AUTO ACCIDENT QUESTIONAIRE

Core Chiropractic and Wellness, L.L.C.

Dear Patient: This information is considered confidential. We need this information because we care enough to want to know, and your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. Thank you.

Patient Name ____ Date of Birth ________________ Chart # ____________

Date of Accident ____ Time of Accident ____________________A.M./P.M.
Patient's auto insurance carrier ______________________________ Policy # ______________ Claim # _______________

*Please **circle** the correct statement below.
Were you the: driver , passenger , pedestrian , other ____
If you were NOT the driver, Name of the driver of the vehicle in which you were injured ________________________
Insurance company of driver ________________________________ Policy #____________________________________

At the time of impact you were: parked , moving , stopped at traffic light/stop sign , other ________________________
Street that accident occurred _____________________________ Nearest cross street _________________________________
City and State that the accident occurred ____
Direction your vehicle was heading: North , South , East , West
Direction other vehicle involved in accident was heading: North , South , East , West
What was your vehicle point of impact? Rear , Front , Driver's side , Passenger's side , other _______________
Did your vehicle strike another vehicle? YES , NO
Your location in the vehicle: Front seat , Back seat , Third row , other _____________________________________
Were you using your seat belt? YES , NO
As a result of the accident, were traffic citations issued to you? YES , NO
To the driver of the other vehicle YES , NO . Or the driver of the vehicle in which you were injured YES , NO
Were police notified? YES , NO
Were you knocked unconscious? YES , NO If so, for how long?_________________________________
Did airbags deploy? YES , NO

Where did you feel pain IMMEDIATELY following the accident? ____
Did you receive care at the accident scene? YES , NO
Where were you taken following the accident? ____
How did you get there? Ambulance , Car
What treatment was given (x-rays, CT scan, MRI, medication)? ____
Was any other physician consulted since the time of the accident? YES , NO
If so, what was the doctor's name: ____
What was your diagnosis? ____
What treatment was given? ____
How often did you see this doctor? ____
Have you EVER had ANY previous trauma (motor vehicle accidents, work injury…)? YES , NO
If so, please describe (when, did you receive treatment…)____
____
Have you EVER had complaints in the currently involved areas? YES , NO
If so, please describe ____

Before this injury were you capable of working on an equal basis with others your age? YES , NO
Are your work activities restricted as a result of this accident? YES , NO
Have you lost any days of work? YES , NO Dates______________________

Since the time of the injury, are your complaints: Getting Worse , Same , Improving

Have you been contacted by an insurance adjuster or company representative regarding this claim? YES , NO
Name of adjuster ____

Have you retained an attorney regarding this accident? YES , NO
Name of Attorney ________________________________ Phone number of Attorney ____________________

Explain in detail how your accident happened:____
____
____
____
____
____
____
____
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____

Core and Chiropractic and Wellness, L.L.C. Chart#__________
4900 US Highway 19
New Port Richey, FL 34652
P:727-807-7020
F:727-807-7021

PATIENT INFORMATION

Full Name:________________________________ Birth Date:_________ Gender: M / F

Address:_____________________________City:_______________State:____Zip:______

Email address :____

Home Phone:________________Cell#:______________**Cell Provider**:______________
Work Phone:____________________ SS#_____-___-______

Marital Status: S M W D Sep Spouse Name:_________________Birth Date:_______

Are You A Minor Y / N Are You A Student Y / N

Your Employer:__________________________________Your Occupation:___________
Employer Address:____

Spouse Employer:________________________________Spouse Occupation:__________

Insurance (Please allow our staff to photocopy your health insurance cards)

Name of Primary Insurance:_______________________________ID#:_______________

Name of Insured if Different from Patient:____________________Date of Birth:______

Relationship to Patient:______________________

Name of Seconday Insurance:_____________________________ID#:________________

- I authorize payment of medical benefits to this office.
- I will allow this office to treat me, with other health care providers present, and to record my medical information, including consultation and examination, for documentation purposes, if necessary.
- There will be a $25.00 charge for any Returned/NSF checks and missed appointments.
- We utilize Capital Accounts for any Delinquencies.

