Auto/PI or Workman's Comp

INFORMATION

Last Name____________________**First Name**______________________**Goes By**_____________________

Date of Birth____/____/_____ **Gender:** ☐Male ☐Female **Status:** ☐Single ☐Married ☐Divorced ☐Widowed

Spouse's Name__________________**Children:** ☐No ☐Yes: *Names*_________________________________

Address______________________________**City**_________________**State**______**Zip**_________________

Cell Phone_________________________________**Work Phone**_____________________________________

Email____**Best Contact Method:** ☐Cell Phone ☐Email

Occupation___________________________ **Employer** ____

Emergency Contact Name_______________**Emergency Contact Phone Number**__________________

INJURY/ACCIDENT DETAILS

Date of Accident: ___________ **Time of Accident:** _________ **City:** _______________ **State:** ________

Please explain in detail how your accident happened.

____

____

____

You were heading North/ East/ South/ West on _______________ (street or highway)
Other vehicle was heading North/ East/ South/ West on __________ (street or highway)
Were police notified? Yes/ No
Where did you feel pain immediately after the accident? ____________________________________
List the extent of your injuries as you know them:

____

____

Were you knocked unconscious? Yes/ No If so, for how long? ____________________________
You were struck from Behind/ Front/ Left Side/ Right Side______________________________
You were Driver/ Passenger/ Front seat/ Back Seat – Were you wearing seat belts? Yes/No
Number of people in the vehicle _______
Approximate speed of your car _______ MPH - Other Car ______ MPH
Did the air bags deploy? Yes/No
Did either car have a Dash Cam? Yes/No
Have you retained an attorney? Yes/No
Where were you taken after the accident? ____________Hospitalized: (circle one) Yes/ No
If yes, admitted? ____________How long? ____________Name of Hospital_______________________
Was any other doctor consulted after your accident? Yes/ No
If so, what was the doctor's name? ____________________ D.C., M.D., D.O., D.D.S.
What was the diagnosis? ____________________What treatment was given? _________________
How often did you see the doctor? ________________
Have you ever had any complaints in the involved area before? Yes/ No
If so, what were the complaints? ____
Before the injury were you capable of working on an equal basis with others your age? Yes/ No
Are your work activities restricted as a result of this accident? Yes/ No
Since this injury are your symptoms: (circle one) Improving Getting worse Same

Make, model, and year of your car ____________________

Make, model, and year of car that was involved ____________________

Amount of damage to your car ____________________ $$$ __________

Number of cars involved in accident _________

Did you lose any time from work? Yes/No

Did the accident force you to take any medications? Yes/No - If so, what? __________

PAIN SCALE

On a scale of 1 to 10, 10 being the worst possible pain

1. What is your pain level **right now**?______
2. What is your **average** level of pain?_____
3. What is your pain level at its **worst**?_____

HEALTH HISTORY

List Current Medications ____________________

____

List all Surgical Operations and Dates ____________________

____

Have you ever been in an auto accident? ☐No ☐Yes: *Date(s)*____________*Injury?*____________

Have you ever had/have? ☐Stroke ☐Cancer ☐Heart Disease ☐Spinal Surgery ☐Seizures ☐Spinal Bone Fracture ☐Scoliosis ☐Diabetes ☐Bone Fracture ☐Severe Fall ☐Concussion

Have you ever been under regular Chiropractic Care? ☐No ☐Yes

*If yes, where*____________________*Date of last adjustment*____________

Why are you seeking Chiropractic Care? ☐Spinal Correction ☐Pain Relief ☐Pain Management ☐Maintain health ☐Sports Performance ☐Symptom Relief ☐Quality of Life Improvement

What is your main goal in seeking care in our office? ____________________

____

Check symptoms you have noticed since the accident:

