MIDTOWN
CLINIC OF CHIROPRACTIC

PERSONAL INFORMATION / APPLICATION FOR CARE

Today's Date:_____

Last Name: _____ First Name:_____

Social Security #:_____

Name of Spouse or Parent:_____

Number of Children:_____Ages:_____

Emergency Contact:_____ Phone Number:_____

Relationship to Emergency Contact:_____

Your Employer:_____ Status: Full Time or Part Time (circle one)

Occupation:_____ Time at Job:_____

Job Descriptions (Standing? Sitting? Heavy Lifting? Computer Work?)_____

_____

Are you on any medication right now? Yes____ No____ List medications:_____

_____

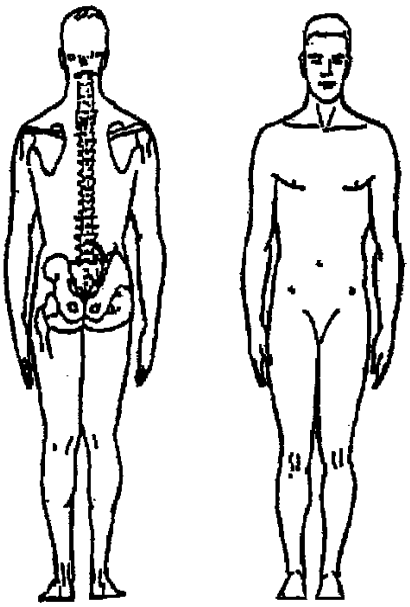
Any side effects from medication:_____

Do you have any allergies?_____

Have you had any surgeries? (Include dates)_____

Any residual effects from surgery?_____

_____



MAJOR COMPLAINTS

(Please list any conditions you are being treated for or conditions you are experiencing)

_____

_____

_____

_____

_____

_____

_____

Rate pain 0 1 2 3 4 5 6 7 8 9 10 (10 being worst pain ever experienced)

AUTO ACCIDENT REPORT

Name:_____ Today's date:_____

Name of auto insurance: _____

Policy #_____ Claim #_____

Time of accident: _____AM / PM Date of accident:_____

1. Where you: the driver / passenger / pedestrian / on a bicycle / on a motorcycle
2. What vehicle (make and model) where **you**in?_____
3. What vehicle (make and model) did **the other involved person**had?_____
4. Where was the damage on **your vehicle**? Front / back / right side / left side
5. How bad was the damage **on your vehicle**? Mild / moderate / severe
6. How bad was the damage to the **other** vehicle? Mild / moderate / severe
7. Did you see the accident coming? Yes / No
8. Where you able to brace for impact? Yes / No
9. Did the airbags deploy on your vehicle? Yes / No
10. How high are the headrests on your vehicle? Low / medium / high / no head rests
11. Where was your head pointing at the time of impact? Forward / looking to the right / looking to the left / looking back
12. Did you loose consciousness with the impact? Yes / No
13. Did you get medical attention at the scene? Yes / No
14. Did an ambulance take you to the hospital? Yes / No
15. If you went to the hospital, did they take x-rays? Yes / No, gave you medication? Yes / No

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1. Have you seen any other doctor or clinic for this accident? Yes / No, Name of clinic:_____
2. What day did you first treat at this clinic:_____
3. Other than an exam, what services where rendered at that clinic:_____
4. What benefits did you get from that treatment? Great / moderate / mild / none
5. Are you still receiving treatment at that clinic? Yes / No

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1. Do you drink alcohol? Yes / No / Socially
2. Do you smoke? Yes / No
3. Do you drink coffee? Yes / No
4. Conditions that your mother, father, or siblings suffer from:_____

   _____
5. Other than the conditions cause by this accident, any conditions that you previously suffer from?_____

   _____
6. History of surgery:_____
7. Medication(s):_____

REVIEW OF SYSTEM

Please check any illness, symptom or problem that you have had in the last month.

1. CONSTITUTIONAL

- ◯ *Depression*
- ◯ *Fever*
- ◯ *sweats*
- ◯ *Uncontrollable weight loss*
- ◯ *Uncontrollable weight gain*
- ◯ *None*

2. ***HEENT***

- ◯ *Hearing*
- ◯ *Eyesight problems*
- ◯ *Swallowing*
- ◯ *None*

3. ***CARDIO***

- ◯ *Chest pain*
- ◯ *Ankle swelling*
- ◯ *Palpitations*
- ◯ *None*

4. ***GASTRO INTESTINAL***

- ◯ *Abdominal pain*
- ◯ *Vomiting*
- ◯ *Nausea*
- ◯ *Constipation*
- ◯ *None*

5. RESPIRATORY

- ◯ *Shortness of breath*
- ◯ *Cough*
- ◯ *Pain taking a deep breath*
- ◯ *None*

6. GASTRO URINARY

- ◯ *Blood in urine*
- ◯ *Discharge*
- ◯ *Urinary incontinence*
- ◯ *None*

7. SKIN

- ◯ *Bruising*
- ◯ *Itching*
- ◯ *Scratching*
- ◯ *None*

8. PSYCHOLOGICAL

- ◯ *Excessive stress*
- ◯ *Loss of interest*
- ◯ *None*

9. ENDOCRINE

- ◯ *Increased thirst*
- ◯ *Intolerance to heat*
- ◯ *Intolerance to cold*
- ◯ *None*