Patient's Signature:____ Date:____________
Spouse / Guardian's Signature:________________________________ Date:____________
(Authorization expires 3 years from date above)

Core Chiropractic and Wellness, L.L.C.
4900 US Highway 19
New Port Richey, FL 34652
(727) 807 7020

Patient DOB: _________

CASE HISTORY

Full Name:____Date:_________________

History of Present Injury/Illness
Please list below complaint(s) you have in order of importance. Also the length of time you have had these complaint(s).

1. ____How long?________________
2. ____How long?________________
3. ____How long?________________

Is your condition(s) related to an accident: __YES __NO
Date of accident:_________Type of accident: __Auto __Work Related__Other_____________________________
Have you had any previous Trauma or Accidents? When ____

When is your condition most severe? ____
When is your condition least severe? ____
What makes your condition feel worse? ____
What makes your condition feel better? ____

Have you seen any other health care provider for you present condition? __YES __NO
Who? ____
Current Medications ____ ( ) None
Allergies ____ ( ) None

Are you or could you be pregnant? __YES __NO 1st day of last menstrual period ___________________

Do you use __Alcohol __Tobacco __Other Substances: _________________________ ( ) None

Are you experiencing or do you have any of the following?

__ A sore that won't heal	__ Difficulty swallowing	__ Persistant cough/hoarseness
__ Any bleeding/discharge	__ Lump/thickening anywhere	__ Wart/mole changes
__ Bladder/bowel problems	__ Night pain	__ Weight loss without trying
		__ None of the above

Review of Systems
In addition to the symptom(s)/dysfunction(s) listed above, are you experiencing any of the following?
Neuromusculoskeletal System

__ Anxiety	__ Facial drooping	__ Loss of balance	__ Seizures
__ Atrophy	__ Headache	__ Memory loss	__ Sensory changes
__ Concussion	__ Joint deformity	__ Mood swings	__ Speech problems
__ Depression	__ Joint locking	__ Muscle weakness	__ Stiffness
__ Tremors	__ Joint swelling	__ Numbness	__ Difficulty walking
__ Dizziness	__ Lack of coordination	__ Popping noises	__ Twitches
__ Vision trouble	__ Limited range of motion	__ Extremity deformity	__ Psychiatric disorders
			__ None of the above

Cardiovascular System

__ Ankle Swelling	__ Chest pain	__ Jaw pain	__TIA
__ Blood clots	__ Dizziness	__ Known vascular disease	__ Previous stroke
__ Fainting	__ Carotid blockage	__ Mitral valve prolapse	__ Shortness of breath
__ Hypertension	__ Changes in skin color	__ Phlebitis	__ Varicose veins
			__ None of the above

Past History
List any surgeries you have had (including appendix, tonsils, and wisdom teeth)
1. ____________________Date____________ 3. ______________________Date__________________
2. ____________________Date____________ 4. ______________________Date__________________

Have you ever been hospitalized in addition to surgeries? __YES __NO
If so, when and for what reason? ____
Have you ever been diagnosed with any condition? (diabetes, heart trouble, cancer, stroke, rheumatoid, etc.)
__YES __NO ____
Do you have a family history of any disease? (diabetes, heart trouble, cancer, stroke, rheumatoid, etc.)
__Yes __NO ____
Are you currently under a doctor's care for conditions other than ones you are seeking care for today?
__YES __NO ____

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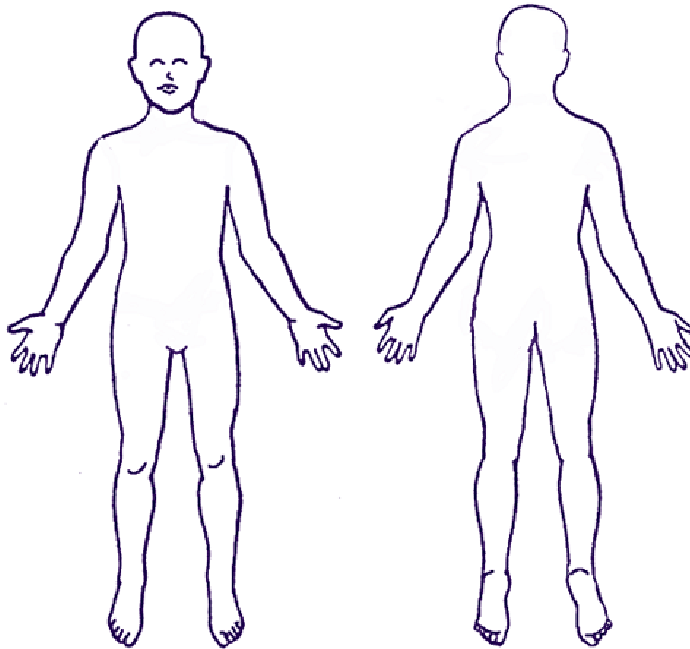
PAIN DRAWING

