The following paperwork is for new patients who are seeking treatment for injuries due to a motor vehicle accident. All paperwork needs to be completed before the end the of the patient's first visit. Some forms ask for signatures AFTER information has been provided or AFTER services have been provided.

If you have any questions about what each form means, please wait to sign those until you are in the office and we will be happy to answer any questions.

Please arrive 20 minutes early for your appointment to answer questions about the accident and your injuries.

Bring any imaging (x-rays, MRIs…) and the reports with you if you have them.

KEYSTONE CHIROPRACTIC

Confidential Patient Information

Last Name: _____ First Name: _____ Nickname: _____

Today's date: _____ Date of birth: _____ Sex: □ Male □ Female

Occupation: _____ □ Single □ Married □ Divorced □ Widowed

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Mobile phone: _____

Please check your mobile phone carrier - used for appointment text reminders: □ Alltel □ AT&T □ Boost Mobile □ Metro PCS □ Nextel □ Sprint PCS □ T-Mobile □ US Cellular □ Verizon □ Virgin Mobile Other: _____

I understand that I may be subject to a missed appointment fee of $25 for each cancelled or no-show appointment (within 24 hours of my appointment time) after the 2nd occurrence for chiropractic appointments.
□ Initial and check if you prefer to NOT receive text or email appointment reminders. ____

E-mail address: (for receipts) _____

Social Security #: (only if billing an insurance company) _____

How did you hear about our office? □ Friend / Family □ BNI □ Chamber of Commerce □ Internet Search □ Facebook □ Youtube □ Gonstead Directory □ Dr. or Mrs. Neff

□ Attorney Referral: _____ □ Doctor Referral: _____

Other: _____

Signature: _____

KEYSTONE CHIROPRACTIC

Medical History Information

Do you have a **family doctor**? ☐ No ☐ Yes Name of doctor:	
Date of last visit: / /	Date of last exam: / /
Have you been to a **chiropractor** before? ☐ No ☐Yes Where?	
Reason for visit(s):	
Date of last visit: / /	Date of last exam and/or x-rays: / /

Please list surgeries and dates – use back of page if needed.

Date:	Type of surgery:	Date:	Type of surgery:

Personal History: Current and previous conditions – please check all that apply

☐ AIDS	☐ Cirrhosis/Hepatitis	☐ Hay Fever	☐ Irritable Bowel	☐ Prostate Trouble
☐ Allergies	☐ Constipation/Diarrhea	☐ Headaches	☐ Kidney Trouble	☐ Rheumatic Fever
☐ Anemia	☐ Diabetes	☐ Heart Condition	☐ Low Blood Pressure	☐ Scoliosis
☐ Arthritis	☐ Dislocated Joints	☐ Heartburn/Acid Reflux	☐ Mental/Emotional Difficulty	☐ Seizures
☐ Asthma	☐ Diverticulitis	☐ Hemorrhoids	☐ Menstrual Cramps	☐ Sinus Trouble
☐ Bedwetting	☐ Dizziness	☐ High Blood Pressure	☐ Multiple Sclerosis	☐ STDs
☐ Bone Fracture	☐ Ear Infections	☐ HIV/ARC	☐ Pacemaker	☐ Thyroid Trouble
☐ Cancer	☐ Epilepsy	☐ Insomnia	☐ Polio	☐ Ulcers
Type of cancer:			Other:	

Family History (Parents, Grandparents): Current and previous conditions – please check all that apply

☐ AIDS	☐ Cirrhosis/Hepatitis	☐ Hay Fever	☐ Irritable Bowel	☐ Prostate Trouble
☐ Allergies	☐ Constipation/Diarrhea	☐ Headaches	☐ Kidney Trouble	☐ Rheumatic Fever
☐ Anemia	☐ Diabetes	☐ Heart Condition	☐ Low Blood Pressure	☐ Scoliosis
☐ Arthritis	☐ Dislocated Joints	☐ Heartburn/Acid Reflux	☐ Mental/Emotional Difficulty	☐ Seizures
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☐ Bedwetting	☐ Dizziness	☐ High Blood Pressure	☐ Multiple Sclerosis	☐ STDs
☐ Bone Fracture	☐ Ear Infections	☐ HIV/ARC	☐ Pacemaker	☐ Thyroid Trouble
☐ Cancer	☐ Epilepsy	☐ Insomnia	☐ Polio	☐ Ulcers
Type of cancer:			Other:	

