Full Life Chiropractic
1003 Dale Mabry Hwy
Lutz, FL 33548

PIP Patient Packet

Please READ and complete pages 1 thru 15

Please READ and sign pages 7, 8, 9, 10, 11, 12, and 13

PERSONAL INFORMATION

(PLEASE PRINT CLEARLY) **Today's Date**_____

Name: _____ **S.S. #:** _____

Marital Status: □S □M □W □D **Date of Birth:** _____

Age: _____ □Male □Female **Height:**_____ **Weight:**_____

Address: _____ **Home Tel #** _____

_____ **Cell #** _____

City **State** **Zip code**

Drivers License #: _____ **State:** _____

Occupation:_____ □Full Time □Part Time

Employer:_____ **Work #** _____

Emergency Contact: _____ **Phone #** _____

E-Mail Address: _____

INSURANCE INFORMATION

Please Provide A Picture ID, Your Auto, and Health Insurance Card

Auto Insurance Company: _____

Date of Accident:_____ **State Accident Occurred:** _____

Have you notified your Auto Insurance Carrier: □Yes No

If yes, were you assigned a Claim Number: □Yes □No

If yes, Claim Number: _____

If Name Is Different From the Policy Holder **(Policy Holder Is: Parent or Spouse)**

Policy Holder's Name:_____ **S.S. #:** _____

Policy Holder's Date of Birth:_____ **Age:**_____ □Male □Female

Health Insurance Company: _____

Policy Number:_____ **Group #** _____

If Name Is Different From the Policy Holder **(Policy Holder Is: Parent or Spouse)**

Policy Holder's Name:_____ **S.S. #:** _____

Policy Holder's Date of Birth:_____ **Age:**_____ □Male □Female

Were you referred to this office? □Yes □No

If yes, who do we need to thank? _____

If no, how did you find our office? _____

In Order For This Office, its Physicians, and it's Agents to BETTER HELP YOU Please READ and COMPLETE the Following Questions.

If This Is NOT A MOTOR VEHICLE ACCIDENT, Please SKIP DOWN TO PAGE 3

AUTO ACCIDENT INFORMATION

Date of Accident/Injury:_____ **Time of Day:**_____ **□AM □PM**

I was: □Driver I was: □Passenger
□Front Seat □Middle □Right
□Rear Seat □Left □Middle □Right

IF OTHER THAN YOURSELF, DRIVER WAS: _____

What type of vehicle were you in? _____

What type was the other vehicle? _____

I was stopped at: **□Stop Sign** **□Traffic Signal** **□Due to traffic** **□Other** _____

I was traveling: **□Forward** **□Turning Right** **□Turning Left**
□Backing up **□Turning Right** **□Turning Left**

I was struck on:	**□Front**	**□Left**	**□Center**	**□Right**
	□Driver side	**□Front**	**□Center**	**□Rear**
	□Passenger Side	**□Front**	**□Center**	**□Rear**
	□Rear	**□Left**	**□Center**	**□Right**
I struck other vehicle on:	**□Front**	**□Left**	**□Center**	**□Right**
	□Driver side	**□Front**	**□Center**	**□Rear**
	□Passenger Side	**□Front**	**□Center**	**□Rear**
	□Rear	**□Left**	**□Center**	**□Right**

Impact caused my vehicle to: **□Hit another vehicle** **□Hit a Pole** **□Hit a Wall** **□Hit a Fence** **□Spin out of control** **□Flip over** **□Other** _____

Wearing seatbelt: **□Yes □No**
Air Bag deployed: **□Yes □No**
If child, restrained: **□Car Seat** **□Booster Seat** **□Other** _____

I struck my	**... against:**				
□Head	**□Windshield**	**□Steering**	**□Dashboard**	**□Headrest**	**□Door**
□Face	**□Windshield**	**□Steering**	**□Dashboard**	**□Headrest**	**□Door**
□Chest	**□Windshield**	**□Steering**	**□Dashboard**	**□Headrest**	**□Door**
□Rt. Shoulder	**□Windshield**	**□Steering**	**□Dashboard**	**□Headrest**	**□Door**
□Lt. Shoulder	**□Windshield**	**□Steering**	**□Dashboard**	**□Headrest**	**□Door**
□Rt. Leg	**□Windshield**	**□Steering**	**□Dashboard**	**□Headrest**	**□Door**
□Lt. Leg	**□Windshield**	**□Steering**	**□Dashboard**	**□Headrest**	**□Door**
□Rt. Knee	**□Windshield**	**□Steering**	**□Dashboard**	**□Headrest**	**□Door**
□Lt. Knee	**□Windshield**	**□Steering**	**□Dashboard**	**□Headrest**	**□Door**
Other:					

