Chiropractic Registration and History

1 Patient Information

Date: ____
Patient: ____
Address: ____
____
City State Zip
Sex: M○ F○ Age: ____ Birth Date: ___/___/___
○Single ○Married ○Widowed ○Separated ○Divorced
Patient SS#: ____-____-____
Occupation: ____
Employer: ____
Employer Address: ____
____
Employer Phone: ____
Spouse's Name: ____
Birth Date: ___/___/___ -SS#: ___-___-___
-Occupation: ____
-Employer: ____
Whom may we thank for referring you? ____
____

2 Insurance

Who is responsible for the account? ____
Relationship to patient: ____
Insurance Co.: ____
Group #: ____
Is patient covered by additional insurance? ○Yes ○No
Subscribers Name: ____
Birth Date: ___/___/___ SS#: ___-___-___
Relationship to patient: ____
Insurance Co.: ____
Group #: ____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with____________ and assign directly to Back in Line Chiropractic Center Inc., all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Back in Line Chiropractic Center Inc. to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. Also, Payment Now fees are to be paid at time of service.

____
Responsible Party Signature

____ ____
Relationship Date

3 Phone Numbers

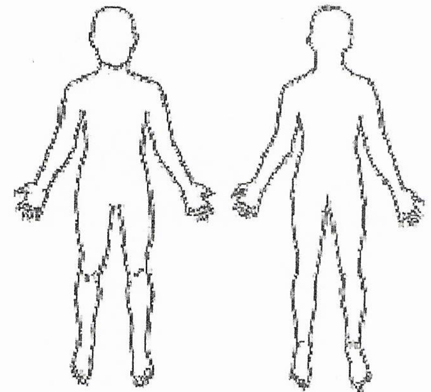
Home: ____ Work: ____
-Ext.: ____
Cell Phone: ____
IN CASE OF EMERGENCY CONTACT:
Name: ____ Relationship: ____
Phone Number: ____

4 Accident Information

Is condition due to an accident? ○Yes ○No
Date: ___/___/___
Type of Accident: Auto Work Home Other ____
To whom have you made a report of your accident?
Auto Insurance Employer Worker Comp. Other ____
Attorney Name (if applicable) ____

5 Patient Condition

What is your major symptom/problem? ____
____
When did the symptoms appear? ____
____
Is this condition getting progressively worse? ○Yes ○No ○Unknown
Have you noticed any visceral or neurological problems since the condition occurred?
(For example: High blood pressure, loss of balance, numbness, etc. ____
____



● **Mark an X on the picture where you continue to have pain, numbness, or tingling.**
Rate the severity of the pain on a scale from 1 (least pain) to 10 (most pain) ____
Type of pain: ☐Sharp ☐Dull ☐Throbbing ☐Numbness ☐Aching ☐Radiating
☐Shooting ☐Burning ☐Tingling ☐Cramps ☐Stiffness ☐Swelling
Other ____
How Often do you have the pain? ____
Is it constant or does it come and go? ____
Does it Interfere with your? ☐Work ☐Sleep ☐Daily Routine ☐Recreation
What makes your condition better? ____
What makes your condition worse? ____
Activities or movements that are painful to perform ☐Sitting ☐Standing ☐Walking ☐Bending ☐Lying Down ☐ ____
Is there a particular time of day that your problem is better or worse? ____

Patient Medical History

Back in Line Chiropractic Center

Name: ______________________________ Date: ______________

List any surgery(s) and dates: ______________________________

List any falls or accidents: ______________________________

Broken bones, dislocations or fractures: ______________________________

Were you ever knocked unconscious? ◯ Yes ◯ No

Do you suffer from any condition(s) other than that for which you are consulting us? ______________________________

Are you presently taking any medication, prescription or over the counter? ______________________________

Do you have any allergies? ______________________________

When did you last see a chiropractor? ______________________________ Dr. ______________

Please indicate conditions you have by marking below with (X), conditions you have had in the past with (O), and family history of conditions with (F):

