CONFIDENTIAL PATIENT INFORMATION

Patient ID #: _____

First Name:_____Middle Initial: _____ Last Name: _____

Address:_____

City:_____State: _____ Zip Code: _____

Date of Birth:_____ Age:_____ Number of Children: _____

SS number: _____

Marital Status: ☐ Married ☐ Single Spouse's Name: _____

(if applicable)

☐ Widow ☐ Divorced

Occupation:_____ Dominant Hand: ☐ Right ☐ Left ☐ Both

Email:_____@_____._____

Home#: (___)_____-_____Work#: ( ) ___ -_____Cell#: (___)_____-_____

May we email you? Y / N May we text you? Y / N May we leave a voicemail? Y / N

Emergency Contact:_____Contact #: (____)_____-_____

Medications: _____

Health Conditions: _____

Auto Insurance Company:_____ Date of Injury _____

Auto Insurance Address: _____

Policy Holder (If different than patient): _____

Claim Number/Policy ID: _____

Did you receive treatment anywhere? If so, where? _____

Attorney:_____

Attorney Contact#: (____) _____-_____ Contact person: _____

DESCRIPTION OF SYMPTOMS

(INDICATE YOUR SYMPTOMS IN THE SECTIONS BELOW)

Area of Pain:	Which Side?			Type of Pain: *You are welcome to choose from the list of descriptors below*
Headaches ☐ Front of head ☐ Top of head ☐ Back of head	☐ Left	☐ Right	☐ Both Sides	
Jaw	☐ Left	☐ Right	☐ Both Sides	
Eye	☐ Left	☐ Right	☐ Both Sides	
Neck	☐ Left	☐ Right	☐ Both Sides	
Upper Back	☐ Left	☐ Right	☐ Both Sides	
Mid Back	☐ Left	☐ Right	☐ Both Sides	
Low Back	☐ Left	☐ Right	☐ Both Sides	
Chest	☐ Left	☐ Right	☐ Both Sides	
Abdomen	☐ Left	☐ Right	☐ Both Sides	
Ribs	☐ Left	☐ Right	☐ Both Sides	
Buttocks	☐ Left	☐ Right	☐ Both Sides	
Shoulder	☐ Left	☐ Right	☐ Both Sides	
Upper Arm	☐ Left	☐ Right	☐ Both Sides	
Forearm	☐ Left	☐ Right	☐ Both Sides	
Hand	☐ Left	☐ Right	☐ Both Sides	
Knee	☐ Left	☐ Right	☐ Both Sides	
Hip	☐ Left	☐ Right	☐ Both Sides	
Leg	☐ Left	☐ Right	☐ Both Sides	
Foot	☐ Left	☐ Right	☐ Both Sides	

Common Descriptors of Pain:

Dull	Sharp	Aching	Cutting	Shocking
Throbbing	Burning	Numbing	Tingling	Cramping
Spasm	Stinging	Shooting	Pounding	Constricting

Patient Name:_____ ID#_____ Date:_____

INFORMED CONSENT

Health care providers are required to advise patients of the nature of the treatment to be provided, the risks and benefits of the treatment and any alternatives to the treatment. There are some risks that may be associated with chiropractic manipulation and massage treatments in particular you should note:

A. While rare, some patients have experienced rib fractures or muscle and ligament sprains or strains following treatment.

B. There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustment though no scientific study has ever demonstrated such injuries are cause, may be caused, by spinal or soft tissue manipulation or treatment.

C. There have been reported cases of injury to a vertebral artery following osseous spinal manipulation. Vertebral artery injuries have been known to cause a stroke, sometimes with serious neurological impairment, and may, on rare occasion result in paralysis or death. The possibility of such injuries resulting from cervical spinal manipulation is extremely remote.

Osseous and soft tissue manipulation has been the subject of government report and multi-disciplinary studies conducted over many years which have demonstrated it to be highly effective in treatment for spinal conditions including general pain and loss of mobility, headaches, and other related symptoms.