FULL LIFE CHIROPRACTIC

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IF ACCIDENT/INJURIES WERE DUE TO A MOTOR VEHICLE ACCIDENT PLEASE CONTINUE TO "AT THE TIME OF ACCIDENT"

IF ACCIDENT/INJURIES WERE NOT DUE TO A MOTOR VEHICLE ACCIDENT, PLEASE WRITE IN YOUR OWN WORDS HOW ACCIDENT/INJURY HAPPENED

_____

_____

_____

_____

_____

_____

_____

AT THE TIME OF THE ACCIDENT/INJURY

I had loss of consciousness: ☐ **Yes** ☐ **No**
I was dazed: ☐ **Yes** ☐ **No**
I complained of: _____

_____

I had bruises to: _____

_____

I had cuts to: _____

_____

Police Responded to scene of accident: ☐ **Yes** ☐ **No**

Fire Rescue Responded to scene of accident: ☐ **Yes** ☐ **No**

If yes, what did Fire Rescue/Paramedics perform:

☐ **Nothing** **Cut me out of the vehicle** ☐ **IV was started**
☐ **Head/neck immobilized** ☐ **Placed on long spine board** ☐ **Oxygen given**
☐ **Transported to hospital by:** ☐ **Ambulance** ☐ **Air Rescue**

Name of hospital you were transported to by Fire Rescue: _____

At the hospital I was transported to by Fire Rescue I had:

☐ **X-Rays** ☐ **CT scan** ☐ **MRI** ☐ **Stitches** ☐ **Cast to my** _____
☐ **Prescription medication** ☐ **Referred to Specialist** ☐ **Emergency Surgery**
☐ **Hospitalized for:** _____ **day(s)** ☐ **Other** _____

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☐ **I did not seek medical attention at the time of the accident**

☐ **I continued about my day** ☐ **I went to work** ☐ **I went home**

I followed up with family doctor: Name: _____ **Date:** _____

Treatment: _____

☐ **I followed up with Orthopedic: Name:** _____ **Date:** _____

Treatment: _____

☐ **I followed up with Neurologist: Name:** _____ **Date:** _____

Treatment: _____

☐ **I followed up with other: Name:** _____ **Date:** _____

Treatment: _____

☐ **I later went to hospital/clinic: Name:** _____ **Date:** _____

At the hospital/clinic I had:

☐ **X-Rays** ☐ **CT scan** ☐ **MRI** ☐ **Stitches** ☐ **Cast to my** _____
☐ **Prescription medication** ☐ **Referred to Specialist** ☐ **Emergency Surgery**
☐ **Hospitalized for:** _____ **day(s)** ☐ **Other** _____

Since the accident what have you been doing for your symptoms:

☐ **Nothing** ☐ **Over the counter medications** ☐ **RX/prescription medication**
☐ **Hot/cold packs** ☐ **Massages** ☐ **Other** _____

Please List Each of Your Complaints SEPARATELY And in ORDER of PRIORITY:

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

9. _____

10. _____

Since accident/injury I am unable to:

☐ **Stand more than** _____ **minutes** ☐ **Sit more than** _____ **minutes**
☐ **Walk more than** _____ **minutes** ☐ **Run more than** _____ **minutes**
☐ **Lift more than** _____ **pounds** ☐ **Other:** _____

Is there any other information that you believe may be important to the doctor to know?