Patient Name:____________________________ Date:_________________________

Please mark the areas where you feel the following sensations:

PAIN = P	BURNING = B
NUMBNESS = N	TINGLING = T
ACHE = A	SHARP = S



Indicate severity of pain by marking an X on the appropriate number:
(0 means no pain- 10 means worst possible pain)

How bad is your Neck Pain? 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

How bad is your Back Pain? 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

How bad is your Arm Pain? 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

How bad is your Leg Pain? 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Chart # ________________
Date of Birth ________________

Core Chiropractic and Wellness, L.L.C.
4900 US Highway 19
New Port Richey, FL 34652

Agreement to Office Policies:

By initialing the statements listed below, I acknowledge that I have read, understand and agree to abide by the policies of this office:

________I agree to follow the doctor's appointment schedule. I understand that I will be expected to make up any missed appointments. All missed appointments must be made up within seven(7) days.

________I understand that it is my responsibility to inform the office of any address or telephone number changes.

________I understand that my payment is due at the time of service (Self-pay, co-payments, and deductibles)

________I understand that refunds will be issued within 4-6 weeks from the date requested, if there are no pending insurance claims.

________I understand the Cancellation Policy. It states that if I have a scheduled appointment that I will not be able to make, it is my responsibility to call and reschedule the appointment with 24 hours notice. Failure to do this will result in a service charge of $25, which will be billed to me directly, and is not payable by insurance, lien, worker's comp,

________I understand that a returned check will result in a $25 service charge and all future payments will only be accepted in the form of cash or credit card.

________I understand that there is a $25 charge for the completion of paperwork (disability, FMLA, etc).

________I understand that this office will use Capital Accounts for any delinquencies. I will also be responsible for any costs incurred in collection of said balance, which may include collection agency, court costs, and attorney fees.

________I agree to follow all other recommendations made by the doctor(s), including the proper use of spinal supports, doing my exercises as prescribed, etc.

________I agree to make a personal financial agreement and promptly fill out all necessary medico legal and insurance forms to aid in the timely payment for my care.

________I understand that Core Chiropractic and Wellness offers a time of service discount. In order to be eligible for this discount, two requirements must be met: payment must be made in full at the time of service, and Core Chiropractic and Wellness will not file any insurance claim.

________I understand that until a relationship is established between Core Chiropractic and Wellness and myself, checks will not be accepted. We gladly accept cash, credit or debit cards.

________**I understand that I may be responsible for a $10.00 cost for personal use electrodes for the Electric Muscle Stimulation Unit, if the doctor's determine that I will benefit from this treatment. This charge is not reimbursable by health insurance.**

________I have received a copy of Core Chiropractic and Wellness Notice of Privacy Practices.

If I elect to use my health care coverage:

Core Chiropractic and Wellness will file my insurance claim as a courtesy; however, I am ultimately responsible for understanding my insurance policy. The office has a relationship with me, the patient, not my insurance company. Although Core Chiropractic and Wellness does attempt to verify my chiropractic benefits with my insurance policy, I realize this is only an estimate of my coverage based on the information given to Core Chiropractic and Wellness at the time of inquiry. If a service is not covered and needs to be performed, I am responsible for these fees at the time of service. I understand that if my insurance company has not paid my claims within sixty (60) days, a copy of that unpaid claim will be given to me and I will be responsible to follow up on the status of payment. I will also inform Core Chiropractic and Wellness of any changes to my insurance policy so my coverage can be re-verified prior to my appointment.

Core Chiropractic and WEllness realizes that temporary financial problems may affect timely payment of you account. If such problems do arise, we urge you to contact us promptly for assistance in the management of your account. If you have any questions about the above information, please do not hesitate to ask us. **WE are here to help YOU**!

