# COASTAL CHIROPRACTIC

**Dr. Lee Smith, DC**

100 W. New Haven Ave. | Melbourne | Fl. 32901
Phone: 321-327-7014 | Fax: 321-821-1924
Email: reception@ccspine.com | website: www.ccspine.com

## PERSONAL INJURY QUESTIONNAIRE

**TO SAVE TIME AND ALLOW US TO BETTER SERVE YOU PLEASE COMPLETE ALL QUESTIONS**

### PATIENT/INSURED'S INFORMATION

| | | | | | |
|---|---|---|---|---|---|
| **Patient** Last Name | First Name | M.I. | Date of Birth | Social Security Number | ☐ M ☐ F |
| **Insured's** Last Name | First Name | M.I. | Date of Birth | Social Security Number | ☐ M ☐ F |

| | | | | |
|---|---|---|---|---|
| **Insured's** Address | City | State | Zip Code | Phone Number |

### INSURANCE COMPANY

| | | | | |
|---|---|---|---|---|
| **Primary Insurance Carrier** | Policy # | | Claim# | |
| Address | City | State | Zip Code | Ins. Co. Phone Number |
| **Secondary Insurance Carrier** | Policy # | | Claim# | |
| Address | City | State | Zip Code | Ins. Co. Phone Number |

### ATTORNEY INFORMATION

| | | | |
|---|---|---|---|
| **Attorney** Name | Phone Number | Fax Number | |
| Address | City | State | Zip Code |

### ACCIDENT INFORMATION

| | | | |
|---|---|---|---|
| What type of Injury?<br>☐ Auto Accident ☐ Work Comp. ☐ Other | Date of Injury: | Time of Injury:<br>☐ AM ☐ PM | Date of First Treatment: |

### HISTORY OF INJURY:

In your own words, please briefly describe your how the accident happened:

_____

_____

_____

_____

_____

_____

### PREVIOUS CONDITIONS AND TREATMENT:

In your own words, please list any previous accidents. injuries, or conditions which may have contributed to your present complaints: _____

_____

_____

_____

_____

**PLEASE TURN OVER**

**Coastal Chiropractic**
100 W. New Haven Ave. Melbourne, Fl. 32901
Office: 321.327.7014 ~ Fax: 321.821.1924

# CAD INJURY HISTORY FORM

**GENERAL INFORMATION:**
Patient Name: _____ Today's date: _____ Date of Injury: _____
Were you employed at time of the crash? ___ Y ___ N Are you currently employed? ___ Y ___ N
If no, is your unemployment status due to the crash? ___ Y ___ N
Type of work: ___ Office/Clerical ___ Light Labor ___ Moderate Labor ___ Heavy Labor

**INJURY HISTORY:**
Was the crash on the job? ___ Y ___ N
You were: ___ Driver ___ Front seat passenger ___ Rear seat passenger ___ Motorcycle operator ___
Motorcycle passenger ___ Other: _____
Vehicle driven by: _____
Your vehicle year/make/model: _____
Your estimated speed at the moment of the crash: ___ Stopped ___ Slowing ___ Accelerating
Other vehicle year/make/model: _____
Time of day: ___ Daylight ___ Dawn ___ Dusk ___ Dark
Road conditions: ___ Dry ___ Damp ___ Wet ___ Snow ___ Ice ___ Other: _____
Head restraints: ___ None ___ Integral type ___ Adjustable ___ Up ___ Down ___ Don't Know
If adjustable, was the position altered by the crash? ___ Y ___ N
Was the seat back adjustment altered by the crash? ___ Y ___ N
Was the seat broken? ___ Y ___ N Seat belt: ___ Wearing ___ Not wearing ___ Don't Know
Did the air bag deploy? ___ Y ___ N If yes, were you struck? ___ Y ___ N
Body position: ___ Good ___ Forward lean ___ Other: _____
Head position: ___ Forward ___ Left ___ Right ___ Up ___
Down Hand position: ___ One on the wheel ___ Two on the wheel ___ N/A
Brakes applied? ____ Y ____ N
Were you aware of impending crash? ___ Y ___ N

**DURING THE CRASH:**
Did you strike any parts of the vehicle? ___ Y ___ N
If yes, describe: _____
Did the vehicle strike any objects after impact? ___ Y ___ N
If yes, describe: _____
Wearing hat or glasses? ____ Y ____ N If yes, were they still on after the crash? ___ Y ___ N
Did you lose consciousness? ___ Y ___ N If yes, for how long? _____
Estimated property damage to your vehicle: $_____
Estimated damage to other vehicle(s): ___ None ___ Minimal ___ Moderate ___ Major
Were the police on-scene? ___ Y ___ N
If yes, was a report made? ___ Y ___ N

