Bretz Chiropractic Clinic

Patient Intake Form

Treating Office: Sarasota ___

Patient Name: ______________________ Soc Sec #: ___________________________

___MVA ___S/F ___W/C ___PI ___Other / Driver ___ Passenger___ Pedestrian___
___Motorcycle ___Bicycle If passenger, did the vehicle belong to: Patient___ Other ___
Date: / / Date of **injury**: / / Was accident work related: Yes__No__

Address: ____ Apt# _____________

City: ____________________________ State: __________ Zip: __________________

Home Phone: ______________________ Work/Cell phone: ______________________

E-mail address: ____

Age: _______ Date of Birth: ___/___/___ Sex: M___ F ___

State accident occurred:_____________ Marital Status: M S D W

Are you currently under a doctor's care for this injury? Yes ___ No ___

If yes, please list facility / Doctor and phone number:

____

____

____

Did you have **X-rays**? Yes___ No ___ **MRI's**? Yes___ No ___ **CT's**? Yes___ No ___

Primary care physician: ______________________ Phone: ______________________

Attorney Name: ______________________________ Phone: ____________________

Attorney Address: ____

City: ___________________________ State: ___________ Zip: _________________

Please have your driver's license, Auto Insurance card, Health Insurance Card and Accident Report available for copy. Thank You.

Office use only
LOP requested: Yes ___ No ___, Date: _________ Received: _________
AOB Sent: Yes ___ No ___, Date: _________

Letter of intent to bill sent: Yes ___ No ___, Date: _________ Received: _________

Updated 2/3/16

Past Medical History

Patient Name: ____

Do you have or have you been treated for any of the following: Circle yes or no

asthma	Y / N	heart diseas	Y / N	high blood pressure	Y / N	gastritis/ulcers	Y / N
fibromyalgiɛ	Y / N	stroke	Y / N	osteoporosis	Y / N	low/high thyroid	Y / N
liver diseasɛ	Y / N	depression	Y / N	immunodeficiency	Y / N	kidney disease	Y / N
diabetes	Y / N	seizures	Y / N	bleeding disorder	Y / N	cataracts	Y / N
cancer (type)________________			Y / N	hepatitis(type)______	Y / N	glaucoma	Y / N
HIV/AIDS (precautionary measures)			Y / N	Contagious Skin Disordɛ	Y / N		

Please list any health problems not listed above:____________________________________

Hospitalization (include this accident)/Operations/Previous Auto Accidents

Date **Incident** **Reason/Procedure** **Hospital**

____

____

____

Current Medication (please include any vitamins or herbal medications)

Name **Dose** **Frequency**

____

____

Medication Allergies

List any medication allergies and the type of reaction: (if none are known check here___)

____

Family History: please check all that apply to your family members (M / Mother, F / Father)

allergy	___M ___F N/A____	high blood pressure	___M ___F N/A____
osteoporosis	___M ___F N/A____	kidney disease	___M ___F N/A____
seizures	___M ___F N/A____	stroke	___M ___F N/A____
cancer	___M ___F N/A____	depression	___M ___F N/A____
diabetes	___M ___F N/A____	other	___M ___F N/A____
heart disease	___M ___F N/A____		

Social History

1. Do you presently smoke? Yes___No___ # packs/day ___ # yrs___
2. Have you ever smoked? Yes___No___ # packs/day ___ # yrs___
3. Do you drink alcohol? Yes___No___ # drinks/day ___
4. Have you ever used any addictive substances? Yes___(substance:___________)No___

Review of systems: please circle yes or no. If yes, please explain.

