Congress Chiropractic

7534 Congress St. NPR FL, 34653

E-mail: _____ **Date:** _____

Name: _____ **Date of Birth:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Cell Phone: _____ **Work:** _____

Social Security # _____ **Male** _____ or **Female** _____

Marital Status: _____**Married** _____ **Single** _____ **Divorced** ____**Widow** _____**Other** **Age:** _____

Name of Spouse/Nearest Relative: _____ **Phone:** _____

Referred to this office: Friend/Family Member: _____ **Name?** _____

Your Occupation: _____ **Employer:** _____

Insurance Company: _____ **Your SS #:** _____

Is your visit because of an: Auto Accident _____ **or Worker's Comp:** _____ **When:** _____

Are you covered by more then one insurance company? Y or N Company Name: _____

Medical History

(Circle letter if yes)

Arthritis	Y	Kidney Disorder	Y
Asthma	Y	Bowl Control Loss	y
Back Pain	Y	Multiple Sclerosis	Y
Chest pain	Y	Numbness	y
Concussion	Y	Poor Circulation	Y
Diabetes	Y	Serious Injury	y
Epilepsy	Y	Sinus Trouble	Y
High Blood Pressure	Y		

S (Self) M (Mother) F (Father)

HIV/ARC	S	M	F	AIDS	S	M	F
Heart Trouble	S	M	F				

Have you been treated by a physician for any condition in the last year? Y or N

Describe Condition _____ Date of Last Physical Exam _____

Surgical History:

1. _____ **Date:** _____
2. _____ **Date:** _____
3. _____ **Date:** _____
4. _____ **Date:** _____

Have you had a metal implant? Y or N _____ **Have you ever had gunshot? Y or N**

Accident History:

1. _____ **Date** _____ **Auto** __ **Job** ___ **Other** ___
2. _____ **Date** _____ **Auto** __ **Job** ___ **Other** ___
3. _____ **Date** _____ **Auto** __ **Job** ___ **Other** ___

NAME: _____ DATE: _____

E-MAIL ADDRESS: _____

CONGRESS CHIROPRACTIC CLINIC
ADDITIONAL COMPREHENSIVE HISTORY QUESTIONNAIRE

Chief Complaint: (what brings you into the office today?)...List all areas of complaint.

_____

_____

Onset: (when did the problem(s) begin; how long has it bothered you?

_____

_____

Palliative: (what makes it feel better?...rest, ice, medication(aspirin, tylenol, prescription, etc.)

_____

_____

Provocative: (what makes it worse?...bending, walking, standing, lifting, working, etc.)

_____

_____

Quality of symptoms: (how would you describe the symptoms?...sharp, stabbing, dull, throbbing, numbness or tingling, etc.)

_____

_____

Radiation of symptoms: (does your pain remain localized in one area or does it refer to another area, and if so; where does it go?)

_____

_____

Severity: (how would you rate the severity of pain?)
(please circle one) 1, 2, 3, 4, 5, 6, 7, 8, 9, 10...(10 being the worst)

Timing: (is there a time of day that your condition is worse (please circle one) Morning, Afternoon, Evening and does your condition affect your sleep? Yes / No
if yes, please explain

_____

_____

Assignment of Benefits

DIRECTION TO PAY; AND ASSIGNMENT OF RIGHTS & BENEFITS WITHIN THE MEANING OF §627.736, FLORIDA STATUTES; PROVIDER'S LIEN; AUTHORIZATION TO SCHEDULE PATIENT INTERVIEWS; PATIENT'S LETTER OF PROTECTION; SPECIAL POWER OF ATTORNEY

This agreement allows me, _____ (hereinafter "Patient"), to be treated by Dr. KEVIN P. CONNER, P.A. (hereinafter "Provider"), without paying for my care and treatment in advance. I understand and acknowledge Provider's waiver of its right to receive immediate payment is given in exchange for good and valuable consideration, including, but not limited to a) my assignment of benefits of any available insurance benefits to Provider; b) a grant to Provider of a lien against any eventual proceeds of my claim for damages for the injuries which Provider is treating me. This mutual consideration is considered good and sufficient by the parties.