Are you currently pregnant? ☐ No ☐ Yes ☐ Trying	(We will not take any x-rays if you are pregnant)
Are you a smoker? ☐ No ☐ Yes ☐ Former	Average alcoholic drinks per day ____ Per week ____
Do you consume any: ☐ sugar free drinks ☐diet soda ☐ chewing gum ☐ coffee/tea sweeteners ☐ protein shakes ☐ calorie-free foods ☐ sugar-free food or drink ☐ water flavoring mixes	
How many hours of exercise do you get per week? What type?	

Signature: _____ Date: _____

KEYSTONE CHIROPRACTIC

Medical History Information

Do you have a **family doctor**? ☐ No ☐ Yes Name of doctor:	
Date of last visit: / /	Date of last exam: / /
Have you been to a **chiropractor** before? ☐ No ☐Yes Where?	
Reason for visit(s):	
Date of last visit: / /	Date of last exam and/or x-rays: / /

Please list surgeries and dates – use back of page if needed.

Date:	Type of surgery:	Date:	Type of surgery:

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☐ Cancer	☐ Epilepsy	☐ Insomnia	☐ Polio	☐ Ulcers
Type of cancer:			Other:	

Family History (Parents, Grandparents): Current and previous conditions – please check all that apply

☐ AIDS	☐ Cirrhosis/Hepatitis	☐ Hay Fever	☐ Irritable Bowel	☐ Prostate Trouble
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☐ Cancer	☐ Epilepsy	☐ Insomnia	☐ Polio	☐ Ulcers
Type of cancer:			Other:	

Are you currently pregnant? ☐ No ☐ Yes ☐ Trying	(We will not take any x-rays if you are pregnant)
Are you a smoker? ☐ No ☐ Yes ☐ Former	Average alcoholic drinks per day ____ Per week ____
Do you consume any: ☐ sugar free drinks ☐diet soda ☐ chewing gum ☐ coffee/tea sweeteners ☐ protein shakes ☐ calorie-free foods ☐ sugar-free food or drink ☐ water flavoring mixes	
How many hours of exercise do you get per week? What type?	

Signature: _____ Date: _____

KEYSTONE CHIROPRACTIC

Please update your current medications (prescribed and over the counter) and medication allergies. The office has to collect this information from every patient for mandatory government updates. Thank you for your cooperation.

Name: _____ Date: _____

Current Medications and Supplements: (Please use the back or attach a list if more room is needed)

Name or Reason for Taking:	Frequency:	Date Started:

Current Medication Allergies:

Medication:	Reaction:

Would you like the doctor to recommend any supplements for you specifically?

□ Yes □ No □ Not sure

We offer clinical nutrition with a functional medicine approach using a system call *Science Based Nutrition (SBN)*. A complete analysis of body function is done through an extremely thorough testing process using common (although under-utilized) blood, urine, stool, and hair tests. Based on the results, a specific dietary and vitamin protocol is recommended. After a few weeks to a few months, re-testing is done to track progress and make necessary adjustments to the protocols.

This type of functional testing is ideal for people who wish to reduce their need for prescription drugs, or assess their risk for conditions like diabetes, heart disease, auto-immune disorders, and cancer.

Would you like any information on SBN?

□ Yes □ No □ Not sure

KEYSTONE CHIROPRACTIC

Treatment Authorization

Chiropractic healthcare is primarily concerned with the relationship between structure (primarily the spine) and function (primarily of the nervous system). Dr. Neff evaluates the patient using standard examination and testing procedures (orthopedic and neurologic evaluation, labs, x-rays) along with specialized chiropractic evaluation. The chiropractic evaluation focuses on structural and/or functional abnormalities which damage or irritate nearby nerves, joints and/or tissues. The primary goal of chiropractic treatment is to restore normal joint motion, decreasing the body's inflammatory response, resulting in improved function and/or decreased symptomology. This is accomplished by performing a procedure unique to the chiropractic profession called an "adjustment". A chiropractic adjustment involves the application of a quick, precise force, by hand, directed over a very short distance to a specific vertebra or bone. In addition to adjustments, other treatments that may be used by Dr. Neff include physiotherapy modalities (e.g. ultrasound, ice, electric stimulation, soft-tissue manipulation), nutritional and supplemental recommendations and rehabilitative procedures.

