Total Health of Vero Beach New Patient Questionnaire

Patient Information

Please Print

Name_____ Date_____
Address_____City_____State_____Zip_____
Seasonal Address_____City_____State_____Zip_____

Male☐ Female☐ Married☐ Single☐ Widowed☐ Divorced☐ Separated☐
Birthdate_____Home Phone_____Cell Phone_____Work Phone_____

Email Address _____
Employer_____Occupation_____# years_____
Spouse or Parent Name_____Birthdate_____Phone #_____
Emergency Contact_____Phone #_____Relation_____
Name of Local Primary Physician_____May we contact them?____

Who may we thank for referring you to us?_____
Did you see our? Web Page?_☐___ Facebook?_☐___ Business Sign?_☐___ Word of mouth?_☐____

Symptoms

Main complaint_____When did it start_____
How did it start_____
_____
What activity bothers it most_____Getting Better/Worse?_____
When is the pain at its worst? (Circle) AM PM Mid Day Sleep Sitting Moving Resting Working
Rate the pain - (0 pain free – 10 unbearable pain) 0 1 2 3 4 5 6 7 8 9 10
Secondary Complaint_____

Other chiropractors? _____ Positive experience?_____Last Visit?_____
Other type of physician or therapist?_____Positive experience_____

Health History – Please circle all that apply

AIDS/HIV	Allergy Shots	Anemia	Anorexia	Appendicitis	Arthiritis	Asthmas	Bleeding
Breast Lump	Bronchitis	Bulimia	Cancer	Cataracts	Chicken Pox	Depression	Diabetes
Emphysema	Epilepsy	Fractures	Glaucoma	Goiter	Gonorrhea	Gout	Heart Dx
Hepatitis	Hernia	Herniated Disc	Herpes	Hi Cholesterol	Kidney Dx	Liver Dx	Measles
Migraines	Miscarriage	Mono	M.S.	Mumps	Osteoporosis	Pacemaker	Parkinson's
Pneumonia	Polio	Prostate	Prosthesis	Implants	Rheumatoid	Stroke	Thyroid
Chronic Fatigue	Hi Blood Pressure		Fibromyalgia	Other_____			

Women – How many children?_____ Are you pregnant?_____Date of Last Menstrual Cycle_____
Nursing?_____ Taking birth control pills?_____

Previous surgeries and dates_____
_____
List all medication your are currently taking_____
What kind of exercise do you do?_____
What supplement do you take?_____
How much do you smoke per day?_____ Drink per week?_____

*All above questions have been answered accurately, and I understand that giving incorrect information can be dangerous and can hinder treatment. I authorize this office to release any information pertaining to my treatment to third party payers or other health care providers. I authorize and request my insurance company to pay directly to this office any payable benefits. I further understand that payment may be less than the actual cost of services and will be responsible for any outstanding money amount owed to this office.

Patient signature_____ **Date**_____

Informed Consent to Chiropractic Treatment

The Nature of Chiropractic treatment: The Doctor of Chiropractic may perform an examination of the area of complaint and **if medically necessary**, s/he may take radiographs in order to correctly diagnose the condition. The doctor uses their hands or a mechanical device to move your joints. You may hear a "click" or a "pop" similar to your knuckles cracking and you may feel the joint moving. Additional therapies such as myofascial release, ice, electric muscle stimulation or cold laser may also be used. The doctor will make a very reasonable effort during the examination to screen for contraindications to care: however if you have a condition that would otherwise not come to the doctor's attention, it is your responsibility to inform the doctor.

Possible Risks: As with any healthcare procedure, complications are possible following a chiropractic manipulation. These complications could include but not limited to: fractures of bone, muscular strain, ligamentous strain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. Some patients may feel stiff and sore after the first few days of treatment.

Probability of Risks Occurring: The risks of complications due to chiropractic treatment have been described as rare. The risk of cerebrovascular injury or stroke has been estimated at one in one million to one in twenty million.

Other Treatments which could be considered outside this office may include: over the counter analgesics and rest, medical care including medically prescribed anti-inflammatories, tranquilizers, analgesics, medical pain management including injections, hospitalization or surgery.

Risks of Remaining Untreated: Delay of treatment may allow the formation of adhesions, scar tissue, and other degenerative changes which can further decrease skeletal mobility and induce chronic pain cycles. Over time, this process may complicate the condition and make future rehabilitation more difficult.

I, _____, have read the above explanation of chiropractic treatment and will present any questions that I may have to the doctor. By signing below I state that I have weighed the risks involved in undergoing treatment. I have freely decided to undergo the recommended treatment and I give my full consent to treatment.