By my signature below, for good and valuable consideration (including but not limited to the extension of credit to me), I hereby assign, transfer and convey to Provider all of my rights, title and interest in and to medical expense reimbursement in whatever form, including but not limited to any automobile liability medical expense payments or other health benefits indemnification and/or agreement otherwise payable to me. **This is a direct assignment of my rights and benefits due to me under any policy of insurance which would otherwise pay benefits directly to me**. This payment shall not exceed my indebtedness to Provider and I acknowledge that I will timely pay any indebtedness owed by me to Provider that is not otherwise satisfied by the above-mentioned assigned proceeds.

I further authorize Provider, their agents, counsel, or assigns, to negotiate, collect and settle any claim with any insurance carrier or other third-party payor with regard to these services, which authorization shall include authority to (1) request and receive from any insurer or any other party any and all documentation and records that I am empowered to request regarding this claim, including without limitation any Independent Medical Examination Reports, Records Review Reports, Explanations of Benefits, and Benefit Payment Sheets or Logs (P.I.P. Payout Sheets), without regard as to whether such documentation has already been provided to me, (2) endorse in my name any check issued for payment where benefits were assigned; and (3) file suit to collect payment of insurance benefits. The insurer shall further be directed to furnish the provider with an itemized specification of unpaid charges of each item the insurer reduces or denies (including bills applied to deductible or received after policy exhaustion) in accordance with F.S. § 627.736(4)(b). This request includes a request for the name and address of the insurer's designated recipient for demand letters and disputes of denials pursuant to F.S. § 627.736(11).

I hereby authorize Provider, their agents, counsel, or assigns, to contact any insurer or other party in order to coordinate any recorded statements, sworn statements, examinations under oath, independent medical examinations, or similar investigative interview. I further direct my insurer to coordinate the aforementioned examinations directly with Provider, their agents, counsel, or assigns.

I further direct my insurer to direct all payments for services rendered by Provider to the billing address of the provider identified on the medical billing claim forms submitted by Provider and direct the insurer to set aside as disputed funds any amounts reduced or denied by the insurer and resolve said dispute before exhausting the remaining policy benefits.

THIS IS A DIRECT AND IRREVOCABLE ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER MY POLICY OF INSURANCE.

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

I have read the foregoing and understand and agree to each of the above provisions:

DATED THIS _____ DAY OF _____, 20____.

_____

Patient/Insured

Printed Name:_____

CONGRESS CHIROPRACTIC CLINIC

DR. KEVIN P. CONNER, DC, CCSP
CERTIFIED CHIROPRACTIC SPORTS PHYSICIAN

7534 CONGRESS STREET
NEW PORT RICHEY, FL. 34653-1105
TELEPHONE (727) 847-3852
FAX (727) 849-9900

MEMBER
NORTH SUNCOAST CHIROPRACTIC SOCIETY
AMERICAN CHIROPRACTIC ASSOCIATION
FLORIDA CHIROPRACTIC ASSOCIATION
FLORIDA CHIROPRACTIC SOCIETY

I, _____, authorize _____ Insurance Company/Attorney to issue the check for ___ _____ payable to Dr. Kevin P. Conner or Congress Chiropractic for, _____, which is the final balance.

Thank you for your cooperation in this matter.

Sincerely yours,

_____.

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Authorization and Promise of Payment

Patient name: _____ Date: _____

I, _____, hereby agree and understand that I am responsible to pay Congress chiropractic/Dr. Kevin P Conner for any treatment rendered to me, as a result of the injury, accident, or condition that I am being treated for that happened on_____. Congress chiropractic/Dr. Kevin P Conner, has agreed to delay any collection activity against me until such time as it is determined that the at-fault person's insurance company is held responsible for my outstanding medical bills.

