Herba Family Chiropractic

PATIENT HISTORY

(Please Print, All information is confidential)

Name:_____
Address:_____
_____
Home Phone: _____
Office Phone: _____
Email:_____
DOB:_____ Age: _____

Referred By: _____
Marital Status: _____ # of children: ____
Spouse Name: _____
SS #: _____
Cell Phone: _____
Occupation: _____
Employer: _____

Driver License #:
_____
Insurance Name: _____
Policy/Card #: _____
Secondary: _____
Policy/Card #: _____
Claim #:_____
Claims Adjuster:_____
Adjuster Phone #:_____

If patient is a minor (under 18yrs old), Please fill out this section. If not, skip:

Parent/ Guardian's Name: _____Date of Birth: _____Age: _____

Address: _____City/State: _____Zip: _____ Phone # _____ SS#_____

Occupation: _____ Employer:_____ Work Phone: _____

Please mark X for present conditions, O for past conditions

_____ Fractured Bones
_____ Auto Accidents
___ 0-1 years ago
___ 1-5 years ago
___ More than 5
_____ Other Accidents/Falls
_____ Back Curvature
_____ Arthritis
_____ Diabetes
_____ Swollen/Painful Joints
_____ Convulsions/Epilepsy
_____ Skin Problems
_____ Cancer
_____ Frequent Colds/Flu
_____ Depressed
_____ Irritable
_____ Anemia
_____ Tremors
_____ Allergies
_____ Sinus Problems
_____ Eating Disorders
_____ Trouble Sleeping
_____ Trouble Concentrating
_____ Learning Disability

_____ Mood Changes
_____ Headache
_____ Pain/Stiff Neck R L
_____Numbness/Tingling/Pain
Arms/Hands/Fingers R or L
_____ Jaw Pain/TMJ R L
_____ Head/Shoulders Feel Tired
_____ Difficulty in Excessive
(Standing, Walking, Bending, Riding,
Twisting, Lifting, Household Duties)
_____ Shoulder Pain R L
_____ Dizziness
_____ Ringing in Ears R L
_____ Hearing Loss R L
_____ Fainting
_____ Loss of Balance
_____ Blurred Vision R L
_____ Double Vision R L
_____ Upper Back Pain/Stiffness
_____ Mid Back Pain/Stiffness
_____ Low Back Pain/Stiffness
_____ Numbness, Tingling or Pain in
buttocks, thighs, legs, feet, toes
_____ Pain with cough, sneeze

_____ Hip Pain R L
_____ Foot Trouble R L
_____ Chest Pain
_____ Asthma
_____ Lung Problems
_____ Difficulty Breathing
_____ Heart Problem
_____ Stroke
_____ High/Low Blood Pressure
_____ Varicose Veins
_____ Liver Trouble
_____ Gall Bladder Trouble
_____ Digestive Problems
_____ Heartburn
_____ Ulcers
_____ Diarrhea/Constipation
_____ Colon Trouble
_____ Hemorrhoids
_____ Prostate Problems
_____ Impotence
_____ Kidney Trouble
_____ Menstrual Problem/PMS
_____ Menopausal Problems
_____ Pregnant (now)

Please mark X for present conditions, O for past conditions

Accident Description

Please answer the questions below. **DATE OF MVA:** _____
If you do not know the answer to any of the questions, *do not answer that question*.

1. Your vehicle type
❑Car ❑Station Wagon
❑Van ❑Pickup Truck
❑Large Truck ❑Bus
Other_____

2. Your position in vehicle
❑Driver ❑Front Passenger
❑Left Rear Passenger ❑Right Rear Passenger
Other_____

3. What was your vehicle doing at the time of the accident?
❑Stopped at intersection
❑Stopped in traffic
❑Stopped at light
❑Making a right turn
❑Making a left turn ❑Parking
❑Proceeding along ❑Slowing down
❑Accelerating
Other_____

4. Time/Speed/Damage
Date of Accident _____
Time of accident_____
Your vehicle's speed: _____mph
Their vehicle's speed: _____mph

Damage to your vehicle
❑Mild ❑Moderate
❑Totaled

5. Details of Accident

Visibility at time of accident
❑Poor ❑Fair ❑Good

Who hit who/what?
❑You hit other vehicle
❑Other vehicle hit you
You hit...(object) _____