Musculoskeletal care contributes to your overall well-being. **The risks of injuries or complications from treatment is substantially lower than associated with many medical or other treatments, medications, and procedures given the same symptoms.**

I consent to the treatment offered or recommended to me by my healthcare provider, including osseous and soft tissue manipulation. I intend this consent to apply to call my present and future care with North Florida Rehab and Chiropractic.

Patient Printed Name:_____**Dated this**_____**day of** _____

20_____

Patient Signature (or legal guardian): _____

Dr. Laura W. McChesney D.C. Physician Signature:_____

PATIENT'S STATEMENT OF PRIVACY RIGHTS

Patient Name:_____ Date: _____

As a patient of this practice, you have the right to privacy of your Personal Health Information, and to know that such information shall be properly and securely maintained by this practice, in accordance with our own policy and in compliance with the Health Information Accountability and Portability Act of 1996 (HIPAA). HIPPA was enacted to give you, the patient of a health care provider and covered under a health insurance claim, more control over your health information, to set boundaries on the use and release of health records, establish appropriate safeguards that health care providers and others must achieve to protect the privacy of Personal Health Information, and to hold violators accountable, with appropriate penalties for violation of a patient's right to privacy.

This notice takes effect on_____and remains in effect until we replace it.

AS A PATIENT OF THIS PRACTICE:

1. You are entitled to an individually delivered, written notification of your Privacy Rights at the time of your first visit to this practice's facility. The document you are reading is this notice. PLEASE REVIEW TO CAREFULLY.
2. You are entitled to see your medical records.
3. You are entitled to receive a copy of your medical records. (Forms are available upon request.) As per allowance by HIPAA the charge will be $0.10 per page.
4. You are entitled to make an amendment to your patient health information within those records. (Forms are available upon request.)
5. While the doctor has a right to deny inclusion of amendments into a patient file, you gave the right to disagree with the doctor's refusal of such inclusion of amendment to those records. (Forms are available upon request.) If the doctor disagrees, he shall supply you with written notification of such disagreement.
6. The doctor has a right to a rebuttal to the patient's disagreement. But any time a file is sent out of the office, a copy of that rebuttal must be included in the file.
7. You have the right to specify how access to your health information is restricted and from whom.
8. You have the right to indicate the method and/or phone numbers and/or addresses to which telephonic and written communications to you shall be forwarded.
9. All covered entities under HIPAA, such as this practice or other health care providers, or business associated such as billing companies or claims administrators, as are designated by the HIPAA Privacy Rule, and with whom this practice must work on your behalf from the standpoint of effective treatment or billing of medical services and administration of such services, shall be part of a "chain of trust" under applicable with those parties. This means that those parties are bound to maintain the same privacy and security of your health information, as are we.
10. No personal health information shall be released to any person without a signed consent from patient.
11. You are entitled to this practice's best efforts to maintain the security of Personal Health Information on your behalf within and outside this office.
12. The practice shall provide Personal Health Information to require parties on the basis of the minimum necessary standard of release (releasing only that information necessary for those parties to provide treatment, reimbursement, or administrative services on your behalf) and so as to maintain the intent of HIPAA in establishing that standard.
13. You have the right to inquire of this office and gain correct and appropriate answers to any questions regarding your privacy rights at any time, consistent with those rights as covered by HIPAA.
14. You have the right to contact the Depart of Health and Human Services, Office of Civil Rights, which administrates HIPAA, with questions or to file a complaint at Toll Free: 1-877-696-6775 or Email: www.hhs.gov/ocr.

PATIENT'S AFFIRMATION OR RECEIPT OF PATIENT'S STATEMENT OF PRIVACY RIGHTS

ACKNOWLEDGEMENT FORM

I have received this office's Statement of Privacy Rights, provided on my behalf and in accordance with law, and have read and understand my rights to privacy and security of Personal Health Information, as a patient of this practice.

