Manatee Wellness & Chiropractic Centers

8788 East S.R. 70, Suite 101, Bradenton, FL 34202-3705
Phone (941) 756-4362   Fax (941) 755- 4652

Today's Date:__________

PATIENT INFORMATION:

Patient's Full Name:______________________ Birthdate:_________ Age:_____ Sex: M/F
Address:______________________ City:___________ State:_____ Zip Code:___________
Home Phone:________________ Cell Phone:________________ Social Security #:______________
Email:______________________ Height:___________ Weight:______________
Emergency Contact:______________ Relationship:________ Emergency Contact #:______________

EMPLOYMENT INFORMATION:

Employment Status (circle): Retired Employed PT Student FT Student Other______________
Employer:______________________ Occupation:______________________
Employer Address:______________________ City:__________ State:____ Zip Code:______
Work Phone:______________________ Hours Worked Per Week:______________________

SPOUSE INFORMATION:

Name:______________________ Birthdate:_____________ Age:___________
Employer:______________________ Occupation:______________________
Work Phone:______________________ Cell Phone: ______________________

SOCIAL HISTORY:

Do You Smoke? Y/N # of Cigarettes/Day?_____ Do You Drink Alcohol? Y/N # of Drinks/Day?_______
Do You Exercise: Y/N How Often?______

HEALTH HISTORY:

Has any member of your immediate family had any of the following (X)?

Disease	Father	Mother	Brother	Sister	Grandmother	Grandfather
Alcoholism						
Diabetes						
Cancer (Name Type)						
Heart Disease						
High Blood Pressure						
Stroke						
Arthritis						
Depression						
Thyroid Disease						
Osteoporosis						

Do you have a history of the following (circle):

Arthritis	Y/N	Kidney Stones	Y/N	Frequent Urination	Y/N
High Blood Pressure	Y/N	Nausea	Y/N	Blurred Vision	Y/N
Poor Circulation	Y/N	Hernia	Y/N	Heart Burn	Y/N
Loss of Bladder Control	Y/N	Weight Loss/Gain	Y/N	Dizziness	Y/N
Shortness of Breath	Y/N	Osteoporosis	Y/N	Hearing Loss	Y/N
Difficulty Walking	Y/N	Headaches	Y/N	Ringing in Ears	Y/N
Insomnia	Y/N	Fatigue	Y/N	Diarrhea	Y/N

List any hospitalizations and dates:______________________________________
List any injuries/accidents and dates:______________________________________
List any major surgeries and dates:______________________________________
Taking medications? Y/N If so, please list:______________________________________
Taking over the counter medication? Y/N If so, please list:______________________________

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AUTOMOBILE ACCIDENT QUESTIONNAIRE

Patient Name: ______________________________ Date: ______________

1. Date of accident: ______________________________
2. Location of accident (City/State): ______________________________
3. Briefly describe how the accident occurred: ______________________________

____

____

4. Were you the driver? No / Yes If a passenger, were you in the front or back seat? ______________
5. Make and model of the car you were driving? ______________________________
6. Make and model of the other car involved in the accident? ______________________________
7. Were you wearing your seatbelt? No / Yes
8. Did the airbags deploy? No / Yes
9. Did you know the crash was about to happen? No / Yes Did you brace yourself for the impact? No / Yes
10. Did you get cut or scraped anywhere? No / Yes Describe ______________________________
11. Did you get bruised anywhere? No / Yes Describe ______________________________
12. Did you have any immediate pain? No / Yes Describe ______________________________

____

13. Did you hit your head? No / Yes Did you lose consciousness? No / Yes
14. Did the police investigate the accident? No / Yes Did an ambulance arrive? No / Yes
15. Did you go to the hospital by ambulance? No / Yes What hospital? ______________
16. Were you transported on a backboard? No / Yes Did you wear a neck collar? No / Yes
17. At the hospital: Were you examined? No / Yes
    Were x-rays taken? No / Yes
    Was a CT scan performed? No / Yes
    Was any laboratory work performed? No / Yes
    Were you given prescriptions? No / Yes What kind? ______________
19. Were you admitted to the hospital? No / Yes Or were you released to see your own doctor? No / Yes
21. Have you been examined or treated by any other physician since the accident? No / Yes
22. What treatments have you received since the accident? ______________________________

