PuraVida Wellness Center

2945 S Congress Ave, Suite A, Palm Springs, FL 33461
Ph: 561-388-0909

Personal Injury Intake Form and Chiropractic Care Agreement

Patient Information:

Today's Date _____
Name _____ Home Phone _____
I prefer to be called _____ Work Phone _____
Address _____ Email _____
_____ Social Security # _____
_____ Date of Birth _____
Sex **Male** **Female** Height ____' ____" Weight _____ lbs
Occupation _____ Marital Status _____
Employer _____ No of Children _____
Address _____
If minor, name of parent or guardian _____
Who should we contact in case of an emergency? _____
Relation _____ Phone _____
Address _____
Attorney _____ Phone _____
Primary Care Physician _____ Phone _____
How did you hear about our office? _____
Have you ever been to a chiropractor before? **YES** **NO** If so, whom? _____

Health Insurance Information:

Insurance Company _____ Policy number _____
Policy Holder's Name _____ Social Security # _____
Address _____ Phone _____

Auto Insurance Information:

Insurance Company _____ Policy number _____
Address _____ Phone _____
Adjustor Name _____ Claim # _____

Accident Information:

Date _____ Time _____ AM PM Was it reported to the police? **YES** **NO**
Was a traffic violation issued? **YES** **NO** To whom? _____

Location of accident (Street, Town) _____ # of other passengers _____
Were there other witnesses? **YES** **NO** Make/model of vehicle you were in _____

Please explain in detail how the accident occurred _____
_____
Please list symptoms felt immediately after the accident _____
_____
In which direction were you headed? **N** **S** **E** **W** Approx. speed of vehicle ___ MPH

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Did the impact to your vehicle come from the: **FRONT** **REAR** **RIGHT** **LEFT** **OTHER**
During impact, were you facing: **RIGHT** **LEFT** **FORWARD**
Were you **AWARE** or **SURPRISED** by the impact?
Were you the **DRIVER** **FRONT SEAT PASSENGER** **BACK SEAT PASSENGER**?
Were you wearing a seat belt? **SHOULDER HARNESS** **LAP HARNESS**
Was the vehicle equipped with air bags? **YES** **NO** Did they inflate? **YES** **NO**
In relation to the base of your skull, where was the headrest? **ABOVE** **BELOW** **AT BASE**
What did your vehicle impact? **ANOTHER VEHICLE** **OTHER** _____
If another vehicle, what was the make/model? _____ Direction _____Speed _____MPH
Did any part of your body strike anything in the vehicle? **YES** **NO** Describe _____
Did the accident render you unconscious? **YES** **NO** If yes, for how long? _____

Post-Injury Information:

Have you seen any other doctor(s) since the accident? **YES** **NO** Name _____
When did you go? **IMMEDIATELY** **NEXT DAY** **2 DAYS PLUS**
How did you get there? **AMBULANCE** **PRIVATE TRANSPORTATION**
Name of hospital and/or attending doctor: _____
Was he/she a: **D.C.** **M.D.** **D.O.** **D.D.S.**
Please describe any treatment you received _____
Were X-Rays done? **YES** **NO** An MRI? **YES** **NO** CAT scan? **YES** **NO**
Was medication prescribed? **YES** **NO** If yes, what? _____
Have you missed any work since the accident? **YES** **NO** Date(s) _____
Are your work activities restricted as a result of your injury? **YES** **NO**
Indicate the symptoms that are a result of this accident:

DIZZINESS	**DIFFICULTY SLEEPING**	**JAW PROBLEMS**	**NAUSEA**
MEMORY LOSS	**ARM/SHOULDER PAIN**	**IRRITABILITY**	**BACK PAIN**
HEADACHE(S)	**NUMB HANDS/FINGERS**	**FATIGUE**	**LOW BACK PAIN**
BLURRED VISION	**TENSION**	**CHEST PAIN**	**BACK STIFFNESS**
BUZZING IN EAR	**NECK PAIN**	**SHORT BREATH**	**LEG PAIN**
EARS RINGING	**NECK STIFF**	**STOMACH UPSET**	**NUMB FEET/TOES**

OTHER _____

Did you ever experience similar symptoms prior to the accident? **YES** **NO**
Has your condition **IMPROVED** **WORSENED** or **STAYED SAME** since the accident?
Is your condition affecting your **WORK** **SLEEP** or **DAILY ROUTINE**? Please explain _____

