Apex Health & Wellness
5110 S. Florida Ave. #103
Lakeland, Fl. 33805

Patient Information

Please allow our staff to photocopy your drivers license and all available insurance cards.

WELCOME! PLEASE PRINT!

Name: _____ Birth Date: _____-_____-_____

Age: _____ □ Male □ Female E-mail: _____

Address: _____ City: _____

State: _____ Zip: _____ Marital Status: □ Single □ Married SS# _____

Home Phone: _____Mobile Phone: _____

Health Insurance: _____Member ID #: _____

Auto Insurance: _____ Claim #: _____

Is your condition due to an car accident: □ Yes □ No

If yes, Date of Accident: _____

Emergency Contact:

Name: _____ Relationship: _____ Phone Number: _____

Parent or Guardian:

Name: _____ Relationship: _____ Phone Number: _____

Describe the major complaints that bring you in our office: _____

MR# _____

1. I authorize payment of medical benefits to this office.
2. I will allow this office to treat me, with other health care providers present, and to record my medical information, including consultation and examination for document purposes, if necessary.
3. I give this office the right to use my name for any office publications.
4. Authorization may be denied or retracted by notifying the office manager.

Patient's Signature: _____ Date: _____

Guardian's Signature: _____ Date: _____

Case History

Please answer the questions below concerning your health history. Be sure to list all conditions or symptoms, both past or present. An understanding of your health history will help us to determine appropriate care.

Name: _____ DOB: _____ MR#: _____

Height: _____ Weight: _____

Review of Systems

1. Do you have skin, hair or nail problems: ❑ Yes ❑ No _____
2. Do you have mouth and/or throat problems? ❑ Yes ❑ No _____
3. Do you have nose and/or sinus problems? ❑ Yes ❑ No _____
4. Do you have ear problems? ❑ Yes ❑ No_____
5. Do you have eye problems? ❑ Yes ❑ No _____
6. Do you have chest or lung (breathing) problems? ❑ Yes ❑ No _____
7. Do you smoke? ❑ Yes ❑ No Amount per day? _____ How Long? _____
8. Do you have heart and/or blood vessel problems? ❑ Yes ❑ No _____
9. Do you have blood or lymph node problems? ❑ Yes ❑ No _____
10. Do you have digestive problems? ❑ Yes ❑ No _____
11. Do you have genital problems (e.g. prostate; testicular, vaginal)? ❑ Yes ❑ No _____
12. Do you have urinary (including kidney or bladder) problems? ❑ Yes ❑ No _____
13. **Females**, have you had menstrual problems? ❑ Yes ❑ No _____

Have you ever taken birth control pills? ❑ Yes ❑ No For how long? _____

Is there any chance that you are currently pregnant? ❑ Yes ❑ No

Do you have any breast problems? ❑ Yes ❑ No _____

14. Do you have any nervous system diseases and/or mental health problems? ❑ Yes ❑ _____
15. Do you have any gland and/or-hormone problems? ❑ Yes ❑ No_____
16. Do you have allergy or immunity problems? ❑ Yes ❑ No _____
17. Do you have any muscle, tendon or ligament problems? ❑ Yes ❑ No _____
18. Do you have any bone or joint diseases (examples: bone = osteoporosis, joint arthritis? Yes ❑ No __

_____

Past History

19. List any diseases which you have had in the past, including childhood diseases: _____

_____

20. Tell us if you have ever been diagnosed as having a condition such as diabetes, cancer, AIDS, etc.: __

_____

21. Have you had any physical injuries such as falls or blows, automobile accidents, whiplash, concussion or head injury; lacerations, sprains, strains, dislocations, broken or cracked bones? ❑ Yes ❑ No_____

_____

22. List any surgeries you have had (don't forget appendix, tonsils, ear tubes, wisdom teeth):

_____ Date: _____

_____Date: _____

_____ Date: _____

_____ Date: _____

Case History (Continued)

23. Have you ever been hospitalized for any reason other than surgery? ❑ Yes ❑ No_____
24. **Medications:** Please list all medications (prescription & non-prescription) you are currently taking or take on an occasional basis: _____
25. Your diet is: 0 Balanced ❑ Fair ❑ Poor ❑ Excessive ❑ Restricted

Family History

26. Are there any diseases or conditions that are common among your family members (i.e. inherited diseases or conditions)? ❑ Yes ❑ No _____

Social History

27. In what position do you usually sleep, and how well? _____
28. Do you exercise on a regular basis? ❑ Yes ❑ No How? _____
29. How do you spend your spare time (hobbies, etc)? _____
30. Do you use: ❑ Caffeine? ❑ Tobacco? ❑ Nicotine? ❑ Recreational Drugs? ❑ Alcohol?
31. Please describe your work.