1. **Ears**: ringing/dizziness/drainage/hearing loss Y / N Explain: __________
2. **Mouth/throat**:pain or difficulty swallowing/hoarseness/lumps in neck Y / N Explain: __________
3. **Cardiopulmonary**:chest pain/palpitations/short of breath/heart murmur/cough Y / N Explain: __________
4. **Genitourinary**:burning or frequency of urination Y / N Explain: __________
5. **Gastrointestinal**:heartburn/vomiting/diarrhea/abdominal pain Y / N Explain: __________
6. **Psychological**:depression Y / N Explain: __________
7. **Sleep pattern**: Snoring/Daytime sleepiness Y / N Explain: __________
8. **Endocrine**:Heat Intolerance/Cold intolerance/Excessive thirst Y / N Explain: __________
9. **Eyes**: recent changes in vision/Impaired vision/Double vision Y / N Explain: __________
10. **Neurologic**:weakness/numbness Y / N Explain: __________
11. **Musculoskeletal**:TMJ disorder/Arthritis Y / N Explain: __________
12. **General**:nausea/fever/fatigue/weight gain Y / N Explain: __________
13. **Skin**:Skin cancer Y / N Explain: __________
14. **Hematologic/Lymphatic**:Swollen lymph nodes Y / N Explain: __________
15. **Immunologic**:Hepatitis/Frequesnt Infections/Immune Disorders Y / N Explain: __________
16. **Constitution**: Sudden weight loss or gain? Y / N Explain: __________

16.Are you pregnant? Yes___No___ How many months?______

17.Are you breast feeding? Yes___No___

Patient Signature:________________________________

Bretz Chiropractic Clinic

Patient History Checklist

Patient Name:______________________________________ Date:____________________

Height:____________ Weight:__________ Age:__________

Left or Right handed: Left_____ Right_____ Date of accident: ___/___/___

Vehicle information: Car___ Truck ___ SUV ___ Motorcycle ___ Bus ___ Bike ___
Where was the vehicle hit? Front ___ Rear___ Right side___ Left side___
Were you the? Driver___ Passenger___ Pedestrian___ Bike___ Motorcycle___
Were seat belt restraints used? Yes ___ No ___

Please answer the following questions as it relates to your condition AFTER the accident:
Circle yes or no and explain if yes.

Head:

1. Do your recall hitting your head during impact? Y / N Explain: ____________
2. Do you have headaches? Y / N Explain: ____________
3. In what area do you feel the headache? ______________________
4. Were you dazed? Y / N Explain: ____________
5. Did you lose consciousness? Y / N Explain: ____________
6. What is the 1st thing you remember after impact? ______________________
7. Did you see a bright flash of light? Y / N Explain: ____________
8. Have you seen? Floating spots: Y / N Explain: ____________
   Sparkling dots: Y / N Explain: ____________
9. Any:Dizziness? Y / N Explain: ____________
10.Any:Blurry Vision? Y / N Explain: ____________
11.Any:Nausea/Vomiting? Y / N Explain: ____________
12.Do you notice a head rush/light headedness when you stand up? Y / N Explain: ____________
13.Does your head or face have? Numbness? Y / N Explain: ____________
   Tingling? Y / N Explain: ____________
   Stinging? Y / N Explain: ____________
14. Any ringing in your ears? Y / N Explain: ____________
15. When you open your jaw do you have? Clicking? Y / N Explain: ____________
   Popping? Y / N Explain: ____________

Cranial Nerves:

1. When you have headaches do you have pain behind your eyes? Y / N Explain: ____________
2. When you have headaches do you have sensitivity to light? Y / N Explain: ____________
3. Any:Loss of normal vision? Y / N Explain: ____________
4. Any: Loss of ability to move both eyes w/o a problem? Y / N Explain: ____________
5. Any problem winking eyes or closing them? Y / N Explain: ____________
6. Any:Loss of ability to taste? Y / N *Trouble moving your tongue? Y / N Explain: ____________
7. Any loss of ability to hear? Y / N Explain: ____________
8. Any difficulty Swallowing Y / N *Pain when swallowing: Y / N Explain: ____________
9. Any Hoarseness in your voice? Y / N Explain: ____________
10. Any trouble shrugging your shoulders? Rt / Lft? Y / N Explain: ____________
11. Any trouble smiling? Y / N Explain: ____________