Patient Health Questionnaire - PHQ

Patient Name ______________________ Date ______________

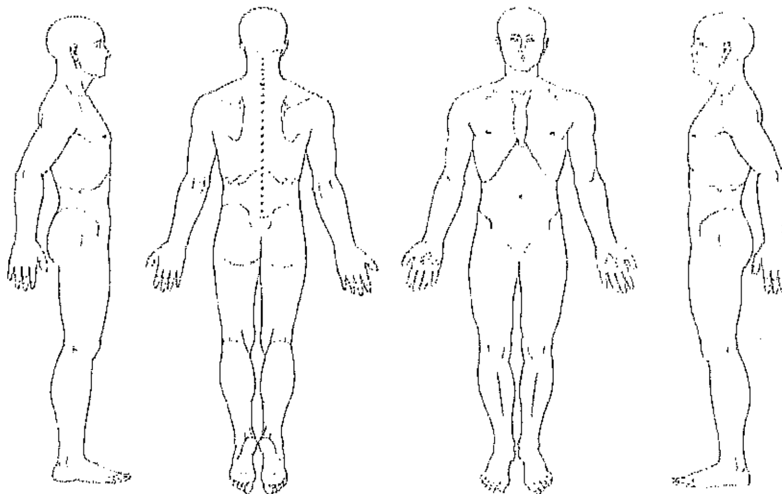
1. Describe your symptoms ______________________

   a. When did your symptoms start? ______________________

   b. How did your symptoms begin? ______________________

2. How often do you experience your symptoms?
   ① Constantly (76-100% of the day)
   ② Frequently (51-75% of the day)
   ③ Occasionally (26-50% of the day)
   ④ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

① Sharp	④ Shooting
② Dull ache	⑤ Burning
③ Numb	⑥ Tingling

4. How are your symptoms changing?
   ① Getting Better
   ② Not Changing
   ③ Getting Worse

5. During the past 4 weeks:

   a. Indicate the average intensity of your symptoms — None ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Unbearable

   b. How much has pain interfered with your normal work (including both work outside the home, and housework)

   ① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

6. During the past 4 weeks how much of the time has your condition interfered with your social activities? (like visiting with friends, relatives, etc)

   ① All of the time ② Most of the time ③ Some of the time ④ A little of the time ⑤ None of the time

7. In general would you say your overall health right now is...

   ① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

8. Who have you seen for your symptoms?

   ① No One ② Other Chiropractor ③ Medical Doctor ④ Physical Therapist ⑤ Other

   a. What treatment did you receive and when? ______________________

   b. What tests have you had for your symptoms and when were they performed?

   ① Xrays date: ________ ③ CT Scan date: ________
   ② MRI date: ________ ④ Other date: ________

9. Have you had similar symptoms in the past? ① Yes ② No

   a. If you have received treatment in the past for the same or similar symptoms, who did you see?

   ① This Office ② Other Chiropractor ③ Medical Doctor ④ Physical Therapist ⑤ Other

10. What is your occupation?

    ① Professional/Executive ② White Collar/Secretarial ③ Tradesperson ④ Laborer ⑤ Homemaker ⑥ FT Student ⑦ Retired ⑧ Other

    ____

    a. If you are not retired, a homemaker, or a student, what is your current work status?

