WEST BRADENTON – Personal Injury - New Patient Intake Form

Name _____ Preferred Name (if applicable) _____

Address _____City _____

State _____ Zip Code _____ **Preferred Number:** □ Home □ Cell □ Work

Home Phone (_____) _____-_____ **Cell Phone (_____) _____-_____**

Work Phone (_____) _____-_____ **Email _____ (for appointment reminders)**

Date of Birth: _____ **Sex:** □ Male □ Female □ Unspec. **Social Security Number: _____-____-_____**

Marital Status: M S W D **Preferred Language:** □ English □ Other _____ **Race/Ethnicity:** _____

How were you referred to our office? _____

Employer Data_____

Employer _____ Occupation _____

Emergency Contact Data _____

Name _____ Phone Number _____

Primary Care Physician/Family Medical Doctor_____□ **I was referred by this physician**___

Name _____ Phone Number _____

When doctors work together, it benefits you. Do we have your permission to update your medical doctor regarding your care in our office? □ Y □ N

Insurance Information: Please check any and all insurance coverage that may be applicable in this case:

□ Major Medical □ Medicare □ Auto Accident □ Medical Savings Account & Flex Plans □ Other

Name of Primary Insurance Company: _____

Name of Secondary Insurance Company (if any):_____

Primary Insured's Name: _____ Primary Insured's Date of Birth: ____/_____/_____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

Please list who we may speak with regarding your chiropractic care and account (please note, we cannot speak with or release any information to anyone not listed): _____

_____

Patient or Legal Guardian Signature: _____ Date: _____

Patient's Name: _____ Date: _____

NOTICE OF OUR PRIVACY PRACTICES

As required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your individually identifiable health information.

PLEASE REVIEW THIS NOTICE CAREFULLY

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (**IIHI**). In conducting our business, we will create records regarding you and your treatment and the services we provide for you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at this time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may us and disclose your IIHI
- Your privacy rights in your IIHI
- Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Harbor Chiropractic, 6220 Manatee Ave W, Ste 204, Bradenton, FL 34209, (941) 761-1100

C. WE MAY USE AND DISCLOSURE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your IIHI.

1. **Treatment.** Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. Any of the people who work for our practice – including, but not limited to, our doctors and nurses, or indirectly with any provider we refer you to – may use or disclose your IIHI in order to treat you, or to assist others in your treatment. Additionally, we may need to disclose your IIHI to others who may assist in your care, such as your spouse, children, or parents.
2. **Payment.** Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment and health status to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members or insurance companies. Also, we may use your IIHI to bill you directly for services and items.
3. **Health Care Operations.** Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you receive from us, or to conduct cost-management and business planning activities for our practice.

4. **Appointment Reminders.** Our practice may use and disclose your IIHI to contact you or a family member who answers the phone (or to leave a recorded message) to remind you of an upcoming appointment.
5. **Treatment Options.** Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.
6. **Health-Related Benefits and Services.** Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.
7. **Release of Information to Family/Friends.** Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to our office for care. In this example, the babysitter may have access to this child's medical information.
8. **Disclosures Required by Law.** Our practice will use and disclose your IIHI when we are required to do so by federal, state, or local law.

D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES
The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public Health Risks. Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:

- Maintaining vital records, such as births and deaths.
- Reporting child abuse or neglect.
- Preventing or controlling disease, injury or disability.
- Notifying a person regarding potential exposure to a communicable disease.
- Notifying a person regarding a potential risk for spreading or contracting a disease or condition.
- Reporting reactions to drugs or problems with products or devices.
- Notifying individuals if a product or device they may be using has been recalled.
- Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information.
- Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health Oversight Activities. Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and Similar Proceedings. Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. In general, we will require that the party that requests your records provide a records-release form, signed by you within the last 3 months.

4. Law Enforcement. We may release IIHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement.
- Concerning a death we believe has resulted from criminal conduct.
- Regarding criminal conduct at our offices.
- In response to a warrant, summons, court order, subpoena or similar legal process.
- To identify/locate a suspect, material witness, fugitive or missing person.

- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identify or location of the perpetrator).

5. Deceased Patients. Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. Organs and Tissue Donation. Our practice may release your IIHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation in you are an organ donor.

7. Research. Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IIHI for research purposes except when: (a) our use or disclosure was approved by an Institutional Review Board or a Privacy Board; (b) we obtain the oral or written agreement of a research that (i) the information being sought is necessary for the research study; (ii) the use or disclosure of your IIHI is being used only for the research and (iii) the researcher will not remove any of your IIHI from our practice; or (c) the IIHI sought by the research only relates to decedents and the researcher agrees either orally or in writing that the use or disclosure is necessary for the research, and if we request it, to provide us with proof of death prior to access to the IIHI of the decedents.