Medical History Since the Accident

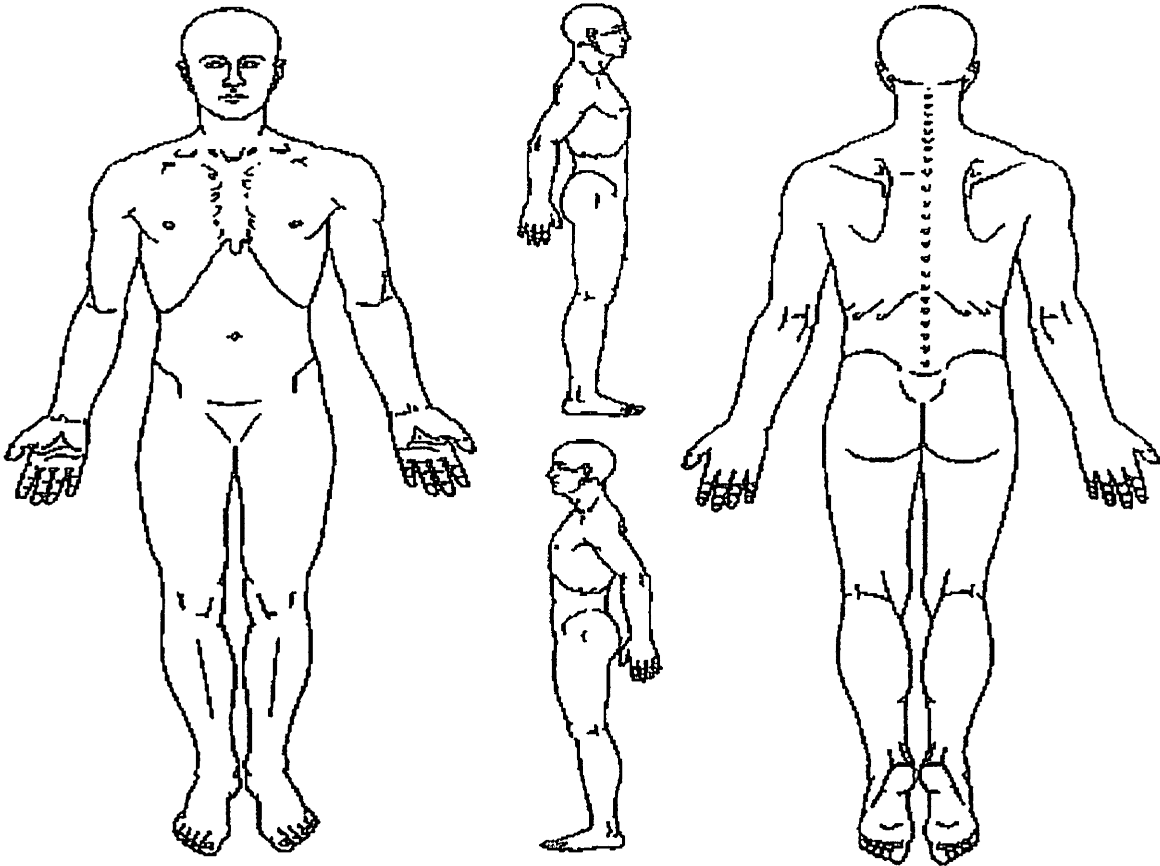
1. Difficulty sleeping due to pain? Yes___ No___
2. Trouble with memory? Yes___ No___
3. Mood swings since accident? Yes___ No___
4. Feel depressed? Yes___ No___
5. Feel tired or fatigued? Yes___ No___
6. Any sexual problems? Yes___ No___
7. Are you employed, retired, disabled, student or minor?__________________________
8. Were you out of work due to this accident? Yes___ No___ How long?__________
9. What type of work do you do?______________(computer,long sitting, standing, bending. Etc)

Patient Signature: ______________________________ Dr. Initials________

PAIN DIAGRAM

NAME ______________________________ DATE ______________

On the diagram below, please indicate where you are experiencing pain or other symptoms, right now.



