MANASOTA ACCIDENT AND INJURY CENTER

NEW PATIENT INTAKE

MANASOTA ACCIDENT AND INJURY CENTER

PATIENT INFORMATION

Name:_____ Date:_____ ☐M ☐F
Address:_____
City:_____ State:_____ Zip:_____
Telephone No.:_____ Cell Phone:_____
Date of Birth:_____ Social Security No.:_____
EMAIL ADDRESS:_____

INSURANCE

Is this an auto accident: ☐Y ☐N Date of Accident: _____
Do you have an auto insurance policy? ☐Y ☐N
If Yes, the name of the insurance co: _____
Your Policy No:_____ Your Claim No.:_____
Named Insured on the Policy: _____
Adjustor's Name:_____ Phone No.:_____
If No, do you live with someone who has an auto insurance policy: ☐Y ☐N
If Yes, the name of the insurance co: _____
Their Policy No: _____
If No, were you in a vehicle at the time of the accident that was insured? ☐Y ☐N
If Yes, the name of the insurance co: _____
Their Policy No: _____

ATTORNEY INFORMATION

Attorney's Name:_____ Phone No.:_____
Address:_____
City:_____ State:_____ Zip:_____
Fax No._____ LOP REQUESTED: _____

EMPLOYMENT INFORMATION

Employed By:_____ Telephone No.:_____

VEHICLE ACCIDENT INFORMATION

PATIENT INFORMATION

Patient Name _____ Date _____

Date of Accident _____ Time of Accident _____ ☐ A.M. ☐ P.M.

Please describe the accident in your own words: _____

_____

_____

_____

Were you the: ☐ Driver ☐ Front Passenger ☐ Pedestrian

Rear Passenger: ☐ Left ☐ Right ☐ Middle

How many people were in the accident vehicle ---▼

ACCIDENT SITE

Road/Street Name _____

City/State _____

Nearest Intersection _____

Driving Conditions ☐ Dry ☐ Wet ☐ Icy

Which direction were you headed? ---------▼

Speed you were traveling? _____

VEHICLE

Make and model of vehicle you were in:

_____

Were you wearing a seatbelt? ☐ Yes ☐ No

If yes, what type? ☐ Lap ☐ Shoulder

Was vehicle equipped with airbags? ☐ Yes ☐ No

If yes, did they inflate properly? ☐ Yes ☐ No

Did your seat have a headrest? ☐ Yes ☐ No

If yes, what was the position of the headrest?

☐ Low ☐ Midposition ☐ High

IMPACT

Did your car impact another vehicle? ☐ Yes ☐ No

Did your car impact a structure? ☐ Yes ☐ No

If Yes, explain _____

_____

Did any part of your body strike anything in the vehicle? ☐ Yes ☐ No

If Yes, explain _____

Was impact from:

☐ Front ☐ Rear ☐ Left ☐ Right ☐ Other _____

At the time of the accident were you:

☐ Looking straight ahead ☐ Looking to the right

☐ Looking to the left ☐ Looking down

☐ Looking up

Were both hands on the steering wheel? ☐ Yes ☐ No

If No, which hand was on the wheel ☐ Right ☐ Left

Was your foot on the brake? ☐ Yes ☐ No

If Yes, which foot was on the brake? ☐ Right ☐ Left

Were you: ☐ Surprised by impact ☐ Braced for impact

OTHER VEHICLE

(If applicable)

Make and model of other vehicle:

_____

Which direction was other vehicle headed? ---------▼

Speed other vehicle was traveling _____

POLICE

Did the police come to the accident site? ☐ Yes ☐ No

Were there any witnesses? ☐ Yes ☐ No

Was a police report filed? ☐ Yes ☐ No

Was a traffic violation issued? ☐ Yes ☐ No

If yes, to whom? _____

PATIENT CONDITION

Were you unconscious immediately after the accident? ☐ Yes ☐ No If yes, for how long? _____

Please describe how you felt immediately after the accident: _____

_____

_____

TREATMENT

Did you go to the hospital? ☐ Yes ☐ No

When did you go? ☐ Immediately after accident ☐ Next day ☐ 2 days or more after the accident