8. Serious Threats to Health or Safety. Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

9. Military. Our practice may disclose your IIHI if you are member of the U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. National Security. Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

11. Inmates. Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

12. Workers' Compensation. Our practice may release your IIHI for worker's compensation and similar programs.

Patient or Legal Guardian Signature: _____ Date: _____

Patient's Name: _____ Date: _____

CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic procedures, including various modes of physio therapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor(s) of chiropractic at Harbor Chiropractic, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor(s) of chiropractic at Harbor Chiropractic and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all 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 further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if I wish to cancel the treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient or Legal Guardian Signature: _____ Date: _____

Patient's Name: _____ Date: _____

OFFICE AND FINANCIAL POLICY

Our recommendations are based on a desire to see you get well and stay well. Chiropractic care is covered under many insurance plans in the active care phase. Most of our patients that have health or accident insurance will fall under one of the plans discussed in this policy. Regardless of your coverage, we'll suggest the chiropractic care we think you need. We ask that you read and understand our policy as it applies to your particular situation.

SCHEDULING

While we do schedule appointments in order to reduce waiting time for you and others, patients are welcome to stop in anytime. Please be aware, however, that walk-in patients will be seen after all regularly scheduled patients have been seen. **Although we do not charge for missed or cancelled appointments, we do request 24 hours' notice when possible.** In consideration of our other patients, we will be unable to schedule further appointments if three (3) consecutive appointments are missed without notification.

PATIENTS WITHOUT INSURANCE

We request that 100% of the first visit be paid at the time of the visit. For future visits, we will discuss payment options to make you chiropractic care more affordable.

GROUP OR INDIVIDUAL INSURANCE

Your insurance is an agreement between you and your insurance company, not between your insurance company and our office. We cannot be certain if your insurance covers Chiropractic, although most policies do provide coverage. The amount they pay varies from one policy to another. When possible, we will call to verify benefits on your insurance; however, **the benefits quoted to us by your insurance company are not a guarantee of payment.** As a courtesy to you, our office will complete any necessary insurance forms at no additional charge, and file them with your insurance company to help you collect. It is to be understood and agreed that any services rendered are charged to you directly and **you are personally responsible for payment of any non-covered services, deductibles or co-pays.** You may also pay the full amount due each day thereby qualifying for our Time of Service Reduction in fees. You may then submit the bill to your insurance carrier for reimbursement.

PERSONAL INJURY OR AUTOMOBILE ACCIDENTS

Please present your auto insurance card, your health insurance card, and tell us if you have retained an attorney. There are a few options available to the PI patient:

1. Pay cash for your care and we will submit reports whenever necessary.
2. We will bill (accept assignment) from the Med Pay/PIP portion of your auto insurance.
3. We will accept a Letter of Protection or Doctor's Lien from an attorney and await payment at the time of settlement as long as you remain an active patient.

Although you are ultimately responsible for your bill, we will wait for settlement of your claim for up to six months after your care is completed. Once the claim is settled or if you suspend or terminate care, any fees for services are due immediately.

MEDICARE

We do accept assignment from Medicare. The check is usually sent directly to our office in payment of the services that Medicare will cover which for Chiropractors is ONLY manual manipulation of the spine. Medicare pays 80% of the allowable fee once the deductible has been met. You are required to pay the deductible and the remaining 20%. All other services we provide are NON-COVERED. These services include, but are not limited to, x-rays, examinations, therapies, orthotics, supports, and/or nutritional supplements. Medicare patients are fully responsible for charges of non-covered services. Secondary insurance may or may not pay for these non-covered services. Our office completes and files the forms for Medicare at no charge.

Patient's Name: _____ Date: _____

SECONDARY INSURANCE

Please inform us of any secondary insurance you may have. We will assist you if you need help in filing but are unable to speak directly.

MANAGED CARE PLANS

We are preferred providers for most insurance companies. Some plans require you to pay a co-pay at the time of service. Other plans may have a deductible amount to be met first. After that deductible has been satisfied, you and your insurance company will share a percentage of the cost that varies from plan to plan. A referral from your primary care physician may also be necessary. Out of network benefits are usually available if a referral is not obtained.

FLEX PLANS/MEDICAL SAVINGS ACCOUNTS

Please inform us if you have a medical savings account, sometimes known as a 'flex plan'. We will be happy to provide you with a statement of your charges for reimbursement.

INSURANCE FORMS/PAYMENT

If you receive any correspondence from your insurance carrier pertaining to the care you have received at this office or a request of more information regarding your care, please bring it in as soon as possible. It is very important that we keep your file as up to date as possible. Occasionally, either by mistake, or due to provisions in your policy, the check issued by the insurance company for payment of services rendered in our office, may come to you instead of the office. If you should receive any unexpected check in the mail, please contact up to see if it does represent payment of your bill here.

