WISE CHIROPRACTIC

Name: _____ Phone Number: _____

Street Address: _____

City: _____ State: _____ Zip code: _____

Age: _____ Birthdate: _____ Sex: M/F Social Security #: _____

Employer's Name: _____

Employer's Address: _____

Your Health Ins Co.: _____

How did you find out about Wise Chiropractic: ❑ Internet /Google ❑ Attorney ❑ Friend ❑ Other

-Please hand the Front Desk all of your insurance cards-
-They will copy them & return back to you-

AUTO INSURANCE INFORMATION

Responsibility Party's Name: _____

Address: _____

City: _____ State: _____ Zip code: _____

Policy Holder's Name: _____ Policy #: _____

Agent's Name: _____ T #: _____ Ext: _____

ATTORNEY INFORMATION

Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip code: _____

Were there any witnesses? ____ Yes ____ No Name(s): _____

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AREA OF COMPLAINT

Check symptoms you have noticed since the injury/ accident /slip & fall (mark all that apply)

□ Headaches □ Irritability □ Numbness in Toes □ Digestive Problems □ Face Flushed □ Neck Pain □ Chest Pain □ Shortness of Breath □ Shoulder Pain □ Buzzing in ears □ Stiff Neck □ Dizziness/Loss of balance □ Fatigue □ Elbow Pain □ Fainting □ Back Pain □ Head Seems to Heavy □ Depression □ Wrist/Hand Pain □ Loss of Taste □ Sore throat □ Pins & Needles in Arms □ Lights bother eyes □ Upper Back Pain □ Loss of Smell □ Nervousness □ Pins & Needles in Legs □ Loss of Memory □ Ears Ringing □ Diarrhea □ Tension □ Numbness in Fingers □ Ankle/Foot Pain □ Heart Burn □ Cold Sweats □ Feet Cold □ Hands Cold □ Stomach Upset □ Constipation □ Fever □ Bruises, cuts, scrapes and/ or scars if so please explain:

_____

_____

□Other:

_____

_____

Is your condition getting worse? □ Yes □ No **Is it Constant?** □ Yes □ No **Comes and Goes?** □ Yes □ No

Have you already seen other doctors for this/these condition(s)? □ Yes □ No

Please list other doctors seen and approximate date seen (including primary care physician):

Doctor / Facility Approximate Date Seen

1. _____
2. _____

Have you ever been involved in an accident/injury/slip & fall prior to this one? □ Yes □ No, If yes what type was it? □ Auto □ Work □ Slip n Fall □ Leisure □ Sports □ Other _____

When?: _____

Briefly Explain: _____

Are you presently taking any medication? □ Yes □ No

Please List: _____

Have you lost time from work? □ Yes □ No If yes how many days: _____

Did you go to the Emergency Room? □ Yes □ No If yes, when? _____

Name of the Hospital Emergency Room: ❑ n/a _____

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Where you admitted? □ Yes □ No □ ,If hospitalized, date admitted _____ date discharged _____

List any medications that you were given: _____

Have you had a prior diagnostic imaging study or examination (MRI, CT, Ultrasound, X-ray) etc. regarding this injury.

If yes, please list: ❑ n/a

Body part	Date
MRI _____	_____/_____/_____
CT/CAT Scan _____	_____/_____/_____
X-Ray _____	_____/_____/_____

Do you have any future appointments with any doctor regarding your injuries? □ Yes □ No
If yes, when and with whom? _____

Do you have Auto Insurance? □ Yes □ No
Auto Insurance Company Name:
_____
(Only for auto accident patients)

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I or my minor child ever has a change in health.
I certify that I, and/or my dependent(s) have insurance with the aforementioned Insurance Companies and assign directly to Wise Chiropractic Center all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.
Wise Chiropractic Center may use my health care information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my currant treatment plan is completed or one year from the date signed below.