Chiropractic treatments are one of the safest interventions available to the public as evidenced by malpractice statistics. While there are risks involved with treatment, these are seldom great enough to contraindicate care. Nonetheless, they must be considered when making the decision about whether or not to receive care. **Local discomfort, headache, tiredness and radiating discomfort are all possible temporary side effects of an adjustment, but most resolve in 24 to 48 hours.** Rare complications include rib fracture, burns (with certain physiotherapies), disc herniation, Cauda Equina Syndrome (1 case per 100 million adjustments) and compromise of the vertebrobasilar artery (i.e. stroke) (1 case per 1-5 million adjustments). The Gonstead system of chiropractic greatly limits the risk of these complications.

I understand that x-rays should NOT be taken on pregnant women. I have advised Dr. Neff if I am pregnant or if I may be pregnant.

I am informed and understand that there are some very slight risks with chiropractic adjustments, including, but not limited to, muscle sprain, ligament strain, disc injury and stroke. I expect Dr. Neff to exercise judgment, based upon the known facts, and act in my best interest.

I understand that I am able to discuss with Dr. Neff the nature and purpose of chiropractic adjustments including any questions that I have. If, at any time, I am uncomfortable with any recommended treatments, I may decline treatment. I have been informed that it is not uncommon for patients to become tired or to be sore after an adjustment. I am aware that I should apply ice to the area and rest if I do experience discomfort. If I am concerned about any symptom, I understand that I may call Dr. Neff. If I am unable to contact Dr. Neff, I am aware that I can go to the emergency room.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including physical therapy and x-rays, by Dr. Neff or his authorized personnel.

Patient Printed Name_____ Date _____

Patient Signature _____

KEYSTONE CHIROPRACTIC

Financial Policy

The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services.

For self-pay patients:

- We are able to offer our time-of-service (TOS) discounted rates (which are 15-20% less than our standard rates) to patients paying in-full for treatments at the time that service was provided. [For example, a standard fee of $68 for an ankle x-ray is reduced to $55 for self-pay patients paying at the time of the service.]
- **All fees are due at the time of the service. If payment is unable to be made at the time of service, future treatments will not be provided until the balance has been paid.**
- Financial hardship options are available if needed. Please discuss this with Dr. Neff if you are interested.

For patients going through their automobile PIP insurance:

- By Law, all Copays are due and payable on the same day that services are rendered. Prompt payment allows us to control costs. Outstanding accounts cost both of us time and money therefore, all patients will be required to establish financial arrangements for payment of their account.
- All new patients will be required to remit full payment to establish an account.
- Your insurance coverage is an agreement between you and your insurer. ***As a courtesy, our practice will provide an estimate of your insurance benefits. It is your responsibility to remit payment for charges not covered by your claim and insure that your insurance payments are made to our office.*** If a problem occurs with your claim, you will be required to establish a separate written arrangement with our practice until your insurance claim is resolved.
- In some cases, your insurance company may send a check directly to you as payment for service rendered. ***It is imperative that this check and the Explanation of Benefits (EOB) be brought to our office as payment for services rendered. Without the Explanation of Benefits, you are liable for the full amount of services rendered.***
- You will receive a statement for services if you have an outstanding balance. This will be due and payable within 30 days. If your payment is late, or if you have not previously made financial arrangements, we will then mail one reminder notice indicating there is a problem with your account. If you are experiencing a set of circumstances out of your control, please call our practice and we will be happy to make special arrangements.
- Please notify us immediately if a mistake appears on your statement.
- All patients refusing to remit payment after 61 days of notice without pending insurance or financial arrangements
  will force us to send your account to our Collection Agent. You will be responsible for your full account balance and any fees associated with the collection of your account.
- All patients will be required to sign a written legal agreement with our practice to alleviate any discrepancy.

Our practice firmly believes that a good doctor/patient relationship is based upon understanding and open communications. I have instructed our staff to make every effort available to you to clarify any misunderstanding you have concerning your balance. We hope to avoid any misunderstanding over payment for professional services. If you have any questions concerning our policy or need assistance, please contact us immediately.