A = ACHE　**B** = BURNING　**N** = NUMBNESS
P = PINS & NEEDLES　**S** = STABBING　**O** = OTHER

I certified that I have read and understand all of the information requested of me concerning my medical history and health problems, and that my answers are true and accurate to the best of my knowledge.
I further certify that I do have the indicated health problem(s) and that I desire an appropriate medical examination, treatment and/or advice necessary.

Date____________________ Print Name____

Patient Signature____

Attending Doctor: I have personally reviewed the history and review of systems:

Date____________________ Doctor's Signature:____

Bretz Chiropractic Clinic

3436 Bee Ridge Road
Sarasota, Fl. 34239
(941) 921-2225 Fax (941) 927-8234

Office: Sarasota ___

Patient Name: ______________________________
Address: ____
City: ____________________ St: _________________ Zip: ______________
DOI: __________ Claim # ____

ASSIGNMENT OF BENEFITS/POLICY RIGHTS/DIRECT PAYMENT AUTHORIZATION

I hereby assign from any and all automobile policies which provide medical benefits or no-fault benefits, all rights, title and interest to Bretz Chiropractic Clinic ("Assignee") for payment for services rendered unto me both by reason of accident or illness. In the event my insurance company fails to pay Assignee the full amount owing to Assignee after proper statutory notice, I hereby also assign by this instrument, all rights and causes of action in tort, in contract and the laws of Florida, against the personal injury protection carrier for the above named insured/patient for it's failure to pay for services rendered unto me by assignee in relation to any accident or illness. This assignment may only be rescinded/reassigned by the mutual consent of the patient/insured/assignor and health care provider/assignee.

RESERVATION OF BENEFITS

Please be advised that I am hereby placing you on notice pursuant to Florida case law that should you deny, reduce or fail to pay either a part or an entire bill, which was submitted on my behalf from this healthcare provider. I am requesting you reserve, or hold aside, that same amount until the dispute is resolved. Additionally, should the remaining amount of any benefits approach an amount where there would be insufficient funds to pay the amount you reduced, denied or failed to pay, or if my benefits should become exhausted, please notify me and this health care provider of this fact immediately.

DIRECTION OF PAYMENT/RELEASE OF INFORMATION

I hereby authorize any insurance company or attorney to pay direct to Assignee the amount of this and/or any future bills for services rendered unto me. I also agree to pay in a current manner any difference between the total charges and the amount paid by the insurance company directly to the Assignee. I hereby authorize Assignee to release any information requested that is pertinent to my case to any insurance company or attorney involved in this case. Pursuant to FS 627.4137, I hereby request a copy of the PIP payment log and any available policy of Insurance or declaration sheet, to be provided by the insurance company to the Assignee. I hereby authorize Assignee permission to request and receive a current copy of my PIP payment log periodically as they deem necessary. A photocopy of this assignment shall be considered as valid and effective as the original.

________________________________ ________________
Patient's signature or patient/guardian Date

Application For Benefits – Personal Injury Protection

(To enable us to determine if you are entitled to benefits under the personal injury protection law, please complete this form.)

Date__________Our Policy Holder____________________________DOI__________CL#__________________

Your Name___________________________________DOB______________Home#___________________________

Your Address____Bus.#____________________________

Date and Time of Acc.___________________Place of Acc.__________________SS#_______________________
Brief Description of Acc.

At time of Accident: Were you the driver of the policyholder's car? Yes__ No__ Were you the passenger in the policyholder's car? Yes__ No__ Were you a pedestrian? Yes__ No__

Are you a member of our policyholder's household's household? Yes__ No__ Relationship to policyholder_________
As a result of the accident, were you injured? Yes__ No__ If your answer is yes, please complete the rest of this form. If No, Sign here and return the form to us.