I authorize and direct my attorney to make payment of my outstanding balance due to Congress chiropractic/Dr. Kevin P Conner for services rendered to me as result of this injury out of any proceeds that I may be awarded. I am requesting this Authorization and Promise of Payment be honored by my current lawyer, or any other lawyer that may represent me for this accident, now or in the future. I understand that if I am no longer represented by a lawyer for this accident, collection activity will no longer be delayed and payment for outstanding balance will be due.

I hereby acknowledge, agree, and understand I will not be released from financial liability regardless of the outcome of my pending legal suit. I understand, at the conclusion of this legal suit whether my case is upheld or denied I am responsible for payment to Congress chiropractic/Dr. Kevin P Conner of the outstanding balance for services rendered.

By signing, I am acknowledging that I have read and fully understand the contents of this agreement.

_____ _____

PRINT – Patient Name Patient Signature Date

Financial Responsibility

I _____am aware that I have a $_____ deductible. According to my insurance carrier this is an amount that I freely choose. I am also aware that my insurance carrier only covers _____% of all charges after I pay my deductible. I understand that I am fully and legally responsible for the deductible, as well as any percentage not covered by my carrier. If I am not able to pay these charges in full at this time, I will make arrangements to make payments on any and all charges for which I am responsible.

We accept cash, check, credit card and debit card for your convenience. There is a $30.00 fee for any returned checks.

I authorize and request the performance of Chiropractic services for myself or my minor child so designated below, and give consent to any advisable and necessary procedures and X-Rays to be administered by the attending physician or by his supervised staff or diagnostic purposes and chiropractic treatments.

If default be made in payment and if such default is not made good within 10 days, the entire principal sum and accrued interest shall at once become due and payable without notice. Failure to exercise this option shall not constitute a waiver of the right to exercise the same at a later date for the same default and if placed in the hands of a collection agency, or an Attorney of Law for collection, the undersigned agrees to pay all costs of collection including reasonable Attorney's fees. Presentment, protest, and notice is hereby waived.

I understand that it is my responsibility to know the benefits of my insurance policy and any co-payments that I may owe. I also understand that I am ultimately responsible for any balance due on my account for professional services rendered. I also understand that my diagnosis is what I am being treated for. I have read and completed this form and certify that all the above information is correct to the best of my knowledge.

Our confirmation of benefits/coverage on the phone with your Insurance Company is not a guarantee of payment or coverage and that you are responsible for any unpaid balances, deductibles, or if coverage is denied.

Patient Signature: _____ **Date:** _____

Social Security #: _____

Parent/Guardian: _____

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Informed Consent

I, _____ hereby give permission to Dr. Kevin Conner to release any information to my insurance company, hospital, or other Physicians, acquired in the course of my examination or treatment.

I, _____ hereby give Dr. Kevin Conner and/or his Associates permission to administer treatment and perform such general procedures, as he/they may deem necessary in the diagnosis and/or treatment of my condition. If I have insurance, I understand that that I am responsible for **all payments** until my insurance benefits are verified by this office or if I am not covered.

I clearly understand and agree that without insurance coverage all services rendered to me are charged directly to me and that I am personally responsible for payment at the time of service.

Risk of Manipulation

Chiropractic care has been shown to be generally helpful in many health conditions; however, as in all health care, there are risks that may occur such as joint irritation, dizziness, fractures, any unforeseeable injury and rarely, incidence of stroke. Statistics show the risk is as little as one in one million adjustments for stroke and decreases over the age of 45. Alternative care to chiropractic can consist of pain medications, surgery, physical therapy or I can do nothing, but I have elected to have Chiropractic care.

I understand all the above statements and am signing this document freely and voluntarily.

Patient signature: _____ **Date:** _____

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I was provided with a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed info my patient chart and maintained for six years.

