# ***Personal Injury Intake Form and Chiropractic Care Agreement***

# **Patient Information:**

|  |  |
| --- | --- |
| Today’s Date Name I prefer to be called Address   Sex  **Male Female** Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Employer Heigh | Home Phone Cell Phone Work Phone Email Date of Birth Age Height \_\_\_\_’­­­­­­\_\_\_\_\_” Weight lbsMarital Status No. of Children  |

Address

If minor, name of parent or guardian

Who should we contact in case of an emergency?

Relation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone

Address

Attorney \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone

Primary Care Physician Phone

### Were you referred to us by a treating physician?  **YES NO** If so, who? \_\_

### Have you ever been to a chiropractor before?  **YES NO** If so, who?

### Are we replacing your current chiropractor?  **YES NO** If so, reason for change?\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health Insurance Information:**

#### Insurance Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy number

#### Policy Holder’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Secondary Health (if any) Insurance:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Auto Insurance Information:**

#### Insurance Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy number

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone

Adjustor Name Claim #

**Accident Information:**

## Date \_\_\_\_\_\_\_\_\_\_\_\_ Time \_\_\_\_\_\_\_ AM PM Was it reported to the police?  **YES NO**

### Was a traffic violation issued?  **YES NO** To whom?

### Location of accident (Street, Town) # of other passengers

### Were there other witnesses?  **YES NO** Make/model of vehicle you were in

### Please explain in detail how the accident occurred

Please list symptoms felt immediately after the accident

In which direction were you headed?  **N S E W** Approx. speed of vehicle MPH

Did the impact to your vehicle come from the:  **FRONT REAR RIGHT LEFT OTHER**

During impact, were you facing:  **RIGHT LEFT FORWARD**

Were you  **AWARE** or  **SURPRISED** by the impact?

Were you the  **DRIVER FRONT SEAT PASSENGER BACK SEAT PASSENGER**?

Were you wearing a seat belt?  **SHOULDER HARNESS LAP HARNESS**

Was the vehicle equipped with air bags?  **YES NO** Did they inflate?  **YES NO**

In relation to the base of your skull, where was the headrest?  **ABOVE BELOW AT BASE**

What did your vehicle impact?  **ANOTHER VEHICLE OTHER**

If another vehicle, what was the make/model? Direction Speed MPH

Did any part of your body strike anything in the vehicle?  **YES NO** Describe

Did the accident render you unconscious?  **YES NO** If yes, for how long?

Are you disabled or otherwise applying for disability benefits? **YES NO**

Is this visit related to Worker’s Compensation or are you otherwise applying for Worker’s Compensation benefits? **YES NO**

Does your current injury or discomfort relate to any pending litigations or proceedings? **YES NO** If so, please describe? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

#### \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Post-Injury Information:**

Have you seen any other doctor(s) since the accident?  **YES NO** Name

When did you go?  **IMMEDIATELY NEXT DAY 2 DAYS PLUS**

### How did you get there?  **AMBULANCE PRIVATE TRANSPORTATION**

Name of hospital and/or attending doctor:

Was he/she a:  **D.C. M.D. D.O. D.D.S.**

Please describe any treatment you received

Were X-Rays done?  **YES NO** An MRI?  **YES NO** CAT scan?  **YES NO**

### Was medication prescribed?  **YES NO** If yes, what?

Have you missed any work since the accident?  **YES NO**  Date(s)

Are your work activities restricted as a result of your injury?  **YES NO**

Indicate the symptoms that are a result of this accident:

  **DIZZINESS DIFFICULTY SLEEPING JAW PROBLEMS NAUSEA**

 **MEMORY LOSS ARM/SHOULDER PAIN IRRITABILITY BACK PAIN**

 **HEADACHE(S) NUMB HANDS/FINGERS FATIGUE LOW BACK PAIN**

 **BLURRED VISION TENSION CHEST PAIN BACK STIFFNESS**

 **BUZZING IN EAR NECK PAIN SHORT BREATH LEG PAIN**

 **EARS RINGING NECK STIFF STOMACH UPSET NUMB FEET/TOES**

 **OTHER**

Did you ever experience similar symptoms prior to the accident?  **YES NO**

Has your condition  **IMPROVED**  **WORSENED** or  **STAYED SAME** since the accident?

#### Is your condition affecting your  **WORK SLEEP** or  **DAILY ROUTINE**? Please explain \_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please indicate your daily job duties and any activities that you are occasionally asked toperform:

 **STANDING OPERATING EQUIPMENT DRIVING SITTING**

 **TWISTING WORK W/ARMS ABOVE HEAD WALKING CRAWLING**

 **TYPING LIFTING BENDING STOOPING**

What positions can you work in with minimum physical effort, and for how long?

