Welcome to Deerwood Lake Chiropractic

Patient Information

Date: _____

First Name: _____

Last Name: _____ Middle Initial: _____

Address _____ Apt # _____

City/State _____ Zip _____

E-mail _____

Sex ☐ **Male** ☐ **Female**

Age _____ **Birthdate** _____

☐ Married ☐ Widowed ☐ Single ☐ Minor
☐ Separated ☐ Divorced ☐ Partnered for _____ years

Current Height: _____ Current Weight: _____

Number of Children/Ages:

_____

_____

Occupation _____

Patient Employer/School _____

Employer/School Address _____

Spouse's Name _____

Auto Insurance

Insurance Company: _____

Member # : _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Insurance Co. _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent (s) , have insurance coverage with _____ and assign directly to Deerwood Lake Chiropractic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on al insurance submissions.

The above-named office may use my health care information and may disclose such information to the above-named Insurance Company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____

Signature of Patient, Parent, Guardian or Personal Representative

_____

Please print name of Patient, Parent, Guardian or Personal Representative

_____

Date Relationship to Patient

Contact Information

Home Phone (_____) _____

Cell Phone (_____) _____

Best time & place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Contact Number (_____) _____

Accident Information

Is condition due to an accident? ☐ Yes ☐ No

Date of accident: _____

Type of Accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?

☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable)

_____

Health/History Information

Is today's problem caused by: ☐ Auto Accident ☐ Workman ' s Compensation ☐ Other: _____

How would you rate your overall Health? ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

What type of exercise do you do? ☐ Stenuous ☐ Moderate ☐ Light ☐ None

What activities do you do at work?

☐ **Sit:** ☐ Most of the day ☐ Half the day ☐ A little of the day

☐ **Stand:** ☐ Most of the day ☐ Half the day ☐ A little of the day

☐ **Driving** ☐ Most of the day ☐ Half the day ☐ A little of the day

☐ **Reads a lot** ☐ **Travels Frequently**

☐ **Computer Work:** ☐ Most of the day ☐ Half the day ☐ A little of the day

☐ **On the Phone:** ☐ Most of the day ☐ Half the day ☐ A little of the day

☐ **Performs Manual Labor:** ☐ Most of the day ☐ Half the day ☐ A little of the day

What activities do you do outside of work? _____

Have you ever been hospitalized? ☐ No ☐ Yes, if yes, why? _____

Have you had significant past trauma ☐ No ☐ Yes

Anything else pertinent to your visit today? _____

HEALTH HISTORY

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

	PAST	PRESENT
Headache	□	□ Yes □ No
Neck Pain	□	□ Yes □ No
Upper Back Pain	□	□ Yes □ No
Mid Back Pain	□	□ Yes □ No
Low Back Pain	□	□ Yes □ No
Shoulder Pain	□	□ Yes □ No
Elbow/Upper Arm Pain	□	□ Yes □ No
Wrist Pain	□	□ Yes □ No
Hand Pain	□	□ Yes □ No
Hip Pain	□	□ Yes □ No
Upper Leg Pain	□	□ Yes □ No
Knee Pain	□	□ Yes □ No
Ankle/Foot Pain	□	□ Yes □ No
Jaw Pain	□	□ Yes □ No
Joint Pain/Stiffness	□	□ Yes □ No
Arthritis	□	□ Yes □ No
Rheumatoid Arthritis	□	□ Yes □ No
Cancer	□	□ Yes □ No
Tumor	□	□ Yes □ No
Asthma	□	□ Yes □ No
Chronic Sinusitis	□	□ Yes □ No
Other: _____		

	PAST	PRESENT
High Blood Pressure	□	□ Yes □ No
Heart Attack	□	□ Yes □ No
Chest Pains	□	□ Yes □ No
Stroke	□	□ Yes □ No
Angina	□	□ Yes □ No
Kidney Stones	□	□ Yes □ No
Kidney Disorder	□	□ Yes □ No
Bladder Infection	□	□ Yes □ No
Painful Urination	□	□ Yes □ No
Loss of Bladder Control	□	□ Yes □ No
Prostate Problems	□	□ Yes □ No
Anormal Weight Gain/	□	□ Yes □ No
Loss	□	□ Yes □ No
Loss of Appetite	□	□ Yes □ No
Abdominal Pain	□	□ Yes □ No
Ulcer	□	□ Yes □ No
Heptatis	□	□ Yes □ No
Liver/Gall Bladder	□	□ Yes □ No
Disorder	□	□ Yes □ No
General Fatigue	□	□ Yes □ No
Muscular Incoordination	□	□ Yes □ No
Visual Disturbances	□	□ Yes □ No
Dizziness	□	□ Yes □ No