COMPLETION OF FORMS

There is a $25.00 charge per form for all FMLA, short term and long-term disability forms. Payment will be collected at the time the paperwork is received in our office. Paperwork will be completed as quickly as possible (up to 2 weeks). Our office will contact you when it is completed.

I have read and understand the Office and Financial Policy of Harbor Chiropractic. **I understand (if applicable) that my insurance is an arrangement between me and my insurance company, and NOT between Harbor Chiropractic and my insurance company.** I request that Harbor Chiropractic prepare the customary forms at no charge so that I may obtain insurance benefits. I also understand that if my insurance does not respond within 60 days, or if I suspend or terminate my schedule of care as prescribed by the doctors of Harbor Chiropractic that fees will be due and payable immediately.

Patient or Legal Guardian Signature: _____ Date: _____

Patient's Name: _____ Date: _____

Assignment of Benefits

Financial Responsibility: All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits: I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Harbor Chiropractic for services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information: I hereby authorize Harbor Chiropractic to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Harbor Chiropractic on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Patient or Legal Guardian Signature: _____ Date: _____

Patient's Name: _____ Date: _____

Authorization for the Release of Medical Records

Patient Date of Birth: _____

I hereby request and authorize:

Harbor Chiropractic
6220 Manatee Ave W, Ste 204
Bradenton, FL 34209
T: (941) 761-1100 / F: (941) 761-1103

_____To Disclose information to: _____To Receive Information from:

Provider/Medical Facility/Hospital: _____
Address: _____
Phone Number: _____ Fax Number: _____

Information to be disclosed include copies of:

_____Entire Record
_____Progress Notes
_____Physical Exam forms
_____Daily chart notes
_____X-ray Reports
_____X-ray Films
_____Other, specify:
_____

This authorization will be effective after the date signed, unless cancelled in writing. I understand that the cancellation will have no effect on information released prior to receiving the cancellation. A copy of this authorization is as valid as the original.

_____ Date: _____
Patient's Signature

_____ Date: _____
Guardian/Parent/Legal Representative Signature

If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law.

Notice to recipient of information: This information has been disclosed to you from confidential records, which are protected by law. Unless you have further authorization, laws may prohibit you from making any further disclosures of this information without the specific written consent of the patient or legal representative.

Patient's Name: _____ Date: _____

RHC Health Services, LLC d/b/a Harbor Chiropractic

IRREVOCABLE 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 irrevocably assign the rights and benefits of my automobile Insurance, also known as Personal Injury Protection (hereinafter PIP), Uninsured Motorist and Medical Payments policy of insurance to the above health care provider. I understand it is the intention of the provider to accept this assignment of benefits in lieu of demanding payment at the time services are rendered. I understand this document will allow the provider to file suit against an insurer for payment of the insurance benefits or an explanation of benefits and to seek §627.428 damages from the insurer. 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 transportation, 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 receipt of this document. Failure to inform the provider shall result in a waiver by the insurer to contest the validity 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 he 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 contain or are accompanied by language releasing the insurer or its insured/patient from liability unless there has been a prior written settlement agreed to by the health provider (specifically the office manager) and the insurer as to the amount payable under the insurance policy. The insured and provider hereby contests and objects to any reductions or partial payments. Any partial or reduced payment, 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 the Medicare Fee Schedule or any other fee schedule contained within F.S. 627.736 then the insurer is instructed & directed to provide this provider with a copy of the policy of insurance within 10 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/billing manager and mailed to the attention of the **Office/Billing Manager.** 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 appear at 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 services rendered after the policy of insurance exhausts and for any other 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 patient.

Release of information: I hereby authorize this provider to: furnish an insurer, 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; and for my insurance carrier **to send insurance coverage information (declaration sheet & policy of insurance) in writing and telephonically to the above-named provider**; 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 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 insurer. The provider is permitted to produce my medical records to its attorney in connection with any pending lawsuits. The insurer is directed to keep the patient's 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. **PLEASE NOTE: The insurer is not authorized to release protected health information (PHI) to third party vendors that schedule independent medical examinations or independent medical examination physicians.**

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, and the insurance policy to the above provider within 15 days, as well as notify the provider pursuant to F.S. 627.736(6)(f) when benefits have been exhausted. The insurer is directed 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 then 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 to the results that may be obtained by any treatment or service; I agree the provider's prices for medical services, treatment and supplies are reasonable 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 Signature _____ Date _____

(If patient is a minor, signature of parent/guardian)

Patient's Name: _____ Date: _____

Doctor's Lien

To: Attorney/Insurance Carrier

_____
_____
_____

RHC Health Services, LLC
d/b/a Harbor Chiropractic
6220 Manatee Avenue West, Suite 204
Bradenton, FL 34209
941-761-1100

Re: Medical Reports and Doctor's Lien

I do hereby authorize the above provider to furnish you with a report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was involved.