_____

_____

_____

_____

_____

PAST MEDICAL HISTORY

Previous Accidents/Injuries	Date	Resolved
1		Yes No
2		Yes No
3		Yes No
4		Yes No

Hospitalizations for	Date	Resolved
1		Yes No
2		Yes No
3		Yes No
4		Yes No

Surgeries Performed	Date	Resolved
1		Yes No
2		Yes No
3		Yes No
4		Yes No

I also have a past medical history of:

□TMJ	□Vertigo	□Allergies	□Memory Loss	□High Blood Pressure
□Fractures	□Anemia	□Migraine	□Loss of Vision	□Diabetes
□Headaches	□Epilepsy	□Digestive	□Eating Disorder	□Heart/Cardiac
□Sinus	□Hearing	□Fractures	□Kidney Problems	□Cholesterol
□Liver	□Prostate	□Gallbladder	□Ringing of the ears	□Lung/Pulmonary
□Ulcers	□Arthritis	□Hyperactive	□Learning Disability	□Stroke/CVA or TIA
			□Depression/Anxiety	□Cancer

□**Other:** _____

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BEFORE THIS ACCIDENT/INJURY I HAD COMPLAINTES OF:

□Headaches	□Jaw pain	□Stomach Pain	□Hip Pain	□Ringing of the ears
□Neck Pain	□Arm Pain	□Arm Numbness	□Hand Pain	□Hand Numbness
□Mid Back Pain	□Chest pain	□Rib Pain	□ Knee pain	□Shoulder Pain
□Low back Pain	□Leg pain	□Leg Numbness	□Foot Pain	□Foot Numbness

□Other: _____

Have you been under Chiropractic care in the past? □Yes □No

If yes, Doctor's Name: _____

Address: _____

When was the last date you were seen: _____

Presently under care of your private medical physician for the above medical history: □Yes □No

Presently on RX/prescription medications for the above medical history: □Yes □No

Have you notified your private medical physician for your recent accident/injury: □Yes □No

ALLERGIES TO MEDICATIONS: □Yes □No

If yes, please list all: _____

PERSCRIPTION MEDICATIONS: □Yes □No

If yes, please list: _____

_____

OVER THE COUNTER MEDICATIONS: □Yes □No

If yes, please list all: (how many, how often) _____

FEMALES ONLY

First day of your last menstrual period: _____
Month / Day / Year

Are you pregnant? □Yes □No

If yes, when is your due date: _____
Month / Day / Year

When was your last examination with you OB/GYN: _____
Month / Day / Year

Have you notified you OB/GYN of your recent complaint: □Yes □No

Number of pregnancies: _____

Number of children: _____

Number of children delivered NATURALLY: _____

Any complications with Natural Childbirth □Yes □No

If yes, what was the complications? _____

_____

Number of children delivered CESAREAN: _____

Any complications with Natural Childbirth □Yes □No

If yes, what was the complications? _____

_____

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FAMILY/SOCIAL HISTORY

Mother's History: □**Alive** □**Deceased**
□**High Blood Pressure** □**Diabetes** □**Heart Problems**
□**Lung Problems** □**Cancer** □**Osteoporosis/Osteoporoses**
□**CVA/Strokes** □**Other** _____

Father's History: □**Alive** □**Deceased**
□**High Blood Pressure** □**Diabetes** □**Heart Problems**
□**Lung Problems** □**Cancer** □**Osteoporosis/Osteoporoses**
□**CVA/Strokes** □**Other** _____

Do you drink alcohol: □**Yes** □**No**
If yes how often: _____
Do you use tobacco: □**Yes** □**No**
If yes how often: _____
Do you use recreational drugs: □**Yes** □**No**
If yes how often: _____
Do you workout/exercise: □**Yes** □**No**
If yes, prior to this accident/injury I worked out_____per week
□**Walking_____miles** □**Running_____miles**
□**Bicycle_____miles** □**Cardio Training**
□**Weight Training** □**Other:** _____

WORK STATUS

□**I am unemployed** □**I am Disabled** □**I work Full-time_____hours per week**
□ **Part-time_____hours per week** **Occupation:** _____

Have you returned to work since accident/injury: □**Yes** □**No**

Patient Acknowledgement

By my signature, I understand and acknowledge that Full Life Chiropractic its Physicians and agents will treat my condition, as they deem necessary through the use of Chiropractic Therapy and adjunctive therapies. I also understand that all original documents and original x-rays Full Life Chiropractic created as a result of the performance of examinations will remain the property of Full Life Chiropractic it's Physicians and agents will not be held responsible for any undisclosed pre-existing conditions.

I certify that the above information is complete and accurate to the best of my knowledge. I agree to notify the doctor immediately whenever I have changes in my health condition or health plan coverage in the future.