Type: ❑ Professional ❑ Physical Labor ❑ Driver ❑ Clerical ❑ Factory ❑ Homemaker

Physical Demands: ❑ Heavy ❑ Moderate ❑ Mild ❑ Sedentary

Stress Level: ❑ High ❑ Medium ❑ Low

Additional Questions

32. Do you have problems with recurring headaches? ❑ Yes ❑ No
33. Are you losing weight without trying? ❑ Yes ❑ No
34. Does your pain wake you up at night? ❑ Yes ❑ No
35. Have you had a change in bowel or bladder habits? ❑ Yes ❑ No_____
36. Have you had a sore that doesn't heal? ❑ Yes ❑ No _____
32. Have you recently had any unusual bleeding or discharge? ❑ Yes ❑ No _____
38. Do you have a thickening/lump in the breast or elsewhere? ❑ Yes ❑ No_____
39. Do you have indigestion or difficulty swallowing? ❑ Yes ❑ No _____
40. Have you had an obvious change in a wart or mole? ❑ Yes ❑ No _____
41. Do you have a nagging cough or hoarseness? ❑ Yes ❑ No _____
42. In the space below, please explain or give additional details regarding the information you have given above. Also, if there is any information about your health history which was not requested, please fill it in below. _____

_____

43. Please describe your current complaint. In other words, what brought you here?
44. Who is your:

Medical Doctor? _____

OB/GYN? _____

Dentist? _____

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Auto Accident Questionnaire

This information is considered confidential. We need this information to help determine if chiropractic care can help you. If we do not believe your condition will respond, we will not accept your case. Please be neat and accurate as possible. Thank you.

Name: _____ DOB: _____ MR#:_____
Date/Time of Accident: _____
Insurance Company: _____ Policy#: _____ Claim#: _____
Have you been contacted by a company representative regarding this claim? □ Yes □ No
Name of Insurance Adjuster: _____

Driver of other Vehicle (if any)
Name: _____ Ins. Co.: _____ Policy#: _____
Driver of vehicle in which you were injured (if applicable)
Name: _____ Ins. Co.: _____ Policy#: _____
You were: □ Driver □ Passenger □ Pedestrian, □ Walking □ Running □ Stationary
You were: □ Parked □ Moving
You were sitting: □ Front □ Back | □ With Seatbelt □ Without Seatbelt
You were traveling: □ North □ South □ East □ West On _____
Other vehicle was headed: □ North □ South □ East □ West On _____
Did your care strike the other(s) involved? □ Yes □ No
Or, Did the other car strike your car? □ Yes □ No
You were struck from: □ Front □ Back □ Passenger Side □ Driver Side
Please explain in detail how your accident happened: _____
_____
_____
Were the police notified? □ Yes □ No
Were there citations issued? If yes, to who: _____

Were you knocked unconscious? □ Yes □ No If so, for how long? _____
Where did you feel pain following the accident? _____
Where were you taken after the accident? □ Home □ Hospital □ Walk- In Name: _____
What treatment was given? _____
Was any other doctor consulted after your accident? □ Yes □ No
If so, provide Doctor's Name: _____
What was the diagnosis? _____
Before the injury were you able to work without problems? □ Yes □ No
Have you lost any days of work? □Yes □ No If so, how many? _____
Since this accident your symptoms are: □ Improving □ Getting Worse □ Same

Law Firm: _____ Case Manager: _____ Contact#: _____

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Acknowledgement of receipt of notice of privacy practices and informed consent form

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.

I hereby request and consent to the performance of chiropractic adjustment and other chiropractic/medical procedures, including various modes of physical therapy and diagnostic x-rays by Apex Health and Wellness. This consent is extended to other licensed chiropractic physicians, chiropractic assistants or licensed massage therapists, who now or in the future, are employed by, working with or associated with this office.

I certify that I have had the opportunity to discuss, with the Doctor of Chiropractic and/ or other office personnel, the nature and purpose of the care that is being provided. I understand that the results are not guaranteed. Further, I have been informed and I understand that, as in the practice of any of the healing arts, in the practice of chiropractic, there are some risks and complications. I will rely on the doctor to exercise appropriate judgement during care, based on the facts known at this time, and in my best interest.