I hereby authorize and direct you to pay directly to said doctor such sums as may be due and owing him for medical services rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from settlement, judgment, or verdict as may be necessary to adequately protect said doctor. And 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 or myself as the result of the injuries for which I have been treated or injuries in connection herewith.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered to me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee.

Patient's Name: _____
Patient's Signature: _____ Date: _____
Guardian's Signature Authorizing Care: _____ Date: _____

The undersigned does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect said doctor above named.

This lien does not constitute a request or agreement between the parties for the attorney or law firm to act as a collection agency for the above-named doctor/doctor's office.

Patient or Legal Guardian Signature: _____ Date: _____

Patient's Name: _____ Date: _____

HISTORY OF PRESENT ILLNESS:

Please answer each section for each individual symptom. (i.e.: Low back pain and neck pain would be completed separately) If only one symptom, only complete region #1. If more than 2 regions of complaint, please request an additional sheet.

#1: Location on body: _____ R / L Pain Intensity: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

When did your symptoms begin? _____ How did they begin? _____

Are your symptoms a result of: □ Motor Vehicle Accident □ Work Related Accident □ Other_____
Current Open Insurance Claim: □ Yes □ No

How often do you experience your symptoms?
□ Constantly: (76-100% of the day) □ Frequently (51-75% of the day) □ Intermittently (26-50% of the day) □ Occasionally (0-25% of the day)

Is the pain: □ Not applicable
□ Unaffected by time of day? □ Worse in the morning? □ Worse in the afternoon? □ Worse at night

What describes the nature of your symptoms?
□ Ache □ Burning □ Dull □ Sharp □ Stabbing □ Throbbing
□ Weakness □ Numbness/Tingling □ Stiffness □ Other _____ □ Radiates into _____

Does anything aggravate your pain? □ No If yes, check below
□ Activity (circle: Heavy / Light / Moderate) □ Bending □ Lifting □ Standing □ Stress
□ Temperature Changes □ Twisting □ Other _____

Does anything improve your pain? □ No If yes, check below
□ Cold □ Heat □ Activity □ Lying Down □ OTC Medication □ Postural Changes □ Rest
□ Prescribed Medications □ Stretching □ Support Brace □ Adjustments □ Other _____

#2: Location on body: _____ R / L Pain Intensity: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

When did your symptoms begin? _____ How did they begin? _____

Are your symptoms a result of: □ Motor Vehicle Accident □ Work Related Accident □ Other_____
Current Open Insurance Claim: □ Yes □ No

How often do you experience your symptoms?
□ Constantly: (76-100% of the day) □ Frequently (51-75% of the day) □ Intermittently (26-50% of the day) □ Occasionally (0-25% of the day)

Is the pain: □ Not applicable
□ Unaffected by time of day? □ Worse in the morning? □ Worse in the afternoon? □ Worse at night

What describes the nature of your symptoms?
□ Ache □ Burning □ Dull □ Sharp □ Stabbing □ Throbbing
□ Weakness □ Numbness/Tingling □ Stiffness □ Other _____ □ Radiates into _____

Does anything aggravate your pain? □ No If yes, check below
□ Activity (circle: Heavy / Light / Moderate) □ Bending □ Lifting □ Standing □ Stress
□ Temperature Changes □ Twisting □ Other _____

Does anything improve your pain? □ No If yes, check below
□ Cold □ Heat □ Activity □ Lying Down □ OTC Medication □ Postural Changes □ Rest
□ Prescribed Medications □ Stretching □ Support Brace □ Adjustments □ Other _____

If there are MORE regions of complaint, please request additional sheet from one of our chiropractic assistants.

Patient's Name: _____ Date: _____

Social History: (Check all that apply to you)

Tobacco Use: □ Current tobacco use □ Not a current tobacco user □ Never a tobacco user
Alcohol Use: □ None □ Light/Moderate □ Heavy □ Former Alcoholic
Activity Level: □ None □ Light □ Moderate □ Vigorous

Hospitalizations: _____

Surgeries: _____

Prior Accidents/Injuries: _____

Past Medical History/Current Conditions (Check any/all that apply to you)

□ Arthritis □ Cancer □ Diabetes □ Heart Disease □ High Blood Pressure □ Stroke
□ Psychiatric Illness □ Skin Disorder □ Fibromyalgia □ Asthma □ Osteopenia/Osteoporosis
□ Other: _____

Current Medications/Supplements: Please List: _____

Allergies: _____

Family History (If known):