Signature:_____ **Date:** _____

***PLEASE READ*: This questionnaire is designed to help this office to better understand how much your NECK pain has affected your ability to manage your everyday activities. Please answer each section by checking the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but PLEASE JUST CHECK THE ONE. CHOOSE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.**

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.	**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.
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, I wash with difficulty and stay in bed	**Work** ☐ I can do as much work as I want to. ☐ I can only 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.
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 lift very lightweights. ☐ I cannot lift or carry anything at all.	**Driving** ☐ I can drive my car without any neck pain. ☐ I can drive my car as long as I want with slight pain in my neck. ☐ I can drive my car as long as I want with moderate pain in my neck ☐ 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 pain in my neck. ☐ I cannot drive my car at all.
Reading ☐ I can read as much as I want to with no pain in my neck. ☐ I can read as much as I want to with slight pain in my neck. ☐ I can read as much as I want to with moderate pain in my neck. ☐ I cannot read as much as I want because of moderate pain in my neck. ☐ I cannot read as much as I want because of severe pain in my neck. ☐ I cannot read at all.	**Sleeping** ☐ I have no trouble sleeping. ☐ My sleep is slightly disturbed (less than 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)
Headaches ☐ I have no headaches at all. ☐ I have slight headaches, which 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.	**Recreation** ☐ I am able to engage in all of my recreational activities with no neck pain at all. ☐ I am able to engage in all of my recreational activities with some pain in my neck. ☐ I am able to engage in most, but not all of my recreational activities because of pain in my neck. ☐ I am able to engage in a few of my recreational activities because of pain in my neck. ☐ I can hardly do any recreational activities because of pain in my neck. ☐ I cannot do any recreational activities at all.

NAME:_____ **DATE:** _____

***PLEASE READ*: This questionnaire is designed to help us to understand how much your BACK pain has affected your ability to manage your everyday activities. Please answer each section by checking the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but PLEASE JUST CHECK THE ONE. CHOOSE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.**

Pain Intensity ☐ **The pain comes and goes and is very mild.** ☐ **The pain is mild and does not vary much.** ☐ **The pain comes and goes and is moderate.** ☐ **The pain is moderate and does not vary much.** ☐ **The pain comes and goes and is severe.** ☐ **The pain is severe and does not vary much.**	**Standing** ☐ **I can stand as long as I want without pain.** ☐ **I have some pain while standing, but it does not increase with time.** ☐ **I cannot stand for longer than one hour without increasing pain.** ☐ **I cannot stand for longer than ½ hour, without increasing pain.** ☐ **I cannot stand for longer than ten minutes, without increasing pain.** ☐ **I avoid standing, because it increases the pain straight away.**
Personal Care ☐ **I would not have to change my way of washing or dressing in order to avoid pain.** ☐ **I do not normally change my way of washing or dressing even though it causes some pain.** ☐ **Washing and dressing increases the pain, but I manage not to change my way of doing it.** ☐ **Washing and dressing increases the pain and I find it necessary to change my way of doing it.** ☐ **Because of the pain, I am unable to do some washing and dressing without help.** ☐ **Because of the pain, I am unable to do any washing or dressing without help.**	**Sleeping** ☐ **I get no pain in bed.** ☐ **I get pain in bed, but it doesn't prevent me from sleeping well** ☐ **Because of my pain, my normal night's sleep is reduced by less than one-quarter.** ☐ **Because of my pain, my normal night's sleep is reduced by less than one-half.** ☐ **Because of my pain, my normal night's sleep is reduced by less than three-quarters.** ☐ **Pain prevents me from sleeping at all.**
Lifting ☐ **I can lift heavy weights without extra pain.** ☐ **I can lift heavy weights, but it causes extra pain.** ☐ **Pain prevents me from lifting heavy weights off the floor.** ☐ **Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. 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, at the most.**	**Social Life** ☐ **My social life is normal and gives me no pain.** ☐ **My social life is normal, but increases the degree of my pain.** ☐ **Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing, etc.** ☐ **Pain has restricted my social life and I do not go out very often.** ☐ **Pain has restricted my social life to my home.** ☐ **I have hardly any social life because of the pain.**
Walking ☐ **Pain does not prevent me from walking any distance.** ☐ **Pain prevents me from walking more than one mile.** ☐ **Pain prevents me from walking more than ½ mile.** ☐ **Pain prevents me from walking more than ¼ mile.** ☐ **I can only walk while using a cane or on crutches.** ☐ **I am in bed most of the time and have to crawl to the toilet.**	**Traveling** ☐ **I get no pain, while traveling.** ☐ **I get some pain while traveling, but none of my usual forms of travel make it any worse.** ☐ **I get extra pain while traveling, but it does not compel me to seek alternate forms of travel.** ☐ **I get extra pain while traveling which compels me to seek alternative forms of travel.** ☐ **Pain restricts all forms of travel.** ☐ **Pain prevents all forms of travel except that done lying down.**
Sitting ☐ **I can sit in any chair as long as I like without pain.** ☐ **I can only sit in my favorite chair as long as I like.** ☐ **Pain prevents me from sitting more than one hour.** ☐ **Pain prevents me fromsitting more than 1/a hour.** ☐ **Pain prevents me from sitting more than ten minutes.** ☐ **Pain prevents me from sitting at all.**	**Changing Degree of Pain** ☐ **My pain is rapidly getting better.** ☐ **My pain fluctuates, but overall is definitely getting better.** ☐ **My pain seems to be getting better, but improvement is slow at present.** ☐ **My pain is getting neither better nor worse.** ☐ **My pain is gradually getting worse.** ☐ **My pain is rapidly worsening**