6. Road conditions

Road conditions at time of accident
❑Icy ❑Wet ❑Sandy ❑Dark ❑Clean and dry

Point of impact
❑Head-On ❑Left Front ❑Right Front
❑Read-End ❑Left Rear ❑Right Rear

7. Body Position, etc.
Does your vehicle have headrests? ❑Yes❑No
What was the position of your headrest at the time of the impact?
❑Even with top of head ❑Even with bottom of head ❑Middle of neck
Did you see the accident coming: **❑Yes ❑No**
Were you braced for the impact? **❑Yes ❑No** Did you have a seat belt on? **❑Yes ❑No**
What was the direction of your head at the time of the impact?
❑Facing straight forward ❑Turned to the right ❑Turned to the left
Was your shoulder harness on? **❑Yes ❑No**
Did driver side airbag deploy? **❑Yes ❑No** Did passenger side airbag deploy? **❑Yes ❑No**
Side airbags? **❑Yes ❑No**

8. Additional accident information
In the case of a motor vehicle accident, enter any additional info here that is not covered by the above check offs.
_____
_____
_____

9. During the accident:
Did your body strike inside of your vehicle? **❑Yes❑No**
If yes, describe:_____

Did you lose consciousness during the injury? **❑Yes❑No**
If yes, for how long? _____
Your vehicle's estimated damage? _____
Damage to their vehicle: ❑Mild ❑Moderate ❑Totaled
Did police show up at the scene? **❑Yes ❑No**
Was accident report filled out? **❑Yes ❑No**

10. After the accident:
Check off your symptoms following the accident:
❑Headache ❑Dizziness ❑Mid back pain
❑Cold hands ❑Cold feet ❑Irritability
❑Neck pain ❑Nausea ❑Low back pain
❑Neck stiffness ❑Confusion ❑Nervousness
❑Fainting ❑Fatigue ❑Depression ❑Diarrhea
❑Ringing in ears ❑Tension ❑Toe numbness
❑Loss of smell ❑Constipation ❑Chest Pain ❑Anxious
❑Shortness of breath ❑Sleeping problems

11. Emergency Room?

Where did you go after the accident?

❑Home ❑Work ❑Hospital ER ❑Private Doctor

How did you get there?

❑Self ❑Somebody else ❑Ambulance. ❑Police

X-rays done? ❑Yes❑No Lab work? ❑Yes❑No

Body parts X-rayed?_____

What lab work?_____

The X-rays revealed: _____

Treatments: ❑Cervical Collar ❑Ice **Other:**____

Medications:____ : **❑Yes❑No**

(list) _____

Follow-up instructions: _____

_____

12. Treatment History:

Fill in other doctor(s) seen prior to your first visit to our office.

1. Dr. _____ First visit date:___/___/___

Specialty:_____ X-rays done? **❑Yes❑No**

Types of treatments received:_____

Currently treating? **❑Yes❑No**

Did treatments benefit you? **❑Yes❑No**

Last visit date: ____/____/____

2. Dr. _____ First visit date___/___/__

Types of treatments received:_____

How many treatments received? _____

Currently treating? Y N

Did treatments benefit you? **❑Yes ❑No**

Last visit date: ____/____/____

HISTORY OF COMPLAINT

Please describe your current complaints_____

Have you suffered with any of this or a similar problem(s) in the past? ❑ No ❑ Yes If yes when?_____

Please state what type of treatment you have tried for this problem(s) _____

Who provided it?: _____ **When?** _____

What were the results? ☐ Favorable ☐ Unfavorable→ please explain. _____

How long were you under care: _____

What were the results? _____

Have you had any surgeries? ☐ Yes ☐ No

If yes please provide dates and descriptions: _____

Please list all medications you are currently taking_____

_____

SOCIAL HISTORY

1. Smoking: ❑cigars ❑ pipe ❑ cigarettes →How often? ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never

2. Alcoholic Beverage: consumption occurs → ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never

3. Recreational Drug use: ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never

4. Hobbies -Recreational Activities- Exercise Regime: How does present problem affect the following:

IDENTIFY TYPE:	**EFFECT:**
_____	☐ No Effect ☐ Painful (can do) ☐ Painful (limits) ☐ Unable to Perform
_____	☐ No Effect ☐ Painful (can do) ☐ Painful (limits) ☐ Unable to Perform
_____	☐ No Effect ☐ Painful (can do) ☐ Painful (limits) ☐ Unable to Perform