( ) Aids
( ) Anemia
( ) Arthritis
( ) Epilepsy
( ) Cancer
( ) Tuberculosis
( ) Polio
( ) Diabetes
( ) Hypertension
( ) Parkinson's Disease
( ) Rheumatic Fever
( ) Multiple Sclerosis

PLEASE CHECK ALL PRESENT SYMPTOMS:

CARDIOVASCULAR

- ☐ general swelling
- ☐ loss of coordination
- ☐ swelling in face
- ☐ chest pain
- ☐ rapid heart beat
- ☐ blue or purple skin
- ☐ blue or purple nailbeds
- ☐ fainting
- ☐ ringing in ears
- ☐ heart attack
- ☐ high blood pressure
- ☐ irregular heart beat
- ☐ hardening of the arteries
- ☐ dizziness with nausea
- ☐ blurred vision
- ☐ fainting spells
- ☐ stroke
- ☐ diabetes
- ☐ cold hands and/or feet
- ☐ area of numbness
- ☐ arthritis of the neck
- ☐ previous neck or head injury
- ☐ loss of memory
- ☐ periods of blindness in one eye
- ☐ check if any of your family members have had a stroke

VERTEBROSILAR

- ☐ double vision
- ☐ pain across shoulders
- ☐ irregular muscle movement

MUSCULARSKELETAL SYSTEMS/HEAD

- ☐ unusually frequent headache
- ☐ unusually severe headache
- ☐ head feels heavy
- ☐ vertigo
- ☐ light-headedness
- ☐ loss of smell
- ☐ loss of taste
- ☐ loss of balance
- ☐ dizziness

NECK

- ☐ pain in neck
- ☐ neck pain with movement
- ☐ swelling in neck
- ☐ pinched nerve in neck
- ☐ neck out of place
- ☐ muscle spasms in neck
- ☐ grinding sounds in neck
- ☐ popping sounds in neck
- ☐ stiff neck
- ☐ limited neck movement

SHOULDERS

- ☐ pain in shoulders (right) (left)
- ☐ swelling in legs
- ☐ tension in shoulders
- ☐ muscle spasms in shoulder
- ☐ can't raise arm (right) (left)

ARM AND HANDS

- ☐ pain in upper arm
- ☐ pain in forearm
- ☐ pain in hands or fingers
- ☐ sensation of pins and needles in arms or fingers
- ☐ fingers fall asleep
- ☐ hands cold
- ☐ swollen joints in fingers
- ☐ sore joint in fingers
- ☐ loss of grip strength

MID BACK

- ☐ mid back pain
- ☐ pain between shoulder blades
- ☐ pain from front to back
- ☐ pain over kidney area
- ☐ muscle spasms in mid back

LOW BACK

- [ ] low back pain
- [ ] low back feels out of place
- [ ] muscle spasms in low back

HIPS, LEGS, AND FEET

- [ ] pain in buttocks
- [ ] pain down leg
- [ ] knee pain
- [ ] leg cramps
- [ ] pins and needles in legs
- [ ] numbness in leg or toes
- [ ] cold feet
- [ ] swollen ankles or feet

SKIN HAIR NAIL

- [ ] eczema
- [ ] itchy skin
- [ ] dry scalp
- [ ] oily scalp
- [ ] rough, scaly skin
- [ ] dry skin
- [ ] oily skin
- [ ] psoriasis
- [ ] yellow skin
- [ ] bruise easily
- [ ] paper thin nails
- [ ] hair loss

EYES

- [ ] blurring of vision
- [ ] double vision
- [ ] eyes fatigue easily
- [ ] excessive tearing
- [ ] lack of tearing
- [ ] light bothers eyes
- [ ] excessive itching
- [ ] pain in eyeball

EARS

- [ ] loss of hearing
- [ ] pain in ears
- [ ] discharge from ears
- [ ] vertigo
- [ ] ringing in ears