    ① Full-time ② Part-time ③ Self-employed ④ Unemployed ⑤ Off work ⑥ Other

Patient Signature ______________________ Date ______________

Neck Index

Patient's Name:______________________ Date:__________
Patient's Signature:______________________

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all

Personal Care

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my care as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Headaches

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time

Neck Index Score ______

Back Index

Patient's Name:______________________________ Date:______________
Patient's Signature:______________________________

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes
⑤ I avoid sitting because it increases pain immediately.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Back Index Score ☐

Duties Performed Under Duress at Work and Home

Patient ______________________ Date ___________ Date of Injury ___________

☐ Initial ☐ Update

Please check all that apply to your WORK *because of the accident.*

- ☐ I go to work but work in pain
- ☐ I limit my work activities
- ☐ Bending at work hurts
- ☐ Stooping at work hurts
- ☐ Sitting at work hurts
- ☐ Using the Computer at work hurts
- ☐ Pushing at work hurts
- ☐ Pulling at work hurts
- ☐ Kneeling at work hurts
- ☐ I have lost status in my company
- ☐ I have lost job security
- ☐ I didn't get a promotion
- ☐ I don't enjoy work as much as before
- ☐ I doze off at work
- ☐ I take unpaid time off work to go to Dr.
- ☐ I daydream at work more than before
- ☐ I feel tired at work
- ☐ ______________________
- ☐ ______________________
- ☐ I work in pain because I have bills to pay
- ☐ I can't take time off because I would lose my job
- ☐ I keep working so I don't lose status at company
- ☐ My business would fail if I took time off
- ☐ I believe in working even when I'm in pain
- ☐ I feel obligated to work even though I'm in pain
- ☐ My business would lose money if I took time off
- ☐ My work is not as good as it was before accident
- ☐ My boss reprimanded me for poor performance
- ☐ I got a different job within the same company
- ☐ I got a different job in another company
- ☐ I make less money than before the accident
- ☐ I cannot do the same work/job as before accident
- ☐ I can't concentrate as well at work
- ☐ I take paid time off to go to Dr.
- ☐ I make mistakes at work I didn't used to
- ☐ I hide my poor work performance from my boss
- ☐ ______________________
- ☐ ______________________

Please check all that apply to your HOME/DOMESTIC duties *because of the accident.*

- ☐ My house is not as clean now
- ☐ My yard is not as neat now
- ☐ My garden is not as productive now
- ☐ I do yard work, but do it in pain
- ☐ I cannot do my normal yard work
- ☐ I do house work, but do it in pain
- ☐ I cannot do my normal house work
- ☐ Doing laundry hurts me
- ☐ I cannot do laundry now
- ☐ Washing dishes hurts me
- ☐ I cannot wash dishes now
- ☐ Vacuuming hurts me
- ☐ I cannot vacuum now
- ☐ Cooking hurts me
- ☐ I cannot cook now
- ☐ Washing the car hurts me
- ☐ I cannot wash my car
- ☐ ______________________
- ☐ ______________________
- ☐ I cannot take time off because I care for children
- ☐ I have _____ children ages ______________
- ☐ I had to hire a paid housekeeper
- ☐ I asked someone for unpaid housekeeping help
- ☐ I had to hire a paid gardener
- ☐ I asked someone for unpaid yard work help
- ☐ Mowing the lawn hurts me
- ☐ I cannot mow the lawn
- ☐ Taking out the trash hurts me
- ☐ I cannot take out the trash
- ☐ I do not enjoy my gardening/yardwork like I used to
- ☐ I do not enjoy my housework like I used to
- ☐ Gardening hurts me
- ☐ I cannot do my gardening at all since the accident
- ☐ Others living with me do my share of the work now
- ☐ Others living with me do my share of the yard work
- ☐ Others living with me do my share of the gardening
- ☐ ______________________
- ☐ ______________________

______________________ ______________________
Signature Date

Loss of Enjoyment of Sports, Hobbies, Travel, Daily Activities, & School (p. 1 of 2)

Patient ______________________ Date __________ Date of Injury __________

☐ Initial ☐ Update

Please check all that apply to your EXERCISE & SPORTS Activity *because of the accident.*