NAME:_____ **DATE:** _____

Name: _____ **Date:** _____

Please Read: This survey asks for your views about how your pain now affects how you function in everyday activities. This information will help you and your doctor know how you feel and how you are able to do your daily tasks at this time. Please answer every question by marking an "X" along the line to show how much your pain problem has affected you (from having no problem at all to having the most severe problems you can imagine).

BE SURE TO ANSWER ALL QUESTIONS.

1. Does your pain interfere with your normal work inside and outside the home?
Work normally — *Unable to work at all*
0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10

2. Does your pain interfere with personal care (such as washing, dressing, etc.)?
Take care of myself completely — *Need help with all my personal care*
0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10

3. Does your pain interfere with your traveling?
Travel anywhere I like — *Only travel to see doctors*
0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10

4. Does your pain affect your ability to sit or stand?
No problems — *Cannot sit I stand at all*
0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10

5. Does your pain affect your ability to lift overhead, grasp objects, or reach for things?
No problems — *Cannot do at all*
0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10

6. Does your pain affect your ability to lift objects off the floor, bend, stoop, or squat?
No problems — *Cannot do at all*
0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10

7. Does your pain affect your ability to walk or run?
No problems — *Cannot walk/run at all*
0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10

8. Has your income declined since your pain began?
No decline — *Lost all income*
0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10

9. Do you have to take pain medication every day to control your pain?
No medication needed — *On pain medication throughout the day*
0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10

10. Does your pain force you to see doctors much more often than before your pain began?
Never see doctors — See *doctors weekly*
0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10

11. Does your pain interfere with your ability to see the people who are important to you as much as you would like?
No problem — *Never see them*
0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10

12. Does your pain interfere with recreational activities and hobbies that are important to you?
No interference — *Total interference*
0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10

13. Do you need the help of your family and friends to complete everyday tasks (including both work outside the home and housework) because of your pain?
Never need help — *Need help all the time*
0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10

14. Do you now feel more depressed, tense, or anxious than before your pain began?
No depression/tension — *Severe depression/tension*
0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10

15. Are there emotional problems caused by your pain that interfere with your family, social, and/or work activities?
No problems — *Severe problems*
0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10

Full Life Chiropractic

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Patient Consent for Use and Disclosure

of Protected Health Information

I hereby give my consent for Full Life Chiropractic (FLC) to use and disclose protected health information (PHI) about me to carry out treatment, payment, and health care operations (TPO). I have the right to review the Notice of Privacy Practices prior to signing this consent.

FLC reserves the right to revise its Notice of Privacy Practices. I have the right to request that FLC restrict how it uses or discloses my PHI to carry out TPO.

With this consent, FLC may call, mail or email me PHI in reference to matters that assist in carrying out TPO, such as appointment reminders, patient statements, and insurance items pertaining to my care.

All documents and x-rays created as a result of services provided at FLC will remain the property of FLC.