**AFTER THE CRASH:**
Symptoms: ___ Headache ___ Dizziness ___ Nausea ___ Confusion/disorientation ___ Neck pain ___
Parasthesia(s) If yes, where?_____ ___
Extremity pain? If yes, where? _____ Back pain? ___ Y ___ N
When did symptoms first appear? _____

**AFTER THE CRASH (CON'T)**

Immediately (describe which symptom & how many hours afterward) _____
Where did you go after the crash? ___ Home ___ Work ___ Hospital
Mode of transportation: _____

**CRASH DETAILS**

_____
_____
_____
_____
_____
_____

**CRASH DIAGRAM**

**EMERGENCY DEPARTMENT:**

Radiographs: ___ Y ___ N
Body parts imaged: _____
Results _____ Lab work ___ Y ___ N
Cervical collar ___ Y ___ N Ice ___ Y ___ N
Medications: _____
Other : _____
Follow up instructions: ___ Y ___ N If yes, explain _____
Have you had any prior treatment for the injuries sustained in this crash (ie. emergency room, family physician, physio) __ Y __ N

**PAST MEDICAL HISTORY:**

Surgeries (dates and residuals): _____

Fractures (dates and residuals): _____

Serious illness (dates and residuals): _____

Workers' comp. injuries (date, TX, awards, residuals): _____

Personal Injuries (date, TX, awards, residuals): _____

Sports or other injuries to head, neck, or back: _____

NAME: DATE: / / Account#:

Please check all symptoms you, **HAVE** or have **EVER HAD**, even if they do not seem related to your current problem

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Fatigue | | Irritability | | Joint Stiffness/Swelling | | Seizures/Tremors |
| | Chronic Fever | | Depression | | Spinal Curvature | | Dizziness |
| | Chills | | Memory Loss | | Back Pain | | Tremors |
| | Night Sweats | | Headache | | Constipation/Diarrhea | | Loss of Sensation |
| | Fainting | | Muscle Pain | | Digestive Issues | | Loss of Coordination |
| | Nervousness | | Muscle Weakness | | Stiff Neck | | Paralysis |
| | Concentration Loss | | Muscle Cramps | | Lumps / Masses | | Difficulty of Speech |

**Do you have a pacemaker?** ___YES ___NO

Are you Pregnant? ___YES ___NO

Do you think you may be pregnant? ___YES ___NO

List any surgeries, key slips, falls or accidents you've had from childhood to present:

1) Date

2)

3)

4)

5)

6)

| What medications are you currently taking? | What medications (if any) are you allergic to? |
|---|---|
| 1) | 1) |
| 2) | 2) |
| 3) | 3) |

| HAVE YOU EVER TAKEN: | Yes | No | Year |
|---|---|---|---|
| Insulin | | | |
| Cortisone | | | |
| Thyroid Medicine | | | |
| Male/Female Hormones | | | |
| Blood Pressure | | | |
| Tranquilizers/Sedatives | | | |
| Birth Control | | | |
| | | | |
| | | | |

**Hospitalizations:** _____

Height: ___ft. ___in. Weight: _____

Frequency of Exercise: ___Never ___Rarely ___Occasionally ___Moderately ___Regularly

Intensity of Exercise: ___Low Level ___Medium Level ___High Level ___Competition Level

Sufficient Rest: ___Never ___Rarely ___Occasionally ___Moderately

Hours of Sleep: ___6 ___8 ___10 ___More than 10

Well balanced diet: ___Never ___Rarely ___Occasionally ___Moderately

Do you smoke? ___No ___Occasionally ___1 to 2 ___2 to 3 ___4 to 5 ___More than 5 packs/day

Do you drink caffeinated beverages? ___No ___Occasionally ___1 to 2 ___2 to 3 ___4 to 5 ___More than 5 drinks/day

Do you drink alcoholic beverages? ___No ___Occasionally ___1 to 2 ___2 to 3 ___4 to 5 ___More than 5 drinks/day

Have you ever used street drugs? ___No ___Yes

Hobbies: _____

Patient history was obtained from: ___Patient ___Father ___Mother ___Son ___Daughter

Notes / Comments: _____

# Coastal Chiropractic's
# Consent for Purpose of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by **Coastal Chiropractic** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct health care operations of I understand that diagnosis or treatment of me by the doctors and practitioners of the **Coastal Chiropractic** may be conditioned upon my consent as evidenced by my signature on this document. I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. **Coastal Chiropractic** is not required to agree to the restrictions that I may request. However, if **Coastal Chiropractic** agrees to a restriction that I request, the restriction is binding on **Coastal Chiropractic** and its doctors and practitioners. I have the right to revoke this consent, in writing, at any time, except to the extent that the doctors and practitioners of the **Coastal Chiropractic** have taken action in reliance on this consent. My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me. I understand I have a right to review **Coastal Chiropractic** Notice of Privacy Practices prior to signing this document. The **Coastal Chiropractic** Notice of Privacy Practices is available at the front desk. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations of the **Coastal Chiropractic**. This Notice of Privacy Practices also describes my rights and the **Coastal Chiropractic's** duty with respect to my protected health information. **Coastal Chiropractic** reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing the **Coastal Chiropractic** website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____

Signature of Patient or Personal Representative

_____

Name of Patient or Personal Representative

_____

Date

_____

Description of Personal Representative's Authority

COASTAL CHIROPRACTIC

# Financial Agreement

Please remember that insurance is considered a method of reimbursing the patient for fees put to the doctor and is NOT A SUBSTITUTE FOR PAYMENT. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance.