NOSE NASOPHARYNX

- [ ] unusual nasal discharge
- [ ] nose bleeds
- [ ] pressure over eyes
- [ ] pressure under eyes
- [ ] obstruction in nose
- [ ] frequent colds
- [ ] sinusitis
- [ ] nasal allergies
- [ ] loss of sense of smell
- [ ] any trauma to nose

MOUTH AND THROAT

- [ ] cavities
- [ ] pain in mouth
- [ ] pain in throat
- [ ] bleeding gums
- [ ] difficulty swallowing
- [ ] changes in voice

RESPIRATORY

- [ ] shortness of breath
- [ ] dry cough
- [ ] productive cough
- [ ] coughing up blood
- [ ] wheezing

GASTROINTESTINAL

- [ ] poor appetite
- [ ] indigestion
- [ ] can't eat some foods
- [ ] nausea and vomiting
- [ ] abdominal pain
- [ ] change in bowel habits
- [ ] diarrhea
- [ ] constipation
- [ ] hemorrhoids

WOMEN ONLY

- [ ] painful period
- [ ] spotting
- [ ] vaginal discharge
- [ ] premenstrual symptoms
- [ ] irregular periods
- [ ] lumps in breast
- [ ] take birth control pills
- [ ] # of pregnancies: ________
- [ ] # of deliveries: ________

GENITOURINARY

- [ ] urination
- [ ] frequents
- [ ] normal
- [ ] infrequent
- [ ] low
- [ ] need to get up at night to urinate
- [ ] abnormal intense desire to urinate
- [ ] difficulty starting urination
- [ ] decreased output
- [ ] pain on urinating
- [ ] dribbling
- [ ] blood in urine
- [ ] cloudy urine
- [ ] lack of bladder control

VENERAL DISEASE

- [ ] AIDS
- [ ] syphilis
- [ ] gonorrhea

SOCIAL HISTORY

- [ ] smoking
- [ ] other tobacco use
- [ ] alcohol use
- [ ] drink coffee or tea

diet is: ○ balanced ○ not balanced

rest is: ○ sufficient ○ not sufficient

recreation is: ○ sufficient ○ not sufficient

my stress level is: ○ severe ○ moderate ○ minimal ○ none

GENERALLY FEEL

- [ ] nervousness
- [ ] irritability
- [ ] fatigue

Patient Consent for Use and Disclosure of Protected Health Information

Back in Line Chiropractic Center

I hereby give consent for Back in Line Chiropractic Center to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations. (TPO)

Back in Line Chiropractic Center's Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have read Back in Line Chiropractic Center's Notice of Privacy Practices prior to signing this consent. Back in Line Chiropractic Center reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Back in Line Chiropractic Center, 6991 W. Broward Blvd. #107, Plantation, FL 33317.

With this consent, Back in Line Chiropractic Center may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Back in Line Chiropractic Center may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as there marked Personal and Confidential.

With this consent, Back in Line Chiropractic Center may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Back in Line Chiropractic Center restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Back in Line Chiropractic Center's use and disclosures of my PHI to carry out TPO.

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, Back in Line Chiropractic Center may decline to provide treatment to me.

____

Signature of Patient or Legal guardian

____ ________________

Patient's Name (print) Date

____

Print Name of Patient or Legal Guardian

Informed Consent of Chiropractic Treatment

Doctors of chiropractic who use manual therapy techniques are required to advise patients that there are or may be some risks associated with such treatment. In particular, you should note:

a) While rare, some patients may experience short-term aggravation of symptoms, rib fractures or muscle and ligament strains or sprains as a result of manual therapy techniques.
b) There are reported cases of stroke associated with many common neck movements including adjustment of the upper cervical spine. Present medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical spine adjustment and the occurrence of stroke. Furthermore, the apparent association is noted very infrequently. However, you are being warned of this possible association because stroke sometimes causes some neurological impairment, and may on rare occasion result in injuries including paralysis. The possibility of such injuries resulting from upper cervical spinal adjustment is extremely remote.
c) There are rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused or may be caused by spinal adjustments or chiropractic treatment.