	PAST	PRESENT
Diabetes	□	□ Yes □ No
Excessive Thirst	□	□ Yes □ No
Frequent Urination	□	□ Yes □ No
Smoking/Tobacco	□	□ Yes □ No
Drug/Alchohol	□	□ Yes □ No
Dependance	□	□ Yes □ No
Allergies	□	□ Yes □ No

If yes, list allergies: _____

_____

Depression	□	□ Yes □ No
Systemic Lupus	□	□ Yes □ No
Epilepsy	□	□ Yes □ No
Dematitis/Eczema/Rash	□	□ Yes □ No
HIV/AIDS	□	□ Yes □ No

Do you have any immediate family members with:

☐ ALS ☐ Cancer ☐ Diabetes ☐ Lupus

☐ Heart Problems ☐ Rheumatoid Arthritis

☐ Other: _____

LIST ALL PRESCRIPITION MEDICATIONS YOU ARE CURRENTLY TAKING:

Name	For what?
_____	_____
_____	_____

LIST ALL OF THE OVER-THE-COUNTER MEDICATIONS YOU ARE CURRENTLY TAKING:

Name	For what?
_____	_____
_____	_____
_____	_____

Are you taking any nutritional supplements? □ No □ Yes, if yes, please list: _____

LIST ALL SURGICAL PROCEDURES YOU HAVE HAD:

Type/procedure (please describe)	Date/Year (estimate)
_____	_____
_____	_____
_____	_____

HAVE YOU BEEN TO A CHIROPRACTOR BEFORE?

☐ NO ☐ YES, if yes, who? _____ Last visit date, approx:_____

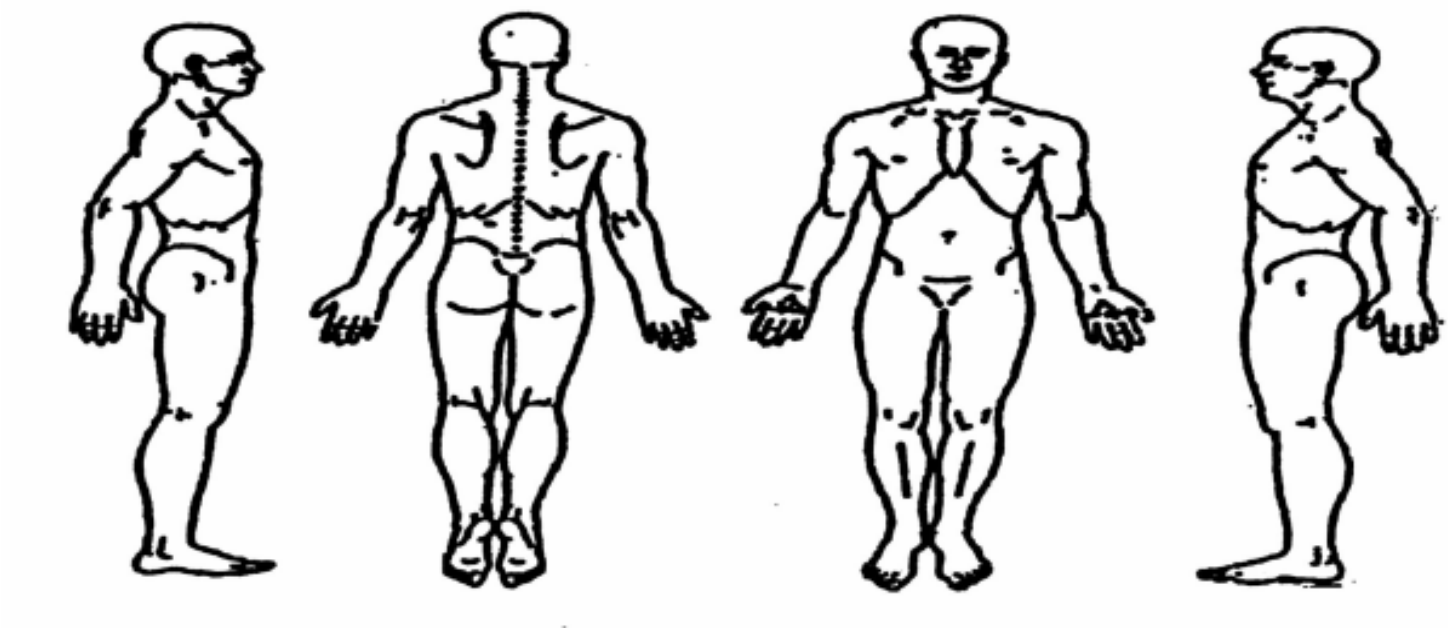
How would you rate your past results? ☐ GREAT ☐ GOOD ☐ FAIR ☐ MIXED ☐ POOR