Please indicate your degree of difficulty (on a scale of 1-5, with 1 being comfortable, 3 being uncomfortable, and 5 being painful) in performing the following activities:

___ Lying on Back	___ Lying on Side	___ Lying on stomach	___ Sitting
___ Standing	___ Stretching	___ Lovemaking	___ Walking
___ Running	___ Sports	___ Working	___ Lifting
___ Bending	___ Kneeling	___ Pulling	___ Reaching

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How many hours are in your normal workday? _____

Please indicate your daily job duties and any activities that you are occasionally asked to perform:

STANDING	**OPERATING EQUIPMENT**	**DRIVING**	**SITTING**
TWISTING	**WORK W/ARMS ABOVE HEAD**	**WALKING**	**CRAWLING**
TYPING	**LIFTING**	**BENDING**	**STOOPING**

What positions can you work in with minimum physical effort, and for how long? _____
Do you work with others who can help you with any heavy lifting? **YES** **NO**
While in recovery, are there any light duty tasks you could request? **YES** **NO**

Health History

Have you ever had any of the following diseases or conditions?

HEART ATTACK or STROKE	**HEART SURGERY or PACEMAKER**	**HEART MURMUR**
CONGENITAL HEART DEFECT	**MITRAL VALVE COLLAPSE**	**ARTIFICIAL VALVES**
ALCOHOL/DRUG ABUSE	**VENEREAL DISEASE**	**HEPATITIS**
HIV+/AIDS	**SHINGLES**	**CANCER**
FREQUENT NECK PAIN	**EMPHYSEMA**	**ANEMIA**
HIGH/LOW BLOOD PRESSURE	**PSYCHIATRIC PROBLEMS**	**RHEUMATIC FEVER**
SEVERE/FREQ. HEADACHES	**KIDNEY PROBLEMS**	**ULCERS/COLONITIS**
FAINTING/SEIZURE/EPILEPSY	**SINUS PROBLEMS**	**ASTHMA**
DIABETES	**DIFFICULTY BREATHING**	**TUBERCULOSIS**
LOWER BACK PROBLEMS	**ARTIFICIAL BONES/JOINTS**	**ARTHRITIS**

Please list **any other** medical conditions that you have or have ever had. _____
_____
Please list any allergies. _____
_____
Please list previous surgeries and dates. _____
_____
Please list any past motor vehicle accidents or traumas and dates. _____
_____
Is there anything else about your health history or family health history that you feel is important to share? _____
_____

Do you exercise? **YES** **NO**
Are you on a special diet? **YES** **NO** Since: ____/____/____
Do you smoke? **YES** **NO** How much? _____ How long? _____
Are you wearing: **ORTHOTICS** **HEEL LIFTS** **ARCH SUPPORTS**

For women: Are you taking birth control? **YES** **NO**
Are you pregnant? **YES** **NO** How long? _____ Nursing? **YES** **NO**

Patient/Legal Guardian Signature_____ **Date** _____

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ASSIGNMENT OF INSURANCE BENEFITS

Patient Name: _____

I hereby authorize payment to be made directly to PuraVida Wellness Center, of all benefits which may be due and payable under insurance coverage for the above named Patient. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments. I further acknowledge that this assignment of benefits does not in any way relieve me of liability and that I will remain financially responsible to PuraVida Wellness Center.

Furthermore, I hereby IRREVOCABLY ASSIGN to PuraVida Wellness Center, the rights and benefits under any policy of insurance, indemnity agreement, or any other collateral source as defined in the state Florida statutes for any service and or charges provided by PuraVida Wellness Center.

Signature of Patient or responsible party: _____

Signature of witness: _____

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OFFICE POLICIES

The following are PuraVida Wellness Center's office policies. Please read carefully, and be sure to ask any questions you might have before signing the document.

Consent for Treatment. The Patient and/or the undersigned, give PuraVida Wellness Center my/our permission to evaluate and treat the Patient's injury or condition. I further understand that, in the course of recommended treatment, conditions may worsen on rare occasions. I further understand that **no guarantee or promise** has been made to me concerning the results of evaluation, care treatment.