*Signature of Patient, Parent, Guardian or Personal Representative

_____

WISE CHIROPRACTIC

I have the right and the **duty to confirm** that the services have already been provided. I was **not solicited** by any person to seek any services from the medical provider of the services above. This means that no person has initiated contract with me and/or persuaded me to use the doctor or licensed professional, clinic or medical institution that provided the services. The medical provider has **explained** the services to me for which payment is being claimed. 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;

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.

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

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.

The coding procedures on the accompanying statement or bill are proper. This means that **no service has been up coded, unbundled** or constitutes an invalid or **no 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)	Signature	Date

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

_____	_____	_____
Name (Print)	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 Statues.

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.

WISE CHIROPRACTIC

ASSIGNMENT OF INSURANCE BENEFITS, RELEASE & DEMAND

Insurer and Patient Please Read the Following in its Entirety Carefully!

I, the undersigned patient/insured knowingly, voluntarily and intentionally assigned the rights and benefits of my automobile insurance, a/k/a Personal Injury Protection (hereinafter PIP), Uninsured Motorist and Medical Payments policy of insurance to the above health care provider. If the provider's bills are applied to a deductible, I agree this will serve as a benefit to me. This assignment of benefits includes the cost of transportations, medications, supplies, overdue interest and any potential claim for common law or statutory bad faith/unfair claims handling. If the insurer disputes the validity of this assignment of benefits then the insurer is instructed to notify the provider in writing within five days of receipts of this document. Failure to inform the provider shall result in a waiver by the insurer to contest the validity of this document. The undersigned directs the insurer to pay the health care provider the maximum amount directly without any reductions & without including the patient's name on the check. To the extent the PIP insurer contends there is a material misrepresentation on the application for insurance resulting in the policy of insurance is declared voided, rescinded or canceled, I, as the named insured under said policy of insurance hereby assign the right to receive the premiums paid for my PIP insurance to this provider and to file suit for recovery of the premiums. The insurer is directed to issue such a refund check payable to this provider only. Should the medical bills not exceed the premium refunded, then the provider is directed to mail the patient/named insured a check which represents the difference between the medical bills and the premiums paid.

Disputes: The insurer is directed by the provider and the undersigned to not issue any checks or drafts in partial settlement of a claim that contains or are accompanied by language releasing the insurer or its insured/ patient from liability unless there has been a prior written statement agreed to by the health care provider (specifically the Office Manager) and the insurer as to the amount payable under the insurance policy. The insured and the provider hereby contests and objects to any reductions or partial payments. Any partial or reduced payments, regardless of the accompanying 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 reduced amount as payment in full. The insurer is hereby placed on notice that this provider reserves the right to seek the full amount of the bills submitted. If the PIP insurer states it can pay claims at 200% of Medicare then the insurer is instructed & directed to provide this provider with a copy of the policy of insurance within10 days. Any effort by the insurer to pay a disputed debt as full satisfaction must be mailed to the address above, after speaking with the Office Manager and mailed to the attention of Wise Chiropractic. See Fla. Stat. §673.3111.

EUOs and IMEs: If the insurer schedules a defense examination or examination under oath (hereinafter "EUO") the insurer is hereby INSTRUCTED to send a copy of said notification to this provider. The provider or the provider's attorney is expressly authorized to any EUO or IME set by the insurer. The health care provider is not the agent of the insurer or the patient for any purpose.

This assignment applies to both past and future medical expenses and is valid even if undated. A photocopy of this assignment is to be considered as valid as the original. I agree to pay any applicable deductible, co-payments for the services rendered after the policy of insurance exhausts and for any services unrelated to the automobile accident. The health care provider is given the power of attorney to: endorse my name on any check for services rendered by the above provider and to request and obtain a copy of any statements or examinations under oath given by patients.