- ☐ My exercise was affected by this crash
- ☐ I go to the gym & work out in pain
- ☐ I no longer go to the gym to work out
- ☐ I run but in pain
- ☐ I no longer run
- ☐ I take walks & have pain while walkiing
- ☐ I no longer take walks
- ☐ I used to make income at sports
- ☐ I have lost sports income since crash
- ☐ I am an amateur athlete
- ☐ I am a professional athlete
- ☐ ______________________
- ☐ ______________________
- ☐ I have gained _____ pounds since the accident
- ☐ I had to quit my ________ team after the accident
- ☐ I had to quit my ________ team after the accident
- ☐ I had to quit my ________ team after the accident
- ☐ I had to quit my ________ team after the accident
- ☐ I don't enjoy the sport of _________ anymore
- ☐ I didn't enjoy the sport of ________ for ____ weeks
- ☐ I don't enjoy the sport of _________ anymore
- ☐ I didn't enjoy the sport of ________ for ____ weeks
- ☐ I don't enjoy the sport of _________ anymore
- ☐ I didn't enjoy the sport of ________ for ____ weeks
- ☐ I don't enjoy the sport of _________ anymore
- ☐ I didn't enjoy the sport of ________ for ____ weeks

Please check all that apply to your HOBBY Activities *because of the accident.*

- ☐ My hobbies were affected by accident
- ☐ Hobby #1 ________________
- ☐ I can't do hobby #1 anymore
- ☐ I do hobby #1 but in pain
- ☐ I have lost money from not doing #1
- ☐ I didn't do hobby #1 for _____ weeks
- ☐ Hobby #2 ________________
- ☐ I can't do hobby #2 anymore
- ☐ I do hobby #2 but in pain
- ☐ I have lost money from not doing #2
- ☐ I didn't do hobby #2 for _____ weeks
- ☐ Hobby #3 ________________
- ☐ I can't do hobby #3 anymore
- ☐ I do hobby #3 but in pain
- ☐ I have lost money from not doing #3
- ☐ I didn't do hobby #3 for _____ weeks
- ☐ Hobby #4 ________________
- ☐ I can't do hobby #4 anymore
- ☐ I do hobby #4 but in pain
- ☐ I have lost money from not doing #4
- ☐ I didn't do hobby #4 for _____ weeks
- ☐ ______________________

Please check all that apply to your TRAVEL Activities *because of the accident.*

- ☐ Business travel was affected by crash
- ☐ Pleasure travel was affected by crash
- ☐ I hurt driving in my own car
- ☐ I am in too much pain to drive
- ☐ I hurt when a passenger in a car
- ☐ I am in too much pain to sit in a car
- ☐ I have anxiety when I'm in a car
- ☐ I hurt when I'm on an airplane
- ☐ I am in too much pain to travel by plane
- ☐ Travel Plan #1 ________________
- ☐ I did not go on travel plan #1
- ☐ I went, but did not enjoy #1 as much
- ☐ I went and the accident had no effect on #1
- ☐ Travel Plan #2 ________________
- ☐ I did not go on travel plan #2
- ☐ I went, but did not enjoy #2 as much
- ☐ I went and the accident had no effect on #2
- ☐ I missed time with my family/friends b/c can't travel

Loss of Enjoyment of Sports, Hobbies, Travel, Daily Living, & School (p. 2 of 2)

Patient ______________________ Date ____________ Date of Injury ___________

☐ Initial ☐ Update

Please check all the DAILY LIVING Activities that cause you pain *because of the accident.*