□ Arthritis □ Cancer □ Diabetes □ Heart Disease □ High Blood Pressure □ Stroke □ Other: _____

Previous Chiropractic Care: □ Yes □ No If YES, Date of last adjustment: _____

Preferred Method of Adjusting (if applicable): □ Manual/Hands On □ Instrument

Previous Tests: □ MRI □ X-Rays □ CT

Region, Date, and Results: _____

WOMEN ONLY: Are you pregnant or possibility of being pregnant? □ Yes □ No □ Uncertain (LMP: ____)

If yes, due date: _____

Patient's Name: _____ Date: _____

Review of Systems (Check box if you have/have had trouble with any of the following. Leave blank if not applicable)

General		**HEENT**		**Skin/Hair**	
Lethargy/Weakness		Headaches/Migraines		Rashes/Skin Trouble	
Recurring Fever		Eye/Vision Problem		Flushing	
Weight Loss/Gain		Nose Bleeds		Excess Acne	
Dizziness		Sore Throat		Eczema	
Fever		Hoarseness		Psoriasis	
Chills		Swollen glands		Skin Cancer	
		Sinus Trouble		Skin Color Change	
Cardiovascular:		Ear/Hearing Problem		Change in hair/nail	
Chest Pain/Pressure		Dental Problems		Easy Bruising	
Heart Attack		TMJ Problems			
Shortness of Breath				**Gastrointestinal**	
Palpitations		**Respiratory**		Loss of Appetite	
Swelling hands/feet		Chronic Cough		Nausea/Vomiting	
Hypertension (HBP)		Asthma/Wheezing		Diarrhea	
High Cholesterol		Short of Breath		Constipation	
Heart Murmur		Exercise Intolerance		Abdominal Pain	
Blood Clots		Sleep Apnea		Ulcers	
Pacemaker		Emphysema		Bloating/Cramping	
Mitral Valve Prolapse				Heartburn	
		Musculoskeletal		Hemorrhoids	
Neurologic		Arthritis		Hepatitis	
Frequent Headache		Joint Pain/Swell		Cirrhosis	
Migraines		Neck Pain		Gastric Reflux	
Dizziness		Back Pain		Bowel/Bladder Issues	
Fainting		Trauma			
Memory Loss		Osteoporosis		**Blood/Lymph**	
Poor Balance		Scoliosis		Anemia	
Numbness/tingling		Cramping		Bleeding	
Pins/Needles				Bruising	
Muscle Weakness		**Endocrine**		Blood Clots	
Seizures		Diabetes		Past Transfusions	
Stroke		Thyroid Problems		Leukemia	
Tremors		Sweating		Lymphoma	
Head Injury		Hot/Cold Intolerance		HIV/AIDS	
		Weight Loss		Sickle Cell	
Psychiatric		Weight Gain			
Insomnia		Excess Urination		**Urinary**	
Diff Concentrating		Excess thirst		Excess/Pain Urination	
Memory Loss/Confusion		Appetite Change		Incontinence	
Depression				Urgency	
Anxiety		**Female**		Kidney Stones	
Agitation/Irritability		Menstrual Irregularity			
		Hot Flashes		**Male**	
Allergies		Breast Pain/Lumps		Testicular Pain/Lumps	
Seasonal		Menopause		Prostate Disease	
Food					
Medication					

Patient's Name: _____ Date: _____

Rate your current difficulties by placing the appropriate number in the box (below; a **1 / 2 / 3**). NO check marks! If an activity does not cause pain or if pain does not affect an activity, leave box **blank**.

[1] This activity causes some pain, but it is of minor annoyance.
[2] This activity causes a significant amount of pain.
[3] I cannot perform this activity due to pain and disability.

Self-Care and Personal Hygiene: ___bathing ___brushing teeth ___putting on shoes ___doing laundry ___grooming hair ___making bed ___putting on pants ___doing dishes ___washing face ___putting on shirt ___cooking ___taking out trash ___going to bathroom or sitting on toilet

Physical Activities: ___standing ___walking ___reaching ___bending right ___twisting right ___sitting ___squatting ___bending ___bending left ___twisting left ___reclining ___bending back ___kneeling ___looking left ___looking right

Functional Activities: ___carrying small objects ___lifting weight off table ___push/pull standing ___carrying large objects ___climbing stairs/incline ___exercising upper body ___exercising lower body ___carrying purse/case ___lifting objects off floor ___push/pull seated

Social & Recreational Activities: ___jogging ___biking ___swimming ___dancing ___golfing ___bowling ___hunting ___fishing ___gardening ___basketball ___soccer ___hockey ___competitive sports

Difficulties with Travel: ___driving in car ___riding as passenger ___entering and exiting vehicle ___driving for long periods of time ___riding as passenger for long period of time

Other Activities: ___concentrating ___studying ___listening ___reading ___writing ___using computer ___sleeping ___sexual relation

How does your condition interfere with the things you do every day? Please think about the 4 following areas and make notes on how these daily activities have been affected since the condition began.