Affirmed,

Print Name:_____

Birth Date:_____

Signature:_____

AUTHORIZATION FOR
RELEASE OF PERSONAL HEALTH INFORMATION

I,_____hereby authorize _____ to release my personal health information not already excepted by HIPAA ore related statutes, or other information as noted below to the part of North Florida Rehab and Chiropractic at Millhopper Medical Center, 2341 NW 41st Street, Suite C, Gainesville, Florida 32606 for the purpose of chiropractic treatment for a period commencing on the date below and ending one year from that date.

Review of_____.
I reserve the right to cancel this authorization by notification in writing to the above party to whom I have given such authorization.

Affirmed by the patient,

PRINTED NAME_____

SIGNATURE_____

DATE _____

SOCAL SECURITY NUMBER _____

Assignment and Authorization

For good and valuable consideration, including the agreement of North Florida Rehab and Chiropractic ("NFRC") to accept this assignment in lieu of demanding full payment for services from the undersigned on the date each service is rendered, the undersigned patient executes this document hereby assigning to NFRC the right to receive insurance benefits, to me or on my behalf, for services rendered by NFRC, **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 NFRC, is hereby directed to issue payment for those benefits directly to and payable to NFRC.

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

NFRC accepts the aforesaid assignment and hereby notifies any insurer issuing payment that NFRC 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 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 you fully understand this document and you fully agree to the terms of this document.

_____ _____

Patient's Signature (or Guardian's Signature) **Date**

_____

Print Patient's Name (or Print Guardian's Signature)

_____ _____

Witness to Patient's or Guardian's Signature Date

_____ _____

Authorized Signatory for NFRC Date

Additional Authorization and Direction to Insurer

AUTHORIZATION FOR DISCLOSURE OF INSURANCE DECLARATION PAGE: I, the patient and insured, further authorize and direct any insurance company that may be obligated to pay any insurance benefits to me, or on my behalf, to provide North Florida Rehab and Chiropractic ("NFRC")a copy of any declaration page of any insurance policy that may provide any insurance benefits to me for this aforesaid accident.

AUTHORIZATION FOR DISCLOSURE OF INSURANCE PAYMENT RECORD: I further authorize and direct any insurance company that may be obligated to pay any insurance benefits to me, or on my behalf, to provide to NFRC a copy of any ledger or payment record of payments made under any insurance coverage available to me, without redacting the names of any other medical provider or entity to whom insurance benefits have been paid and without redacting the amount of any insurance benefits that have been paid.

DIRECTION NOT TO EXHAUSE BENEFITS BY PAYMENT OF OTHER CLAIMS: I further authorize and direct any insurance company that may be obligated to pay any insurance benefits to me, or on my behalf, to not exhaust insurance benefits or coverage until all claims submitted by NFRC have been pain in full, or at 80% if the insurance policy is limited to pay 80% coverage of medical claims. If any insurance company obligated to pay any insurance benefits to me, or on my behalf, has denied payment or a claim submitted by NFRC, or made payment to NFRC at an amount lesser than the amount billed, or lesser than 80% of the amount billed if my coverage is limited to 80% for medical claims, I direct the aforesaid insurance company to hold in escrow the amount in dispute, and if other claims would exhaust benefits of coverage by payment of the amount I have hereby requested be held in escrow. I further authorize and direct the aforesaid insurance companyto notify NFRC that benefits have been exhausted except the amount held in escrow, to enable NFRC to attempt to resolve the disputed claim in a manner acceptable to NFRC.

DIRECTION TO INURER TO MAINTAIN CONFIDENTIALITY: I further direct any insurance company that may be obligated to pay any insurance benefits to me, or on my behalf, to maintain the privacy and confidentiality of my medical records. I do not authorize any insurer to provide my medical records to anyone with first obtaining a written authorization from me to provide medical records to any other entity.

AUTORIZATION FOR RELEASE OF RECORDS TO PROVIDER: I hereby authorize any insurance company that may be obligated to pay any insurance benefits to me, or on my behalf, to release a copy of my complete medical records in possession of such insurer to NFRC upon the request of NFRC. This authorization includes the authorization to release to NFRC a copy of any medical examination or evaluation of me requested by any insurance company.