My signature below certifies that I have read or have had read to me the above consent. I also certify that I have had the opportunity to ask questions and options to care have been explained. By signing this consent form, I agree to the care being provided to me for the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

_____ _____

Patient Name Witness's Signature

_____ _____

Patient Signature Date

_____

Parent or Guardian

_____ _____

Date DOB

_____ _____

Dr. Blackburn MR#

Apex Health & Wellness
5110 S. Florida Ave. #103
Lakeland, FL 33813

Missed Appointment Policy

We want to thank you for choosing us as. your chiropractic health provider. To provide you and our other patients with the best optimal spinal care, we request that you follow our guidelines. regarding broken and/or canceled appointments. Please remember that we have reserved appointment times especially for you. Therefore, we request at least a 24 hours' notice in order to reschedule your appointment. This will enable us to offer your canceled time to other patients that desire to get their treatment completed. When you cancel your appointment at the last minute, everyone loses — you, the doctor and other patients that would like to have utilized your appointment time_ Our office does charge for broken or canceled appointments if we are not given at least 24 hours advanced notice. Insurance will not cover missed appointment fees. Your account will be charged $20.00 for the missed appointment Please realize how important it is to keep your reserved time. Thank you for your consideration of our policies and for the opportunity to be your chiropractic office of choice.

Patient Signature: _____

Date: _____

Apex Health & Wellness
5110 S. Florida Ave. #103
Lakeland, Fl. 33813
Robert Blackburn, D.C
863-816-5864

Name: _____

The primary treatment used by Doctor of Chiropractic is the spinal adjustment. I will use that procedure to treat you.

- The nature of the chiropractic adjustment

I will use my hands upon your body in such a way as to move your joints. That may cause an audible "pop or click," much as you have experienced when you "crack" your knuckles. You may feel or sense movement.

- The material risks inherent in chiropractic adjustment.

As with any health care procedure, there are certain complications which may arise during a chiropractic adjustment. Those complications include: fractures, disc injuries, dislocations, and muscle strain, Homer's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment.

- The probability of those risks occurring

Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during exam and X-ray. Stroke has been the subject of tremendous disagreement with the profession with one prominent authority (1) saying that there is as most of a one-in-a million chance of such an outcome. Since even risk should be avoided if possible, we employ tests in our exam which are designed to identify if you may be susceptible to that kind of injury. The other complications are also generally described as "rare".

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

Please check the appropriate block and sign below:

I have read ❑ or have had read to me ❑ the above explanation of the chiropractic adjustment. I have discussed it with Dr. Robert Blackburn and have had my questions answered to my satisfaction. By signing below, I state that I have weighed. the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

_____ _____

Date Patient Name (Print)

_____ _____

Witness Signature Patient Signature

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Lakeland, FL 33805

ADDITIONAL AUTHORIZATION AND DIRECTIONS 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 to **Apex Health & Wellness** a copy of any declarations page of any insurance policy that may provide any insurance benefits to me for the 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 **Apex Health & Wellness** 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 who insurance benefits have been paid and without redacting the amount of any insurance benefits that have been paid.

DIRECTION NOT TO EXHAUST 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 **Apex Health & Wellness** have been paid in full or at 80% if the insurance policy is limited to pay 80% coverage of medical claims. If any insurance obligated to pay any insurance benefits to me, or on my benefit, has denied payment of a claim submitted by **Apex Health & Wellness** or made payment to **Apex Health & Wellness** 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 I direct the aforesaid insurance company to hold in escrow the disputed amount and to not exhaust benefits or coverage payment of the amount I have hereby requested be held in escrow. I further authorize and direct the aforesaid insurance company to notify **Apex Health & Wellness** that benefits have been exhausted except for the amount held in escrow, to enable Apex & Injury Rehabilitation to attempt to resolve the dispute claim in a acceptable to **Apex Health & Wellness**

DIRECTION TO INSURER TO MAINTAIN CONFIDENTIALITY:

I further direct any insurance company that may be obligated to pay insurance benefits to me, or on my behalf, to maintain the privacy and confidentiality of any medical records. I do not authorize any insurer to provide my medical records to anyone without first obtaining a written authorization from me to provide the medical records to any other entity.

AUTHORIZATION FOR REALEASE OF RECORDS 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 **Apex Health & Wellness** upon the request of **Apex Health & Wellness** This authorization includes the authorization to release **Apex Health & Wellness** copy of any medical examination of me requested by any insurance company.

DIRECTION TO INSURER TO PROVIDE THE 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 Apex & Injury Rehabilitation of any physical 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. Your signature below is your agreement you fully understand this document and you fully agree to the terms of this document.

AUTHORIZATION FOR LIMITED POWER OF ATTORNEY:

I authorize **Apex Health & Wellness** or their agent, to sign my name on any checks or draft drawn in my name or in both our names, whereby such check is in payment for fees or treatment or other medical services rendered by them, on my behalf.