_____
Date

_____ _____
Patient's Signature Doctor's Name

_____ _____
Signature of Parent/Guardian if Minor Doctor's Signature

Acknowledgement of Receipt of Notice of Privacy Practices

At Total Health of Vero Beach

Please **check one** of the following:

_____I acknowledge that I have declined the opportunity to receive a paper copy of the Notice of Privacy Practices but I understand it is available to read at any time upon request.

-or_

____I acknowledge that I wanted and was provided a paper copy of the Notice of Privacy Practices and that I have read and understand the Notice of Privacy Practices

I understand this for will be placed in my patient chart and maintained for 6 years.

Patient Name Printed

Signature of Patient/Parent/Legal Guardian

Optional*
All medical records on file with Total Health Physical Medicine (DBA Total Health of Vero Beach) are kept private and confidential. However, I authorize Total Health Physical Medicine to discuss my medical history/treatment with the following individuals: _____ (Initials)

*This information will remain on file for 6 years unless informed otherwise by the above named patient

Total Health Physical Medicine
2006 32nd Ave, Vero Beach, FL 32960
Phone 772-778-2225
Fax 772-778-0304

PERSONAL INJURY QUESTIONNAIRE

Total Health of Vero Beach

Name: _____Date of Accident: _____Time of Accident: _____

Describe the accident: _____

_____

_____

Please Circle your response to the questions below

At the time of accident were you the: Driver Front Passenger Left Rear Passenger Right Rear Passenger
Did your vehicle strike other vehicle? No Yes If yes where? _____
Was your car struck by another vehicle? No Yes If yes where? _____
At the time of Impact were you: Looking straight ahead Looking Right Looking Left No Recall
Were both hands on the steering wheel? No Yes
Was your foot on the brake? No Yes
Were you braced for impact? No Yes
Where in the car were you after the accident? _____
Were you wearing a seat belt? No Yes
Did you strike anything in vehicle at impact? No Yes If Yes what body part _____
Did your airbags deployed? No Yes
Immediately following the accident how did you feel? _____
Were you unconscious? No Yes
Were you in a daze? No Yes
Did you go to the hospital? No Yes If yes when: at the time of the accident or the next day?
How did you get to the hospital? By ambulance by private transportation? Not applicable
Did the ambulance attendants place you in a Neck collar? A splint? Brace? Not applicable
Name of Hospital_____
Were you admitted to the hospital? No Yes If admitted, how long did you stay? _____
Did you have x-rays taken? No Yes
What treatment or meds prescribed? _____
What was your diagnosis? _____
Have you seen any other doctor as a result of this accident? No Yes If yes who? _____
Do you have pain in your: neck upper back mid back low back knee foot shoulder arm hand headache
Is the pain: Constant Comes and Goes Sharp Dull Mild Moderate Severe
Do you have any numbness or tingling into your arms/hands or into your legs/feet?
Your most comfortable position: Sitting Standing On your side On your back Other _____
Your pain is helped by using: Ice pack Heating Pad Hot shower/bath Muscle rub Resting Moving

Have you lost any time from work because of this accident? No Yes
If yes, give dates of time lost: From _____ to _____

Any additional information: _____

_____

_____

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

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

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

1. The services or treatment set forth below were **actually rendered.** This means that those services have **already been provided.**

_____

_____

2. I have the right and the **duty to confirm** that the services have already been provided.

3. I was **not solicited** by any person to seek any services from the medical provider of the services described above.

4. The medical provider has **explained** the services to me for which payment is being claimed.

5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to $500.

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

Name *(PRINT or TYPE)*	Signature	Date

The undersigned licensed medical professional or medical director, if applicable, affirms the statement numbered 1 above and also:

A. I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.

B. The treatment or services rendered were explained to the insured person, or his or her guardian, **sufficiently** for that person to sign this form with informed consent.

C. The accompanying statement or bill is **properly completed** in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to **truthfully, accurately**, and in a **substantially complete** manner.

D. The coding of procedures on the accompanying statement or bill is proper. This means that **no service has been upcoded, unbundled**, or constitutes an invalid **or not medically necessary diagnostic test** as defined by Section 627.732(14) and (15), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Licensed Medical Professional Rendering Treatment/Services or Medical Director, if applicable *(Signature by his/ her **own hand**)*:

Name *(PRINT or TYPE)*	Signature	Date

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of Claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234(1)(b), Florida Statutes.

Note: The **original** of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may **not** be electronically furnished. Failure to furnish this form may result in non-payment of the claim.