Signature:

Describe your injury:

Were you treated by a doctor: Yes__ No__ Date of first treatment_______________If you were treated in the hospital:
Inpatient___ Outpatient___
Doctor's name and address:

Hospitals name and address:

Amount of bills to date_________ Will you have more medical expenses? Yes__ No__ Were you employed at time of accident? Yes__ No__
Did you lose time from work? Yes__ No__ If yes. Amount lost: $__________Average weekly wage or salary:$_______
If you lost time: Date disability began___/___/___ Date you returned to work___/___/___

Have you received or are you eligible for benefits under:
1) Workman's Compensation Law? Yes__ No__ If yes, amount: $_________________
2) Employment by U.S. Government? Yes__ No__ ___ per week ___ per month
3) Military? Yes__ No__

List name and addresses of your employers at the date of the accident and give occupation and dates of employment

Employer address______________________Occupation ____________________From ________ To__________

Employer address______________________Occupation ____________________From ________ To__________

Any person filing a statement of claim containing any false, incomplete of misleading information is guilty of a felony of the third degree. I declare that the facts shown hereon are true and complete to the best of my knowledge and that no attempt has been made to conceal facts or to deceive any insurance company.

Signature____ Date _____/_____/_____

Bretz Chiropractic Clinic

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(941) 921-2225 Fax (941) 927-8234

Office: Sarasota ___

Patient Name: ______________________________

Authorization to obtain PIP Payouts / Payment EOB's

Request under section S.627.736(7)

Policy# ____

Claim# ____

I, _________________________ authorize my PIP Insurance carrier to immediately provide a PIP Payout explanation to **Bretz Chiropractic Clinic** I also authorize an Explanation Of Benefits (EOB) be included with each payment to this physicians office.

____
Patient's signature

____
Date

Patient's Assignment of Benefits is attached

Bretz Chiropractic Clinic

3436 Bee Ridge Road
Sarasota, Fl. 34239
(941) 921-2225 Fax (941) 927-8234

Office: Sarasota ___ St Pete ___

Patient Name: ________________________________

IRREVOCABLE DOCTOR'S LIEN

Attorney Name & Address: ____
____
____

I do hereby authorize Bretz Chiropractic Clinic to furnish you, my attorney with a full report of my case history, examination, diagnosis, treatment, and prognosis in regard to my accident/illness which occurred/began on _____________.

I hereby authorize and irrevocably direct you my attorney, to pay directly to Bretz Chiropractic Clinic sums due and owed for professional services rendered both by reason of this accident and any other bills that are due this office and to be necessary adequately to protect Bretz Chiropractic Clinic, Inc. I hereby further give a 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 therewith.

I fully understand that I am directly and fully responsible to Bretz Chiropractic Clinic, for all professional bills, submitted by them for services rendered me, and that this agreement is made solely for said facility's additional protection and in consideration of payment. I further understand that such payment is not contingent on any recover said fee.

___________________________________ ____________________
Patient/client signature Date

I have been advised that if my attorney does not cooperate, Bretz Chiropractic Clinic will not await payment, but may declare the entire balance due and payable.

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

___________________________________ ____________________
Attorney's signature Date

Bretz Chiropractic Clinic

3436 Bee Ridge Road
Sarasota, Fl.34239
(941) 921-2225 Fax (941) 927-8234

Office: Sarasota ___

Patient Name: ________________________________

AUTHORIZATION TO PROVIDE A LETTER OF PROTECTION

Bretz Chiropractic Clinic has requested a Letter of Protection for any balance that is due this doctor or facility at the time that my case is settled or otherwise disposed of. The balance due will be deducted from the proceeds of such settlement, subsequent to the deduction of attorneys' fees and cost. Of course, in the event no recovery is obtained, I shall remain responsible for the payment of this account.

I do authorize my attorney to provide the above mentioned a Letter Of Protection.

___________________________________ ____________________
Patient/client signature Date

Bretz Chiropractic Clinic
3436 Bee Ridge Road.
Sarasota, Fl.34239
(941) 921-2225 Fax (941) 927-8234

Office: Sarasota ___ St Pete ___

Patient Name: ______________________________

Benefit Assignment to Patient

I, ____________________________________ am seeking medical treatment for injuries sustained in a motor vehicle accident on, _____ / _____ / _____.