_____

Patient Name (Print)

_____ _____

Patient/Guardians Signature Date

_____ _____

Witness to Patient/Guardians Signature Date

_____

Claim #

Apex Health & Wellness
5110 S. Florida Ave. #103
Lakeland, FL 33813

Notice of initiation of Treatment

Date: _____

Physician: _____

Patient Name: _____

Insurance Company: _____

Claim#: _____

First Treatment date: _____

Date of Accident: _____

To Whom It May Concern:
This document shall serve as our formal Notice of Initiation of Treatment pursuant to Fla. Stat. 627.736(5)(c). This notice is being sent, pursuant of Florida Statutes, within 21 days after this facility's first examination or treatment of the above referenced claimant. Because this notice has been timely provided, the law allows statements from this provider to include charges for treatment or services rendered up to, but not more than, 75 days before postmark date of statement sent.

Please take not and govern yourself accordingly.

_____
Patient Name (Print)

_____
Patient Signature

ASSIGNMENT OF INSURANCE RIGHTS AND BENEFITS

By my signature below, for good and valuable consideration (including but not limited to the extension of credit to me), I hereby assign, transfer and convey to my healthcare services provider (hereafter "Provider") **Apex Health Solutions, LLC DBA Apex Health & Wellness** (if blank or not otherwise exactly matching the name in box 33 of the medical bill accompanying this assignment, it is the intent of the parties that "provider" be deemed to be the medical services provider submitting this claim as identified in box 33 of the medical bills accompanying this assignment and any successor, assign or related entity of that party) all of my rights, title and interest in and to medical expense reimbursement for services rendered by this facility/assignees in whatever form, including but not limited to any automobile liability medical expense payments or other health benefits indemnification and/or agreement otherwise payable to me. This payment shall not exceed my indebtedness to the above-named assignees and I acknowledge that I will timely pay any indebtedness owed by me to the assignees that is not otherwise satisfied by the above-mentioned assigned proceeds.

I further authorize the Provider to negotiate, collect and settle any claim with any insurance carrier or other third-party payer with regard to these services, which authorization shall include authority to: (1) request and receive from any insurer or any other party any and all documentation and records that I am empowered to request regarding this claim, including without limitation any policies, declarations pages, statements of coverage, examination under oath transcripts and notices, denial letters, Independent Medical Examination Notices and Reports, Records Review Reports, Explanations of Benefits, and Benefit Payment Sheets or Logs (P.I.P. Payout Sheets), without regard as to whether such documentation has already been provided to me, (2) endorse in my name any check issued for payment where benefits were assigned; and (3) file suit to collect payment of insurance benefits or otherwise enforce contractual or statutory rights. The insurer is hereby directed to furnish the provider with a copy of the insurance policy and declarations information pursuant to F.S. § 627.4137, copies of all IME reports pursuant to F.S. § 627.736(7), copies of all IME and EUO requests (whether furnished to me or not), as well as an itemized specification of unpaid charges of each item the insurer reduces or denies (including bills applied to deductible or received after policy exhaustion) in accordance with F.S. § 627.736(4)(b) and 627.736(7). This request includes a request for the name and address of the insurer's designated recipient for demand letters and disputes of denials pursuant to F.S. § 627.736(10).

I further direct my insurer to send all payments for services rendered by the Provider to the billing address of the provider identified on the medical billing claim forms submitted by the provider and direct the insurer to set aside as disputed funds any amounts reduced or denied by the insurer and resolve said dispute before exhausting the remaining policy benefits. Any reduced or partial payment shall be deposited under protest and shall not be deemed an intention of the provider to constitute an accord and satisfaction of the debt.

THIS IS A DIRECT AND IRREVOCABLE ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER MY POLICY OF INSURANCE.

A photocopy or electronic copy of this form shall be considered as effective and valid as the original. I have read the foregoing and understand and agree to each of the above provisions:

_____ _____

Patient's Signature Date

_____ _____

Patient's Name (Print) Claim#

Apex Health & Wellness
5110 S. Florida Ave. #103
Lakeland, FL 33813

Authorization of direct payment and doctor's lien

To:

Attorney Name: _____

Patient Name: _____

I hereby authorize-and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him for medical services rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor. And I hereby further give a lien on my case to said doctor against any and all proceeds of any settlement, judgment or verdict which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated or injuries in connection herewith.

I fully Understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for services rendered me and that this agreement is made solely for the doctor's additional protection and is consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement-judgment or-verdict by-which may eventually recover said fee.

Patient's Signature: _____ Date: _____

Witness's Signature: _____ Date: _____

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

Attorney's Signature: _____ Date: _____

Please date sign and return one copy to above doctor's office. Thank you.