- ☐ Dressing
- ☐ Putting on pants
- ☐ Putting on shoes
- ☐ Tying my shoes
- ☐ Putting on shirt
- ☐ Drying my hair
- ☐ Combing my hair
- ☐ Washing my hair
- ☐ Taking a shower
- ☐ Taking a bath
- ☐ Leaning forward
- ☐ Laying in bed
- ☐ Sitting in my favorite chair
- ☐ Sleeping
- ☐ Going out with my friends
- ☐ Sitting in a restaurant
- ☐ Shopping
- ☐ Driving to/from work
- ☐ Sitting in Church
- ☐ Playing with my children
- ☐ Caring for my children
- ☐ Bending at the waist
- ☐ Sitting in a movie theater
- ☐ Exercise
- ☐ Eating
- ☐ Stooping
- ☐ Squatting down
- ☐ Kneeling
- ☐ Brushing my teeth
- ☐ Riding in a car
- ☐ Opening a jar
- ☐ Lifting a pan when cooking
- ☐ Closing the trunk on my car
- ☐ Opening the garage door
- ☐ Using my home computer
- ☐ Climbing stairs
- ☐ Going down stairs
- ☐ Sexual activity
- ☐ Turning my head to left or right
- ☐ Holding my head up all day
- ☐ Watching TV
- ☐ I have pain sitting & doing nothing
- ☐ Talking on the phone
- ☐ Reading
- ☐ Writing
- ☐ Opening doors
- ☐ Drying with a towel after a bath or shower
- ☐ Life has become a chore just to do normal things
- ☐ It is depressing to live like this
- ☐ ______________________________
- ☐ ______________________________
- ☐ ______________________________
- ☐ ______________________________
- ☐ ______________________________
- ☐ ______________________________
- ☐ ______________________________
- ☐ ______________________________
- ☐ ______________________________

Please check all that apply to your SCHOOL & EDUCATION Activities *because of the accident.*

- ☐ School was affected by the accident
- ☐ I am a student at ______________
- ☐ I am in the __________ year/grade
- ☐ I was ☐ full time ☐ part time
- ☐ I am now ☐ full time ☐ part time
- ☐ I had to take fewer classes b/c of crash
- ☐ I missed _____ days of school
- ☐ I had to drop out of school b/c of crash
- ☐ My grades are lower since the crash
- ☐ I have pain carrying my school books
- ☐ I hurt sitting in class more than ______ minutes
- ☐ My neck hurts when I look down to read
- ☐ I don't learn as quickly as before the crash
- ☐ I don't learn things as well as before the crash
- ☐ I have difficulty concentrating in class
- ☐ It takes much longer to study/do my homework
- ☐ ______________________________
- ☐ ______________________________

______________________________ ______________________
Signature of Patient Date

Manatee Wellness & Chiropractic Centers
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Phone (941) 756-4362 Fax (941) 755- 4652

CONSENT TO TREAT

Having been accepted as a patient at Manatee Wellness & Chiropractic Centers, (hereafter also called the office), I understand and agree to the following conditions of acceptance:

CONSENT TO TREATMENT: I hereby request and consent to the performance of procedures, which may include, but is not limited to, spinal and extremity manipulation, massage, electrical muscular stimulation, ultrasound, and/or therapeutic modalities by either Dr. Amanda Mitchell D.C., Dr. Justin Mitchell D.C., and/or other licensed doctors or therapists who, now or in the future, treat me while employed by or associated with Manatee Wellness & Chiropractic Centers. I have had an opportunity to discuss with the doctor and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and/or other procedures. I understand and am informed that in the practice of chiropractic there are some risks to treatments including, but not limited to, fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests. I have read or have had read to me, the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

NOTIFICATION OF CHANGES: I will immediately notify the office of changes in my health status, home and work telephone numbers, mailing address, insurance benefits, attorney representing me in a personal injury law suit, and any information I have given on the patient intake forms.

RELEASE OF INFORMATION: To the extent necessary to determine liability for payment and obtain reimbursement, I authorize the office to furnish, upon written request authorized by me, any information in my medical record including photographs or computer images to any and all persons or organization which are or may be liable for all or any portion of my medical charges at the office. I authorize the office to release any information pertinent to my case to any insurance company or their representative involved in this case.

FILING INSURANCE CLAIMS: As a courtesy and at my request for the office to accept delayed payment for my care, the office will submit insurance claim forms for payment of my medical benefits. I authorize the office to submit claims for each service rendered and charge usual, reasonable and customary charge in this area for each service.

ATTORNEY LIEN: In the event I receive medical payment benefits, no-fault benefits, health and accident benefits, workers compensation benefits, or other reimbursement from any settlement, judgment or verdict on my behalf, I hereby authorize and direct my attorney to first pay the office the amount due for services rendered before any other disbursements are made from any funds received by the attorney's office on my behalf. This attorney lien is binding on any and all attorneys involved in my case prior to and subsequent to the date of this agreement with the office. I may only revoke this lien by a certified letter received at the office.