How did you get to the hospital? ☐ Ambulance ☐ Private transportation

Name of hospital _____ Name of doctor _____

Diagnosis _____

_____

_____

Treatment received _____

X-rays Taken? ☐ Yes ☐ No Other Procedures _____

SYMPTOMS / INJURIES

Have you been able to work since this injury? ☐ Yes ☐ No How many work days have you missed? ----

Prior to the injury, were you able to work on an equal basis with others your age? ☐ Yes ☐ No

If you have had any of the following symptoms since your injury, please check:

- ☐ Arm/Shoulder pain
- ☐ Back pain
- ☐ Back stiffness
- ☐ Chest pain
- ☐ Dizziness
- ☐ Ear Buzzing
- ☐ Ear ringing
- ☐ Fatigue
- ☐ Feet/toe numbness
- ☐ Hand/finger numbness
- ☐ Headaches
- ☐ Irritability
- ☐ Jaw problems
- ☐ Leg pain
- ☐ Memory loss
- ☐ Loss of bowel or bladder function
- ☐ Neck Pain
- ☐ Neck stiffness
- ☐ Shortness of breath
- ☐ Sleep difficulty
- ☐ Stomach upset
- ☐ Tension
- ☐ Vision blurred
- ☐ Nausea

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Select the region on the picture where you continue to have pain, numbness or tingling:

Type of pain:
- ☐ Sharp
- ☐ Numbness
- ☐ Burning
- ☐ Stiffness
- ☐ Dull
- ☐ Aching
- ☐ Tingling
- ☐ Swelling
- ☐ Throbbing
- ☐ Shooting
- ☐ Cramps

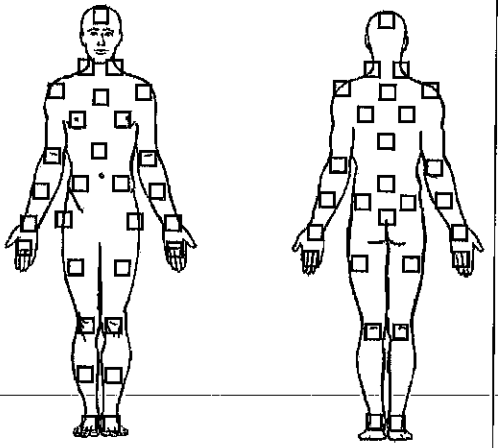
Rate the severity of your pain on a scale from 1 (least) to 10 (severe) ----

How often do you have this pain? (SELECT)

Is it constant or does it come and go? (SELECT)

Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Pain with: ☐ Sitting ☐ Standing ☐ Walking Bending ☐ Lying Down



To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

Patient Name_____ Date_____

MEDICAL HISTORY

Medication	Dose	Frequency	Reason for Medication

Please list ALL medical conditions and surgeries:

Please list ALL allergies and reactions:	
Allergy	Reaction

Review of Systems (Select all that pertain to you):

☐ Fever ☐ Recent Weight Loss ☐ Seizures ☐ Fainting Spells

☐ Difficulty Swallowing ☐ Shortness of Breath ☐ Abnormal Bleeding ☐ Chest Pain

Past Medical History (Select all that pertain to you):

☐ Congestive Heart Failure ☐ Bleeding Disorder ☐ Fibromyalgia

☐ Emphysema ☐ High Cholesterol ☐ Thyroid

☐ High Blood Pressure ☐ Blood Clots ☐ Stomach Ulcers

☐ Diabetes ☐ Anxiety ☐ Stroke

☐ Cancer ☐ Depression ☐ Bipolar

Family History (Select all that pertain to you):

Coronary Artery Disease ☐ Cancer ☐ Stroke ☐ Diabetes ☐ None

Social History:

Smoking: ☐ Yes ☐ No ☐ Previous Amount per day:_____

Alcohol: ☐ Yes ☐ No ☐ Occasionally Drinks per week:_____

Recreational Drugs: ☐ Yes ☐ No ☐ Previous

If Applicable: Are you currently pregnant? ☐ Yes ☐ No ☐ Unknown

MANASOTA ACCIDENT AND INJURY

LETTER OF PROTECTION

I, _____, hereby authorize and direct my attorney, _____, to promptly pay *Manasota Accident and Injury*, from the proceeds of any recovery as a result of litigation or a claim related to incident of _____ (Date), the unpaid balance of such sums as may be due and owing both for professional services rendered by said clinic on my behalf, said professional services to include those for chiropractic treatment, physical therapy, massage therapy, etc., heretofore and hereafter rendered, to the time of settlement or recovery, as well as those for medical records and reports. Payment of this amount herein directed shall be the same as if paid by me.