Chiropractic treatment, including spinal adjustment has been the subject of government reports and multi-disciplinary studies conducted over many years and has been demonstrated to be effective treatment for many neck and back conditions involving pain, numbness, muscle spasm, loss of mobility, headaches, and other similar symptoms.

Chiropractic care contributes to your overall well being. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

I acknowledge I have discussed, or have had the opportunity to discuss with my chiropractor the nature and purpose or chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of this Consent.

I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal adjustment. I intend this consent to apply to all my present and future chiropractic care.

Dated this __________ day of ________________________________ 20______________________

____
Patient Signature (or Legal Guardian)

____
Signature of Witness

____
Patient Name (printed)

____
Witness Name (printed)

Prior Chiropractic Treatment Information

Name of Chiropractor: ____

Location: ____

When was your last treatment? ____

Have you had X-rays? ____

Notice to Patients

Please note that all x-rays are analyzed for alignment and possible fractures at the time of the initial Report of Findings. A final analysis review will also be conducted by the physician upon their convenience; at which, the findings will be disclosed to the patient. Should the physician locate any matter which may be out of their scope of practice, the x-rays will be sent out to be analyzed and reported on by an independent radiologist for a service fee of $35.00. The patient will be responsible for this fee.

Additionally, if patient prefers to have the final analysis conducted sooner, the x-rays may be sent out to be analyzed and reported on by an independent radiologist for a service fee of $35.00. The patient will be responsible for this fee.

____ Yes, I would prefer my x-rays sent out immediately for final analysis for a fee of $35

______________________________ ______________

Patient Signature Date

____

Patient Name

ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

____
Patient Name (please print)

____
Date

____
Parent, Guardian or Patient's legal representative

____
Signature

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.

List below the names and relationship of people to whom you authorize the Practice to release PHI.

____________________________	____________________________
____________________________	____________________________
____________________________	____________________________

ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

By checking the lines below I authorize being contacted for practice reminders by:
Mail ________;
Email________; at email address ____;
Telephone numbers_________;
____;
By voice mail ____________;
By text message __________;
By FaceBook address ____.

By checking this checking the lines below I authorize being contacted for birthday greetings or promotions about the practice by:
Mail ________;
Email ________ at email address ____;
Telephone numbers_________;
____;
By voice mail ____________;
By text message __________;
By FaceBook address ____.

By checking this checking the lines below I authorize the doctor to personally discuss with me products that may benefit my health or condition. ________

____
Patient Name (please print)

____
Date

____
Name of Parent, Guardian or Patient's legal representative

____
Signature of Patient, Parent, Guardian or Patient's legal representative

ADVANTAGE RADIOLOGY SERVICE

(419) 269-2424 *(844) 283-4163*

PATIENT ______________________ CLINIC ______________________ FILM DATE ____________

AGE_____ SEX M☐ F☐ SOCIAL SECURITY #______/______/______ DATE OF BIRTH ____________

PATIENT ADDRESS______________________ CITY______________ STATE______ ZIP__________

X-RAY ASSIGNMENT AGREEMENT

I understand that the services of a chiropractic radiologist are being utilized to insure the highest quality interpretation of my x-rays. I acknowledge that these services are separate from those of the clinic where I am receiving care, and that the charges for these services will be submitted to my insurance carrier, Workers' Compensation carrier or State Bureau, and/or to my attorney in the case of personal injury.

In the event that I receive payment for these services, I agree to promptly remit payment to Advantage Radiology Service (ARS).

I assign my insurance benefits and rights to payment to ARS to the extent of their charges, and authorize them, or their agents, to bill and release information to my insurance company, attorney, and/or any third-party payer. I authorize my treating physician, insurance company, attorney, and/or any third-party payer to provide ARS or their agents with any information concerning my claim, their services, and/or payment for the services provided.

By my signature below, I acknowledge that I have read, understand, and agree to the above provisions, and I assign my insurance benefits as described above.