HOME: _____
_____

WORK: _____
_____

RECREATION: _____
_____

PERSONAL LIFE: _____
_____

Patient's Name: _____ Date: _____

Oswestry Disability Index for LOWER BACK PAIN (if applicable)

This questionnaire has been designed to give the doctor information as to how your low back pain has affected your ability to manage in everyday life. In each section, please circle the choice which **most closely** describes your problem.

Section 1 – Pain Intensity

- ❑ I have no pain at the moment.
- ❑ The pain is very mild at the moment.
- ❑ The pain is moderate at the moment.
- ❑ The pain is fairly severe at the moment.
- ❑ The pain is very severe at the moment.
- ❑ The pain is the worst imaginable at the moment.

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 gives extra pain.
- ❑ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (i.e. 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 lift only very light weights.
- ❑ I cannot lift or carry anything.

Section 4 – Walking

- ❑ Pain does not prevent me walking any distance.
- ❑ Pain prevents me walking more than 1mile.
- ❑ Pain prevents me walking more than 1/2 of a mile.
- ❑ Pain prevents me walking more than 100 yards.
- ❑ I can only walk using a stick or crutches.
- ❑ I am in bed most of the time.

Section 5 – Sitting

- ❑ I can sit in any chair as long as I like.
- ❑ I can sit in my favorite chair as long as I like.
- ❑ Pain prevents me from sitting for more than 1 hr.
- ❑ Pain prevents me from sitting for more than 30 min.
- ❑ Pain prevents me from sitting for more than 10 min.
- ❑ Pain prevents me from sitting at all.

Section 6 – Standing

- ❑ I can stand as long as I want without extra pain.
- ❑ I can stand as long as I want but it gives me extra pain.
- ❑ Pain prevents me from standing more than 1 hour.
- ❑ Pain prevents me from standing for more than 30 min.
- ❑ Pain prevents me from standing for more than 10 min.
- ❑ Pain prevents me from standing at all.

Section 7 – Sleeping

- ❑ My sleep is never disturbed by pain.
- ❑ My sleep is occasionally disturbed by pain.
- ❑ Because of pain, I have less than 6 hours sleep.
- ❑ Because of pain, I have less than 4 hours sleep.
- ❑ Because of pain, I have less than 2 hours sleep.
- ❑ Pain prevents me from sleeping at all.

Section 8 – Sex life (if applicable)

- ❑ My sex life is normal and causes no extra pain.
- ❑ My sex life is normal but 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 cause me no extra pain.
- ❑ My social life is normal but increases the degree of pain.
- ❑ Pain has no significant effect on my social life apart from limiting my more energetic interests, i.e. sport.
- ❑ Pain has restricted my social life and I do not go out as often.
- ❑ Pain has restricted social life to my home.
- ❑ I have no social life because of pain.

Section 10 – Traveling

- ❑ I can travel anywhere without pain.
- ❑ I can travel anywhere but it gives extra pain.
- ❑ Pain is bad but I manage journeys of over 2 hours.
- ❑ Pain restricts me to short necessary journeys under 30 min.
- ❑ Pain prevents me from traveling except to receive treatment.

Patient's Name: _____ Date: _____

NECK Disability Index for NECK PAIN (if applicable)

This questionnaire has been designed to give the doctor information as to how your NECK pain has affected your ability to manage in everyday life. In each section, please circle the choice which **most closely** describes your problem.

Section 1 – Pain Intensity

- ❑ I have no pain at the moment.
- ❑ The pain is mild at the moment.
- ❑ The pain comes and goes and is moderate.
- ❑ The pain is moderate and does not vary much.
- ❑ The pain is very severe but comes and goes.
- ❑ The pain is severe and does not vary much.

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 gives extra pain.
- ❑ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example 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 – Reading

- ❑ I can read as much as I want to with no neck pain.
- ❑ I can read as much as I want to with slight neck pain.
- ❑ I can read as much as I want with moderate neck pain.
- ❑ I cannot read as much as I want because of moderate neck pain.
- ❑ I cannot read as much as I want because of severe neck pain.
- ❑ I cannot read at all.

Section 5 – Headaches

- ❑ I have no headaches at all.
- ❑ I have slight headaches that come infrequently.
- ❑ I have moderate headaches which come infrequently.
- ❑ I have moderate headaches which come frequently.
- ❑ I have severe headaches which come frequently.
- ❑ I have headaches almost all the time.

