ACCIDENT CENTER
AT REJUVENX

REQUIRED ACCIDENT INFORMATION

Name_____ Today's Date _____

Date of accident _____

Have you reported this accident to your insurance company? _____YES ____NO

Have you reported an injury or opened a personal injury (medical) portion of a claim with your insurance company? ____YES ____NO

(If the answer to either of these questions is NO, you must call today an open a claim and/or report that you are seeking care for an injury).

Insurance Company _____ Phone number_____

Address _____ City _____ State_____ Zip _____

Claim # _____ Policy # _____

PIP Adjustor _____ Phone number _____ extension _____

Insured's name (if different from your own) _____

Relationship to insured _____

Insured's address_____ City _____ State _____ Zip _____

Insured's phone number _____ Insured's Date of Birth_____

Have you signed with an attorney regarding this accident? _____YES _____NO

If yes, whom? _____

Address_____ City _____ State_____ Zip_____

Phone #_____ Fax #_____

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Injury Questionnaire

First Name: _____ Middle Initial: _____ Last Name: _____

Home Phone #: _____ Cell Phone #: _____ Work Phone #: _____

Address: _____City: _____

State _____ Zip: _____ E-mail Address: _____

SS#:_____-_____-_____ Age: _____ DOB: __ __ /__ __ /__ __ Race: _____ Male / Female

Primary Care Physician Name: _____ Physician Phone Number: _____

ACCIDENT INFORMATION: Date of Accident:_____ State of Accident: _____

Where (Street/Intersection):_____

Were any tickets issued and to whom? _____

Were you the: ☐ Driver ☐ Front Seat Passenger ☐ Back Seat Passenger LEFT ☐ Back Seat Passenger RIGHT

Who else was in the car with you? ☐ No one _____

Did the impact to your vehicle come from the: ☐ Front ☐ Rear ☐ Driver Side ☐ Passenger Side

Since the accident have you experienced: ☐ Confusion ☐ Memory Loss ☐ Nausea ☐ Vomiting ☐ Ringing in Ear(s)
☐ Light Sensitivity ☐ Excessive Fatigue ☐ Blackout

Did the ambulance/paramedics arrive at the scene? ☐ No ☐ Yes

Did you go to the hospital? ☐ No ☐ Yes If Yes, were you taken to the hospital via: ☐ Ambulance ☐ Drove myself/Driven

Which hospital? _____

Were x-rays taken? ☐ No ☐ Yes MRI? ☐ No ☐ Yes Body Part(s)_____ CT? ☐ No ☐ Yes Part(s)_____

Have you been prescribed new medication(s) since the accident? ☐ No ☐ Yes If so please list all: _____

_____

Have you seen anyone else for this accident? ☐ No ☐ Yes If yes, what procedures did they do? _____

_____

PREVIOUS ACCIDENT HISTORY: Have you ever been involved in another motor vehicle accident? ☐ No ☐ Yes

If yes, please describe and give dates: _____

_____

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Application For Patient Care

PATIENT INFORMATION

Name: _____ DOB: __ __ /__ __ /__ __ Date: _____

Occupation:_____ Employer:_____

Average # Hours per Week Currently Worked:_____

At your job how many hours a day do you: Sit_____ Stand_____

Do your work activities mostly involve: ❑ Sitting ❑ Standing ❑ Light Labor ❑ Heavy Labor

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Minor

Spouse's Name:_____ # of Children?_____ Children's Ages:_____

Emergency Contact Name:_____ Relation: _____ Phone #:_____

PRIOR TREATMENT & ACCIDENTS

Have you had an auto accident? (X if applies): ☐ 0-6mo ☐ 6 mo-1 yr ☐ 1-3yrs ☐ 3+yrs ☐ Never

Had a recent fall/other accident? (X if applies): ☐ 0-6mo ☐ 6 mo-1 yr ☐ 1-3yrs ☐ 3+yrs ☐ Never

Have You Ever Received Chiropractic Care? ☐ Yes ☐ No Last Visit?_____

Have You Ever Received Physical Therapy? ☐ Yes ☐ No Last Visit?_____

Have You Ever Received Injections? ☐ Yes ☐ No Last Visit?_____

Have You Ever Had the Following: ☐ CT ☐ MRI If yes please explain the region and approximate Date(s) (i.e. Neck 2005)_____