SIGNATURE: ______________________ DATE:______________

WITNESS: ______________________

PATIENT HISTORY

PATIENT PRESENTATION ____

____

TRAUMA? YES☐ NO☐ EXPLAIN____

PAST MEDICAL HISTORY____

____

MALIGNANCY? YES☐ NO☐ DETAILS____

DIAGNOSIS/CONCERNS/QUESTIONS [NO ICD CODES PLEASE]______________________________

PLEASE COMPLETE INSURANCE/BILLING INFO ON REVERSE SIDE

ADVANTAGE RADIOLOGY SERVICE

(419) 269-2424 *(844) 283-4163*

CASH (no insurance)______ MEDICARE ONLY______ MEDICAID ONLY______

STANDARD

NEED **NON-PARTICIPATING** PROVIDER INSURANCE NAME & BILLING ADDRESS
**PLEASE ATTACH COPY OF FRONT AND BACK OF INSURANCE CARD(S).*

INSURANCE NAME & BILLING ADDRESS (PRIMARY)				INSURANCE NAME & BILLING ADDRESS (SECONDARY)			
CARRIER		TELEPHONE		CARRIER		TELEPHONE	
ADDRESS				ADDRESS			
CITY		STATE	ZIP	CITY		STATE	ZIP
RELATIONSHIP TO INSURED SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ______				**RELATIONSHIP TO INSURED** SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ______			
INSURED NAME		INSURED DATE OF BIRTH		INSURED NAME		INSURED DATE OF BIRTH	
INSURED SOCIAL SECURITY #	INSURED ID #			INSURED SOCIAL SECURITY #	INSURED ID #		
INSURED GROUP #	BCBS 3 LTR PREFIX			INSURED GROUP #	BCBS 3 LTR PREFIX		
INSURED EMPLOYER	TELEPHONE			INSURED EMPLOYER	TELEPHONE		
IF W/C: EMPLOYER ADDRESS	CITY	ST	ZIP	IF W/C: EMPLOYER ADDRESS	CITY	ST	ZIP

AUTO ACCIDENT/PI/WORKERS' COMPENSATION

RELATIONSHIP TO EMPLOYMENT? YES ☐ NO ☐ AUTO ACCIDENT? YES ☐ NO ☐
OTHER? YES ☐ NO ☐

CLAIM # ________________ **DATE OF INJURY**________________

W/C CARRIER or AUTO INSURANCE — **NAME & BILLING ADDRESS** LIST BOTH LIABILITY & MED PAY CARRIERS (USE ADDITIONAL PAPER IF NECESSARY)			**ATTORNEY NAME & BILLING ADDRESS**		
CARRIER	TELEPHONE		ATTORNEY NAME	TELEPHONE	
INSURANCE ADDRESS			ATTORNEY ADDRESS		
CITY	STATE	ZIP	CITY	STATE	ZIP
RELATIONSHIP TO INSURED SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ______			* PLEASE LIST BOTH LIABILITY AND MED PAY CARRIERS USE ADDITIONAL PAPER IF NECESSARY		
INSURED NAME	INSURED SOCIAL SECURITY #				
IF PI: ADJUSTER'S NAME	ADJ. TELEPHONE		**IF W/C:** ALLOWED DIAGNOSIS ICD-9 CODES		

PLEASE COMPLETE PATIENT HISTORY ON REVERSE SIDE

PATIENT NAME:

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers or preceptorship interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit.

Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and if not revoked will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) patient should initial here. ________. Effective as the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

PATIENT SIGNATURE	X (Date)
(Or Patient Representative)	(Indicate relationship if signing for patient)
OFFICE SIGNATURE	X (Date)

AAC-FED

ALSO **SIGN** THE **INFORMED CONSENT** ON **REVERSE** SIDE

ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist named below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may be an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

(Date)

PATIENT SIGNATURE **X**

(Or Patient Representative)

(Indicate relationship if signing for patient)

ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE

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 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. This means that no person has initiated contact with me and/or persuaded me to use the doctor or licensed professional, clinic, or medical institution that provided the services.
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.