There are times when individuals other than staff may see me receive treatment at the clinic or overhear discussions of my condition or my insurance. I consent to others perceiving these interactions at the clinic. If additional privacy is required, I will inform the clinic staff.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, FLC may decline to provide treatment to me.

_____ _____

Patient's Name **Date**

_____

Patient's Signature

_____ _____

Print Name of Legal Guardian, if applicable **Signature of Legal Guardian, if applicable**

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Doctor-Patient Relationship in Chiropractic

It is important to be an aware and informed patient. We have found that an understanding of chiropractic care is helpful. This page is to help inform you of what will be happening today and throughout your care.

Analysis: You will receive a chiropractic examination for the detection of vertebral Subluxations. A vertebral Subluxations is a misalignment of one or more of the 24 vertebra in the spinal column that causes obstruction of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's natural ability to express its maximum health potential.

During the examination, the chiropractor will evaluate how your spine moves and what it feels like. Based upon the results of the examination, X-rays of your spine may be taken. X-rays will tell the doctor how far and in what direction the vertebra is misaligned. The X-rays will also help determine the most efficient chiropractic techniques to effectively adjust and correct the spine.

Diagnosis: Only a chiropractor can determine if your case is a chiropractic case. Your diagnosis will reflect spinal nerve interference that is caused by vertebral Subluxations. Our doctors will work with any other health care provider for your benefit. Also, you should expect other health care providers to work with your chiropractor for your benefit. This team approach to your health care will serve you the best.

Chiropractic Adjustments: By coming to the chiropractor for care, you give the chiropractor permission to adjust you. In rare cases, physical defects, deformities, or pathology may render the patient susceptible to injury. The chiropractor will not provide chiropractic adjustments if he is aware of any such conditions. If the patient is aware of any latent pathological defects, illness or deformities that would not otherwise come to the attention of the chiropractor, it is the patient's responsibility to notify the chiropractor. A chiropractor does not treat or diagnosis disease. The chiropractor provides a specialized health service for the detection and correction of vertebral Subluxations. Upon request, alternatives to chiropractic care and any risks regarding chiropractic care will be explained in detail. Risks, although rare, may include increased muscle spasm, strain, and exacerbation of disc conditions, fractures or TIA.

Results: The goal of chiropractic is to adjust vertebral Subluxations for the purpose of allowing the proper transmission of nerve energy over nerve pathways so that every part of the body may have a proper nerve supply at all times. This allows the natural healing ability of the body to work at maximum efficiency. Since there are many variables, it is difficult to predict the time schedule or results of chiropractic care. The healing process takes time. The longer the problem has been in the body, the longer the healing process will take.

Questions: We want to help you achieve your goal of health. Any time your progress is not satisfactory or you have any concerns, the chiropractor will gladly answer any questions that arise or assist you in choosing a referral doctor for another opinion. Your health is our number one priority.

Acknowledgment: I have read and understand the above.

Patient Name:_____ **Signature:**_____ **Date:** _____

Full Life Chiropractic
1003 Dale Mabry Hwy, Lutz, FL 33548
Records Release / Request

I authorize and direct Full Life Chiropractic to Release copies of my medical records, x-rays, exam results and any other protected health information to:

Name: _____

Address: _____ **Phone:** _____

_____ **Fax:** _____

_____

I authorize and direct Full Life Chiropractic to Request copies of my medical records, x-rays, exam results and any other protected health information from:

Name: _____

Address: _____ **Phone:** _____

_____ **Fax:** _____

_____

This authorization is given pursuant to Florida Statute 456.057 and HIPPA regulations. Any third party that receives protected health information is prohibited from further disclosing any information contained in the medical records without the consent of the patient or the patient's legal guardian.

_____ _____ _____
Patient Name **Social Security** **Date Of Birth**

_____
Patient Signature

_____
Date

Office of Insurance Regulation

Bureau of Property & Casualty Forms and Rates

Standard Disclosure and Acknowledgment Form
Personal Injury Protection - Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:
1. The services set forth below were actually rendered. This means that those services have already been provided.

_____

_____

2. I have the right and the duty to confirm **that the services have already been provided.**

3. I was not solicited **by any person to seek any services from the medical provider of the services described above.**

4. The medical provider has explained **the services to me for which payment is being claimed.**

5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to $500.