5. Work Activities: Please complete all questions!

Hours worked per day: _____ Days per week: _____ Does your job require lifting? ☐ No ☐ Yes

If yes, what is the maximum required? ☐ Min (<5 lbs) ☐ Light (5-20 lbs) ☐ Med (20-50lbs) ☐ Hvy (>50 lbs)

Lifting Frequency**:** ☐ Constant (66-100%of day) ☐ Frequent (33-66% of day) ☐ Occasional (0-33% of day)

Lifting Postures**:** ☐ Knee ☐ Torso ☐ Arm ☐ Shoulder ☐ Off Posture

Standing:_____ Hrs per day Sitting: _____ Hrs per day Pushing: _____ Hrs per day

Twisting:_____ Hrs per day Climbing:_____ Hrs per day Pulling: _____Hrs per

Kneeling:_____ Hrs per day Reaching: _____ Hrs per day Walking: _____Hrs per day

6. Repetitive Activities:

Computer: _____ Hrs per day Grasping: _____ Hrs per day Hand Tools: _____ Hrs per day

Machinery: _____ Hrs per day Assembly: _____ Hrs per day Phone: _____ Hrs per day

Other: _____ _____ Hrs per day

7. Impact of Current Condition on Work Capacity: ☐ No Effect ☐ Painful ☐ Limits ☐ Unable to work

8. **How** many years of school did you complete? ❑ 1-8 ☐ 8-12 ☐12-14 ☐14-16 ☐ 16 +

FAMILY HISTORY:

1. Does anyone in your family suffer with the same condition(s)? ❑ No ❑ Yes

If yes whom: ❑ grandmother ❑ grandfather ❑ mother ❑ father ❑ sister ❑ brother ❑ son(s) ❑ daughter(s)

Have they ever been treated for their condition? ❑ No ❑ Yes ❑I don't know

Any other hereditary conditions the doctor should be aware of. ❑ No ❑Yes: _____

PAST HISTORY

If you have ever been diagnosed with any of the following conditions please indicate with a **P** for in the **Past, C** for **Currently** have and **N** for **Never** have had a**:** [ ]Disability [ ]Broken Bone

[ ]Fracture [ ]Dislocations [ ]Tumors [ ]Rheumatoid Arthritis [ ]Osteo Arthritis

[ ]Cerebral Vascular [ ]Heart Attack [ ]Diabetes

[ ]Other serious conditions: _____

PLEASE, identify ALL PAST and any **CURRENT** conditions you feel may be contributing your present problem:

Description of Symptoms AREA #1(Describe your symptoms in the sections below, in the order of severity)

I. Current Symptom: (Please check off the boxes below to describe your symptom.

II. The pain is located _____

The pain started_____

The pain is made better by _____

and worse by _____

How would you describe the pain: □ Dull □ Sharp□ Aching□ Cutting □ Throbbing □ Burning□ Numbing□ Tingling

□ Cramping □ Spasm □ Stinging □ Shooting□ Pounding □ Constricting

[ ] There is [ ] There is not radiation into _____

[ ] There is [ ] There is not referred pain into _____

[ ] There is [ ] There is not parasthesia (tingling/numbness) into:_____

III. The pain is (as far as timing is concerned: □ In the A.M. □ In the P.M.

□ Up to 1/4 of awake time □ 1/4 to 1/2 of time □ 1/2 to 3/4 of awake time □ Most all the time

Actions affecting this pain

	Brings On	Aggravates	Relieves
□ Bending forward.	□	□	□
□ Bending back	□	□	□
□ Bending left	□	□	□
□ Bending right	□	□	□
□ Twisting left	□	□	□
□ Twisting right	□	□	□
□ Coughing	□	□	□
□ Sneezing	□	□	□
□ Straining	□	□	□
□ Standing	□	□	□
□ Sitting	□	□	□
□ Lifting	□	□	□