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 **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.

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

______________________	______________________	______________
Name *(PRINT or TYPE)*	Signature	Date

Licensed Medical Professional Rendering Treatment *(Signature by his or 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.

AUTHORIZATION TO OBTAIN PIP BENEFITS PAYOUT INFORMATION

Name of insurer: ______________________________

PIP Policy Number: ___________________________

Name of Insured: _____________________________

Date of Accident: _____________________________

I, __________________________*(name of insured)*, hereby authorize and direct __________________________*(name of insurer)* to send to **Back In Line Chiropractic Center, Inc.**, 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 Signed

Address of Insured

____

____

____

Back In Line Chiropractic Center, Inc.

Automobile Accident Form

Patient Name: ______________________________ Date: ____/____/____

Social Security #: ______________________________ Date of Birth: ____/____/____

Date of Injury: ____/____/____ Time of Injury: __________ ◯AM ◯PM

Location of Accident: ______________________________

Were you the ◯driver ◯passenger ◯pedestrian?

What is the estimated damage to your vehicle? $ ______________________________

◯Yes ◯No Do you have automobile personal injury insurance coverage?

Name/Address/Phone #: ______________________________

____

What is your automobile insurance medical coverage limit? $ ______________________________

What is your claim #: ______________________________

◯Yes ◯No Have you reported this injury to your car insurance company?

◯Yes ◯No Do you know the claim adjuster's name? ______________________________

◯Yes ◯No Did the police come to the scene of the accident and make a report?

◯Yes ◯No Was anyone issued a citation? Who? ☐Driver of your car ☐Driver of other car

◯Yes ◯No Do you have an attorney for this case? Name / Address / Phone:

____

____

Where was your car hit? ☐Front ☐Back ☐Driver's Side ☐Passenger's Side

◯Yes ◯No Was your car moving? MPH ____ ◯Yes ◯No Was the other car moving?

Please describe the accident: ______________________________

____

____

____

How did you feel after the accident? ______________________________

____

◯Yes ◯No Did you lose consciousness? ◯Yes ◯No Did you go to the hospital?

Check symptoms you have noticed since the accident:

☐Headache	☐Irritability	☐Numbness in Toes	☐Cold Feet
☐Neck Pain	☐Chest Pain	☐Shortness of breath	☐Ringing in Ears
☐Neck Stiffness	☐Dizziness	☐Fatigue	☐Loss of Balance
☐Sleeping Problems	☐Head seems heavy	☐Depression	☐Fainting Spells
☐Mid Back Pain	☐Lower Back Pain	☐Pins & Needles in arms	☐Tension
☐Numbness in Hand	☐Nervousness	☐Pins & Needles in legs	☐Loss of Smell
☐Loss of Taste	☐Loss of Memory	☐Cold Hands	☐Sciatic Pain

☐Bleeding (location) ______________________________ ☐Stitches (location) ______________________________

☐Lower Back Stiffness ☐Lower Extremity Pain (location) ______________________________

☐Upper Extremity Pain (location) ______________________________ ☐Missed days from work (#) ______________________________

At the time of impact your vehicle was:

- ○ Slowing down
- ○ Stopped
- ○ Gaining speed
- ○ Moving at steady speed

At the time of impact the other vehicle was:

- ○ Slowing down
- ○ Stopped
- ○ Gaining speed
- ○ Moving at steady speed

During and after the crash, your vehicle:

- ○ Kept going straight, not hitting anything
- ○ Kept going straight, hitting car in front
- ○ Was hit by another vehicle
- ○ Spun around, not hitting anything
- ○ Spun around, hitting another car
- ○ Spun around, hitting object other than car

Describe yourself during the crash.