INSURANCE

Do you have health insurance? ☐ Yes ☐ No Name of Carrier: _____

Do you have secondary insurance? ☐ Yes ☐ No Name of Carrier: _____

PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)

Assignment and Release (insured patients)

I certify that I (or my dependent) have insurance coverage with _____ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN PRACTICE, RejuvenX of _____ _____, LLC, INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize RejuvenX of _____, LLC to sign and submit health claim forms to the no-fault insurance carrier, health insurance carrier, supplemental insurance carrier, Medicare or any supplemental form of health insurance I have. I authorize the use of this signature on all insurance claims, including electronic submissions. I authorize RejuvenX of _____, LLC to obtain any and all insurance information needed for verification purposes. This included deductible amounts, med-pay limits and any other information deemed necessary by RejuvenX of _____, LLC for medical billing purposes.

SIGNATURE (X) _____ **DATE** _____

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Pain Disability Index

Name: _____ Date: _____

Pain disability index: The rating scales below are designed to measure the degree to which aspects of your life are disrupted by pain. In other words, we would like to know how much your pain is preventing you from doing what you would normally do or from doing it as well as you normally would. Respond to each category by indicating the overall impact of pain in your life, not just when the pain is at its worst.

For each of the 7 categories of life activity listed, please circle the number on the scale that describes the level of disability you are experiencing. A score of 0 means no disability at all, and a score of 10 signifies that all of the activities in which you would normally be involved have been totally disrupted or prevented by your pain.

Family/Home responsibilities: This category refers to activities of the home or family. It includes chores/duties performed around the house (eg, yard work) and errands or favors for other family member (eg, driving the children to school).

No disability 0 1 2 3 4 5 6 7 8 9 10 Worst disability

Recreation: This category includes hobbies, sports, and other similar leisure time activities.

No disability 0 1 2 3 4 5 6 7 8 9 10 Worst disability

Social activity: This category refers to activities that involve participation with friends and acquaintances other than family members. It includes parties, theatre, concerts, dining out, and other social functions.

No disability 0 1 2 3 4 5 6 7 8 9 10 Worst disability

Occupation: This category refers to activities that are a part of or directly related to one's job. This includes nonpaying jobs as well, such as that of a housewife or volunteer worker.

No disability 0 1 2 3 4 5 6 7 8 9 10 Worst disability

Sexual behavior: This category refers to the frequency and quality of one's sex life.

No disability 0 1 2 3 4 5 6 7 8 9 10 Worst disability

Self Care: This category includes activities, which involve personal maintenance and independent daily living (eg, taking a shower, driving, getting dressed, etc.)

No disability 0 1 2 3 4 5 6 7 8 9 10 Worst disability

Life-support activity: This category refers to basic life-supporting behaviors such as eating, sleeping, and breathing.

No disability 0 1 2 3 4 5 6 7 8 9 10 Worst disability

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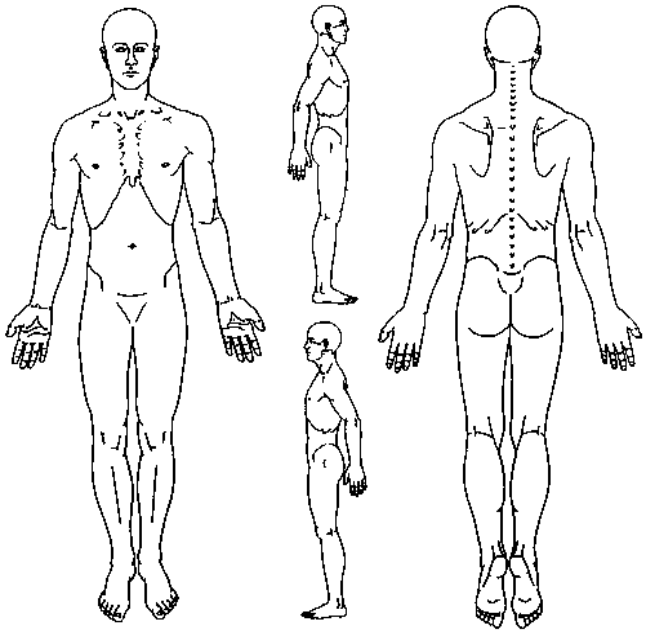
Patient Name:_____
Date:_____