GUARANTEE OF PAYMENT: I understand and agree I am personally responsible for all services received at the office, and promise to pay regardless of my health insurance benefits and/or possible future payment from any judgment or verdict on my behalf. I understand if my account at this office is past 60 days overdue, it may be subject to a 1.5% per month (18% per year) finance charge. If the defaulted amount is referred to a collection agency and/or for legal action I agree to pay for reasonable court costs and other costs of collection.

ASSIGNMENT OF BENEFITS

For good and valuable consideration, including the agreement of Manatee Wellness & Chiropractic Centers to accept this assignment in lieu of demanding full payment for services from the undersigned on the date each service is rendered, the undersigned patient executes this document hereby assigning to Manatee Wellness & Chiropractic Centers the right to receive insurance benefits directly from any insurance company that may be obligated to provide insurance benefits, to me or on my behalf, for services rendered by Manatee Wellness & Chiropractic Centers.

Any insurance company that may be obligated to pay any insurance benefits to me, or on my behalf, for the aforesaid accident for services provided by Manatee Wellness & Chiropractic Centers, is hereby directed to issue payment for those benefits directly to and payable to Manatee Wellness & Chiropractic Centers.

I also authorize and assign to Manatee Wellness & Chiropractic Centers the right to file suit and pursue all legal remedies to obtain payment for services provided to me by Manatee Wellness & Chiropractic Centers. This authorization to file suit is an assignment of my cause of action to obtain payment for services provided to me by Manatee Wellness & Chiropractic Centers and includes the assignment to pursue declaratory relief or any other legal remedies.

Manatee Wellness & Chiropractic Centers accepts the aforesaid assignment and hereby notifies any insurer issuing payment that Manatee Wellness & Chiropractic Centers objects to any "repricing" or reduction of billed amounts unilaterally made by any insurer. Any such reduced payments issued by any insurer are accepted under protest and without waiving any right of the provider to pursue all legal remedies against the insurer.

AUTHORIZATION FOR DISCLOSURE OF INSURANCE DECLARATIONS PAGE: I, the patient and insured, further authorize and direct any insurance company that may be obligated to pay any insurance benefits to me, or on my behalf, to provide to Manatee Wellness & Chiropractic Centers a copy of any declarations page of any insurance policy that may provide any insurance benefits to me for the aforesaid accident.

AUTHORIZATION FOR DISCLOSURE OF INSURANCE PAYMENT RECORD: I further authorize and direct any insurance company that may be obligated to pay any insurance benefits to me, or on my behalf, to provide to Manatee Wellness & Chiropractic Centers a copy of any ledger or payment record of payments made under any insurance coverage available to me, without redacting the names of any other medical provider or entity to whom insurance benefits have been paid and without redacting the amount of any insurance benefits that have been paid.

DIRECTION NOT TO EXHAUST BENEFITS BY PAYMENT OF OTHER CLAIMS: I further authorize and direct any insurance company that may be obligated to pay any insurance benefits to me, or on my behalf,

to not exhaust insurance benefits or coverage until all claims submitted by Manatee Wellness & Chiropractic Centers have been paid in full, or at 80% if the insurance policy is limited to pay 80% coverage of medical claims. If any insurance company obligated to pay any insurance benefits to me, or on my behalf, has denied payment of a claim submitted by Manatee Wellness & Chiropractic Centers, or made payment to Manatee Wellness & Chiropractic Centers at an amount lesser than the amount billed, or lesser than 80% of the amount billed if my coverage is limited to 80% for medical claims, I direct the aforesaid insurance company to hold in escrow the amount in dispute, and if other claims would exhaust benefits I direct the aforesaid insurance company to hold in escrow the disputed amount and to not exhaust benefits or coverage by payment of the amount I have hereby requested be held in escrow. I further authorize and direct the aforesaid insurance company to notify Manatee Wellness & Chiropractic Centers that benefits have been exhausted except for the amount held in escrow, to enable Manatee Wellness & Chiropractic Centers to attempt to resolve the disputed claim in a manner acceptable to Manatee Wellness & Chiropractic Centers.