#### Do you work with others who can help you with any heavy lifting?  **YES NO**

While in recovery, are there any light duty tasks you could request?  **YES NO**

# **Health History**

Please check the box for any of the following which apply to you.

|  |  |  |
| --- | --- | --- |
|  **HEART ATTACK or STROKE** **HEART SURGERY** **ARTIFICIAL VALVES** **HEPATITIS** **FREQUENT NECK PAIN**  **ANEMIA** **RHEUMATIC FEVER** **ULCERS/COLONITIS** **ASTHMA** **TUBERCULOSIS** **ARTHRITIS** |  **PACEMAKER** **CONGENITAL HEART DEFECT** **ALCOHOL/DRUG ABUSE** **SHINGLES** **HIV+/AIDS** **HIGH/LOW BLOOD PRESSURE** **SEVERE/FREQ. HEADACHES** **FAINTING/SEIZURE/EPILEPSY** **DIABETES** **LOWER BACK PROBLEMS** |  **MURMUR** **MITRAL VALVE COLLAPSE** **VENEREAL DISEASE** **Cancer** **EMPHYSEMA** **PSYCHIATRIC PROBLEMS** **KIDNEY PROBLEMS** **SINUS PROBLEMS** **DIFFICULTY BREATHING** **ARTIFICIAL BONES/JOINTS** |

Please list **any other** medical conditions that you have or have ever had. ­

Please list any allergies.

Please list previous hospitalizations or surgeries and dates.

Please list any past motor vehicle accidents or traumas and dates.

Please list any prescription and over-the-counter medications you are currently taking, including supplements. \_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there anything else about your health history or family health history that you feel is important to share?

Do you exercise?  **YES NO**

Are you on a special diet?  **YES NO** Since: / / Describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you smoke or otherwise use tobacco products?  **YES NO** How much?

How long?

Are you wearing:  **ORTHOTICS HEEL LIFTS ARCH SUPPORTS**

Do you require assistance with transportation to or from visits? **YES NO** If so, please advise who provides the transportation and provide contact information\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*For women:* Are you taking birth control?  **YES NO**

Are you pregnant?  **YES NO** How long? Nursing?  **YES NO**

**Patient/Legal Guardian Signature Date**

# ***Patient Agreement to Pay for Chiropractic***

#  ***Services and ASSIGNMENT OF INSURANCE BENEFITS***

I hereby authorize FOX Spine + Sports Medicine, to furnish my insurance carrier **all** information concerning my treatment and/or illness. I also authorize benefits under this claim to be made payable directly to FOX Spine + Sports Medicine. I understand that I am responsible financially to FOX Spine + Sports Medicine for charges not covered by my insurance company, I, the patient or the guardian of the patient, will be responsible in full in payment.

I also understand that all co-payments and / or deductibles are to be paid at the time services are rendered. I agree to assist FOX Spine + Sports Medicine in any collection efforts to receive payment from my insurance company providing the office with any information that may be necessary for the physicians to receive payment.

I understand that by signing this agreement I agree to make all payments to FOX Spine + Sports Medicine that I am responsible for, and that if the insurance denies a claim for any reason that I am responsible ultimately for payment in full to the physicians.

**By not signing this agreement, services may be denied.**

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

**Print: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Guardian Signature (if patient is not competent)**

**Please give the front desk your insurance card and driver’s license to be photocopied. Thank you.**

I authorize the release of any medical information necessary to process this claim in FOX Spine + Sports Medicine’s discretion. I permit a copy of the authorization to be used in the place of the original.

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

I hereby authorize FOX Spine + Sports Medicine to apply for benefits on my behalf for covered services rendered by him/her or by his/her order. I request that payment from my insurance company be made directly to FOX Spine + Sports Medicine (or to the party who accepts the assignment). I certify that the information I have reported with regard to my insurance coverage is correct. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

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

# ***Receipt of Notice of Privacy Practices***

# ***Written Acknowledgement Form***

By signing this form, you hearby acknowledge receipt of the **Notice of Privacy Practices**. Our **Notice of Privacy Practices** provides information about how we may use and disclose your protected information. We encourage you to read it in full. **Our Notice of Privacy Practices** is subject to change.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name (please print) Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent, Guardian or

Patient’s legal representative,

if applicable (please print)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature

List below the names and relationship of people to whom you authorize Fox Spine + Sports Medicine to release your **Protected Health Information** (PHI).

