractor, be rendered under the general of special supervision of any licensed chiropractor or trained professionals at Brevard Chiropractic & Injury Center.

**Patient/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Patient/Guardian Printed Name:** \_\_\_\_\_

**Relation to Minor:** \_\_\_\_\_

## **AGREEMENT WITH MEDICAL SERVICE PROVIDER**

I, \_\_\_\_\_, HEREBY, authorize my attorney to pay the proceeds of any net recovery all outstanding amounts owed to BREVARD CHIROPRACTIC & INJURY CENTER, for medical care or services. I agree that I am responsible to the above-named health care provider for the payment of all services rendered to me, regardless of the outcome of my case. My attorney is authorized to protect medical bills and expenses accrued. My attorney in no way accepts any direct or personal liability for any medical bills, expenses, or the payment of amounts owed to any health care provider. Any request by my attorney for any information or services are made on my behalf and are owed by me and in no way are the obligation of my attorney other than the withholding of sums from my recovery.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Printed Name

\_\_\_\_\_  
Treating Physician Signature

\_\_\_\_\_  
Treating Physician Printed Name

The undersigned attorney for the above patient agrees with the assignment and authorization. Any outstanding amounts, at the time of recovery, will be protected to the extent of the remaining recovery funds. No additional or excess amounts shall be protected or paid unless a separate written agreement is entered into. This protection agreement is valid only so long as the treating healthcare provider strictly complies with the terms above and withholds any collection efforts and does not report any adverse credit information on the above patient.

\_\_\_\_\_  
Attorney Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Attorney Printed Name

### **Brevard Chiropractic & Injury Center**

Timothy Bortz, D.C.  
3260 Murrell Road, Suite 101  
Rockledge, Florida 32955  
(321) 631-1100

## CONSENT TO PARTICIPATE IN TELEMEDICINE CONSULTATION

**Consultant:** Andrew Akerman, M.D. Florida License: ME 93824

Patient's Name: \_\_\_\_\_ Medical Record No: \_\_\_\_\_

1. I understand that my healthcare provider, ***Timothy Bortz, D.C.***, wishes me to engage in a telemedicine consultation with Andrew Akerman, M.D.
2. My health care provider has explained to me how the video conferencing technology will be used to affect such a consultation. I understand that this consultation will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.
3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my health care provider(s) or myself can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
4. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my health care provider and consulting health care provider in order to operate the video equipment. The above mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine examination room; and/or (3) terminate the consultation at any time.
5. I have had the alternatives to a telemedicine consultation explained to me, and in choosing to participate in a telemedicine consultation I understand that some parts of the exam involving physical tests may be conducted by individuals at my location at the direction of the consulting health care provider.
6. In an emergency consultation, I understand that the responsibility of the telemedicine consulting specialist is to advise my local practitioner, and that the specialist's responsibility will conclude upon termination of the video conference connection.
7. I understand that billing will occur from both my practitioner and as a facility fee from the site from which I am presented.
8. I have read this document carefully, and understand the risks and benefits of the teleconferencing consultation and have had my questions regarding the procedure explained and I hereby consent to participate in a telemedicine visit under the terms described herein.
9. I understand that there will be no videotaping or recording of any materials, unless additional written consent is given. Recording of the medical examination is typically not required, and no recording will be done for the express purpose of maintaining confidentiality and patient privacy.

\_\_\_\_\_  
Patient/Parent/Guardian Signature

\_\_\_\_\_  
Date and Time

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date and Time