CURRENT COMPLAINT(S)

1. Indicate on the the diagram below where you have pain/symptoms:

SHARP — **N**UMB — **D**ULL — **T**INGLY — **A**CHY — **B**URNING — **SH**OOTING — **ST**IFF

OTHER:_____



2. Have you had any slips/falls, auto-accidents or any other injuries?_____

If yes, where and when have you been treated for the injury? _____

_____

3. How long have you had this problem? (approximate date)_____

4. What makes it worse?_____

5. What makes it better? _____

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

7. Who else have you seen for your problem?

□ Chiropractor □ Neurologist □ Primary Care Physician □ ER physician □ Orthopedist

□ Massage Therapist □ Physical Therapist □ No one □ Other:_____

8. Any additional comments?: _____

_____

_____

_____

_____

_____

INFORMED CONSENT

The nature of the chiropractic adjustment:

The primary treatment used by the Doctors of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. They may cause an audible "pop" or "click", much as you have experienced when you "crack" your knuckles. You may sense a feel of movement.

Analysis/Examination/Treatment:

As part of the analysis, examination, and treatment, you are consenting to the following procedures:
- Spinal Manipulative Therapy - Range of Motion Testing
- Muscle Strength Testing – Radiographic Studies
- Palpation - Orthopedic Testing - Posture Analysis
- Hot/Cold Therapy – Vital Signs - EMS
- Basic Neurological Testing - Laser Therapy

The material risks inherent in chiropractic adjustments:

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. The Doctor will make every reasonable effort during examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to the Doctor's attention it is your responsibility to inform the Doctor.

The probability of those risks occurring:

Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availaibilty and nature of other treatment options:

Other treatment options for your condition may include:

- Self Administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants, and pain killers.
-Hospitalization
-Surgery

If you choose the above noted "other treatment options" you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated:

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

(Please check the appropriate block and sign below)

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

Dated: _____

Patient's Name: _____

Patient's Signature: _____

Doctor's Signature: _____

HIPPA Notice of Privacy

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient at Deerwood Lake Chiropractic, we may disclose personal and health related information about you in the following ways:

- Your protected health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment, or treatment.
- Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of services provided to you.
- Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

You have a right to request restrictions on our use of your protected health information for treatment, payment and operations purposes. Such requests are not automatic and require the agreement of this office.

Your name, address, telephone number, e-mail address, and health records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

If you are not home to receive an appointment reminder or other related information, a message may be left on your answer machine or with a person in your household. You have a right to confidential communications and to request restrictions relative to such contacts. You also have the right to be contacted by alternative means or at alternative locations.

We are permitted and may be required to use or disclose your health information without your authorization in these following circumstances:

- If we provide health care services to you in an emergency
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

You have a right to receive an accounting of any such disclosure made by this office.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization. If you provide an authorization for release of information you have the right to revoke that authorization at a later date.

Information that we use or disclose based on this privacy notice may be subjected to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules. We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or, if you would

Like the information in a specific form please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Requests to inspect, copy, or amend your health-related information should be provided to us in writing. health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information. We are further required by law to abide by the terms of this notice while it is in effect.

We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any Change in our privacy notice will apply for all of your health information in our files.

This notice is effective as FIRST DATE OF TREATMENT. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

Dated: _____

Patient's Name: _____

Patient's Signature: _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND COMMUNICATION PREFERENCES AND AUTHORIZATION

Please read and initial:

___ I acknowledge that I was provided a copy of the Notice of Privacy Practices (HIPAA). I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices (HIPAA). I understand that this form will be placed in my patient chart and maintained for six (6) years unless I provide written notice to revoke this authorization.

__ I understand that the staff at Deerwood Lake Chiropractic may on occasion send me notifications or newsletters via mail or e-mail. I authorize this type of communication to the address and or e-mail address I have provided on my initial paper work.