Check only the areas that apply to you

- ○ You were unaware of the impending collision.
- ○ You were aware of the impending crash and relaxed before the collision.
- ○ You were aware of the impending crash and braced yourself.
- ○ Your body, torso, and head were facing straight ahead.
- ○ You had your head and/or torso turned at the time of collision:
  - ○ Turned to left ○ Turned to right
- ☐ You were intoxicated (alcohol) at the time of crash.
- ☐ You were wearing a seat belt.
  - If yes, does your seat belt have a shoulder harness? ○ Yes ○ No
- ☐ You were holding onto the steering wheel at the time of impact.

Indicate if your body hit something or was hit by any of the following:

Please draw lines and match the left column to the right column. (Please print form to fill in this section)

Head	Windshield
Face	Steering Wheel
Shoulder	Side Door
Neck	Dashboard
Chest	Car Frame
Hip	Another Occupant
Knee	Seat
Foot	Seat belt

Check if any of the following vehicle parts broke, bent, or were damaged in your car:

- ☐ Windshield
- ☐ Steering wheel
- ☐ Dashboard
- ☐ Seat frame
- ☐ Side/rear window
- ☐ Mirror
- ☐ Knee bolster
- ☐ Other ____________________
- ☐ Other ____________________

Rear-end collisions only

Answer this section only if you were hit from the rear.

Does your vehicle have:

- ○ Moveable head restraints
- ○ Fixed, non-moveable head restraints
- ○ No head restraints

Please indicate how your head restraint was positioned at the time of the crash.*

- ○ At the top of the back of your head
- ○ Midway height of the back of your head
- ○ Lower height of the back of your head
- ○ At the back of your neck
- ○ At the level of your shoulder blades (upper back) below your neck

All types of collisions

Answer this section regardless of the type of crash, indicating those relevant to your case.

Yes	No	
O	O	Did any of the front of your side structures, such as side door, dashboard, or floor board of your car, dent inward during the crash?
O	O	Did the side door touch your body during the crash?
O	O	Were your hands on the steering wheel or dashboard during the crash?
O	O	Did your body slide under the seat belt?
O	O	Was a door of your vehicle damaged to the point where you could not open the door?

Emergency Department

Yes	No	
O	O	Did you go to the emergency department after the accident?
		What is the name of the emergency department? ______________________________
		When did you go (date and time)? ______________________________
O	O	Did you go to the emergency department in an ambulance?
O	O	Did you or another person drive you to the emergency department?
O	O	Were you hospitalized overnight?
O	O	Did the emergency department doctor take X-rays? Check what was taken:
		☐ Skull
		☐ Neck
		☐ Low Back
		☐ Arm or Leg
O	O	Did the emergency department doctor give you pain medication?
O	O	Did the emergency department doctor give you muscle relaxants?
O	O	Did you have any cuts or lacerations?
O	O	Did you require any stitching for cuts?
O	O	Were you given a neck collar or back brace to wear?

When did you first notice any pain after injury?

O Immediately O ______ Hours After Injury O ______ Days After Injury

If you did not see a doctor for the first time within the first week after injury, indicate why.

Check all that apply:

O No pain was noticed
O No transportation
O No appointment schedule available
O Work/home schedule conflicts

If you did not see a doctor for the first time within the first month after injury, indicate why.

Check all that apply:

O No pain was noticed
O No transportation
O I thought pain would go away
O I self-treated with over-the-counter drugs
O No appointment schedule available
O Work/home schedule conflicts
O I had no insurance or money
O I took hot showers, used ice, heat

Have you been unable to work since injury?

O Yes O No If yes, were you off work O partially or O completely?

Please list date(s) off work: ______/______/______ to ______/______/______

BACK IN LINE CHIROPRACTIC CENTER
6991 W. BROWARD BLVD PLANTATION, FL 33317
954-584-BACK (2225)

LETTER OF PROTECTION

TO: Attorney: ______________________________

____

____

RE: PATIENT: ______________________________

I do hereby authorize the above doctor and corporations 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 involved.