Dr. John Neff

_____ _____

Signature Date

KEYSTONE CHIROPRACTIC

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I was provided a copy of the **Notice of Privacy Practices** (red folder in the lobby) and that I have read them or declined the opportunity to read them, and that I understand the **Notice of Privacy Practices** explaining my privacy rights as a patient. I understand that this form will be placed in my patient chart and maintained for six years.

_____ _____
Patient Name (please print) Date

_____
Parent, Guardian or Patient's Legal Representative (please print)

_____
Signature

KEYSTONE CHIROPRACTIC

HIPAA Authorization Form

For office use:	
To:	Date:

Dear Sir/Madam:

I hereby specifically authorize use or disclosure of protected health information about me to be released to J T Neff, LLC, DBA, Keystone Chiropractic, 244 E. Highland Ave., Clermont FL, 34711.
Please be advised that there is no limitation with respect to this Authorization, and as such J T Neff, LLC, DBA, Keystone Chiropractic, should be provided any and all dental, medical, psychiatric, or other health related records of any kind from beginning of treatment to present date. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of person or facility receiving it, and would then no longer be protected by federal privacy regulations.

Furthermore, I understand that I may revoke this Authorization by notifying the above referenced addressee in writing of my desire to revoke this Release/Authorization, or otherwise automatically within seven (7) years from the date of this authorization. However, I understand that any action already taken in reliance on this Authorization cannot be reversed, and my revocation will not affect those actions. Last but not least, I understand that the medical provider to whom this authorization is furnished may not condition its treatment to me on whether or not I sign this Release/Authorization.

_____ _____

Signature Printed Name

_____ XXX-XX-_____

Date of Birth Social Security Number

KEYSTONE CHIROPRACTIC

Notice of Initiation of Treatment

Insured Patient_____

Insurance Co._____

Policy/Claim Number_____

Pursuant to Florida Statute 627.736(5)(c)1., you are hereby notified that treatment on your insured, _____ , was initiated on _____for injuries sustained in an automobile accident on _____.

This patient is now under my care for those injuries. We have enclosed with this notice a Standard Disclosure and Acknowledgement Form, Initial Exam notes and CMS 1500 relating to this first date of service.

This notice has been signed by Dr. John Neff along with the patient as an acknowledgement of services rendered and for future care to be rendered related to this case.

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

_____ _____ _____
(Please Print) (Signature) (Date)

Licensed Medical Professional Rendering Treatment:

____Dr. John Neff_____ _____ _____
(Signature) (Date)

KEYSTONE CHIROPRACTIC

ASSIGNMENT OF BENEFITS

I, _____, assign all of the rights and benefits of any applicable personal injury protection, medical payments, or other coverage provided by any insurance policy issued pursuant to Florida Statutes §627.730 - §627.7405, to Dr. John Neff, for services and supplies provided to me related to my chiropractic treatment.

I agree to pay any co-payment or deductible not covered by the applicable personal injury protection, medical payments, or other insurance coverage. This assignment includes, but is not limited to: all rights to collect benefits directly from any insurance carrier obligated to provide benefits for services and supplies I have received; all rights to take legal or other action against any insurance carrier obligated to provide benefits if for any reason the insurance carrier fails to pay any benefits due; and all rights to recover attorney fees, legal assistant fees, costs, and any interest on fees and costs, for any legal or other action taken by Dr. John Neff as my assignee.

This is an assignment of rights only, and is not a delegation of any of my duties under the subject insurance policy. I understand that I remain fully responsible for payment for all expenses incurred for medical and diagnostic treatment, regardless of payment, partial payment or denial of payment by my insurance company.

I agree that Dr. John Neff may retain any attorney he chooses to bring legal action against any insurance carrier obligated to provide benefits for services and supplies I have received, and that the attorney chosen may be different than any attorney I may have handling any claim I may have for personal injuries.

I understand that I can request a copy of this assignment to retain for my records; I have read this assignment and I am satisfied that I fully understand the purpose and implications of executing this assignment and do so freely and voluntarily.

_____ _____
Patient Signature Date

The undersigned, as authorized representative of Dr. John Neff accepts the assignment of benefits as set forth above.

_____ _____
John Neff D.C. Date

Mailing address:
Keystone Chiropractic
244 E. Highland Ave.
Clermont, FL 34711

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**)*:

John Neff, DC		
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.

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