IN ORDER TO CONTROL YOUR OUTSTANDING BALANCE, IT IS OUR POLICY TO COLLECT CO-PAYS, CO-INSURANCE AND DEDUCTIBLE AT TIME OF SERVICE.

If this account is assigned to an attorney/outside agency for collection and/or suit, Boca Chiropractic shall be entitled to reasonable attorney's fees and for cost of collection.

I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim.

PATIENT SIGNATURE _____ INSURED'S SIGNATURE _____

DATE _____

**LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS**

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to Coastal Chiropractic all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medic al expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement

Signature of Insured/Guardian _____ Date _____

100 W. New Haven Avenue, Melbourne, FL 32901 Phone: 321.327.7014

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 |
|---|---|---|
| Krista Peer | | |

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.

# IRREVOCABLE ASSIGNMENT OF BENEFITS/POLICY RIGHTS

**PATIENT:**_____

- **I, the undersigned patient hereby assign the rights and benefits of insurance** of the applicable personal injury protections, medical payments, and/or other insurance to Coastal Chiropractic d/b/a/ INN8 INC.

the provider of services and/or supplies rendered for treatment of the personal injuries that were sustained on the accident on _____ (DATE) and covered by Personal Injury Protection (P.I.P) Coverage of other insurance coverage in accordance with Florida Statute 627.736 (5). I, the undersigned patient agrees to pay any applicable deductible or co-payment not covered by P.I.P or other insurance coverage. I have read the information herein and is true and to the best of my knowledge.

**This assignment includes, but is not limited to all rights to collect benefits directly from the insurance company for services that I have received; all rights to proceed against the insurance company obligated to provide benefits in any action including legal suit, if for any reason the insurance company fails to make payments of benefits of which I am due.** Specifically, this assignment includes the right to collect payment for the reasonable costs connected with copying and mailing records to the insurer at the insurer's request and in accordance with Florida Statute 627.736 (6). This assignment also includes any right to recover attorney's fees and costs for such action brought by the provider at Patient's assignee. I agree that Dr. Lee Smith may select any attorney he/she/it wishes and understand and agree that the attorney selected by them may be different that the attorney handling my personal injury/bodily injury claim or case.

- As part of this assignment of rights and benefits, I hereby instruct the insurance carrier that in the event the subject medical benefits are disputed for any reason, including medical reasonableness and or necessity that the amount of the benefits claimed by Coastal Chiropractic d/b/a/ INN8 INC.

is to be set aside and not disbursed until the dispute is resolved.

As part of this assignment of rights and benefits, I further instruct the insurance carrier to notify the provider immediately of any dispute as to payment so that he/she/it may exercise their legal rights. I understand that any person who knowingly files anything containing any false, incomplete, or misleading information with the intent to injure, defraud, or deceive any insurance company is guilty of a felony of the third degree. I have read the information herein and it is true and correct to the best of my knowledge and belief.

Patient Signature _____

Patient Name (Please Print)----_____Date_____

- Provider:Coastal Chiropractic d/b/a/ INN8 INC.
- The undersigned of behalf of Coastal Chiropractic d/b/a/ INN8 INC.

hereby accepts assignment of the insurance rights and benefits for the service rendered to _____ (The Insured) and to be paid directly to Coastal Chiropractic d/b/a/ INN8 INC.
under _____ (The Insurer) Personal Injury Protection (P.I.P.) or other insurance coverage with in accordance with Florida Statute 627.736 (5).

Provider Representative's Signature_____Print Name_____

Date: _____

100 W. New Haven Avenue, Melbourne, FL 32901 Phone 321.327.7014

COASTAL CHIROPRACTIC

100 W. New Haven Avenue, Melbourne, FL 32901

Phone: 321.327.7014

# RELEASE OF RECORDS

_____;

Facility

I authorize the release of any medical records or information necessary to fully inform Dr. Lee Smith of my medical condition. Please include all x-rays and reports.

_____ _____

Patient Name (Please Print) Patient Date of Birth

_____ _____

Patient/Guardian Signature Date

PLEASE RELEASE MY RECORDS TO:

Coastal Chiropractic

100 W. New Haven Avenue

Melbourne, FL 32901

Phone: 321.327.7014

I _____ authorize my records to be released to either myself or another facility, Named

_____.

Patient Signature:_____