DIRECTION TO INSURER TO PROVIDE TO PROVIDER ADVANCE NOTICE OF IME OR EUO: I further authorize and direct any insurance company that may be obligated to pay any insurance benefits to me, or on my behalf, to provide at least 15 days advance notice to NFRC of any physical examination or examination under oath of myself that any insurance company may schedule.

Please read this document completely before signing. If you do not completely understand this document or 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 you fully understand this document and you fully agree to the terms of this document.

_____ _____

Patient's Signature (or Guardian's Signature) **Date**

_____

Print Patient's Name (or Print Guardian's Signature)

_____ _____

Witness to Patient's or Guardian's Signature **Date**

MEDICAL REPORTS AND DOCTOR'S LIEN

I do hereby authorize **Laura W. McChesney, D.C.** to furnish you, my attorney, with a full report of his examination, treatment, prognosis, ect. Of myself in regard to my **accident/illness which occurred/ began on_____.**

I hereby give a lien to said doctor on any settlement, claim, judgment, or verdict as a result of said accident/illness, an authorize and direct you, my attorney, to pay directly to said doctor such sums which may be due and owing him for services rendered to me, and to withhold such sums from such settlement, claim, judgment, or verdicts that may be necessary to protect said doctor adequately.

I fully understand that I am directly and fully responsible to said doctor for all chiropractic bills submitted by him for services rendered me, and that consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, claim, 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 no await payment, but will require me to make payments on a current basis.