I **do not** have PIP insurance of my own. Mr. / Ms. ____________________ has motor vehicle insurance with _____________________, Policy #____________________, Claim#__________________, which I meet the state required qualifications, S.627.733 to be covered by this policy.

_________________________ _________________________
Patient's signature Date

I, ______________________________, the policy holder, do authorize the above named person to use my vehicle insurance for filing medical claims for the above mentioned motor vehicle accident, Policy# ______________________,
Claim# ____________________________.

_________________________ _________________________
Policy Holder's signature Date

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Office: Sarasota ___

Explanation of Financial Responsibility, according to Florida PIP Laws

1) If you have a policy with a deductible:

You, the patient, are responsible to pay your deductible.

Should you have an attorney to represent you with your case the deductible share will be part of the settlement at the end of your case, providing your lawyer issues us a Letter of Protection.

2) If you have chosen a policy that pays a percentage of the medical charges:

You, the patient, are responsible to pay the percentage not paid by your insurance.

Should you have an attorney to represent you with your case the percentage share will be part of the settlement at the end of your case.

3) Should you not be represented by an attorney and are faced with financial hardship please notify a staff member.

I have read and understand the above information

________________________________ ________________

Patient's signature **Date**

Bretz Chiropractic Clinic

AUTHORIZATION FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT OR PAYMENT

As part of your healthcare, this practice originates and maintains paper and/or electronic records describing your health history, symptoms, examinations, test results, diagnoses, treatment, any plans for future care or treatment and payment for the services or treatment we provided. We use this information to:

- Plan your care and treatment
- Communicate with other health professionals or entities who contribute to your healthcare
- Submit your diagnosis and treatment information for payment for the services or treatment provided to you

"ONLY AS PERMITTED OR REQUIRED BY FEDERAL OR STATE LAW", WE MAY USE YOUR PROTECTED HEALTHCARE INFORMATION TO DO THE FOLLOWING:

- To disclose, as may be necessary, your health information (including HIV+/AIDS status, drug/alcohol abuse notes and qualified mental health notes) to other healthcare providers and healthcare entities (such as: referrals to or consultation with, other healthcare professionals, laboratories, hospitals, etc.) or to others as may be required by law or court order concerning your treatment, payment and/or healthcare.

- To request from other healthcare entities and/or healthcare providers (i.e. doctors, dentists, hospitals, labs, imaging centers, etc.) specific healthcare information we may need for planning your care and treatment.

- To submit the necessary information to your insurance company(s) for coverage verification as well as the diagnosis and treatment information to your insurance company(s), other agencies and/or individual(s) for payment of our services or treatment we provided to you.

- To leave appointment reminders or other minimum necessary information related to your healthcare or healthcare payments on an your answering machine, your mobile voice mail or with a household family member.
  [ ] Please check here if you do not want us to leave messages on your answering machine or with a household family member.
  [ ] Please check here if you do not want us to leave a message on your mobile voice mail.

- To discuss your health or payment information (only the minimum necessary in our judgment) with family members or other persons who are or may be involved with your healthcare treatment or payments.

- If you choose, please list by name and relationship the persons with whom we may share your healthcare or payment information ______________________________
  ____

- You may request a copy of, or as a new patient, will be given a copy of our *"Notice of Patient Privacy Practices"* that provides a more complete description of health information uses and disclosures as required by the HIPAA standard.

- You have read or have had the right to read the *"Notice of Patient Privacy Practices"* prior to signing this authorization.

I fully understand and agree to this authorization and acknowledge the above rights and disclosures.

Patient Name: ______________________________

Signature	Print name of person signing	Date

*If other than patient is signing, are you the parent, legal guardian, legal custodian or have Power of Attorney for treatment and/or payment for this patient. Yes [ ] No [ ] RELATIONSHIP ______________________________

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 (15) and (16), 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.