Appointment Scheduling and Cancellation Policy. At PuraVida Wellness Center, we understand that unanticipated events happen occasionally in everyone's life. Business meetings, project deadlines, flight delays, car problems, and illness are just a few reasons why one might consider canceling an appointment. In our desire to be effective and fair to all of our patients and staff **24 hour advance notice is required when canceling an appointment otherwise the full fee for the missed appointment will be charged to your account.** This allows the opportunity for someone else to utilize our services during that appointment time.

Office Visits. We understand that the undersigned and/or the Patient may come to the office with family, friends or others. The Patient (or, if a minor, the undersigned) acknowledges that the Patient (or undersigned) is solely responsible for children or those in their care. This is an office; we are busy with patients. Please be careful and aware of your surroundings!

Private Health Insurance. I understand that I am responsible for whatever fees my insurance company does not pay on my claim. (Typically, this includes deductibles and/or co-payments.) It is further understood that I, the undersigned, **agree to pay the full amount** of the charges should my condition be such that it is not covered by my health insurance policy, or if, for any reason, the insurance company and/or my attorney refused to pay my balance at this office.

Patient/Parent or Legal Guardian Signature_____ **Date** _____

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DISPUTE RESOLUTION

Arbitration. The undersigned and the Patient agree that any dispute or claim arising from or relating to the office visit(s) and/or the care provided by PuraVida Wellness Center, shall be resolved exclusively by binding arbitration pursuant to the Florida Arbitration Code, Florida Statutes 682. This includes any injury or losses by you or your children on the premises. Arbitration shall occur in West Palm Beach, Florida and nowhere else.

County Court Exception. The undersigned, the Patient, and PuraVida Wellness Center all agree that any dispute or claim arising from or relating to the office visit(s) and/or the care provided by PuraVida Wellness Center which is within the monetary jurisdiction of county court, Florida Statute 34.01(1)(c), may be brought in arbitration as set forth above or Palm Beach County Court and nowhere else.

Severability/Jury Waiver. In the event any portion of this Chiropractic Care Agreement is deemed unenforceable, that portion shall be severed and all other provisions remain in full force and effect. The undersigned, the Patient, and PuraVida Wellness Center agree that each has waived its rights to a jury trial for any disputes or claims among them.

Chiropractic Care. The undersigned and the Patient agree and acknowledge that PuraVida Wellness Center provides chiropractic care only. The Patient is advised and agrees to consult a medical doctor routinely and as needed. Please ask questions about your health!

Patient/Parent or Legal Guardian Signature_____ **Date** _____

Receipt of Notice of Privacy Practices
Written Acknowledgement Form

I, _____ have read a copy of **Puravida Wellness Center's notice**
Patient Name
of Patient Privacy Practices.

_____ _____
Signature of Patient or Parent or Legal Guardian Date

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CHIROPRACTIC INFORMED CONSENT

The undersigned Patient (which includes the parent/guardian) understands and acknowledges that the Patient is only receiving chiropractic care from PuraVida Wellness Center.

Dr. Kahook is a "chiropractic physician" as defined in Florida Statute 460.403(5)(2008). Chiropractic physicians examine, analyze, and diagnose the human living body and its diseases by use of (a) any physical, chemical, electrical or thermal methods, (b) x-ray for diagnosing, (c) blood tests, and (d) other chiropractic methods. *See* Florida Statute 460.403(3)(b).

Before you, the Patient, receive chiropractic care, it is important that you read this Consent and understand the nature and risks of chiropractic medicine. The "practice of chiropractic medicine" (or chiropractic care) involves the adjustment, manipulation, and treatment of your body in which vertebral subluxations and other malpositioned articulations and structures may be interfering with the normal generation, transmission, and expression of nerve impulse between the brain, organs, and tissue cells, thereby causing disease. *See* Fla.Stat. 460.403(9)(a). Chiropractic adjustments, manipulations, and treatments are intended to restore the normal flow of nerve impulse which produces normal function and consequent health. *See* Fla.Stat. 460.403(9)(a).

The undersigned Patient understands and acknowledges that there are risks associated with the practice of chiropractic medicine and chiropractic care including but not limited to ataxia, bruising, thermal injuries, dislocations/subluxations, dizziness, "drop attacks," fracture(s), mobility disruption, paralysis, quadriplegia, spinal injury, stroke/disruption of blood flow to brain, vision problems, and death.