I hereby authorize and direct you, my attorney to pay directly to the above referenced doctor and corporations such sums as may be due and owing them for medical service rendered me both by reason of this accident and by reason of any other bills that are due their office and to withhold such sums from any insurance payments from whatever source, settlement, judgment, or verdicts may be necessary to adequately protect said doctor and corporations. I herby further give a lien on my case to said doctor and corporations against any and all proceeds of any insurance payments from whatever source, settlement, judgment of verdict which may be paid to you, my attorney, of myself as the result of the injuries for which I have been treated of injuries in connection therewith.

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

In the intent of the undersigned that this assignment is irrevocable and shall apply to the previously described cause of action whether of not the undersigned should engage co-counsel of substitute attorneys at any future time and in that event, the undersigned further agrees to immediately advise the doctor's office and corporations in writing of such substitution at the time said substitution or agreement of co-counsel should occur.

PATIENT'S SIGNATURE: ______________________________ DATE: ____________________

The undersigned, being attorney of record for the above patient, and in consideration of the doctor's agreement to testify, provide medical reports or be disposed, does hereby agree to observe all the terms of the above and agrees to withhold such sums from any insurance from whatever source, settlement, judgment or verdict as may be necessary to adequately protect said doctor and corporations above named and to pay any of the above charges directly to the doctor and corporations within a reasonable time (not more than 10 days after receipt by the undersigned).

The patient's attorney further agrees to immediately notify the doctors' office and corporation in writing should there occur a substitution of counsel, referral to another attorney or law firm, and retention of co-counsel or should the attorney/client relationship be terminated or modified in any manner.

I will personally be responsible for the payment of the following service which the physician and /or above named corporations, agrees to render to the undersigned attorney and amounts due at the time of service.

1. Medical reports3. Expert witness fees for trial testimony5. Photo copy charge and faxing fee
2. Deposition fees4. Conference (phone and/or pre-depo.)

The undersigned further agrees that the charges for medical reports, deposition fees and expert testimony are services rendered to the attorney by the physician and are not on a contingency basis, and shall be paid to the physician and corporations regardless of the outcome of the litigation and even if there is no recovery made of funds obtained from a third party to pay for these services.

In the event it becomes necessary for the doctor or any above named corporation to enforce the terms of this agreement against the undersigned, then and in that event , said corporation and/or doctor shall be entitled to recover all costs incurred including attorney's fees for services rendered in connection with any enforcement of breach of this agreement, including appellate proceedings and post judgment proceedings.

ATTORNEY SIGNATURE: ______________________________ DATE: ____________________

PRINT NAME: ______________________________

Back in Line Chiropractic Center

PATIENT DICLOSURE
AND ACKNOWLEDGEMENT FORM

☐ Office Visit	☐ Electrical Stimulation	☐ Laser
☐ Manual Therapy	☐ Cervical Traction	☐ Traction
☐ Therapeutic Exercises	☐ X-rays	☐ Scan
☐ Therapeutic Ultrasound	☐ Gait Training	☐ Other ____________
☐ Massage Therapy	☐ Functional Activities	☐ Other ____________
☐ Hot/Cold Pack	☐ Balance Work	☐ Other ____________
☐ Whirlpool	☐ Ball Work	☐ Other ____________

1. I acknowledge that I received the treatment listed above.
2. I acknowledge that I have the right and affirmative duty to confirm that services listed was actually rendered
3. I was not solicited by this medical facility or any of its employees to seek medical treatment for injuries sustained as a result of this accident.
4. I understand that if the insured notifies the insurer in writing of any billing errors, the insured may be entitled to a certain percentage of the reduction in the amounts being paid by the insured's motor vehicle insurer.
5. The services being provided to me for which my doctor intends to bill my insurance been explained. I have had the opportunity to have any questions answered to my satisfaction.
6. I hereby acknowledge having been informed of the above and have consented to the treatment and billing for the treatment proposed by my provider.

Patient's Original Signature

____

Patient's Name (print)

______________________________ ____________

Signature of Patient or Legal guardian Date

______________________________ ____________

Provider's Original Signature Date
(The treatment billed for has been explained to the patient)