Insured Person (patient receiving treatment of services) or Guardian of Insured Person:

_____ _____ _____
Insured Person's Name (*Print or Type Name)* **Insured Person's Signature** **Date**

The undersigned licensed medical professional affirms the statement numbered 1 above and also:

A. I have not solicited **or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.**

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

C. The accompanying statement or bill is properly completed **in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to t**ruthfully, accurately**, and in a** substantially complete **manner.**

D. The coding of procedures on the accompanying statement or bill is proper. This means that no service has been upcoded, unbundled, **or constitutes an invalid** or not medically necessary diagnostic test **as defined by Section 627.732 (15) and (16), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.**

Licensed Medical Professional Rendering Treatment / Services or Medical Director (Signature by his or her own hand)

_____ _____ _____
Physician's Name (*Print or Type Name)* **Physician's 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 Statutes

Note: The original of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may not be electronically furnished. Failure to furnish this form may result in non-payment of the claim.

ASSIGNMENT AND AUTHORIZATION OF INSURANCE BENEFITS

I,_____, the undersigned, for good and valuable consideration, including the agreement of Full Life Chiropractic ("Assignee") to accept this assignment in lieu of demanding full payment for services on the date each service is rendered, I authorize and direct any insurance company that may be obligated to provide insurance benefits to me, or on my behalf, ("my insurance company") to accept billing and pay directly to Assignee such sums as may be due and owing Assignee for services rendered to me, both by reason of accident or illness, and by reason of any other bills that are due Assignee; and to withhold such sums from any disability benefits, medical payments benefits, no-fault benefits, or any other insurance benefits obligated to reimburse me or any form of settlement, judgment or verdict on my behalf as may be necessary to adequately protect said Assignee.

I hereby further give lien to said Assignee against any and all insurance benefits named herein and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by Assignee. This is to act as an assignment of my rights and benefits to the extent of the Assignee's services provided.

In the event my insurance company refuses to make such payments, I hereby assign and transfer to Assignee any and all causes of action that I might have or that might exist in my favor against my insurance company. I further authorize and direct you, my insurance company to provide fifteen days advance notice to Assignee of any physical examination or examination under oath of myself that is scheduled by any insurance company.

I authorize and direct you, my insurance company and/or my attorney to release a copy of the payment record (PIP Payout Log) without redacting the names of payees and amounts paid and to release a copy of the declarations page of insurance policy and any pertinent information necessary for me to receive treatment and for Assignee to timely process claims. I also authorize Assignee to release any information pertinent to my care to any insurance company, adjustor, or attorney to facilitate collection under this Assignment and Authorization. I agree that a photocopy of this document may serve as the original.

I,_____, have read and fully understand the above information and agree to receive chiropractic care under these terms.

Patient Signature:_____Date: _____

Witness Signature:_____Date: _____

COMPLETE IF PATIENT IS A MINOR CHILD_____**(Child's Name)**

I,_____being the parent or legal guardian of the above minor child have read and fully understand the above information and agree for my child to receive chiropractic care under these terms.

Signature:_____Date: _____

Full Life Chiropractic

1003 Dale Mabry Hwy, Lutz, FL 33548

PROVIDER'S LIEN

To Attorney: _____

Address: _____

_____

Phone #_____ **Fax #** _____

From: Patient _____

I authorize Full Life Chiropractic (FLC) to furnish my attorney, with my examination reports, diagnosis, and prognosis notes in regard to the treatment that I am receiving from FLC.

I understand that I am directly and fully responsible to FLC for all chiropractic bills submitted by them for services rendered to me. This agreement is made for FLC's protection and in consideration of their awaiting payment.

I hereby give a Lien on my case to FLC against any and all proceeds of any settlement, judgment or verdict that may be paid to me as a result of the injuries for which I have been treated. As such, I hereby authorize and direct you, my attorney, to pay directly to FLC such sums that are due and owing FLC for chiropractic services rendered to me, both by reason of this accident and by reason of any other bills that are due FLC. I further direct you, my attorney, to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect FLC.

Date:_____ **Patient's Signature:** _____

This signed document acts as my express authorization for you, my attorney, to sign an agreement stating your intention to observe on my behalf the above terms.

Date:_____ **Attorney's Signature:** _____

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