Patient signature: _____ Date: _____

Parent/Guardian signature: _____

People and relationship of people the patient wants information shared with

Name: _____ Relation: _____

Name: _____ Relation: _____

Release of Patient records Authorization

I hereby authorize _____,

to release a copy of my patient records or x-rays containing protected health information to

_____.

This authorization is given pursuant to Florida Statute 456.057 and HIPAA regulations. I understand that Florida Statute 456.057(10) makes it clear that any third party to whom records are disclosed to is prohibited from further disclosing of any information in the medical record without the expressed written consent of the patient or the patient's parent/guardian.

_____ _____

Patient / Parent Signature Date of Birth

_____ _____

Patient Name Printed Date Signed

Description of information being requested: _____

Activities that are affected by my current health problems

Name: _____ Date: _____

0 = No affect
1 = I am aware of my problem when I do this activity (Mild)
2 = I don't want to do this activity because of my problem (Moderate)
3 = I can't do this activity at all. (Severe)

Basic

_____ Bending
_____ Climbing Stairs
_____ Falling Asleep
_____ Kneeling
_____ Lifting
_____ Looking Over Shoulder
_____ Lying Down
_____ Rising Out of Chair
_____ Sitting
_____ Standing
_____ Staying Asleep
_____ Walking

Daily Living

_____ Caring for Infirm Family Member
_____ Child Care
_____ Computer Use (extended time)
_____ Computer Use (short time)
_____ Concentrating
_____ Driving
_____ Housework
_____ Lifting Children
_____ Lifting/Carrying Groceries
_____ Pet Care
_____ Reading
_____ Sexual Activity
_____ Yard Work

Occupational Duties

_____ Computer Work
_____ Desk Work
_____ Driving (at work)
_____ Lifting (at work)
_____ Using the Telephone

Personal Care

_____ Bathing
_____ Dressing
_____ Hair Care
_____ Shaving

Recreational Activities

_____ Cycling
_____ Drawing
_____ Exercise
_____ Golf
_____ Needle Work
_____ Piano
_____ Running
_____ Softball
_____ Swimming
_____ Tennis

Neck Disability Index

This questionnaire has been designed to give us information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only the one box that applies to you. We realise you may consider the two or more statements in any one section relate to you, but please just mark the box that most closely describes your problem.

SECTION 1: Pain Intensity

- ○ I have no pain at the moment.
- ○ The pain is mild at the moment.
- ○ The pain comes and goes and is moderate.
- ○ The pain is moderate and does not vary much.
- ○ The pain is very severe, but comes and goes.
- ○ The pain is severe and does not vary much.

SECTION 2: Personal Care (e.g. washing, dressing)

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

SECTION 3: Lifting

- ○ I can lift heavy weights without extra pain.
- ○ I can lift heavy weights, but it gives me extra pain.
- ○ Pain prevents me from lifting heavy weights off the floor I can manage if they are conveniently placed (e.g., on a table.)
- ○ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ○ I can only lift very light weights.
- ○ I cannot lift or carry anything.

SECTION 4: Reading

- ○ I can read as much as I want to with no neck pain.
- ○ I can read as much as I want with slight neck pain.
- ○ I can read as much as I want with moderate neck pain.
- ○ I cannot read as much as I want because of moderate neck pain.
- ○ I cannot read as much as I want because of severe neck pain.
- ○ I cannot read at all.

SECTION 5: Headache

- ○ I have no headaches at all.
- ○ I have slight headaches which come infrequently
- ○ I have moderate headaches which come infrequently.
- ○ I have moderate headaches which come frequently.
- ○ I have severe headaches which come frequently.
- ○ I have headaches almost all the time.

SECTION 6: Concentration

- ○ I can concentrate fully when I want to with no difficulty.
- ○ I can concentrate fully when I want to with slight difficulty.
- ○ I have a fair degree of difficulty in concentrating when I want to.
- ○ I have a lot of difficulty in concentrating when I want to.
- ○ I have a great deal of difficulty in concentrating when I want to.
- ○ I cannot concentrate at all.