__ I understand that Deerwood Lake Chiropractic utilizes phone calls, text messaging and e- mail messaging for appointment reminders and or missed appointments. I authorize the staff at Deerwood Lake Chiropractic to contact me with these reminders and leave a voicemail message if necessary.

_____
Patient Name Printed

_____
Patient Signature

_____
Parent/ Guardian Name & Relationship Printed (If under 18)

_____
Parent or Guardian Signature (If under 18)

_____
DATE

List below the names and relationship of people to whom you authorize the Practice to release PHI (protected health information).

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

X-RAY CONSENT FORM

During your examination, the doctor may feel that x-rays will be needed in order to provide your treatment. In order to perform x-rays on any patient our office requires that patients consent for such tests to be performed.

Please choose one of the following:

_____I understand that the doctor may need x-rays in order to administer my treatment and I give my permission to perform such tests.

_____I understand that it may be necessary for the doctor to take x-rays to administer my care. I choose not to have any x-rays at this time and release the doctor of all liabilities. I also understand that the doctor has the right to refuse treatment to me if I choose this option.

Consent To X-Ray A Minor:

I am the parent or legal guardian of_____, who is a minor,_____years of age. I hereby authorize the performance of diagnostic x-rays of the minor named above. Deerwood Lake Chiropractic has requested the x-rays for further diagnostic purposes. At this time, I know of no other condition which the taking of x-rays would further complicate.

Cardiovascular Health History

Do you wear a pacemaker? ☐ No ☐ Yes:

Do you have a history of heart disease? ☐ No ☐ Yes: If yes, please describe condition: _____

_____

Females: Regarding Possibility of Pregnancy

This is to certify that, to the best of my knowledge, I am **NOT** pregnant. The doctors and certified staff Deerwood Lake Chiropractic have permission to perform diagnostic x-rays. I am aware that taking x-rays, particularly those involving the pelvis, can be hazardous to an unborn child.

PLEASE CHECK MARK AN X	YES	NO	DON'T KNOW
I am pregnant			
I could be pregnant			
My menstrual period is late			
I have an IUD			
Birth Control Pills			
I have had a tubal ligation			
I have had a hysterectomy			
I have irregular menstrual periods			

How many weeks? _____

Signed:_____

Date: _____

AUTO ACCIDENT QUESTIONNAIRE

**** PLEASE FILL OUT FRONT & BACK ****

1. What was your position? ☐ the driver ☐ the front passenger ☐ the rear passenger ☐ a pedestrian ☐ other: _____

2. What type of vehicle were you in? ☐ compact car ☐ mid-size car ☐ full size car ☐ compact truck ☐ full size truck ☐ minivan ☐ full size van ☐ compact sports vehicle ☐ full size sport utility ☐ vehicle semi-truck

3. What speed were you traveling at the time of the accident? ☐ stopped at a stop light ☐ slowing down at an intersection ☐ at a complete stop ☐ moving slowly ☐ merging into traffic ☐ traveling at approximately _____ mph

4. Who hit who? ☐ was struck by another vehicle ☐ struck another vehicle ☐ struck a stationary object

5. What was your vehicles point of impact? ☐ on the front ☐ on the right front ☐ on the left front ☐ on the middle front ☐ on the rear ☐ on the right rear ☐ on the left rear ☐ on the middle rear ☐ on the right side ☐ on the front right side ☐ on the rear right side ☐ on the middle right side ☐ on the left side ☐ on the front left side ☐ on the rear left side ☐ on the middle left side ☐ other: _____

7. What speed was the other vehicle traveling at the time of the accident? ☐ stopped at a stop light ☐ slowing down at an intersection ☐ at a complete stop ☐ moving slowly ☐ merging into traffic ☐ traveling at approximately _____ mph

8. What was the other vehicles point of impact? ☐ on the front ☐ on the right front ☐ on the left front ☐ on the middle front ☐ on the rear ☐ on the right rear ☐ on the left rear ☐ on the middle rear ☐ on the right side ☐ on the front right side ☐ on the rear right side ☐ on the middle right side ☐ on the left side ☐ on the front left side ☐ on the rear left side ☐ on the middle left side ☐ other: _____

9. Were you wearing seat restraints? ☐ was wearing a full lap and shoulder restraint ☐ was wearing a lap restraint ☐ was wearing a shoulder restraint ☐ was not wearing any seat restraints