CURRENT SYMPTOMS

Please check to indicate if you are currently experiencing any of the following conditions and then circle problematic areas on body to right:

❑ Neck Pain/Stiffness	❑ Numb/Pins/Needles in Arms
❑ Back Pain/Stiffness	❑ Numb/Pins/Needles in Legs
❑ Mid Back Pain/Stiffness	❑ Hip Pain
❑ Arm/Hand Pain	❑ Leg/Knee Pain
❑ Shoulder Pain	❑ Elbow Pain
❑ Wrist Pain	❑ Ankle Pain
❑ Headaches	❑ Loss of Memory
❑ Fatigue	❑ Chest Pain
❑ Sleeping Difficulties	❑ Dizziness
❑ Blurred/Double Vision	❑ Swollen Joints
❑ Trouble Concentrating	❑ Loss of Balance
❑ Shortness of Breath	

HEALTH HISTORY

Please check if you have ever had any of the following:

❑ Aids/HIV	❑ Erectile Dysfunction	❑ High Cholesterol	❑ Pacemaker	❑Pneumonia
❑ Appendicitis	❑ Epilepsy	❑ Parkinson's disease	❑ Pinched Nerve	❑ Thyroid Problem
❑ Arthritis	❑ Fractures	❑ Incontinence	❑ Stroke	❑ Vaginal Dryness
❑ Asthma/Wheezing	❑ Glaucoma	❑ Migraines	❑ Pneumonia	❑ High Blood Pressure
❑ Bleeding Disorders	❑ Heart Attack	❑ Multiple Sclerosis	❑ Rheumatoid	
❑ Contacts/Glasses	❑ Heart Problems	❑ Nosebleeds	❑ Psoriatic Arthritis	
❑ Diabetes	❑ Stroke	❑ Osteoporosis	❑ Herniated Disc	

Please list any and all **medications** you are currently taking: ❑ List provided _____

_____

Please list any supplements you are currently taking (vitamins/herbs/minerals):_____

_____

ALLERGIES: (Please place a check mark next to any known allergy that you have.) ___ Check here for No Known Allergies

___ Milk ___Eggs ___Peanuts ___ Shellfish ___Soy ___Wheat ___ Gluten ___Penicillin ___Sulfa Drugs
___Tetracycline ___Codeine ___NSAIDS ___Phenytoin ___Carbamazepine ___Lidocaine ___Latex ___Marcaine
___ OTHER: _____ *(please fill in)*

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Past History: Please list any **surgeries and/or hospitalizations** you have had (type & date):

_____

_____

Family History: Is there a family history of any of the following conditions? *(indicate family member including parents, grandparents & siblings)*

❑ Heart Disease _____ ❑ Diabetes _____
❑ Cancer _____ ❑ Arthritis _____ ❑ Other _____

Social History Caffeine _____ cups/day Alcohol _____ drinks/week Cigarettes _____ packs/day

Do you exercise: ❑ Frequently ❑ Moderately ❑ Occasionally ❑ None

I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health. I will continue to give complete and accurate information during my exam.

SIGNATURE (X) _____ **DATE** _____

X-ray Questionnaire: For WOMEN ONLY

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Name: _____

☐ There is a possibility that I a may be pregnant at this time.
☐ Yes, I am definitely pregnant
☐ No, I am definitely not pregnant at this time
☐ I request that x-ray films not be taken because:
_____

Date of last menstrual period: _____

_____ _____
Patient's Signature Date

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ACKNOWLEDGEMENT OF LIABILITY
ASSIGNMENT OF BENEFITS & RECORDS RELEASE

The undersigned patient and/or responsible party, hereby acknowledges personal responsibility and liability for all the medical services which are provided by RejuvenX of _____, LLC. This personal obligation is not affected by any obligation of insurance companies to pay health care costs. If an insurance company pays, the payment(s) shall be credited to your account. If no insurance payment is received, you are completely responsible to pay for all medical treatments. In addition to continuing personal responsibility, and in consideration of treatment rendered or to be rendered, the undersigned hereby assigns to the physician or facility named above the following rights, power, and authority.