Other Actions:_____

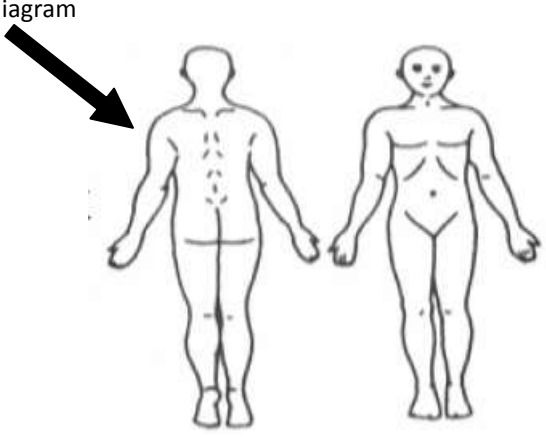
***PLEASE MARK** the areas on the diagram with the following letters to describe your symptoms:

R = Radiating B = Burning

D = Dull A = Aching

N = Numbness

S = Sharp/ Stabbing T= Tingling



The pain is (as far as timing is concerned: i.e. comes & goes, constant, etc.)_____

On a scale of 1- 10 rate your pain: **No Pain 0 1 2 3 4 5 6 7 8 9 10 Severe Pain**

Description of Symptoms AREA #2 (Describe your symptoms in the sections below, in the order of severity)

IV. Current Symptom: (Please check off the boxes below to describe your symptom.

V. The pain is located _____

The pain started_____

The pain is made better by _____

and worse by _____

How would you describe the pain: □ Dull □ Sharp □ Aching □ Cutting □ Throbbing □ Burning □ Numbing □ Tingling

□ Cramping □ Spasm □ Stinging □ Shooting □ Pounding □ Constricting

[ ] There is [ ] There is not radiation into _____

[ ] There is [ ] There is not referred pain into _____

[ ] There is [ ] There is not parasthesia (tingling/numbness) into:_____

VI. The pain is (as far as timing is concerned: □ In the A.M. □ In the P.M.

□ Up to 1/4 of awake time □ 1/4 to 1/2 of time □ 1/2 to 3/4 of awake time □ Most all the time

Actions affecting this pain

	Brings On	Aggravates	Relieves
□ Bending forward.	□	□	□
□ Bending back	□	□	□
□ Bending left	□	□	□
□ Bending right	□	□	□
□ Twisting left	□	□	□
□ Twisting right	□	□	□
□ Coughing	□	□	□
□ Sneezing	□	□	□
□ Straining	□	□	□
□ Standing	□	□	□
□ Sitting	□	□	□
□ Lifting	□	□	□

Other Actions:_____

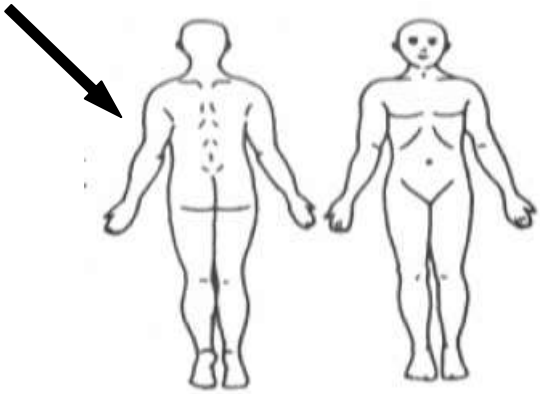
***PLEASE MARK** the areas on the diagram with the following letters to describe your symptoms:

R = Radiating B = Burning

D = Dull A = Aching

N = Numbness

S = Sharp/ Stabbing T= Tingling



The pain is (as far as timing is concerned: i.e. comes & goes, constant, etc.)_____

On a scale of 1- 10 rate your pain: **No Pain 0 1 2 3 4 5 6 7 8 9 10 Severe Pain**

Description of Symptoms AREA #3 (Describe your symptoms in the sections below, in the order of severity)

VII. Current Symptom: (Please check off the boxes below to describe your symptom.

VIII. The pain is located _____

The pain started_____

The pain is made better by _____

and worse by _____

How would you describe the pain: □ Dull □ Sharp □ Aching □ Cutting □ Throbbing □ Burning □ Numbing □ Tingling