DIRECTION TO INSURER TO MAINTAIN CONFIDENTIALITY: I further direct any insurance company that may be obligated to pay any insurance benefits to me, or on my behalf, to maintain the privacy and confidentiality of my medical records. I do not authorize any insurer to provide my medical records to anyone without first obtaining a written authorization from me to provide the medical records to any other entity.

AUTHORIZATION FOR RELEASE OF RECORDS TO PROVIDER: I hereby authorize any insurance company that may be obligated to pay any insurance benefits to me, or on my behalf, to release a copy of my complete medical records in possession of such insurer to Manatee Wellness & Chiropractic Centers upon the request of Manatee Wellness & Chiropractic Centers. This authorization includes the authorization to release to Manatee Wellness & Chiropractic Centers a copy of any medical examination or evaluation of me requested by any insurance company.

DIRECTION TO INSURER TO PROVIDE TO PROVIDER ADVANCE NOTICE OF IME OR EUO: I further authorize and direct any insurance company that may be obligated to pay any insurance benefits to me, or on my behalf, to provide at least 15 days advance notice to Manatee Wellness & Chiropractic Centers of any physical examination or examination under oath of myself that any insurance company may schedule.

Please read this document completely before signing. If you do not completely understand this document or have any questions about this document, please ask us to explain it to you. If there is any portion of this document that you do not wish to authorize, we will remove that portion from this document. Your signature below is your agreement you fully understand this document and you fully agree to the terms of this document.

A photocopy of this agreement shall be considered as effective and valid as the original.

____________________________ ____________________

Printed patient name Date

____________________________ ____________________

Patient signature (or guardian's signature) Date

Manatee Wellness & Chiropractic Centers

8788 East S.R. 70, Suite 101, Bradenton, FL 34202-3705
Phone (941) 756-4362 Fax (941) 755- 4652

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name:
Social Security Number:
Birthdate:

I hereby authorize the Person/Organization providing the information to release medical information about me to Manatee Wellness & Chiropractic Centers.

Dates Of Service Needed: From:_____________________ To: _____________________

Person/Organization Providing The Information	**Person/Organization Receiving The Information**
Name:	**Name:** Manatee Wellness & Chiropractic Centers
Address:	**Address:** 8788 East State Road 70, Suite 101 Bradenton, FL 34202-3705
Phone:	**Phone:** 941-756-4362
Fax:	**Fax:** 941-755-4652

Specific Description of Information Needed:

___X-Ray Reports ___MRI Reports ___CT Reports
___EMG Reports ___Progress Notes ___All Records

- I am aware that such records may contain information related to mental health, substance abuse (both alcohol and drug), and sexually transmissible diseases (including test results related to HIV/AIDS), and I specifically authorize the release of such information pursuant to this authorization.
- I understand that I may revoke the authorization at any time in writing. I further understand that any such revocation will not apply to any information already released under this Authorization. I understand that I am under no obligation to sign this Authorization, and that my ability to obtain treatment from Manatee Wellness & Chiropractic Centers will not depend in any way on whether I sign this authorization.
- I understand that I have a right to request a copy of this Authorization.

By signing below, I authorize the release of my medical information as described above.

Patient Signature:_______________________________________ Date:_______________

Representative Signature (if minor):_________________________ Date:_______________

Relationship to Patient:____

Manatee Wellness & Chiropractic Centers
8788 East State Road 70, Suite 101, Bradenton, FL 34202
Phone (941) 756-4362 Fax (941) 755-4652

Date: ____________________

To My Attorney: ________________________________

____

____

Re: Letter of Protection

Dear ________________________;

Please provide at your earliest convenience a Letter of Protection to Manatee Wellness & Chiropractic Centers confirming that the fees / services will be protected at the time of settlement / adjudication of my case.

Thank you for your assistance in this matter.

Sincerely,

____
Patient Signature

____
Patient Name