10. ***HEMATOLOGIC / LYMPHATIC***

- ◯ *Lumps*
- ◯ *Bruising*
- ◯ *Bleeding*
- ◯ *None*

POA / Assignment of Benefits Form

POWER OF ATTORNEY TO ENDORSE CHECKS AND/OR TO SIGN ANY PAPER WHICH WILL ENHANCE OR EXPEDITE PAYMENT TO PROVIDER FOR SERVICE RENDERED, INCLUDING BUT NOT LIMITED TO A RELEASE OF MEDICAL RECORDS AND ASSIGNMENT OF BENEFITS/AUTHORIZATION TO PAY.

Known by all these present that: the undersigned has made, constituted and appointed, and by these presents does not hereby make, constitute and appoint MIDTOWN CLINIC OF CHIROPRACTIC and any of its duly authorized agents and employees as and to be undersigned's true and lawful attorney for and in the undersigned's name, place and stead to endorse any and all checks, drafts, or money orders which are made payable to the undersigned alone or to the undersigned and MIDTOWN CLINIC OF CHIROPRACTIC which checks, drafts, or money orders are made payable for services which have been made by MIDTOWN CLINIC OF CHIROPRACTIC, at the request of with the knowledge and approval of the undersigned and/or maker of the check, draft or money order.

This assignment includes but it's not limited to, all rights to collect benefits directly from my insurance company for services that I have received and all rights to proceed against my insurance company in any action including legal suit if for any reason my insurance company fails to make payments of benefits due to my assignee or me. This assignment also includes any rights to recover attorney's fees and costs for such action brought by the provider as my assignee.

The undersigned by these presents does give and grant MIDTOWN CLINIC OF CHIROPRACTIC, as attorney the full power and authority to do and perform all and every act whatsoever requisite and necessary to be done in and about the premises as fully to all intents and purposes as the undersigned might or could do to personally present insofar as the endorsing and cashing of said check and concerned as well as any other document.

At any time after Insurer fails to render the applicable payment within 30 days upon receipt of Health Care Providers medical bills got any date of service, this agreement may be revoked. Health Care Provider's said revocation will be effective on the thirty first (31) day after Insurer has received Health Care Provider medical bill(s) that Insurer has denied has denied, withdrawn, reduced, or failed to pay in accordance with Florida Statute 627.736.

A photocopy of this document shall be as binding as an original signature page.

The undersigned does hereby ratify and confirm any and all actions taken by the said attorney in accordance with this special power and which they said attorney shall do cause to be done by virtue of these presents.

ASSIGNMENT OF BENEFITS

I,_____ , hereby authorize _____

(name of insured) (name of insurance company)

to pay and mail directly to MIDTOWN CLINIC OF CHIROPRACTIC, the medical benefits otherwise payable to me for their services, but not to exceed the charges o those services, I hereby irrevocably assign to MIDTOWN CLINIC OF CHIROPRACTIC and benefits under any policy of insurance, indemnity agreement, or any other collateral

_____ _____ _____

PATIENT'S SIGNATURE PATIENT'S NAME DATE

Informed Consent for Chiropractic Care:

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both of us to be working for the same objective. It is important that each patient understand both the objective(s) and the method(s) that will be used to attain this objective. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition and the recommended care to be provided so that you make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks, and alternatives.

Chiropractic is a science, philosophy and art which concern itself with the relationship between the spinal structure and the health of the nervous system. As chiropractors, we understand that health is a state of optimal physical, mental, and social well-being not merely the absence of disease or infirmity. One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/ or do not move properly. This causes an unhealthy change to nerve function and interference to the nervous system.

This may result in pain and dysfunction or may be entirely asymptomatic. Subluxations are corrected and/or reduced by chiropractic adjustment. An adjustment is the specific application of force to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments are done by hand where the doctor will put pressure on the specific segment(s) of the spine to adjust the vertebrae into a better position. If at the beginning or during the course of care we encounter a non-chiropractic or unusual findings, we will advise you of those findings and recommend some further testing or refer you out to another health care provider. Chiropractic care has been proven to be very safe and effective. It is not usual however, to be sore after your first few corrective adjustments. Although rare it is possible to suffer from other side effects; i.e. muscle spasms. stiffness, rib fracture, headache, dizziness and stroke.

All questions regarding the doctor's objective to my care in this office has been answered to my complete satisfaction. The benefits, risks, and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

_____ _____ _____

PrintName Signature Date

Release of Medical Records:

I give my permission for Dr. Colon to request medical information for other medical facilities that may help the doctor to accurately assess and treat my current condition.

_____ _____ _____

Print Name Signature Date

Consent to evaluate and adjust a minor child

I, _____ being the parent or legal guardian of_____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

_____ _____ _____

PrintName Signature Date

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an X-ray evaluation. I have been advised that x-rays can be hazardous to an unborn child.