SECTION 7: Work

- ○ I can do as much work as I want to.
- ○ I can only do my usual work, but no more.
- ○ I can do most of my usual work, but no more.
- ○ I cannot do my usual work.
- ○ I can hardly do any work at all.
- ○ I cannot do any work at all.

SECTION 8: Driving

- ○ I can drive my car without neck pain.
- ○ I can drive my car as long as I want with slight pain in my neck.
- ○ I can drive my car as long as I want with moderate pain in my neck.
- ○ I cannot drive my car as long as I want because of moderate pain in my neck.
- ○ I can hardly drive my car at all because of severe pain in my neck.
- ○ I cannot drive my car at all.

SECTION 9: Sleeping

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

SECTION 10: Recreation

- ○ I am able to engage in all recreational activities with no pain in my neck at all.
- ○ I am able to engage in all recreational activities with some pain in my neck.
- ○ I am able to engage in most, but not all, recreational activities because of pain in my neck.
- ○ I am able to engage in a few of my usual recreational activities because of pain in my neck.
- ○ I can hardly do any recreational activities because of pain in my neck.
- ○ I cannot do any recreational activities at all.

Patient Name: Date: Score:

Oswestry Low Back Pain Disability Questionnaire

Instructions

This questionnaire has been designed to give us information as to how your back or leg pain is affecting your ability to manage in everyday life. Please answer by checking ONE box in each section for the statement which best applies to you. We realise you may consider that two or more statements in any one section apply but please just shade out the spot that indicates the statement which most clearly describes your problem.

SECTION 1: Pain Intensity

- I have no pain at the moment.
- The pain is very mild at the moment.
- The pain is moderate at the moment.
- The pain is fairly severe at the moment.
- The pain is very severe at the moment.
- The pain is the worst imaginable at the moment.

SECTION 2: Personal Care (e.g. washing, dressing)

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

SECTION 3: Lifting

- I can lift heavy weights without extra pain.
- I can lift heavy weights, but it gives me extra pain.
- Pain prevents me from lifting heavy weights off the floor I can manage if they are conveniently placed (e.g., on a table.)
- Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- I can only lift very light weights.
- I cannot lift or carry anything.

SECTION 4: Walking

- Pain does not prevent me walking any distance.
- Pain prevents me from walking more than 1 mile.
- Pain prevents me from walking more than 1/2 mile.
- Pain prevents me from walking more than 100 yards.
- I can only walk using a stick or crutches.
- I am in bed most of the time.

SECTION 5: Sitting

- I can sit in any chair as long as I like.
- I can only sit in my favorite chair as long as I like.
- Pain prevents me sitting more than 1 hour.
- Pain prevents me from sitting more than 30 minutes.
- Pain prevents me from sitting more than 10 minutes.
- Pain prevents me from sitting at all.

SECTION 6: Standing

- I can stand as long as I want without extra pain.
- I can stand as long as I want but it gives me extra pain.
- Pain prevents me from standing more than 1 hour.
- Pain prevents me from standing for more than 30 minutes.
- Pain prevents me from standing for more than 10 minutes.
- Pain prevents me from standing at all.

SECTION 7: Sleeping

- My sleep is never disturbed by pain.
- My sleep is occasionally disturbed by pain.
- Because of pain I have less than 6 hours sleep.
- Because of pain I have less than 4 hours sleep.
- Because of pain I have less than 2 hours sleep.
- Pain prevents me from sleeping at all.

SECTION 8: Sex Life (if applicable)

- My sex life is normal and causes no extra pain.
- My sex life is normal but causes some extra pain.
- My sex life is nearly normal but is very painful.
- My sex life is severely restricted by pain.
- My sex life is nearly absent because of pain.
- Pain prevents any sex life at all.