□ Cramping □ Spasm □ Stinging □ Shooting □ Pounding □ Constricting

[ ] There is [ ] There is not radiation into _____

[ ] There is [ ] There is not referred pain into _____

[ ] There is [ ] There is not parasthesia (tingling/numbness) into:_____

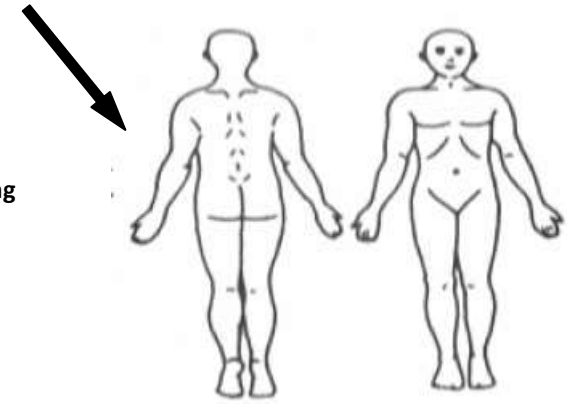
IX. The pain is (as far as timing is concerned: □ In the A.M. □ In the P.M.
□ Up to 1/4 of awake time □ 1/4 to 1/2 of time □ 1/2 to 3/4 of awake time □ Most all the time

Actions affecting this pain

	Brings On	Aggravates	Relieves
□ Bending forward.	□	□	□
□ Bending back	□	□	□
□ Bending left	□	□	□
□ Bending right	□	□	□
□ Twisting left	□	□	□
□ Twisting right	□	□	□
□ Coughing	□	□	□
□ Sneezing	□	□	□
□ Straining	□	□	□
□ Standing	□	□	□
□ Sitting	□	□	□
□ Lifting	□	□	□

Other Actions:_____

***PLEASE MARK** the areas on the diagram with the following letters to describe your symptoms:
R = Radiating B = Burning
D = Dull A = Aching
N = Numbness
S = Sharp/ Stabbing T= Tingling



The pain is (as far as timing is concerned: i.e. comes & goes, constant, etc.)_____

On a scale of 1- 10 rate your pain: **No Pain 0 1 2 3 4 5 6 7 8 9 10 Severe Pain**

Activities of Daily Living Assessment

Rate your current difficulties, resulting from your accident/illness, with regard to the various activities listed below. Use the following 1 to 5 scale and **WRITE IN THE APPROPRIATE NUMBER** that most closely describes your current degree of difficulty:

1 = "I can do it without any difficulty", **2** = "I can do it without much difficulty, despite some pain", **3** = "I manage to do it by myself, despite marked pain", **4** = "I manage to do it, despite the pain, but only if I have help", **5** = "I cannot do it all, because of the pain".

Only fill in areas affected.

Difficulties with Self Care and Personal Hygiene Activities
Bathing____ Drying hair____ Brushing teeth___ Putting on shoes____Preparing meals___Taking out trash____
Showering____ Combing hair____Making bed____ Tying shoes____ Eating____ Doing laundry____
Washing hair___Washing face___Putting on shirt___ Putting on pants____ Cleaning dishes___Going to toilet____

Difficulties with Physical Activities
Standing____ Walking____ Kneeling ____ Bending back ____ Twisting left____ Leaning back____
Sitting____ Stooping____ Reaching____ Bending left____ Twisting right____ Leaning left____
Reclining____Squatting____ Bending forward____ Bending right____ Leaning forward____ Leaning right____
Standing for long periods____Sitting for long periods____Walking for long periods____ Kneeling for long periods____

Difficulties with Functional Activities
Carrying small objects____ Lifting weights off floor____Pushing things while seated____ Exercising upper body____
Carrying large objects____ Lifting weights off table___ Pushing things while standing____Exercising lower body____
Carrying brief case____ Climbing stairs____ Pulling things while seated____ Exercising arms____
Carrying large purse____ Climbing inclines____ Pulling things while standing____ Exercising legs____

Difficulties with Social and Recreational Activities
Bowling____ Jogging____ Swimming____ Ice Skating____ Competitive Sports____ Dating____
Golfing____ Dancing____ Skiing____ Roller Skating____ Hobbies____ Dining out____

Difficulties with Travelling
Driving a motor vehicle____ Riding as a passenger in a motor vehicle____
Driving for long periods of time_ __Riding as a passenger on an airplane____Riding as a passenger for long periods_

Use the following 1 to 5 scale to describe the difficulties below:

1 = "This area is not affected by my condition", **2** = "This area is slightly affected by my condition", **3** = "My condition moderately restricts my ability in this area", **4** = " My condition seriously limits my ability in this area", **5** = "My condition prevents me from using this ability"