Date of last menstrual cycle:_____

_____ _____ _____

PrintName Signature Date

OFFICE FINANCIAL POLICY

CASH

1. All patients are on a cash basis until their respective insurance coverage and deductible may be verified by our staff.

2. This office may make payment plan arrangements on an individual basis. Any such plan or arrangement will be discussed during your report of findings.

INSURANCE

1. If you have insurance, we will gladly accept assignment with the following exceptions and regulations provided that we have prior certification from your insurance company.

2. We accept assignment for the initial treatment plan only. Any follow-up visits will be payable when services are rendered. Once you have been discharged from active care and placed on maintenance care, we will continue to file your insurance but require full payment each visit.

3. We accept assignment as a courtesy to you; you are responsible for your entire bill should your insurance company not pay any of the anticipated charges for any reason. We are not a mediator between you and your insurance company and will not enter into any dispute with the same, as your contract is between you and your insurance company.

4. Whenever you receive any worksheets from your insurance company or explanation of benefits, please bring this information into this office as soon as possible. We must have a copy of this to determine whether proper payment has been made. If you should receive a check from your insurance company during our billing, you must bring it into the office upon receipt. If any over-payment exists after all insurance billing has been done, we will issue you an overpayment check – it will not come from your insurance company. All insurance payments, regardless of which company issues a check first, are applied to your account as long as any balance is due.

5. Any services not covered or coverage reductions by your insurance will be the patient's responsibility.

6. This office will resubmit a claim ONE TIME. We will not enter into any dispute with your insurance company. If coverage problems arise, you will be expected to assist directly in dealing with your insurance company, adjuster, or agent. Any denied or disputed claims will be treated as uncovered services and you will be expected to pay such charges on a timely basis.

7. If the patient is referred to another specialist or discontinues care for any reason other than discharge by the doctor, the bill is due and payment in full expected immediately regardless of any claims submitted.

8. If you have questions concerning this or any other matter, please speak with the receptionist or our insurance department prior to seeing the Doctor.

Thank you.

I have read and understand the Financial Office Policy and agree to abide by these terms.

_____ _____

Patient's Signature Date

MIDTOWN
CLINIC OF CHIROPRACTIC

TO: Attorney_____
_____
_____

Re: Health Report and Doctor's Lien

I (_____) hereby authorize the above doctor to furnish you, my attorney/insurer carrier, with a full report of his examination, diagnosis treatment, prognosis, etc., of myself in regards to the accident/illness which occurred/began on_____.

I hereby give and direct you, my attorney to pay directly to the said doctor such as sums may be due and owning him for professional 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 any settlement, judgment or verdict as may be necessary adequately to protect the said doctor , I hereby future give a lien on my case to the said doctor against any and all proceeds of any settlement, judgment or verdict which may be paid to you attorney, or myself as a result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all professional bills submitted by him for services rendered me and that this agreement is made solely for said doctor additional protection and in consideration of this 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.

Date:_____ Patients Signature:_____

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

Dated:_____ Attorney's Signature:_____

Attorney: Please date, sign and return one copy to the doctor's office at once. Fax (561)439-7348
Keep one copy for your records.

HIPPA

Compliant Medical Release Form

Date:_____

To:_____

Patient Name:_____

Patient Address:_____

_____

Birth Date:_____ SS#:_____

Purpose of release of all medical records/ PHI : Continuing medical care with Dr. Francisco Colon / Dr. Sebastian Colon.

Limited Power of Attorney: In the event that your institution requires a site-specific authorization for release of protected health information, I grant Dr. Colón the ability to use this medical release form I signed with him along with his signature on your form to release my PHI. I do appreciate the fact that you are lolling after my PHI privacy. I hope you understand that i have the right to have my medical records/ PHI sent to Dr. Colon in a timely fashion to ensure the proper documents are made available to him for my continuing medical care and well-being. I have read his HIPPA policy that can be found online at: www.MyMidtownClinic.com. If you have any concerns about releasing my medical records to Dr. Colon, please call (561) 533-3884.

X_____

Patient Signature

MIDTOWN
CLINIC OF CHIROPRACTIC

Certified Mail Receipt #_____

Date:_____

INSURANCE COMPANY AND ADDRESS:

Name:_____

Address:_____

_____

City:_____ State:_____ Zip:_____

NOTICE OF INITIATION OF TREATMENT

Patient:_____

Insured:_____

Date of loss:_____

Claim #:_____

Policy #:_____

To whom it may concern:

Please be advised that I have been consulted by and have commenced rendering medicalservices to the patient referenced above. The first day of treatment was on_____.

Also enclosed please find a direction to pay by which the patient has directed you to send the check for payment for services rendered to the undersigned. The patient has granted us a lien on the benefits.

In accordance with 627.736(5)(b), I will be timely submitting the bills. We expect you govern yourself accordingly.

Sincerely,

Francisco Colon, DC and Sebastian Colon, DC

AUTHORIZED REPRESENTATIVE: _____

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.

OIR-B1-1571
Pub. 1/2004