Release of Information: I authorize this provider to: furnish an insurer's intermediary, the patient's other medical providers, and the patient's attorney via mail, fax or email with any and all information that may be contained in the medical records; to obtain insurance coverage information (declaration sheet & policy of insurance) in writing and telephonically from the insurer; request from any insurer all explanation of benefits (EOBs) for all providers and non-redacted PIP payout sheets; obtain any written and verbal statements the patient or anyone else provided to the insurer; obtain copies of the entire claim file, the property damage file and all medical records, including but not limited to documents, reports, scans, notes, bills, opinions, X-rays, IMEs and MRIs from any other medical provider or any medical records from this provider private and confidential. The insurer is not authorized to provide these medical records to anyone without the patient's and the provider's prior express written permission.

Demand: Demand is hereby made for the insurer to pay all bills within 30 days without reductions and to mail the latest non-redacted PIP payout sheet and the insurance coverage declaration sheet to the above provider within 15 days. The insurer is directly to pay the bills in the order they are received. However, if a bill from this provider and a claim from anyone else is received by the insurer on the same day the insurer is directed to not apply this provider's bill to the deductible. If a bill from this provider and claim from anyone else is received by the insurer on the same day the insurer is directed to pay this provider first before the policy is exhausted. In the event the provider's medical bills are disputed or reduced by the insurer for any reason or amount, the insurer is to: set aside the entire amount disputed or reduced; escrow the full amount at issue and not pay the disputed amount to anyone or any entity, including myself, until the dispute is resolved by a Court. Do not exhaust the policy. The insurer is instructed to inform in writing the provider of any dispute.

Certification: I certify that: I have read and agree to the above; I have not been solicited or promised anything in exchange for receiving health care; I have not received any promises or guarantees from anyone as the results that may be obtained by any treatment or service; and I agree the provider's prices for medical services, treatment and supplies are reasonable, usual and customary.

Caution: Please read before signing. If you do not completely understand this document please ask us to explain it to you. If you sign below we will assume you understand and agree to the above.

_____
Patient's Name

_____
Patient's Signature (if patient is a minor, signature of parent/guardian)

_____
Date

WISE CHIROPRACTIC

AUTHORIZATION TO RELEASE INFORMATIOM/RECORDS

I, _____, request _____

_____ to release my chiropractic and/or medical records including diagnosis, prognosis, initial treatment, x-rays and reports to: **Wise Chiropractic, Inc.**

I will be responsible for incurring the costs associated with this request if known in advanced. Thank you for your prompt attention.

Additional Information: _____
_____
_____

_____ _____

Patient Signature (or guardian if a minor) Date

_____

Witness Signature

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PATIENT HISTORY

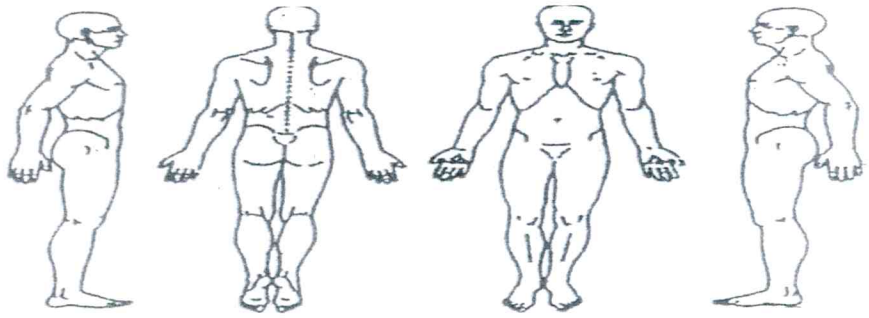
Patient Name: _____ Date: _____

Describe your **PRIMARY** symptoms: _____

List other symptoms: _____

Are your symptoms related to: □ Auto Accident □ Workman's Comp.

Indicate on the drawings below where you have pain/symptoms:



How often do you experience your symptoms?

□ Constant (76-100% of the time) □ Frequent (51-75% of the time)
□ Occasional (26-50% of the time) □ intermittently (1-25% of the time)

How would you describe the type of pain?