The Patient is encouraged to ask questions! Although we are not affiliated with and cannot confirm the content of internet sites, resources such as WebMD, Chiro.org, AmerChiro.org, and others may be helpful. The Patient is specifically instructed to consult a medical doctor before receiving (and during/after) chiropractic medicine.

I, the undersigned Patient, understand the risks and limitations associated with the practice of chiropractic medicine, including the use of chiropractic care, evaluation, diagnosis, adjustments, manipulations, and treatments by PuraVida Wellness Center. I hereby give my informed consent to receive chiropractic medicine from Dr. Kahook.

_____
Patient Name/Signature (and date)

_____
Guardian/Parent's Name/Signature (and date)

NOTICE OF HELATH INFORMATION PRACTICES

Dear Patient:

This notice describes how information about you may be used and disclosed by this office and how you can get access to this information. Please review it carefully.

Understand Your Health Record/Information

A record of your visit is made each time you come to our office. This record describes your symptoms, examinations, test results, diagnoses, treatment, and a plan for future care. This record helps us:

- Plan your care and treatment.
- Communicate among the health professionals who contribute to your care.
- Legally describe the care you received.
- Verify to you or a third-party payer that services billed were actually provided.
- Educate health professionals.
- Perform health related research.
- Improve the health of the nation by being a source of information for public health officials.
- Plan and market our facility.

When you understand the information contained in your record and how this information is used, you are able to:

- Ensure its accuracy.
- Understand who, what, when, where, and why others may access your health information.
- Make better informed decisions when authorizing disclosure to others.

Your Health Information Rights

You have the right to:

- Request a restriction of certain uses of your information as provided by 45 CFR 164.522.
- Obtain a paper copy of the notice of information practices upon request.
- Inspect and obtain a copy of your health record as provided for in 45 CFR 164.524.
- Amend your health record as provided in 45 CFR 164.528.
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528.
- Request communication of your health information by alternative means.
- Revoke your authorization to use of disclose health information in the future.

Our Responsibilities

Our practice is required to:

- Maintain the privacy of your health information.
- Provide you with a notice as to our legal duties and privacy practices.
- Abide by the terms of this notice.
- Notify you if we are unable to agree to a requested restriction.
- Accommodate your reasonable requests to communicate health information by alternative means.

We reserve the right to change our procedures and to make the new provisions effective for all protected health information we maintain. Should our information procedures change, we will mail you a revised notice to the address you have furnished us.

We will not use or disclose your health information without your authorization, except as described in this notice.

For More Information or to Report a Problem

If you have questions and would like additional information, please call our office at 386.428.9327.

If you believe your privacy rights have been violated, you can file a complaint with us or with the secretary of Health and Human Services. There is no retaliation for filing a complaint.

Examples of Disclosures for Treatment, Payment and Health Operations

We will use your health information in order to proved treatment.

Example: Information obtained by a nurse, doctor, or other member of your healthcare team will be recorded in your record and used to determine the course of treatment best for you. Your other doctors will be provided with copies of various reports that should assist him of her in treating you once you are discharged from our care.

We will use your health information for payment.

Example: A bill may be sent to you or a third-party payer. The information may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health operations.

Your health record may be used by our staff to assess the care and outcome in your case and others like it in order to continually improve the quality and effectiveness of the care we provide.

Business associates: In order to provide you with the care you need we deal with outside business associates. Examples include testing services and copy services. When these services are contracted, we may disclose your health information to these business associates sot that they can perform the job we have asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require these associates to appropriately safeguard your information.

Notification: We may use or disclose information in order to notify or assist in notifying a family member, personal representative, or another person responsible for your care.

Communication with family: We may, in our best judgement, disclose to family members, other relatives, close personal friends or any other person you identify, health information relevant to that person's involvement in your care of for payment related to your care.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Fund raising: We may contact you as part of a fund-raising effort.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Law Enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

Effective Date:

* PATIENT COPY *
PLEASE KEEP FOR YOUR RECORDS!

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.

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.

Medical Information Release Form

(HIPAA Release Form)

Name: _____ **Date of Birth:** ____/____/____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other_____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number:_____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is (*day*)_____ between (*time*)_____

Signed: _____ Date: ____/____/____

Witness:_____ Date: ___/____/____