Difficulties with Different Forms of Communication
Concentrating____ Hearing____ Listening____ Speaking____ Reading____ Writing____ Using a keyboard____

Difficulties with the Senses
Seeing____ Hearing____ Sense of touch____ Sense of taste____ Sense of smell____

Difficulties with Hand Functions
Grasping____ Holding____ Pinching____ Percussive movements____ Sensory discrimination____

Difficulties with Sleep and Sexual Function
Being able to have normal, restful nights sleep____ Being able to participate in desired sexual activity____

Prior Symptom History

Prior Similar Symptoms

❑I have NOT had prior symptoms similar to my current complaints.
❑My current complaints DID exist before, but had not been bothering me.
❑My current complaints ALREADY existed and were worsened.

Has your History Contributed to your Current Symptoms?

❑My history HAS contributed to my current symptoms.
❑My history HAS NOT contributed to my current symptoms.
❑I 'm NOT SURE if my history has contributed to my current symptoms.

My most recent prior similar symptoms **(if applicabl**e) occurred____ ❑months ago / ❑years ago **OR on**
Date:_____/_____/_____**Write in below any other Prior Symptom History, not covered above**

NOTICE OF HIPAA PRIVACY PRACTICE

Herba Family Chiropractic, P.A. is required to notify you in writing, that by law we must maintain the privacy and confidentiality of your **P**ersonal **H**ealth **I**nformation. In addition, we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which by law, or as dictated by our office policy, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances

PERMITTED DISCLOSURES:

1. Treatment purposes -- discussion with other health care providers involved in your care.
2. Inadvertent disclosures -- open treating area means open discussion. If you need to speak privately to the doctor please let our staff know so we can place you in a private consultation room or schedule specific time.
3. Disclosure via calling system – we have an open speaker calling system for our patients and your name will be heard by other patients in the office.
4. For payment purposes -- to obtain payment from your insurance company, should they be involved, or any available collateral source.
5. Emergency -- in the event of a medical emergency we may notify a family member.
6. For public health and safety -- in order to prevent or to lessen a serious or eminent threat to the health or safety of a person or general public.
7. To government agencies or law enforcement -- to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons -- discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders -- we may call your home and leave messages regarding a missed appointment or notify you of changes in practice hours or upcoming events.
11. Spouses, household partners and other close family members.
12. Change of ownership- in the event this practice is sold the new owners would have access to your PHI

YOUR RIGHTS:

1. To receive an accounting of disclosures
2. To request mailings to an address different than residence
3. To request restrictions on certain uses and disclosures and with whom we release information to
4. To inspect your records and receive one copy of your records at no charge, with 3 business days advance notice
5. To request amendments to information – however; like restrictions, we are not required to agree to/with them

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information please call ***Zuleida Herba, HIPAA Clinic Compliance Office*** at **407-432-9428.** If they unavailable, you may make an appointment with our receptionist to see them within 2 working days.

Note: This office reserves the right to amend this notice of privacy practice at any time in the future and will make the new provisions effective for all information that it maintains past and present.

I have received a copy of the **Herba Family Chiropractic** Patient Privacy Notice and understand my rights as well as the practice's duty to protect my health information, and have conveyed my understanding to the doctor. At this time, I do not have any questions regarding my rights or any of the information I have received.

_____ _____

Patient signature **Date**

_____ _____

Witness **Date**

Herba Family Chiropractic Center

THIS DOCUMENT COSTITUTES INFORMED CONSENT FOR CHIROPRACTIC CARE.

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important for each patient to understand both the objective and the method that will be used to attain it. This will prevent confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our Chiropractic method of correction is by specific adjustment of the spine.

Health: A state of optimal, physical, mental and social well being, not merely the absence of disease, symptoms or infirmity.

Vertebral Subluxations: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will so advise you. If you desire advice, diagnosis or treatment for those findings we will recommend that you seek the services of the health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression to the body's innate wisdom. Our only method is the specific adjustment of vertebral subluxations. However, we may use other procedures to help your body hold the adjustments.