CONSENT FOR TREATMENT: The undersigned hereby consents to provision of examination, fitness evaluations, treatment, therapies, medical and laboratory procedures, and drugs and supplies to the patient as ordered by the patient's healthcare provider RejuvenX of _____, LLC, their physicians, nurse practitioners, physical therapist, chiropractors or staff and acknowledges that no guarantee or assurance has been made to the results of such treatments, procedures or examinations.

RECORD RELEASE AND RELEASED INFORMATION: I authorized RejuvenX of _____, LLC to release and to permit the examination or copying of any of my medical records, x-rays, laboratory reports, and the results of all tests of any type or character to such person(s) as the Physician and or Facility deems appropriate. I hereby authorize and request you to release my complete pertinent accident medical records to RejuvenX of _____, LLC.

ASSIGNMENT OF RIGHTS: You are assigned to exclusive, irrevocable rights. Any cause of action that exists in my favor against any insurance company or other person or entity to the extent of your bill for total services, including the exclusive, irrevocable right to receive payment for such services, make demand in my name for payments, and prosecute and receive penalties, interest, court costs, or other legally compensable amounts owned by an insurance company or other person or entity. I, as the patient and or responsible party further agree to cooperate, provide information as needed, and appear as needed, wherever to assist in the prosecution of such claims for benefits upon request. The physician and or facility is also assigned the exclusive, irrevocable right to request and receive from any insurance company or health care plan any and all information and documents pertaining to my policies including a copy of such policy and my information or supporting documentation concerning or touching upon the handling, calculation, processing or payment of any claim.

DEMAND FOR PAYMENT: As to any insurance company providing benefits of any kind to me/us for treatment rendered by the physician/facility names above, you are hereby tendered the right to demand payment in full the bill for services rendered by the physician/facility named above following your receipt of such bill for services to extent such bills are payable under the terms of my/our policy for benefits, less any amount which I/we owe personally which are not payable under the terms of your policy.

THIRD PARTY LIABILITY: If patient(s) treatments for injuries are the result of the negligence of any third party, then patient(s) grant a secured interest (lien) against any recovery from such third party(s) to the extent of the bills for treatment in favor of the physician/facility named above.

In the event that any provision of this Agreement is determined to be invalid or unenforceable, all other provisions of this Agreement shall remain enforceable.

A PHOTOCOPY OF THIS INSTRUMENT SHALL SERVE AS ORIGINAL
Signature of patient and/or responsible party.

Patient Signature:_____ Date:_____

Print Name:_____ Date of Accident:_____

Relationship to Patient: _____

ACCIDENT CENTER
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PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ DOB: _____

I acknowledge that I have reviewed the Notice of Privacy Practices of RejuvenX of _____, LLC. (Please initial one of the following options and sign below.)

_____ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office.

_____ I wish to receive a paper copy of Privacy Notice.

_____ I wish to receive an electronic copy of Privacy Notice.

My email address is: _____@_____

Please initial below:

_____ I acknowledge that it is the policy of RejuvenX of _____, LLC to leave reminder messages on my answering machine or with another person in my home. I may make a request of an alternative means of communication (within reason) in writing.

_____ I acknowledge that if I should have a problem or question in regard to my rights, I may speak with the Privacy Officer, Kristen Nelson, about my concerns.

_____ _____
Signature of Patient/Guardian Date

_____ _____
Witness (Office Staff) Date

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

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

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

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

_____

_____

2. I have the right and the **duty to confirm** that the services have already been provided.
3. I was **not solicited** by any person to seek any services from the medical provider of the services described above.
4. The medical provider has **explained** the services to me for which payment is being claimed.
5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to $500.

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

Name *(PRINT or TYPE)*	Signature	Date

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

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

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

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

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

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

Name *(PRINT or TYPE)*	Signature	Date

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

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

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