____ ___________________________

Patient Signature Date

Core Chiropractic and Wellness, L.L.C.
4900 US Highway 19
New Port Richey, FL 34652
Phone: 727-807-7020
Fax: 727-807-7021

Consent to Treat Notice

I ________________________________ hereby request and consent to the performance of chiropractic treatments and other chiropractic/medical procedures, including various forms of physical therapy and diagnostic x-rays by Core Chiropractic and Wellness This consent is extended to other licensed chiropractic physicians, chiropractic assistants, or licensed massage therapists, who now or in the future, are employed by, working with or associated with this office.

I certify that I have had the opportunity to discuss, with the doctor of chiropractic and/or other office personnel, the nature and purpose of the care that is being provided. I understand that the results are not guaranteed. Further, I have been informed and I understand that, as in the practice of any of the healing arts, in the practice of chiropractic, there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations, and sprains. I also understand that the doctor, who has explained all of these things to me, is not expected to be able to anticipate and explain all risks and complications. I will rely on the doctor to exercise appropriate judgment during the course of care, based on the facts known at this time, and in my best interest.

My signature below certifies that I have read, or have had read to me the above consent. I also certify that I have had the opportunity to ask questions and options to care have been explained. By signing this consent form, I agree to the care being provided to me for the entire course of treatment for m present condition(s) and for any future condition(s) for which I seek treatment.

____
Patient or Representative Signature

Vivian Robinson, D.C.
Doctor's Name

____
Witness's Signature

____
Doctor's Signature

____
Date

Release of Protected Health Information Authorization Form

Core Chiropractic and Wellness, L.L.C.
4900 Us Highway 19
New Port Richey, FL 34652
Phone: 727-807-7020
Fax: 727-807-7021

Patient Information:
Name: ______________________________ Date of Birth:___________
Address:____
Phone number:__________________________ SSN:_________________

Information Requested From:
Facility releasing information:_________________________________
Address:____
Phone number:__________________________ Fax:_________________

Information Requested:
☐ Chart Abstract(Specify dictated report/office visit date or range):_______________________________
____
☐ Diagnostic Report(specify date and test type): _______________________________________
____
☐ Radiology Films(specify date and type):____
____
☐ Exclusions:____
PURPOSE OF DISCLOSURE:____

I hereby release Core Chiropractic and Wellness and it's employees, agents, officers, and affiliates from any and all liability, responsibility, claims and damages which may result from the release of information incurred due to this authorization. I hereby authorize the use or disclosure of my individual, identifiable protected health information about me as described above. I understand that this authorization is voluntary. This release includes complete medical records/reports unless specifically listed above under exclusions. I understand that should I wish to revoke this authorization I must provide written notice to Core Chiropractic and Wellness However, I understand that any action taken in reliance on this authorization can not be reversed and my revocation will not affect those actions. This authorization shall expire ninety (90) days from the date set forth below, or upon the following date, event, or condition:__________
____
____

FEES FOR COPIES: Federal law permits a fee to be charged for copying of medical records. You may be required to pre-pay for this copies, if not then you copies will be mailed along with an invoice.

______________________________	____________________	____________________
Signature of Patient or Representative	Relationship	Date
______________________________		____________________
Witness		Date

Core Chiropractic and Wellness, L.L.C.
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Assignment and Authorization

For good and valuable consideration, including the agreement of Core Chiropractic and Wellness, LLC. to accept this assignment in lieu of demanding full payment for services rendered from the undersigned on the date each service is rendered, the undersigned patient executes this document hereby assigning to Core Chiropractic and Wellness, LLC. the right to receive insurance benefits directly from any insurance company that may be obligated to provide insurance benefits, to me or on my behalf, for services rendered by Core Chiropractic and Wellness, LLC. for a motor vehicle accident that occurred on or about ________________________.

Any insurance company that may be obligated to pay any insurance benefits to me, or on my behalf, for the aforesaid accident for services provided by Core Chiropractic and Wellness, LLC. is hereby directed to issue payment for those benefits directly and payable to
Core Chiropractic and Wellness, LLC.

I also authorize and assign to Core Chiropractic and Wellness, LLC. the right to file suit and pursue all legal remedies to obtain payment for services provided to me by Core Chiropractic and Wellness, LLC. This authorization to file suit is an assignment of my cause of action to obtain payment for services provided to me by Core Chiropractic and Wellness, LLC. and includes the assignment to pursue declaratory relief or any other legal remedies.