10. What position were your vehicle head rests in? ☐ head rest was adjusted in the lowest position restraints ☐ head rest was adjusted in the middle position ☐ head rest was adjusted in the highest position ☐ was not equipped with a head rest ☐ don't recall

11. Did your vehicle's air bag deploy? ☐ Air bags were deployed ☐ Air bags were not deployed

AUTO ACCIDENT QUESTIONNAIRE

**** PLEASE FILL OUT FRONT & BACK ****

12. Were you prepared for the impact? ☐ was completely surprised by the accident
☐ saw the collision coming ☐ saw the collision coming and braced appropriately

13. What position was your body in just prior to impact?
☐ a straight position ☐ a tilted forward position ☐ a position rotated to the left
☐ a position rotated to the right ☐ a position that cannot be remembered

14. What happened to your body at the moment of impact?
☐ body was tensed for impact ☐ body whipped violently forward and backward
☐ body violently torqued and twisted ☐ body was thrown over the seat
☐ body was thrown from the vehicle ☐ body was pinned in the vehicle
☐ body was thrown violently from side to side ☐ body was badly cut and bruised
☐ do not recall

15. What was your mental/emotional state immediately follow the accident?
☐ was not rendered unconscious by the impact of the accident
☐ was not rendered unconscious but was shaken and disoriented
☐ was not rendered unconscious but was shaken up
☐ was not rendered unconscious but was disoriented
☐ was rendered unconscious by the impact of the accident

16. Did you receive medical attention at the scene of the accident?
☐ did receive medical attention ☐ did not receive medical attention

17. Where did you go immediately following the accident?
☐ was taken to the hospital ☐ was taken home ☐ was taken to a personal physician
☐ was taken to this office ☐ resumed activities ☐ went home
☐ went home, and went to the doctor's office the next day ☐ was taken to work ☐ went to work

18. List each of your body parts that struck the following vehicle parts during the accident: (

Dashboard: ☐ which area:_____ ☐ body part did not strike
Windshield: ☐ which area:_____ ☐ body part did not strike
Steering Wheel: ☐ which area:_____ ☐ body part did not strike
Right Door: ☐ which area:_____ ☐ body part did not strike
Left Door: ☐ which area:_____ ☐ body part did not strike
Seat Frame: ☐ which area:_____ ☐ body part did not strike

19. Did your vehicle hit anything after the accident? ☐ hit a guardrail ☐ hit a tree
☐ rolled over ☐ was run off the road ☐ not applicable ☐ other: _____

20. During and after the crash what happened to your vehicle? (mark all that apply)
☐ kept going straight ☐ kept going straight hitting a car in front of me ☐ hit a stationary object
☐ was hit by another vehicle ☐ spun around ☐ spun around & hit a stationary object

AUTO ACCIDENT QUESTIONNAIRE

**** PLEASE FILL OUT FRONT & BACK ****

21. What was the estimated damage to the vehicle you were in?
$_____ amount ☐ I don't know the amount

22. What street or intersection were you on when the accident occurred?
_____

23. What direction were you traveling in? ☐ North West ☐ North ☐ North East ☐ West ☐ East ☐ South West ☐ South ☐ South East ☐ I do not recall

24. What city/state did the accident occur in?
If in Jacksonville, FL, please check this box ☐
If not, please indicate: City: _____ State: _____

25. Did you go to the hospital? ☐ Yes **If no, why and do not answer questions 25-33:**
_____

26. How did get to the hospital? ☐ an ambulance ☐ a helicopter ☐ a police car
☐ drove myself ☐ walking ☐ family member/friend drove me to the hospital
☐ other _____

27. What was the name of the hospital? _____

28. Were you hospitalized over night? ☐ Yes ☐ No

29. Mark an X on what you were prescribed at the hospital:
☐ pain medication ☐ muscle relaxers ☐ neck brace ☐ misc.: _____

30. Did you receive any stitches for any cuts at the hospital? ☐ Yes ☐ No

31. Were x rays taken at the hospital? If yes, which area was taken? ☐ skull ☐ neck
☐ mid back ☐ lower back ☐ pelvis ☐ hips ☐ leg ☐ knee ☐ foot ☐ shoulder ☐ arm ☐ no x-rays
☐ other: _____

32. Was an MRI performed? If yes, which area was taken? ☐ skull ☐ neck ☐ mid back
☐ lower back ☐ pelvis ☐ hips ☐ leg ☐ knee ☐ foot ☐ shoulder ☐ arm ☐ no MRI
☐ other: _____

33. Did you receive any special imaging? If yes, which area was taken? ☐ skull ☐ neck
☐ mid back ☐ lower back ☐ pelvis ☐ hips ☐ leg ☐ knee ☐ foot ☐ shoulder ☐ arm
☐ no special imaging ☐ other: _____

34. Did you open up a medical claim with your auto-insurance?

If so, what is your medical claim number? _____

Name of your auto insurance: _____

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.**

CHIROPRACTIC

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
	X	

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
Dr. Peter A. Fort, DC		

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.