POWER OF ATTORNEY AND MEDICAL RELEASE

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

Know by all these that: The undersigned has made, constitued and appointed, and by all these present does herby make, constitute, and appoint TOTAL HEALTH PHYSICAL MEDICINE, P.A. and any of it's duly authorized agents and employees as and need to be the undersigned's true and lawful attorney for and in the undersigned's name, place and stead to endorse any and all checks, drafts or money orders are made payable to the undersigned alone or to the undersigned and the said TOTAL HEALTH PHYSICAL MEDICINE, P.A. at the request or with the knowledge and approval of the undersigned and/or the maker of the check, draft or money order.

Furthermore, the undersigned allows TOTAL HEALTH PHYSICAL MEDICINE, P.A., or any of it's agent to sign any paper that will be necessary to enhance, expedite and/or allow payment to said provider. This may include affidavits of non-ownership of vehicles, insurance forms and other statements.

The undersigned by these presents does give the said TOTAL HEALTH PHYSICAL MEDICINE, P.A. as attorney the full power and authority to do and perform all and every act whatsoever requisite and necessary to be done in and about the premises as fully to all intents and purposes as the undersigned might or could do personally present insofar as the endorsing and cashing of said checks are concerned as well as any other document.

MEDICAL RELEASE

A photocopy of this document shall be sufficient to authorize any person having records of medical treatments, services or supplies pertaining to me to release true copies of same to TOTAL HEALTH PHYSICAL MEDICINE, P.A. or any insurer providing coverage to me in connection with the processing of any claim for benefits made by me or by the herein. A photocopy of this document shall be as binding as an original signature page.

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

Release of information: I hereby authorize the medical provider to : furnish my insurance company or companies and the patient's attorney with any and all information that may be contained in my medical records; to obtain coverage information telephonically from my insurer; to request a written non-redacted PIP payout sheet from the insurer, and to obtain copies of my medical records, including but not limited to, documents, records, scans, notes, opinions, X-rays or MRI's received from any other medical provider or any insurance company. The insurer is directed to keep the patient's medical records private and confidential. The insurer is NOT authorized to provide these medical records to anyone, including but not limited to, third party vendors without the patient's and the provider's prior express written permission.

ASSIGNMENT OF BENEFITS

I,_____Hereby authorize_____
(Name of Insured) (Name of Insurance Carrier)

Payable directly to :
Payable to and mailed directly to:

TOTAL HEALTH PHYSICAL MEDICINE, P.A.
2006 32nd Avenue Ste A
Vero Beach, Fl 32960

The medical benefits otherwise payable to me for their services, but not to exceed the charges of those services. I hereby IRREVOCABLY ASSIGN to TOTAL HEALTH PHYSICAL MEDICINE, P.A. any benefits under any policy of insurance, indemnity agreement, or any other collateral source as defined in Florida Statues for any service and or charges provided by TOTAL HEALTH PHYSICAL MEDICINE, P.A.

In the event that my insurance company does not pay TOTAL HEALTH PHYSICAL MEDICNE, P.A.'s bills in full and pursuant to the terms of my policy of insurance, I hereby instruct the insurance carrier to set aside all funds in an amount that would be sufficient to pay such bills in full in accordance with the charges submitted. As part of this assignment of benefits, I further instruct the insurance carrier to notify the provider immediatley after any dispute as to the payment so it may preserve and excercise its legal rights. Also, in addition to notifying me and my legal represenative, I instruct the insurace carrier to immediately notify the provider of any scheduled examinations under oath or independent medical examinations. I authorize and instruct the insurance carrier to provide the Provider upon request any and all documents in my file, including but not limited to an up to date and unredacted and complete payout register and medical records. I understand that any person who knowingly and with intent to injure, defraud or deceive any insurance company, files a statement containing any false, incomplete or misleading information is guilty of a felony of the third degree. I have read the information herein and it is true to the best of my knowledge and belief.

IN WITNESS WHEREOF the undersigned have hereunto set their hands,
this _____ day of _____.

_____ _____
Patient's Signature Patient's Name (Please Print)

Notice to Patients:

At Total Health of Vero Beach, our first concern is our patients' wellbeing and restoring them to full function as quickly as possible. For your insurance carrier to continue to cover your treatment with us, you must adhere to a consistent treatment schedule at our office. In our experience over the past twenty years with personal injury cases, there are "red flags" that insurance companies look for to deny a patient's benefits. The number one reason patients are denied continuing treatment for their injuries is missed appointments with our doctors. When there are gaps in treatment dates, or infrequent treatment is noticed by your insurance company, their impression is that you do not have a genuine need for treatment. To avoid being "cut off" from services, treatment must be received in our office at least 3 times per week initially and no less than twice weekly after the first month. We are providing this information in writing to help you avoid any interruption in your recovery from your injuries.

I have read and understand the above recommendations.

Patient name_____

Date of Birth_____

Signature_____