Section 6 – Concentration

- ❑ I can concentrate fully when I want to with no difficulty.
- ❑ I can concentrate fully when I want to with slight difficulty.
- ❑ I have a fair degree of difficulty in concentrating when I want to.
- ❑ I have a lot of difficulty in concentrating when I want to.
- ❑ I have a great deal of difficulty in concentrating when I want to.
- ❑ I cannot concentrate at all.

Section 7 – Work

- ❑ I can do as much work as I want to.
- ❑ I can do my usual work, but no more.
- ❑ I can do most of my usual work, but no more.
- ❑ I cannot do my usual work.
- ❑ I can hardly do any work at all.
- ❑ I cannot do any work at all.

Section 8 – Driving

- ❑ I can drive my car without any neck pain.
- ❑ I can drive my car as long as I want with slight neck pain.
- ❑ I can drive my car as long as I want with moderate pain
- ❑ I cannot drive my car as long as I want because of moderate pain in my neck.
- ❑ I can hardly drive at all because of severe neck pain.
- ❑ I cannot drive my car at all.

Section 9 – Sleeping

- ❑ I have no trouble sleeping.
- ❑ My sleep is slightly disturbed (< 1 hour sleepless).
- ❑ My sleep is mildly disturbed (1-2 hours sleepless).
- ❑ My sleep is moderately disturbed (2-3 hours sleepless).
- ❑ My sleep is greatly disturbed (3-5 hours sleepless).
- ❑ My sleep is completely disturbed (5-7 hours sleepless).

Section 10 – Recreation

- ❑ I am able to engage in all my recreation activities with no neck pain at all.
- ❑ I am able to engage in all my recreation activities, with some pain in my neck.
- ❑ I am able to engage in most, but not all, of my usual recreation activities because of pain in my neck.
- ❑ I am able to engage in a few of my usual recreation activities because of pain in my neck.
- ❑ I can hardly do any recreation activities because of pain in my neck.
- ❑ I cannot do any recreation activities at all.

Patient's Name: _____ Date: _____

PIP Insurance Information

Your Insurance Company _____
Insurance Company Address_____
Have you been contacted by an insurance adjustor regarding this claim? □Yes □No
If yes, name of adjustor: _____Phone Number: _____
Claim Number: _____
Do you have an attorney that has advised you in this case? □Yes □No
If yes: Attorney's name_____
Address_____
Phone Number: _____

Patient's Signature: _____ Date: _____
Guardian's Signature Authorizing Care: _____Date: _____

MOTOR VEHICLE COLLISION / PERSONAL INJURY QUESTIONNAIRE

Date of Accident: _____ Time of Accident: _____ Location: _____

CONDITIONS AT THE TIME OF THE ACCIDENT:

Time of day:	**Road Conditions:**	**Visibility:**	**Visibility compromised by:**
□Full daylight	□Dry	□Excellent	□Brightness □Fog
□Dawn	□Damp	□Good	□Darkness □Traffic
□Dusk	□Wet	□Fair	□Rain
□Night		□Poor	

Please describe what happened in the accident: _____
_____
_____

THE FOLLOWING QUESTIONS PERTAIN TO YOU AND THE VEHICLE YOU WERE IN:

Year: _____ Make: _____ Model: _____

Your position in the vehicle:
□Driver
□Passenger -------- Location------ □Left □Middle □Right
□Other _____ □Front Passenger □Rear Passenger □Third Seat (rear)

Speed of your vehicle:
□Stopped □Moving Moderately
□Parked □Moving Fast
□Slowing □Moving at approx. ____MPH
□Moving Slowly

Why Vehicle was slowed or stopped:
□Traffic Signal □Parking
□Pedestrian □Traffic
□Stop Sign □Busy Intersection

Collision Type:
□Driver Side Impact □Head On Collision □Passenger Side Impact □Rear Impact
□Front Impact □Pedestrian Incident

Patient's Name: _____ Date: _____

THE FOLLOWING QUESTIONS CONCERN THE OTHER VEHICLE INVOLVED IN THE ACCIDENT:

Year: _____ Make: _____ Model: _____

THE FOLLOWING QUESTIONS CONCERN THE MOMENT OF IMPACT OF THE ACCIDENT:

Were you...
- ☐Totally unaware that the accident was impending
- ☐Aware that the accident was impending
- ☐Aware that the accident was impending and braced for it

Restraints: (check all that apply)
- ☐Seat belt
- ☐Shoulder harness
- ☐No restraints

If you were the driver of the vehicle, was your foot on the brake pedal? ☐Yes ☐No ☐Knocked off by impact

Was the air bag deployed?
- ☐Car not equipped with air bag
- ☐Air bag deployed
- ☐Air bag not deployed

What position was YOUR headrest in?
- ☐High position
- ☐Middle position
- ☐Low position