SECTION 9: Social Life

- My social life is normal and gives me no extra pain.
- My social life is normal but increases the degree of pain.
- Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. sport.
- Pain has restricted my social life and I do not go out as often.
- Pain has restricted my social life to my home.
- I have no social life because of pain.

SECTION 10: Traveling

- I can travel anywhere without pain.
- I can travel anywhere but it gives me extra pain.
- Pain is bad but I manage journeys over 2 hours.
- Pain restricts me to journeys of less than 1 hour.
- Pain restricts me to short necessary journeys under 30 minutes.
- Pain prevents me from traveling except to receive treatment.

Patient Name: Date: Score:

Congress Chiropractic Clinic
AUTOMOBILE ACCIDENT QUESTIONNAIRE

Patient's Name:_____ Today's Date:_____

Date of Accident:_____

THE FOLLOWING QUESTIONS PERTAIN TO YOU AND THE VEHICLE YOU WERE IN:

Vehicle type:

❑Car ❑Pickup
❑Van ❑Truck
❑Station Wagon ❑Bus
❑Other_____

Vehicle size:

❑Subcompact ❑Full-size
❑Compact ❑Mini
❑Mid-size ❑Light
❑Heavy ❑Other_____

Your position in the vehicle:

❑Driver
❑Passenger -------- Location-------- ❑Left ❑Middle ❑Right
❑Other _____ ❑Front Passenger ❑Rear Passenger ❑Third Seat (rear)

Speed of your vehicle:

❑Stopped ❑Moving Moderately
❑Parked ❑Moving Fast
❑Slowing ❑Moving at apprx ____MPH
❑Moving Slowly

Why Vehicle was slowed or stopped:

❑Traffic Signal ❑Parking
❑Pedestrian ❑Traffic
❑Stop Sign ❑Busy Intersection

Collision Type:

❑Driver Side Impact ❑Head On Collision
❑Passenger Side Impact ❑Rear Impact
❑Front Impact ❑Pedestrian Incident

THE FOLLOWING QUESTIONS CONCERN THE OTHER VEHICLE INVOLVED IN THE ACCIDENT

Vehicle type:

❑Car ❑Pickup
❑Van ❑Truck
❑Station Wagon
❑Other_____

Vehicle size:

❑Subcompact ❑Full-size
❑Compact ❑Mini
❑Bus ❑Mid-size ❑Light
❑Heavy ❑Other_____

CONDITIONS AT THE TIME OF THE ACCIDENT:

Time of day:

❑Full daylight
❑Dawn
❑Dusk
❑Night

Road Conditions:

❑Dry
❑Damp
❑Wet
❑Snow covered
❑Ice covered
❑Patchy Ice/Snow

Visibility:

❑Excellent
❑Good
❑Fair
❑Poor

Visibility compromised by:

❑Brightness
❑Darkness
❑Rain
❑Snow
❑Fog
❑Traffic

THE FOLLOWING QUESTIONS CONCERN THE MOMENT OF IMPACT OF THE ACCIDENT:

Were you...

❑Totally unaware that the accident was impending
❑Aware that the accident was impending
❑Aware that the accident was impending and braced for it

Restraints: (check all that apply)

❑Seat belt
❑Shoulder harness
❑No restraints

If you were the driver of the vehicle, was your foot on the brake pedal? ❑Yes ❑No ❑Knocked off by impact

Was the air bag deployed?

❑Car not equipped with air bag
❑Air bag deployed
❑Air bag not deployed

What position was YOUR headrest in?

❑High position
❑Middle position
❑ Low position

Position of YOUR head at time of impact?

❑Facing straight ahead
❑Tilted forward
❑Rotated to the left
❑Rotated to the right

Was your head thrown...?

❑Backward and then forward
❑Forward then backward
❑To the left ❑To the left then the right
❑To the right ❑To the right, then the left

Position of Your body at time of impact?