Claim #_____

ASSIGNMENT OF BENEFITS

Financial Responsibility

I understand that insurance billing is a service provided as a courtesy and that I am at all times financially responsible to Deerwood Lake Chiropractic and/or its affiliated entities for any charges not covered by health care benefits. It is my responsibility to notify Deerwood Lake Chiropractic of any changes in my health care coverage. In some cases exact insurance benefits can not be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by Deerwood Lake Chiropractic and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form that I am accepting financial responsibility as explained above for all payment for medical services and/or supplies received.

Assignment of Benefits

I authorize direct remittance of payment of all insurance benefits, including Medicare, if I am a Medicare beneficiary, to Deerwood Lake Chiropractic for all covered medical services and supplies provided to me during all courses of treatment and care provided by Deerwood Lake Chiropractic and/or its affiliated entities or otherwise at its direction. I understand and agree this Assignment of Benefits will have continuing effect for so long as I am being treated or cared for by Deerwood Lake Chiropractic, and will constitute a continuing authorization, maintained on file with Deerwood Lake Chiropractic, which will authorize and allow for direct payment to Deerwood Lake Chiropractic of all applicable and eligible insurance benefits for all subsequent and continuing treatment, services, supplies and/or care provided to me by Deerwood Lake Chiropractic.

Authorization to Release Information

I authorize the release of any medical or any other information to Physicians Services medical billing company, my insurance carrier(s), or other entity necessary to determine insurance benefits or the benefits payable for related medical services and/or supplies provided to me by Deerwood Lake Chiropractic. A copy of this authorization will be sent to Physicians Services, my insurance carrier(s), or other medical entity, if requested. The original authorization will be kept on file by Deerwood Lake Chiropractic.

Name of Patient (Printed)	Date of Birth	Social Security Number
Signature of Patient	Date of Signature	Witness Signature

Patient Authorization & Medical Pay Limits Form- PIP

I hereby understand my medical condition caused by the accident and the durable medical equipment medically necessary to ensure my rehabilitation and prevent additional injuries or medical complications that could lead to possible surgical intervention.

I request the insurance carrier authorize this equipment or I may take the necessary legal action that ensures me the proper care that is medically necessary as determined by my physician.

I hereby authorize my medical care insurance company permission to provide Medical Pay Limits to Deerwood Lake Chiropractic.

I also authorize the payment for such services/devices to go directly to the practice.

Practice: Deerwood Lake Chiropractic

Address: 4540 Southside Blvd, Ste # 1101

Jacksonville, FL 32216

Patient Name: _____

Patient DOB: _____

Ins Carrier: _____

Claim #: _____ DOI: _____

Patient Signature: _____ Date: _____

DEERWOOD LAKE CHIROPRACTIC
Dr. Anthony Fort

Patient: _____ **DOB:** _____

I hereby request and authorize: Dr. Anthony Fort, D.C. of Deerwood Lake Chiropractic to:

_____ disclose information to: _____ receive information from:

Provider - _____
Address - _____
City/State/Zip - _____
Telephone _____
Fax _____

Information to be disclosed include(s) copies of:

____ Entire Record	____ X-Ray Reports
____ Progress Notes	____ MRI Report
____ Physical Exam Forms	____ Other; Specify: _____
____ Daily Chart Notes	____ All of the above

Purpose of Disclosure:

_____ To allow for appropriate treatment modalities, adjusting techniques, exercise regimen and spinal rehab protocols.

_____ Other (specify) _____

_____ Patient has an appointment with us on _____

This authorization will be effective for 6 months after the date signed, unless cancelled in writing. I understand that the cancellation will have no effect on information released prior to receiving the cancellation. A copy of this authorization is as valid as the original.

Signature of Patient or Responsible Party: X _____

Date: _____

4540 Southside Blvd. Suite 1101, Jacksonville, Fl 32216
Ph (904) 996-8660 Fax (904) 996-8650