I understand that payment for all services rendered by this clinic to me are not contingent upon payment by my insurance company or the outcome of my claim or litigation. I further understand that *Manasota Accident and Injury.* performed these services without advance payment relying upon this letter of protection to pay to protect its bill.

Under no circumstances is this letter of protection revocable, nor can it be changed unless proof of payment in full of the bill is shown. I hereby give a lien on my case to *Manasota Accident and Injury* against any and all proceeds of any settlement, judgment or verdict, which may be paid to my attorney or myself, as a result of injuries for which I have received treatment.

_____ _____

Patient Signature **Date**

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

_____

Attorney Name

_____ _____

Attorney Signature **Date**

MANASOTA ACCIDENT AND INJURY

INFORMED CONSENT TO CHIROPRACTIC, PHYSICAL THERAPY AND MASSAGE CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic, physical therapists or massage therapists who now or in the future treat me while employed by, working or associated with Manasota Accident and Injury, including those working at the clinic or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedures which the doctor feels at the time, based upon the facts then known, are in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

To be completed by patient:

_____
Print Patient's Name

_____ _____
Signature of Patient Date Signed

To be completed by patient's representative, if necessary, e.g., if patient is a minor or is physically or mentally incapacitated:

_____
Print Name of Patient

_____
Print Name of Patient's Representative

_____
Signature of Patient's Representative

As: _____ _____
Relationship or Authority of Patient's Representative Date Signed

CAMDEN ASSOCIATES, LLC
6703 14TH St West, Ste101, Bradenton, FL 34207

ASSIGNMENT OF INSURANCE BENEFITS, RELEASE, & DEMAND

Insurer and Patient Please Read the Following in its Entirety

I, the undersigned patient/insured knowingly, voluntarily and intentionally assign the rights and benefits of my automobile Insurance, also known as Personal Injury Protection (P.I.P.), and Medical Payments coverage to **Camden Associates, LLC (health care provider).** I understand it is the intention of the provider to accept this assignment of benefits in lieu of demanding payment at the time services are rendered and that this document will allow the provider to file suit against an insurance company for payment of the insurance benefits. This assignment of benefits includes overdue interest payments and any potential claim for common law or statutory bad faith. If the insurer disputes the validity of this assignment of benefits then the insurer is instructed to notify the provider in writing within five (5) days of receipt of this document. Failure to inform the provider shall result in a waiver by the insurer to contest the validity of this document. The undersigned directs the insurer to pay the health care provider directly without including the patient's name on the check. The insurer is directed by the provider and the undersigned to not issue any checks or drafts in partial settlement of a claim that contain or are accompanied by language releasing the insurer or its insured/patient from liability unless there has been a prior written settlement agreed to by the health provider and the insurer as to the amount payable under the insurance policy or contract. The provider hereby objects to any reductions or partial payments. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by the provider shall be done so under protest, at the risk of the insurer, and the deposit shall not be deemed a waiver, accord, satisfaction, discharge, settlement or agreement by the provider to accept a reduced amount as payment in full. The insurer is hereby placed on notice that this provider reserves the right to seek the full amount of the bills submitted. If the insurer schedules a defense examination or examination under oath (herein after "EUO") the insurer is hereby INSTRUCTED to send a copy of said notification to this provider. The provider or the provider's attorney is expressly authorized to appear at any EUO or IME set by the insurer. The health care provider is not the agent of the insurer or the patient for any purpose.

This assignment applies to both past and future medical expenses and is valid even if undated. A photocopy of this assignment is to be considered as valid as the original. **Patient:** I agree to pay any applicable deductible, co-payments, for services rendered after the policy of insurance exhausts, and for any other services unrelated to the automobile accident. The health care provider is given the power of attorney to endorse my name on any check for services rendered by the above provider and to request any statements or examinations under oath the patient provided to any insurer.