_____ _____

Patient's Signature **PRINT Patient's Name**

_____ _____

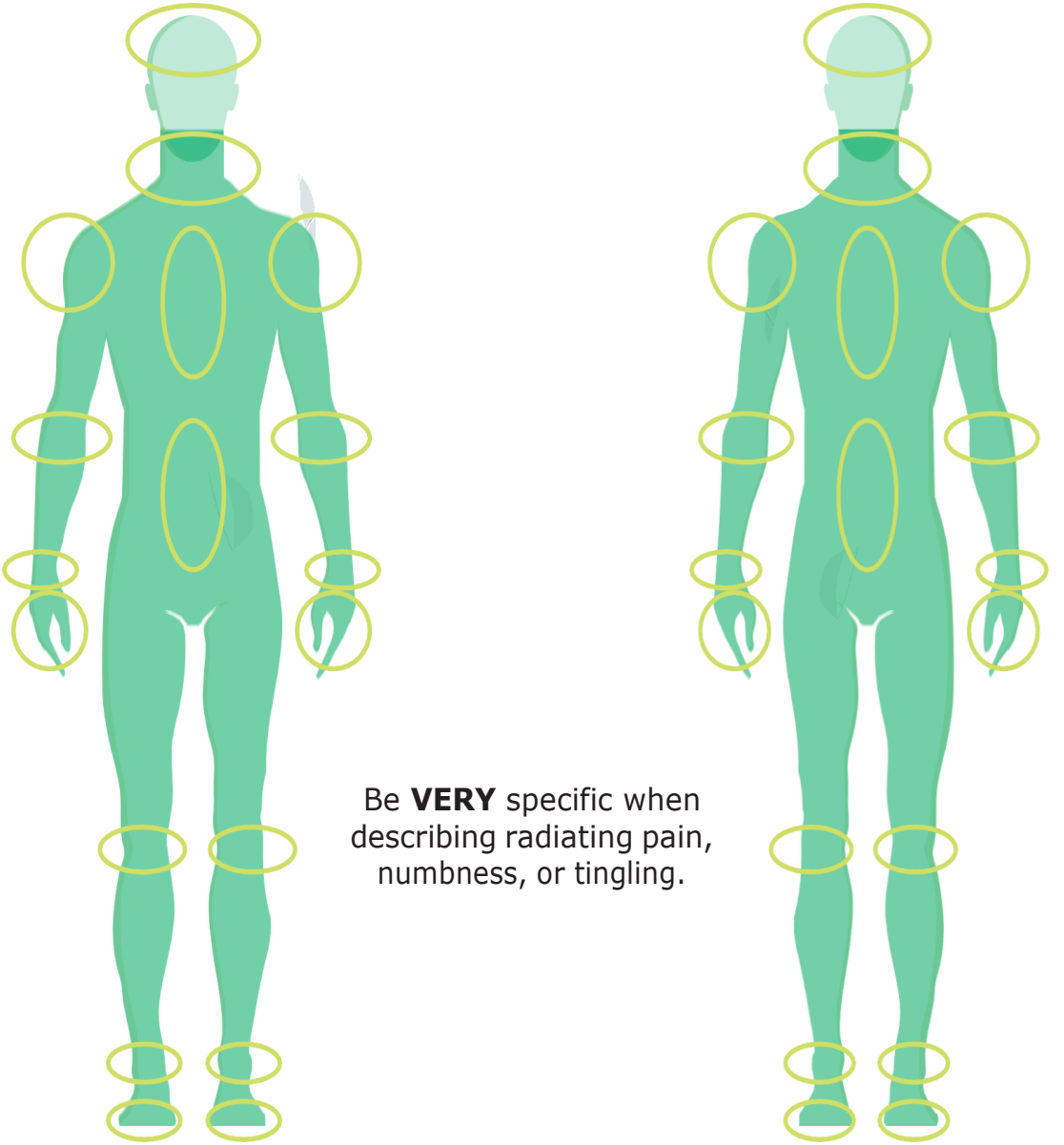
Date Witness

The undersigned, being attorney of record for the above patient does hereby acknowledge receipt of the above lien, and does agree to honor the same to protect adequately said above name attorney.

Attorney's Signature_____Dated _____

PLEASE SPECIFY IN CIRCLED AREAS PAIN

Front **Back**



Be **VERY** specific when describing radiating pain, numbness, or tingling.

RIGHT **LEFT** **LEFT** **RIGHT**

Name:_____ Date:_____

CAPABILITY INDEX

ACTIVITIES OF DAILY LIVING	DO YOU NEED ASSISTANCE TO:	Name:_____ DOB: _____
Dressing	Put on a shirt? Yes ☐ ☐ No Put on pants? Yes ☐ ☐ No	**Housework** Any issues... Sweeping? _____ _____ Does it require more time to complete? Yes ☐ ☐ No
Grooming	Shower/wash hair? Yes ☐ ☐ No Shave face or body? Yes ☐ ☐ No	
Walking How long can you walk without pain?	Affected? Yes ☐ ☐ No Help needed? Yes ☐ ☐ No _____ min(s)	
Sitting How long can you walk without pain?	Affected? Yes ☐ ☐ No Help needed? Yes ☐ ☐ No _____ min(s)	Washing dishes? _____ _____ Does it require more time to complete? Yes ☐ ☐ No
Standing How long can you walk without pain?	Affected? Yes ☐ ☐ No Help needed? Yes ☐ ☐ No _____ min(s)	
Sitting to Standing	Affected? Yes ☐ ☐ No Help needed? Yes ☐ ☐ No	Doing laundry? _____ _____ Does it require more time to complete? Yes ☐ ☐ No
Painful In/out of bed	Affected? Yes ☐ ☐ No Help Needed? Yes ☐ ☐ No	
Lifting Maximum lifted weight	Affected? Yes ☐ ☐ No Help needed? Yes ☐ ☐ No _____	
Driving How long can you drive without pain?	Affected? Yes ☐ ☐ No Help needed? Yes ☐ ☐ No _____ min(s) (Please circle one) hr(s)	**Sleeping** Affected? Yes ☐ ☐ No How long do you sleep at night? _____ Where do you sleep? _____ How long do you sleep without waking up in pain? _____ Interruptions? Yes ☐ ☐ No _____
Child Care: Activities *(if applicable)* Duration	Affected? Yes ☐ ☐ No Help needed? Yes ☐ ☐ No _____ min(s) (Please circle one) hr(s)	