❑Straight
❑Tilted forward
❑Rotated to the left
❑Rotated to the right

Was your body thrown...?

❑Backward and then forward
❑Forward then backward
❑To the left ❑To the left then the right
❑To the right ❑To the right, then the left
❑Across the vehicle
❑Outside the vehicle ❑Under the vehicle

Damage to vehicle YOU were in:

❑Incurred minimal damage
❑Incurred moderate damage
❑Incurred severe damage
❑Was totalled
❑Not known

Citations:

❑None issued
❑Yourself
❑Driver of vehicle patient was a passenger of
❑Driver of other vehicle
❑Not sure

AS A RESULT OF THE FORCE OF THE COLLISION, WHICH OBJECTS IN THE VEHICLE DID YOUR BODY STRIKE?

Head

❑Steering wheel
❑Dashboard
❑Windshield
❑Armrest
❑Headrest
❑Rear view mirror
❑Left door
❑Right door
❑Left window
❑Right window
❑Console
❑Gear shift
❑Front seat
❑Backseat

Left Arm

❑Steering wheel
❑Dashboard
❑Windshield
❑Armrest
❑Headrest
❑Rear view mirror
❑Left door
❑Right door
❑Left window
❑Right window
❑Console
❑Gear shift
❑Front seat
❑Backseat

Right Arm

- ❑Steering wheel
- ❑Dashboard
- ❑Windshield
- ❑Armrest
- ❑Headrest
- ❑Rear view mirror
- ❑Left door
- ❑Right door
- ❑Left window
- ❑Right window
- ❑Console
- ❑Gear shift
- ❑Front seat
- ❑Backseat

Torso

- ❑Steering wheel
- ❑Dashboard
- ❑Windshield
- ❑Armrest
- ❑Headrest
- ❑Rear view mirror
- ❑Left door
- ❑Right door
- ❑Left window
- ❑Right window
- ❑Console
- ❑Gear shift
- ❑Front seat
- ❑Backseat

Left Leg

- ❑Steering wheel
- ❑Dashboard
- ❑Windshield
- ❑Armrest
- ❑Headrest
- ❑Rear view mirror
- ❑Left door
- ❑Right door
- ❑Left window
- ❑Right window
- ❑Console
- ❑Gear shift
- ❑Front seat
- ❑Backseat

Right Leg

- ❑Steering wheel
- ❑Dashboard
- ❑Windshield
- ❑Armrest
- ❑Headrest
- ❑Rear view mirror
- ❑Left door
- ❑Right door
- ❑Left window
- ❑Right window
- ❑Console
- ❑Gear shift
- ❑Front seat
- ❑Backseat

THE FOLLOWING QUESTIONS CONCERN THE TIME PERIOD IMMEDIATELY FOLLOWING THE ACCIDENT:

Did you lose consciousness?

- ❑Yes
- ❑No

Immediately following the accident, did you feel...?

- ❑Dizzy
- ❑Dazed
- ❑Disoriented
- ❑Weak
- ❑Nervous
- ❑Nauseated

Were you able to walk unaided?

- ❑Yes
- ❑No

Where did you go...?

- ❑Drove home
- ❑Was driven home
- ❑Drove to hospital
- ❑Was driven to hospital
- ❑Taken to hospital via ambulance
- ❑Drove to work
- ❑Was driven to work
- ❑Drove to school
- ❑Was driven to school

Next day discomfort...?

❑increased ❑decreased ❑same

Did your major complaints exist before the accident?

❑Yes ❑ No

In what areas did you IMMEDIATELY feel pain?

❑Head	Shoulder	❑Left	❑Right	Hip	❑Left	❑Right
❑Neck	Arm	❑Left	❑Right	Thigh	❑Left	❑Right
❑Upper back	Elbow	❑Left	❑Right	Knee	❑Left	❑Right
❑Mid back	Wrist	❑Left	❑Right	Calf	❑Left	❑Right
❑Ribs	Hand	❑Left	❑Right	Ankle	❑Left	❑Right
❑Chest	Fingers	❑Left	❑Right	Foot	❑Left	❑Right
❑Abdomen	Buttock	❑Left	❑Right	Toes	❑Left	❑Right
❑Low Back ❑Pelvis						

In what areas did you experience lacerations (cuts)?