□ Sharp □ numb □ dull □ Tingly □ diffuse □ Achy
□ Burning □ shooting □ Stiff □ Sharp w/ motion □ stabbing w/ motion
□ shooting w/ motion □ Electric like □ Other: _____

How are your symptoms changing with time?

□ Getting Worse □ Staying the Same □ Getting Better

Using a scale from 0 – 10 (10 being the worst), how would you rate your symptoms with activity?

0 1 2 3 4 5 6 7 8 9 10

Using a scale from 0 - 10 (10 being the worst), how would you rate your symptoms w/out activity?

0 1 2 3 4 5 6 7 8 9 10

List your hobbies: _____

How much has your symptoms interfered with your social activities\hobbies\work?

□ Not at all □A little bit □ moderately □ Quite a bit □ extremely

Who else have you seen for these symptoms?

□ Chiropractor □ Neurologist □ Primary Care Physician □ ER Physician
□ Orthopedist □ Massage Therapist □ Physical Therapist □ Other: _____

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Have you had x-rays/MRI/CT scan taken that are related to your symptoms? □ Yes □ No

Where: _____ Who Ordered Them: _____

What aggravates your symptoms? _____

What concerns you the most about your symptoms\what do they prevent you from doing?

_____

What is your: **Height** _____ **Weight** _____

For Females only: Are you Pregnant? □ Yes □ No Last Menstrual Period: _____

How would you rate your overall health?

□ Excellent □ Very Good □ Good □ Fair □ Poor

What type of exercise do you do?

□ Strenuous □ Moderate □ Light □ None

Indicate if you have any immediate family members with any of the followings:

□ Rheumatoid □ Diabetes □ Lupus □ Cancer □ Als □ Heart Problems

List all medications you are currently taking: _____

_____

_____

List all over-the-counter medications you are currently taking: _____

_____

_____

List all surgical procedures you have had: _____

_____

_____

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Please check the following if you have had in the past or present.

Past	Present		Past	Present		Past	Present	
☐	☐	Headaches	☐	☐	Angina	☐	☐	Loss of Appetite
☐	☐	Neck Pain	☐	☐	Kidney Stones	☐	☐	Abdominal Pain
☐	☐	Upper Back Pain	☐	☐	Kidney Disorder	☐	☐	Ulcer
☐	☐	Low Back Pain	☐	☐	Bladder Infection	☐	☐	Hepatitis
☐	☐	Shoulder Pain	☐	☐	Painful Urination	☐	☐	Liver/Gall Bladder
☐	☐	Elbow/Upper Arm Pain	☐	☐	Loss of Bladder Control	☐	☐	General Fatigue
☐	☐	Wrist Pain	☐	☐	Prostate Problems	☐	☐	Visual Disturbance
☐	☐	Hand Pain	☐	☐	Abnormal Weight Gain/Loss	☐	☐	Dizziness
☐	☐	Hip Pain	☐	☐	Diabetes			
☐	☐	Upper Leg Pain	☐	☐	Excessive Thirst			
☐	☐	Knee Pain	☐	☐	Frequent Urination			
☐	☐	Ankle/Foot Pain	☐	☐	Smoking/Tobacco Use	For Females		
☐	☐	High Blood Pressure	☐	☐	Drug/Alcohol Dependence	Past	Present	
☐	☐	Heart Attack	☐	☐	Depression	☐	☐	Birth Control Pills
☐	☐	Chest Pains	☐	☐	Systemic Lupus	☐	☐	Pregnancy
☐	☐	Stroke	☐	☐	Epilepsy			
☐	☐	Dermatitis	☐	☐	HIV/AIDS			
☐	☐	Jaw Pain	☐	☐	Joint Pain/Stiffness			
☐	☐	Arthritis	☐	☐	Rheumatoid Arthritis			
☐	☐	Cancer	☐	☐	Asthma			
☐	☐	Tumor	☐	☐	Chronic Sinusitis			

What activities do you do during the day?