Visits: HFC values your time and aspires to have the highest level of chiropractic education available. We have established procedures both to make your visit as efficient as possible and to bring wellness education to the community that may include the use of multimedia. As a patient of HFC, you consent to the following: Multimedia produced for ID, posture analysis, and human biomechanics analysis. You also authorize a release for all multimedia taken during HFC patient hours, patient special events, advanced patient talks, for our website, newsletters, and wellness community education. Your name will be recorded and announced aloud in our office as a part of our patient call system.

POLICIES

1. All first visit charges are payable when services are rendered, since it is impossible to determine what insurance covers without a diagnosis of severity.
2. The fee paid for X-rays is for the analysis of those X-rays only. The film itself is the property of this office. Original X-rays cannot be released; however, copies can be made at minimal charge of $20 per film.
3. I have read Herba Family Chiropractic's Notice of Patient Privacy Practices.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand Herba Family Chiropractic (HFC) will prepare any necessary reports and forms to assist in making collections from the insurance company and that any amount authorized to be paid directly to HFCC will be credited to my account upon receipt. However, I clearly understand and agree that all the services rendered to me are charged directly to me and that I am personally responsible for payment.

In case of emergency, notify _____ Phone # _____

I, _____, have read and fully understand the above statements. All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on the basis _____ Date_____

(Signature)

COMPLETE IF THE PATIENT IS A MINOR CHILD: child's name: _____

I, _____ being the parent or legal guardian of the aforementioned child have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

_____ _____

(Signature) (Date)

Herba Family Chiropractic
158 Tuskawilla Road Suite 1308
Winter Springs, Fl 32708
Ph: (407) 327.9000 Fax: (407) 327.9035

ASSIGNMENT OF BENEFITS

I, _____, herby assign my rights, title, and interest from any and all automobile insurance policy which provides Personal Injury Protection (PIP), medical benefits or no fault benefits to HERBA FAMILY CHIROPRACTIC PA, for services rendered to me by HERBA FAMILY CHIROPRACTIC PA for the accident on _____.

_____ _____
Patient's Signature Date

_____ _____
Witness Date

Herba Family Chiropractic Center
158 Tuskawilla Road Suite 1308
Winter Springs Fl, 32708
Ph: (407) 327.9000 Fax: (407) 327.9035

Records Release Authorization

Date: _____

To Doctor or Hospital
Name: _____
Address: _____
_____

I hereby authorize and request release to: Herba Family Chiropractic Center
158 Tuskawilla Road Suite 1308
Winter Springs Fl, 32708
(407) 327.9000

The complete history records in your possession, concerning my illness and/or treatment during the period

From: _____ To: _____

Patient: _____

Date of Injury or Illness: _____

Patient's Signature: _____ Date: _____

Witness: _____ Date: _____

Herba Family Chiropractic PA
158 Tuskawilla Road Suite 1308
Winter Springs, FL 32708
Ph: (407) 327.9000 Fax: (407) 327.9035

PROVIDER'S LIEN

TO: Attorney _____
_____
_____

Re: Reports and Provider's Lien
I do hereby authorize the above provider to furnish you, my attorney, with a full report of this examination, diagnosis, treatment, prognosis, etc of myself in regards to the accident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to Herba Family Chiropractic, P.A., such sums as may be due and owing them for chiropractic services rendered me both by reason of this accident and by reason of any other bills that are due their office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said company. And I hereby further give a lien on my case to said company against any and all proceeds of any settlement, judgment or verdict which may be paid to me as a 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 company for all chiropractic bills submitted by them for services rendered me and that this agreement is made solely for said company's additional protection and in consideration of their awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

Dated: _____Patient's Name: _____
Patient's Signature: _____

The undersigned being attorneys 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 company above named.

Dated: _____Attorney's Signature: _____

Please date, sign and return one copy to doctor's office. Keep a copy for your records.
A photo copy of this form shall be considered as valid as the original.

Herba Family Chiropractic
158 Tuskawilla Road, Suite 1308
Winter Springs, FL 32708
Ph: (407) 327.9000 Fax: (407) 327.9035

Signature on File

( ) I authorize use of this form on all my insurance submissions

( ) I authorize release of information to all my Insurance Companies

( ) I authorize my doctor to act as my agent in helping me obtain payment from my Insurance Companies

( ) I authorize payment direct to my doctor

( ) I permit a copy of this authorization to be used in place of the original

Name (print): _____ SS#: _____

Signature: _____ Date: _____