❑Head	Shoulder	❑Left	❑Right	Hip	❑Left	❑Right
❑Neck	Arm	❑Left	❑Right	Thigh	❑Left	❑Right
❑Upper back	Elbow	❑Left	❑Right	Knee	❑Left	❑Right
❑Mid back	Wrist	❑Left	❑Right	Calf	❑Left	❑Right
❑Ribs	Hand	❑Left	❑Right	Ankle	❑Left	❑Right
❑Chest	Fingers	❑Left	❑Right	Foot	❑Left	❑Right
❑Abdomen	Buttock	❑Left	❑Right	Toes	❑Left	❑Right
❑Low Back ❑Pelvis						

At the hospital, what areas were x-rayed?

❑Head	Shoulder	❑Left	❑Right	Hip	❑Left	❑Right
❑Neck	Arm	❑Left	❑Right	Thigh	❑Left	❑Right
❑Upper back	Elbow	❑Left	❑Right	Knee	❑Left	❑Right
❑Mid back	Wrist	❑Left	❑Right	Calf	❑Left	❑Right
❑Ribs	Hand	❑Left	❑Right	Ankle	❑Left	❑Right
❑Chest	Fingers	❑Left	❑Right	Foot	❑Left	❑Right
❑Abdomen	Buttock	❑Left	❑Right	Toes	❑Left	❑Right
❑Low Back ❑Pelvis						

Where did you experience pain on the day FOLLOWING the accident?

❑Head	Shoulder	❑Left	❑Right	Hip	❑Left	❑Right
❑Neck	Arm	❑Left	❑Right	Thigh	❑Left	❑Right
❑Upper back	Elbow	❑Left	❑Right	Knee	❑Left	❑Right
❑Mid back	Wrist	❑Left	❑Right	Calf	❑Left	❑Right
❑Ribs	Hand	❑Left	❑Right	Ankle	❑Left	❑Right
❑Chest	Fingers	❑Left	❑Right	Foot	❑Left	❑Right
❑Abdomen	Buttock	❑Left	❑Right	Toes	❑Left	❑Right
❑ Low Back ❑Pelvis						

Patient's Signature: _____

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 MVA exam, x-rays, ice pack, cryodrerm, adjustment and therapy

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 (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

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 Release of Records Authorization

I _____ hereby

Authorize _____

to release a copy of my payout sheet/closing statement upon request (No more than once a month) to Dr. Kevin Conner, D.C., CCSP of Congress Chiropractic.

This authorization is given pursuant to **Florida Statue 456.057** and **HIPPA regulations**. I understand that **Florida Statue 456.057 (10)** makes it clear that any third party to whom records are disclosed is prohibited from further disclosing any information in the medical records without the expressed written consent of the patient or the patient's legal representatives.

_____ _____

Patient Signature or Legal Representative Patient's Date of Birth

Date Signed _____

Records Release

I hereby authorize Dr. Conner of Congress Chiropractic to release my records to _____, any information including diagnosis, records of treatment or examination rendered to me or all care during the period from _____

to _____.

_____ Date_____

Patient Signature

_____ Date _____

Staff Signature

Release from Care

I, _____ hereby understand that Dr. Kevin Conner of Congress Chiropractic is releasing me from care, for my accident that occurred on _____, and that I have reached

____ pre-accident status or ____ maximum medical improvement. I further understand that all expenses incurred from this accident are my responsibility or the insurance company's _____.

I will make financial arrangements for payment directly.

_____ Date_____

Patient/Representative Signature

_____ Date _____

Staff member