☐ Sit:	☐ Most of the day	☐ Half of the day	☐ A little of the day
☐ Stand:	☐ Most of the day	☐ Half of the day	☐ A little of the day
☐ Computer Work:	☐ Most of the day	☐ Half of the day	☐ A little of the day
☐ On the phone:	☐ Most of the day	☐ Half of the day	☐ A little of the day

I affirm that the information I have given is correct to the best of my knowledge. The information I have provided will remain confidential and I understand that it is my responsibility to inform this office of any changes in my medical status.

_____	_____	_____
Print Patient Name	Signature	Date

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ACCIDENT/INJURY FORM

NAME_____ _____ DATE_____

Date of Accident_____ Time: ____am ____pm Location of Accident_____

Make/ Model /Year of your Vehicle: _____

Make/ Model /Year of other Vehicle: _____

AUTO INJURY

Were You: ( ) Driver ( ) Passenger ( ) Pedestrian
Were you struck from: ( ) Behind ( ) Right Side ( ) Left Side ( ) Front ( ) Parked

As a result of the Accident, were traffic citations issued to you? ( ) Yes ( ) No

Did police arrive at the scene? ( ) Yes ( ) No

Did EMT arrive at the scene ( ) Yes ( ) No

Were the roads conditions at time of accident? ( ) Wet ( ) Dry

Approximately how fast were you traveling? _____MPH

Approximately how fast was the other car traveling? _____MPH

Where were you looking at time of impact?

( ) Behind ( ) Right ( ) Left ( ) Down Other: _____

Were you wearing your seatbelt? ( ) Yes ( ) No

Did your head hit the head rest? ( ) Yes ( ) No

Did the airbags deploy? ( ) Yes ( ) No

Did the seat break? ( ) Yes ( ) No

Did you see the crash coming? ( ) Yes ( ) No

Were you braced for the impact? ( ) Yes ( ) No

Were any objects thrown around inside the car? ( ) Yes ( ) No

After the impact did you feel? ( ) Disoriented ( ) Discomfort ( ) Immediate Pain ( ) Tightness

( ) Lost Consciousness ( ) Frightened and was Stunned ( ) Went straight to the Hospital

Describe the accident (Be Specific)

_____
_____
_____
_____
_____
_____
_____
_____

ON-THE-JOB INJURY

How did the injury occur? ____

Did you report the injury to your foreman or employer: ( ) Yes ( ) No

Employer: ________________________ Address: ______________________________

****

CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT

( ) Headache
( ) Neck Pain
( ) Neck Stiff
( ) Dizziness
( ) Back Pain
( ) Nervousness
( ) Tension
( ) Irritability
( ) Chest Pain
( ) Sleeping Problems
( ) Head Too Heavy
( ) Pins & Needles in Arms
( ) Pins & Needles in Legs
( ) Numbness in Fingers
( ) Numbness in Toes
( ) Shortness of Breath
( ) Fatigue
( ) Depression
( ) Lights Bother Eyes
( ) Loss of Memory
( ) Ears Ringing
( ) Face Flushed
( ) Buzzing in Ears
( ) Loss of Balance
( ) Fainting
( ) Loss of Smell
( ) Loss of Taste
( ) Diarrhea
( ) Feet Cold
( ) Hands Cold
( ) Stomach Upset
( ) Constipation
( ) Cold Sweats
( ) Fever
( ) Other

Did you require post-accident hospitalization? ( ) Yes ( ) No

Have you lost any days of work? ( ) Yes ( ) No If Yes, _________ through _________

INSURANCE INFORMATION

Your Insurance Company _________________________ Address_____________________

Other Party's Name_____________________________ Address_____________________

Other Party's Ins. Co.___________________________ Address____________________

Have you been contacted by an insurance adjustor regarding this claim ( ) Yes ( ) No

If yes, name of adjustor____________________________Company___________________

Do you have an attorney that has advised you in this case: ( ) Yes ( ) No

If yes, attorney's name_____________________________Address___________________

Signature: ______________________________ Date: _____________________________

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Patient Name: _____ Date: _____

Loss of Enjoyment/Duties under Duress Summary

Complete the following questionnaire as it relates to how your injury(s) affect your performance of your living and work duties. Place a check in front of the day-to-day living or work duties that are painful or difficult for you to perform as a result of the injuries you sustained. Then check mark the appropriate box designating reason for difficulty. Include those duties/responsibilities, which require that you reduce the time you are capable of performing them.