Core Chiropractic and Wellness, LLC. accepts the aforesaid assignment and hereby notifies any insurer issuing payment that Core Chiropractic and Wellness, LLC. objects to any “repricing” or reduction of billed amounts unilaterally made by any insurer. Any such reduced payments issued by any insurer are accepted under protest and without waiving any right of the provider to pursue all legal remedies against the insurer.

Please read this document completely before signing. If you do not completely understand this document or you have any questions about this document, please ask us to explain it to you. If there is any portion of this document that you do not wish to authorize, we will remove that portion from this document. Your signature below is your agreement that you fully understand this document and you fully agree to the terms of this document.

______________________________	______________________
Patient/Guardian Signature	Date
______________________________	______________________
Witness to Patient Signature	Date
______________________________	______________________
Authorized Signatory for Provider	Date

Core Chiropractic and Wellness, L.L.C.
4900 US Highway 19
New Port Richey, FL 34652
Phone: 727-807-7020 Fax: 727-807-7021

AUTHORIZATION TO OBTAIN PIP BENEFITS PAYOUT INFORMATION AND COPY OF POLICY DELCARATION PAGE

NAME OF INSURER:______________________________________
PIP POLICY NUMBER:____________________________________
NAME OF INSURED:______________________________________
DATE OF ACCIDENT:_____________________________________

I,________________ hereby authorize and direct ______________ to send Core Chiropractic and Wellness an accounting of payouts made under all claims submitted for payment under the above referenced policy relating to the automobile accident occurring on the above referenced date as those payouts occur.

____________________________ ____________________
Signature of Insured Date

Address of Insured:____
Chart Number:____________________
Date of Birth:_____________________

Core Chiropractic and Wellness, L.L.C.
Vivian M. Robinson, D.C.
4900 US Highway 19
New Port Richey, FL 34652
Phone: 727-807-7020

Letter of Protection

I do hereby authorize Core Chiropractic and Wellness and Vivian Robinson, D.C. to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was recently involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him for medical service 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 any settlement, judgment, or verdict which may be paid to you, my attorney or myself, as the result of the inquiries for which I have been treated or injuries in connection therewith.

I agree never to rescind this document and that a rescission will not be honored by my attorney. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by him.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered 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.

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but will require me to make payments on a current basis.

Dated ____________ ______________________________ ________________________
Patient Signature Print name

Dated ____________ ______________________________ ________________________
Attorney Signature Print name

Please date, sign and return one copy to the doctor's office. Also keep one copy for your records

Core Chiropractic and Wellness, L.L.C.
Dr. Vivian M. Robinson, D.C.
4900 US Highway 19
New Port Richey, FL 34652
727-807-7020

Promise to Pay for Treatments

I, ______________________, am seeking treatment from Core Chiropractic and Wellness, L.L.C. for injuries sustained in an automobile accident occurring on ________________. I am responsible for paying Core Chiropractic and Wellness for that treatment and any treatments left unpaid are due and owing by me to Core Chiropractic and Wellness. I hereby promise and assure Core Chiropractic and Wellness that any payment by check or any other form from any health insurance company, automobile insurance company, or any other source as compensation or reimbursement for treatment of the aforementioned injuries by Core Chiropractic and Wellness shall be preserved and submitted to Core Chiropractic and Wellness for payment of any balance due on the aforementioned treatments.

I understand that I remain liable to Core Chiropractic and Wellness for any unpaid aforementioned treatments should I cash any check or accept any payment from any health insurance company, automobile insurance company, or any other source as compensation or reimbursement for treatment of the aforementioned injuries.

I agree to promptly advise Core Chiropractic and Wellness of receipt of any payment by check or any other form from any health insurance company, automobile insurance company, or any other source as compensation or reimbursement for treatment of the aforementioned injuries.

Signed this _______________ day of __________, 20__.

____
Patient's name

____
Patient's signature

____
Witness signature

OFFICE OF INSURANCE REGULATION
Bureau of Property & Casualty Forms and Rates

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

The undersigned insured person (or guardian of such person) affirms:

1. The services or treatment 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 or services) or Guardian of Insured Person:

Name *(PRINT or TYPE)*	Signature	Date

The undersigned licensed medical professional or medical director, if applicable, 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. The treatment or services rendered were explained 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 **truthfully, 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, if applicable ***(Signature by his/ her own hand):***

Name *(PRINT or TYPE)*	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.

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