Release of information: I hereby authorize this provider to: furnish an insurer, an insurer's intermediary, the patient's other medical providers, and the patient's attorney via mail, fax, or email, with any and all information that may be contained in the medical records; to obtain insurance coverage information in writing (declaration sheet) and telephonically from the insurer; request from any insurer all explanation of benefits (EOBs) for all providers and non-redacted PIP payout sheets; obtain any statements the patient provided to the insurer; obtain copies of all medical records, including but not limited to, documents, reports, scans, notes, bills, opinions, X-rays, IMEs, and MRIs, from any other medical provider or any insurer. The provider is permitted to produce my medical records to its attorney in connection with any pending lawsuits. The insurer is directed to keep the patient's medical records from this provider private and confidential and the insurer is not authorized to provide these medical records to anyone without the patient's and the provider's prior express written permission.

Demand: Demand is hereby made for the insurer to pay all bills within 30 days without reductions and to mail the latest non-redacted PIP payout sheet and the insurance coverage declaration sheet to the above provider within 15 days. The insurer is directed to pay the bills in the order they are received. However, if a bill from this provider and a claim from anyone else are received by the insurer on the same day the insurer is directed to not apply this provider's bill to the deductible. If the insurer receives a bill from this provider and claim from anyone else on the same day then the insurer is directed to pay this provider first before the policy is exhausted. In the event this provider's medical bills are disputed by the insurer for any reason the undersigned hereby instructs the insurer to set aside any amount disputed (i.e., to escrow the money) and not pay the disputed amount to anyone, including myself, or any entity until the dispute is resolved. The insurer is instructed to immediately explain in writing to the above provider of any dispute.

Certification: I certify that: I have read and agree to the above; I have not been solicited or promised anything in exchange for receiving health care; I have not received any promises or guarantees from anyone as to the results that may be obtained by any treatment or service.

Print Patient's Name _____ Date_____

Patient's Signature _____
(If patient is a minor, signature of parent/guardian and relation to minor)

PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary
information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to
provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

(Print Name)	(Signature)	(Date)

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To Our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly. Thank you for being one of our highly valued patients.

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION/ PATIENT REQUEST FOR ACCESS TO PATIENT HEALTH INFORMATION

Patient Name (Last, First, M.I.) _____ Social Security # _____

Street Address _____ City _____ State _____ Zip _____

Date of Birth _____ Day Phone # _____ Evening Phone # _____

INFORMATION RELEASED FROM	INFORMATION RELEASED TO/EXCHANGED WITH
Name of Clinic:	Name (hospital, clinic, attorney, insurance company, individual) *MANASOTA ACCIDENT & INJURY CENTER*
Facility Address:	Street Address: *P.O. Box 11208*
	City: *BRADENTON* State: *FL* Zip: *34282*
	Date Information Needed: Fax: *(941)751-0158*

AUTHORIZATION TO DISCLOSE MEDICAL/BILLING INFORMATION IS LIMITIED TO THE FOLLOWING:

Medical Condition/Specific Injury: *MOTOR VEHICLE ACCIDENT*

Approximate Visit Dates: _____ ☐ Verbal Release ☐ View Record ☐ Receive Copy

PLEASE INDICATE THE INFORMATION TO BE DISCLOSED:

- ■ Clinical Visit Notes
- ☐ Immunization Records
- ☐ Laboratory Report(s)
- ■ Radiology Report(s)
- ■ Consultation(s)
- ☐ Radiology Films
- ■ Hospital Records
- ☐ Chemical Dependency/Drug or Alcohol Abuse Treatment Records
- ■ Billing Records/Statements (date)_____
- ☐ Secondary Records (specify film/video/monitor tracings)_____
- ☐ Other _____

OR

- ☐ Any and all medical records including chemical dependency/drug or alcohol abuse treatment records

OR

- ☐ Any and all records including medical records, billing records and secondary records, chemical dependency/drug or alcohol abuse treatment records

ALL RECORDS PERTAINING TO PSYCHIATRIC/MENTAL HEALTH AND/OR HIV/HIV RELATED ILLNESSES WILL BE RELEASED UNLESS INDICATED HERE: ☐ DO NOT RELEASE RECORDS RELATED TO MENTAL HEALTH AND/OR HIV

THIS INFORMATION IS TO BE RELEASED FOR THE PURPOSE OF:

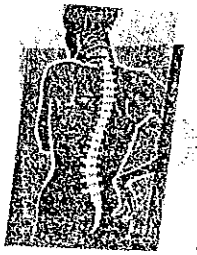
- ☐ Referral for Care
- ■ Transfer of Care
- ☐ Social Security Disability Determination or Appeal
- ☐ Legal/Litigation
- ☐ Insurance Application
- ☐ Insurance Claim or Payment

Authorization expiration date or event _____ (If left blank, will expire one year from date of signature)

I understand that I may revoke this authorization at any time with written notification, but that the revocation will not have any effect on the information released prior to notification of revocation.
A photocopy/fax/scanned image of this authorization will be treated in the same manner as an original

Further, I realize that Manasota Accident & Injury Center cannot prevent the redisclosure of records released as a result of this request and that the records may not be subject to privacy rule protections; therefore, Manasota Accident & Injury Center is released from any and all liability resulting from redisclosure.

Patient/Legal Representative Signature _____ Date _____ Authority to act on behalf of Patient (attach document) _____



MANASOTA ACCIDENT
AND INJURY CENTER

Dr. Yusef Barnes
Doctor of Chiropractic

Dr. Thomas J. Hynds, Jr.
Doctor of Chiropractic

Dr. Brian Edens
Doctor of Chiropractic

Welcome

Dear _____,

Thank you for choosing Manasota Accident and Injury Center! We promise to cater to your needs. Our job is to make you feel better, your job is to be here. If you can't make your appointment, please make sure you contact us to reschedule. If you have any questions, don't hesitate to ask our staff.

Sincerely,

Manasota Accident and Injury Center Staff.

6703 14th St. W., Ste 101
Bradenton, FL 34207
(941)751-0223

WHAT THERAPIES DO PATIENTS RECEIVE?

Intersegmental Mechanical Traction: Therapy that induces passive motion into the spine for the purpose of stretching spinal joints and increasing mobility. Helps to gently and effectively re-establish normal range of motion to the spine.

Patient Initials:_____

Ultrasound Therapy: Provides deep heating to the soft tissues in the body. The tissues include the muscles, tendons, ligaments, and joints. This should not be confused with diagnostic ultrasound which is used to see inside the body.

Patient Initials:_____

Electric Muscle Stimulation: Helps in stimulating the muscles in order to recover faster, reduce muscle soreness, increase muscle strength, and increase blood circulation.

Patient Initials:_____

Ice: helps to reduce inflammation and reduce pain.

Patient Initials:_____

Whirlpool Therapy: Used to help improve circulation, mobility, and comfort after an injury. This modality helps in decreasing swelling, control inflammation, promote healing, improve motion, decrease pain, and decrease muscle spasms.

Patient Initials:_____

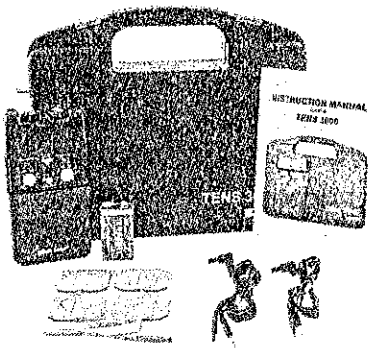
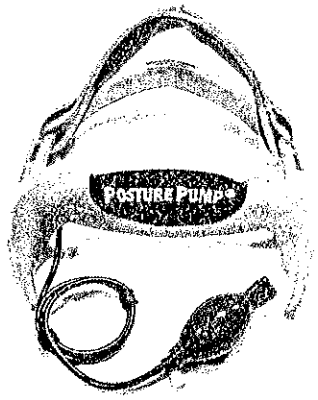
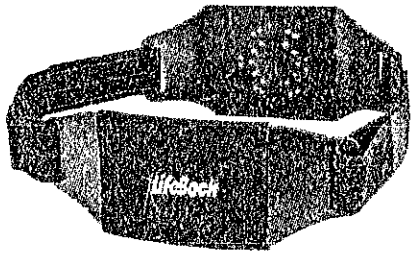
Therapeutic Exercises: Help in strengthening muscles after an injury has occurred and increase range of motion. Can be done actively by the patient and actively with resistance.

Patient Initials:_____

PATIENT NAME:_____ DATE:_____

HOME THERAPEUTIC DEVICES

The following devices are used in conjunction **WITH** your office therapies to facilitate your recovery and alleviate pain and discomfort you are experiencing following your injury. As a reminder, these "at home therapies" are **NOT** a substitute for in-office therapies but intended to be used in conjunction **WITH** your in-office therapies. If you have any questions or concerns or if you experience any discomfort with use, discontinue use until you speak to your doctor at our office.