Job Description: _____

N/A	**Work**	Reason for the Difficulty/Limitation		
	Lifting	☐ Increased Pain	☐ Restricted Movement	☐ Cannot Perform
	Bending	☐ Increased Pain	☐ Restricted Movement	☐ Cannot Perform
	Sitting	☐ Increased Pain	☐ Restricted Movement	☐ Cannot Perform
	Walking	☐ Increased Pain	☐ Restricted Movement	☐ Cannot Perform
	Computer Duties	☐ Increased Pain	☐ Restricted Movement	☐ Cannot Perform
	Other:_____	☐ Increased Pain	☐ Restricted Movement	☐ Cannot Perform

N/A	**Studies/School**	Reason for the Difficulty/Limitation		
	Lifting	☐ Increased Pain	☐ Restricted Movement	☐ Cannot Perform
	Bending	☐ Increased Pain	☐ Restricted Movement	☐ Cannot Perform
	Sitting	☐ Increased Pain	☐ Restricted Movement	☐ Cannot Perform
	Walking	☐ Increased Pain	☐ Restricted Movement	☐ Cannot Perform
	Computer Duties	☐ Increased Pain	☐ Restricted Movement	☐ Cannot Perform
	Other:_____	☐ Increased Pain	☐ Restricted Movement	☐ Cannot Perform

N/A	**Domestic Duties**	Reason for the Difficulty/Limitation		
	Lifting	☐ Increased Pain	☐ Restricted Movement	☐ Cannot Perform
	Bending	☐ Increased Pain	☐ Restricted Movement	☐ Cannot Perform
	Sitting	☐ Increased Pain	☐ Restricted Movement	☐ Cannot Perform
	Walking	☐ Increased Pain	☐ Restricted Movement	☐ Cannot Perform
	Computer Duties	☐ Increased Pain	☐ Restricted Movement	☐ Cannot Perform
	Other:_____	☐ Increased Pain	☐ Restricted Movement	☐ Cannot Perform

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N/A	**Household Duties**	Reason for the Difficulty/Limitation		
	Lifting	☐ Increased Pain	☐ Restricted Movement	☐ Cannot Perform
	Bending	☐ Increased Pain	☐ Restricted Movement	☐ Cannot Perform
	Sitting	☐ Increased Pain	☐ Restricted Movement	☐ Cannot Perform
	Walking	☐ Increased Pain	☐ Restricted Movement	☐ Cannot Perform
	Computer Duties	☐ Increased Pain	☐ Restricted Movement	☐ Cannot Perform
	Other:_____	☐ Increased Pain	☐ Restricted Movement	☐ Cannot Perform

N/A	**Miscellaneous**	Reason for the Difficulty/Limitation		
		☐ Increased Pain	☐ Restricted Movement	☐ Cannot Perform
		☐ Increased Pain	☐ Restricted Movement	☐ Cannot Perform
		☐ Increased Pain	☐ Restricted Movement	☐ Cannot Perform
		☐ Increased Pain	☐ Restricted Movement	☐ Cannot Perform

N/A	**Sports**	Reason for the Difficulty/Limitation		
	Name of Sport: _____	☐ Increased Pain	☐ Restricted Movement	☐ Cannot Perform
	Pre-Accident Level of Participation	☐ Socially	☐ Competitively	☐ Professionally

Patient Signature: _____ Date: _____