Position of YOUR head at time of impact?
- ☐Facing straight ahead
- ☐Tilted forward
- ☐Rotated to the left
- ☐Rotated to the right

Was your head thrown...?
- ☐Backward and then forward
- ☐Forward then backward
- ☐To the left ☐To the left then the right
- ☐To the right ☐To the right, then the left

Position of Your body at time of impact?
- ☐Straight
- ☐Tilted forward
- ☐Rotated to the left
- ☐Rotated to the right

Was your body thrown...?
- ☐Backward and then forward
- ☐Forward then backward
- ☐To the left ☐To the left then the right
- ☐To the right ☐To the right, then the left
- ☐Across the vehicle
- ☐Outside the vehicle ☐Under the vehicle

Damage to vehicle YOU were in:
- ☐Incurred minimal damage
- ☐Incurred moderate damage
- ☐Incurred severe damage
- ☐Was totaled
- ☐Not known

Citations:
- ☐None issued
- ☐Yourself
- ☐Driver of vehicle patient was a passenger of
- ☐Driver of other vehicle
- ☐Not sure

BECAUSE OF THE FORCE OF THE COLLISION, WHICH OBJECTS IN THE VEHICLE DID YOUR BODY STRIKE?

Body Part(s) Struck: Head / Right Arm / Left Arm / Torso / Right Leg / Left Leg / other: _____

☐Steering wheel	☐Right door	☐Dashboard	☐Left window
☐Windshield	☐Right window	☐Armrest	☐Console
☐Headrest	☐Gear shift	☐Rear view mirror	☐Front seat
☐Left door	☐Backseat	☐Other: _____	

THE FOLLOWING QUESTIONS CONCERN THE TIME PERIOD IMMEDIATELY FOLLOWING THE ACCIDENT:

Did you lose consciousness?
- ☐Yes
- ☐No

Immediately following the accident, did you feel...?

☐Dizzy	☐Weak	☐Nauseated
☐Dazed	☐Nervous	☐Disoriented

Patient's Name: _____ Date: _____

Were you able to walk unaided?
□Yes
□No

Where did you go...?
□Drove home □Drove to work
□Was driven home □Was driven to work
□Drove to hospital □Drove to school
□Was driven to hospital □Was driven to school
□Taken to hospital via ambulance
Which hospital? □ Blake □ Manatee □ Lakewood □ Other_____

Next day discomfort...?
□increased □decreased □same

Did your major complaints exist before the accident?
□Yes □ No

In what areas did you IMMEDIATELY feel pain?

□Head	Shoulder	□Left	□Right	Hip	□Left	□Right
□Neck	Arm	□Left	□Right	Thigh	□Left	□Right
□Upper back	Elbow	□Left	□Right	Knee	□Left	□Right
□Mid back	Wrist	□Left	□Right	Calf	□Left	□Right
□Ribs	Hand	□Left	□Right	Ankle	□Left	□Right
□Chest	Fingers	□Left	□Right	Foot	□Left	□Right
□Abdomen	Buttock	□Left	□Right	Toes	□Left	□Right
□Low Back						
□Pelvis						

Did you experience lacerations (cuts)? If so, where? _____

At the hospital, what areas were x-rayed? □N/A
□Head □Neck □Upper back □Mid back □Low Back □Pelvis □Other: _____

Any advanced imaging (CT Scan, MRI)? □N/A
□Head □Neck □Upper back □Mid back □Low Back □ Pelvis □Other: _____

Check symptoms you have noticed since the accident:

□Headaches	□Neck Pain	□Upper back	□Shoulder Pain	□Mid back
□Rib Pain	□Chest Pain	□Low Back	□Depression	□Dizziness
□Fatigue	□Irritability	□Fever	□Nervousness	□Paralysis
□Tension	□Fainting	□Sciatica	□Sinus Pain	□Sore Muscles
□Menstrual Problems	□Pinched Nerve	□Loss of Sleep	□Loss of Balance	□Light Bothers Eyes
□Jaw Pain/Clicking	□Buzzing in Ears	□Arm/Leg Pain	□Numbness/Tingling	□Loss of Memory
□Cold Hands/Feet	□Loss of Smell	□Digestive Problems	□Stomach Upset	□Joint Pain/Stiffness
□Vision Problems	□Urinary Problems	□Sleeping Problems	□Pins/Needles Feeling	
□Difficulty Swallowing		□Head Feels Too Heavy	□Other: _____	

Is there an open insurance claim in process now? □Yes □No
Have you lost time from work? □Yes □No □Haven't returned to work at this time.
□Returned to work on: _____ □Dates of disability: From: _____ to _____

Patient's Signature:_____ Date:_____
Guardian's Signature Authorizing Care:_____ Date:_____