TENS UNIT 	**USE** Transcutaneous Electrical Nerve Stimulation (TENS) is a non-invasive, drug free method of controlling pain. Uses tiny, comfortable electrical impulses through the skin to stimulate the nerves in the treatment area to reduce or eliminate pain sensations	**INSTRUCTIONS** **1.** Place adhesive pads on area of pain **2.** Slowly turn dial on top of unit to desired level of comfort. **3.** Repeat with other dial **4.** Device can be used for as long as desired, with a minimum of 30 minutes. *Device can be used in conjunction with ice pack, but ice should **not** be applied for period greater than 20 minutes.
POSTURE PUMP 	**USE** The Posture Pump is your answer to disc damage, pain, stiffness, and headaches. The posture pump counteracts the improper, harmful posture that places pressure on the nerves in your neck. This device, as shown on multiple MRI studies, decreases disc bulges and spinal cord indentations while enhancing the curve in the cervical spine.	**INSTRUCTIONS** **1.** Place the device on a firm flat surface **2.** Lie face-up with the black padding in the center of your neck **3.** Place strap snuggly across forehead **4.** Squeeze the bulb several times until head is in extension **5.** Begin at 4 minutes your first session and increasing by 2-3 minutes the following session until a total of 20 minutes is reached over the course of several sessions. *Discomfort/soreness is a common side-effect when beginning use but should subside after a few sessions.
BACK BRACE 	**USE** Improved posture means a straight back. A straight back means a straight spine. A straight spine means less stress and less stress means less PAIN! The back brace is used as a lumbar support to help alleviate pain and discomfort that your low back is experiencing due to your injury.	**INSTRUCTIONS** **1.** Wrap brace around your waist with the "LifeBack" logo on your low back. **2.** Inhale deeply while holding both straps and secure straps until belt feels snug. **3.** Brace should be worn anytime you are bending, lifting, or twisting. *Belt should **not** be worn more than 6 hours in a single day as to not weaken muscles.

THANK YOU FOR CHOOSING MANASOTA ACCIDENT AND INJURY CENTER TO CARE FOR YOU DURING SUCH A TRYING TIME.

WE WANT YOU TO BE COMFORTABLE DURING YOUR TREATMENT, SO NEVER HESITATE TO LET ONE OF OUR STAFF MEMBERS KNOW WHAT WE CAN DO BETTER FOR YOU.

WE DO HAVE OFFICE HOURS THAT ARE POSTED ON THE DOOR, BUT THE HOURS ARE LISTED BELOW AS WELL.

MONDAY	**OPEN 9AM-12PM**	**CLOSED 12PM-2PM**	**OPEN 2PM-6PM**
TUESDAY	**OPEN 9AM-12PM**	**CLOSED 12PM-2PM**	**OPEN 2PM-6PM**
WEDNESDAY	**OPEN 9AM-12PM**	**CLOSED12PM-3PM**	**OPEN 3PM-7PM**
THURSDAY	**OPEN 9AM-12PM**	**CLOSED 12PM-2PM**	**OPEN 2PM-6PM**
FRIDAY	**OPEN 9AM-3PM**		

THANK YOU AGAIN FOR TRUSTING US WITH YOUR CARE.

THE STAFF OF MANASOTA ACCIDENT AND INJURY CENTER

MANASOTA

ACCIDENT & INJURY CENTER

ICE AND CERVICAL PILLOW INSTRUCTIONS

ICE:

Apply icepack to painful area (Neck and/or Back) for 15-20 minutes max, and then leave it off for 40 minutes before reapplying. Repeat as needed.

There are 4 normal stages of using ice called CBAN:

#1 The area will get **C**old

#2 The area will develop a slight **B**urning sensation

#3 The area will feel **A**chy

#4 The area will go **N**umb (benefit is to decrease pain and inflammation)

Back Pain Relief Tip:

Lie on your back with your knees bent at 90 degrees or have your legs elevated. This will take the pressure off your back and help you get some relief.

CERVICAL PILLOW:

Lie on your back and place your head in the hole in the center of the pillow with the rounded part under your neck for support.