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Relationship

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Relationship

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Relationship

***OFFICE POLICIES***

**The following are FOX Spine + Sports Medicine’s office policies. Please read carefully, and be sure to ask any questions you might have before signing the document.**

**Consent for Treatment.** I the undersigned give FOX Spine + Sports Medicine, inclusive of its doctors and staff, my/our permission to evaluate and treat the Patient’s injury or condition, including what if any diagnostic procedure must be done to learn more about my condition. I further understand that, in the course of recommended treatment, conditions may worsen on rare occasions. I further understand that **no guarantee or promise** has been made to me concerning the results of evaluation, care treatment. However, I acknowledge that my doctor is available to answer any questions I might have about my treatment. If my doctor recommends a procedure which has special risks such risks will be first explained to me. I further authorize the personnel of FOX Spine + Sports Medicine to assist in providing the services my doctor might recommend.

**Appointment Scheduling and Cancellation Policy.** At FOX Spine + Sports Medicine, we understand that unanticipated events happen occasionally in everyone's life. Business meetings, project deadlines, flight delays, car problems, and illness are just a few reasons why one might consider canceling an appointment. In our desire to be effective and fair to all of our patients and staff **24 hour advance notice is required** **when canceling an appointment otherwise the full fee for the missed appointment will be charged to your account.** This allows the opportunity for someone else to utilize our services during that appointment time.

**Office Visits.** I the undersigned understand that I may come to the office with family, friends or others. I acknowledge that I am solely responsible for children in my care. This is an office; we are busy with patients. Please be careful and aware of your surroundings!

**Private Health Insurance.** I the undersigned understand that I am responsible for whatever fees my insurance company does not pay on my claim. (Typically, this includes deductibles and/or co-payments.) I **agree to pay the full amount** of the charges should my condition be such that it is not covered by my health insurance policy, or if, for any reason, the insurance company and/or my attorney refused to pay my balance at this office.

**Telephone Messages.** We do not leave detailed messages on voicemails or answering machines unless you consent to the same in writing.

**Patient/Parent or Legal Guardian Signature Date**

***CHIROPRACTIC INFORMED CONSENT***

The undersigned Patient (which includes the parent/guardian) understands and acknowledges that the Patient is only receiving chiropractic care from FOX Spine + Sports Medicine, its doctors and staff, (jointly, “FOX Spine + Sports Medicine”).

The Doctors are “chiropractic physician” as defined in Florida Statute 460.403(5)(2008). Chiropractic physicians examine, analyze, and diagnose the human living body and its diseases by use of (a) any physical, chemical, electrical or thermal methods, (b) x-ray for diagnosing, (c) blood tests, and (d) other chiropractic methods.

**Before you, the Patient, receive chiropractic care, it is important that you read this Consent and understand the nature and risks of chiropractic medicine.** The “practice of chiropractic medicine” (or chiropractic care) involves the adjustment, manipulation, and treatment of your body in which vertebral subluxations and other malpositioned articulations and structures may be interfering with the normal generation, transmission, and expression of nerve impulse between the brain, organs, and tissue cells, thereby causing disease. Chiropractic adjustments, manipulations, and treatments are intended to restore the normal flow of nerve impulse which produces normal function and consequent health.

The undersigned Patient understands and acknowledges that there are risks associated with the practice of chiropractic medicine and chiropractic care including but not limited to ataxia, bruising, thermal injuries, dislocations/subluxations, dizziness, “drop attacks,” fracture(s), mobility disruption, paralysis, quadriplegia, spinal injury, stroke/disruption of blood flow to brain, vision problems, and death.

**The Patient is encouraged to ask questions!** Although we are not affiliated with and cannot confirm the content of internet sites, resources such as WebMD, Chiro.org, AmerChiro.org, and others may be helpful. **The Patient is specifically instructed to consult a medical doctor before receiving (and during/after) chiropractic medicine.**

I the undersigned, understand the risks and limitations associated with the practice of chiropractic medicine, including the use of chiropractic care, evaluation, diagnosis, adjustments, manipulations, and treatments by FOX Spine + Sports Medicine. Having read this form and having asked and having had answered any questions I might have about my condition and treatments, and as a result having fully understood the services to be provided by FOX Spine + Sports Medicine and what I should expect from my treatment, including the risks associated therewith. I hereby give my informed consent to receive chiropractic medicine from FOX Spine + Sports Medicine.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name/Signature (and date)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian/Parent’s Name/Signature (and date)