CAPABILITY INDEX

Exercise

Affected? Yes ☐ ☐ No

Help needed? Yes ☐ ☐ No

Duration without pain: _____ min(s) hr(s)
(Please circle one)

Types of Exercise:

- ☐ Swimming
- ☐ Running
- ☐ Bicycling
- ☐ Dancing
- ☐ Golf
- ☐ Bowling
- ☐ Walking
- ☐ Hiking
- ☐ Yoga
- ☐ Martial arts
- ☐ Lifting weights

Additional Exercise:

_____

_____

_____

Job Description

Occupation: _____

Duration: _____ hr(s)

Frequency: _____ day(s)

Typical Activities:

- ☐ Driving a car
- ☐ Driving a truck

Transmission type: *(if applicable)*

- ☐ Manual
- ☐ Automatic

- ☐ Typing
- ☐ Lifting
- ☐ Twisting
- ☐ Standing

Additional Activities :

_____

_____

_____

By signing below, I certify all information is true and correct to the best of my knowledge.
I understand that it is my responsibility to inform the doctor if there are any changes in my health.
I hereby authorize North Florida Rehab and Chiropractic to utilize this information provided to perform the necessary services.

_____ _____

Patient's Signature (or Guardian's Signature) **Date**

_____

Print Patient's Name (or Print Guardian's Signature)

AUTOMOBILE ACCIDENT DESCRIPTION

Please answer the questions below.
If you do not know the answer to any of the questions, do not answer the question.

Your Vehicle Type

- ☐ Car
- ☐ Station Wagon
- ☐ Van
- ☐ Pickup Truck
- ☐ Large Truck
- Bus
- ☐ Other: _____

Your Position in Vehicle

- ☐ Driver
- ☐ Front Passenger
- ☐ Left Rear Passenger
- ☐ Right Rear Passenger
- Other: _____

What was your vehicle doing at the time of the accident?

- ☐ Stopped at intersection
- ☐ Stopped in traffic
- ☐ Stopped at Light
- ☐ Making Right Turn
- ☐ Making Left Turn
- ☐ Slowing Down
- ☐ Proceeding Along
- ☐ Parking
- ☐ Accelerating
- Other: _____

Time of Accident: _____

Your vehicle's speed: _____ MPH

Their vehicle's speed: _____ MPH

Damage to your vehicle

- ☐ Mild
- ☐ Moderate
- ☐ Totaled

Visibility at time of accident

- ☐ Poor
- ☐ Fair
- ☐ Good

Who hit who / what?

- ☐ You hit other vehicle
- ☐ Other vehicle hit you

You hit... (object)

_____

_____

Road Conditions at time of accident

- ☐ Icy
- ☐ Wet
- ☐ Sandy
- ☐ Dark
- ☐ Clean and dry

Point of impact

- ☐ Head-On
- ☐ Left Front
- ☐ Right Front
- ☐ Rear-End
- ☐ Left Rear
- ☐ Right Rear

Did you see the accident coming?	Yes	No
Were you braced for the impact?	Yes	No
Did you have a seat belt on?	Yes	No
Did you have a shoulder harness on?	Yes	No
Does your vehicle have headrests?	Yes	No

What was the position of your headrest at the time of impact?

- ☐ Even with top of head
- ☐ Even with bottom of head
- ☐ Middle of neck

What was the direction of your head at the time of impact?

- ☐ Facing straight forward
- ☐ Turned to the right
- ☐ Turned to the left

Did driver side air bags deploy? Yes ☐ No Did passenger side air bags deploy? Yes ☐ No Did side air bags deploy? Yes ☐ No

8. Accident Description:

_____

_____

9. Have you ever been in an auto accident before? _____ If yes, when, and where did you treat? _____

_____

10. What were your injuries? _____

_____

11. Any previous surgeries or fractures? What? When? _____

_____

Patient Signature: _____ Date: _____