_____Headache	_____Dizziness	_____Depression	_____Fatigue
_____Light Bothers Eyes	_____Buzzing in Ears	_____Diarrhea	_____Neck Pain
_____Head Seems too Heavy	_____Memory Loss	_____Feet Cold	_____Neck Stiff
_____Pins and Needles in Arms	_____Ears Ring	_____Hands Cold	_____Fainting
_____Sleeping Problems	_____Low Back Pain	_____Face Flushed	_____Loss of Balance
_____Pins and Needles in Legs	_____Constipation	_____Tension	_____Nervousness
_____Numbness in Fingers	_____Loss of Smell	_____Fever	_____Irritability
_____Numbness in Toes	_____Loss of Taste	_____Chest Pain	_____Cold Sweats
_____Shortness of Breath	_____Stomach Upset	_____ Blurry Vision	_____TMJ Pain
_____Hip Pain Right/Left	_____Midback Pain		_____Wrist Pain Right/Left
_____Leg Pain Right/Left	_____Sciatica Right/Left		_____Elbow Pain Right/Left
_____Knee Pain Right/Left	_____ Shoulder Pain Right/Left		Other ____________

FAMILY HISTORY (Please Check All that Apply)

Condition	Spouse	Son	Daughter	Mother	Father
Arthritis					
ADHD/ADD					
Bed Wetting					
Cancer					
Carpal Tunnel					
Deceased					
Diabetes					
Digestive Problems					
Ear Infections					
Fibromyalgia					
High Blood Pressure					
Migraines					
Scoliosis					

INSURANCE

Primary Insurance Carrier____________________________Name of Insured___________________________

Insured DOB_________Member ID______________________Group ID_________________________________

Secondary Insurance Carrier_________________________Name of Insured___________________________

Insured DOB_________Member ID______________________Group ID_________________________________

Policies and Fees Schedule

Consultation- includes practice member history (this service is complimentary)
Assessment (new or established practice member)- includes one or more of the following: thermography, surface electromyography, range of motion, motion and/or static palpation, leg check ($50-$100)
Chiropractic Adjustment- The actual re-alignment of the vertebra done by hand or instrument. Often a sound will be heard, but if there is no auditory result, it does not mean that the adjustment has not taken place ($55-$85)
X-Rays- Specific X-ray views taken of your spine to determine a misalignment/subluxation of your vertebrae. These can also be used to indicate progress after period of care. Cost is subject to insurance rate, otherwise $100 per view (per cervical, thoracic, lumbar) under compliance coupon.

Release of Authorization/Assignment of benefits

I authorize and request payment of insurance benefits directly to Andres Julia, D.C. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the patient. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by insurance.

Signature____**Date**______________________________________

DISCLAIMER FOR PI, AUTO, OR WORKMANS COMP

Dear Patient: This information is considered confidential. We need this information because we care enough to want to know and your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form.

Thank you.

Patient's Name ______________________________ DOB ______________

Patient signature ______________________________ DATE ______________

TERMS OF ACCEPTANCE

TO PROMOTE THE MOST EFFECTIVE APPLICATION OF CHIROPRACTIC PROCEDURES AND THE STRONGEST POSSIBLE DOCTOR-PATIENT RELATIONSHIP, WE STATE THE FOLLOWING TO FACILITATE THE GOAL OF OPTIMUM HEALTH THROUGH CHIROPRACTIC.
TO THAT END, WE ASK THAT YOU ACKNOWLEDGE THE FOLLOWING POINTS REGARDING SERVICES WE PROVIDE:

1. CHIROPRACTIC IS A SPECIFIC, SEPARATE, AND DISTINCT PRACTICE AUTHORIZED BY LAW TO ADDRESS SPINAL HEALTH
2. CHIROPRACTIC SEEKS TO RESTORE NORMAL NERVE FUNCTIONING THROUGH THE ADJUSTMENT OF SPINAL SUBLUXATIONS TO MAXIMIZE THE INHERENT HEALING POWER OF THE BODY. SUBLUXATIONS ARE DEVIATIONS FROM NORMAL SPINAL STRUCTURES THAT INTERFERE WITH NORMAL NERVE PROCESSES.
3. THE CHIROPRACTIC ADJUSTMENT PROCESS, AS DEFINED IN THE LAW OF THIS JURISDICTION, INVOLVES THE APPLICATION OF A SPECIFIC DIRECTIONAL THRUST TO A REGION(S) OF THE SPINE WITH THE SPECIFIC INTENT OF REPOSITIONING MISALIGNED SPINAL SEGMENTS. THIS IS A SAFE, EFFECTIVE PROCEDURE APPLIED OVER ONE MILLION TIMES EACH DAY BY DOCTORS OF CHIROPRACTIC IN THE UNITED STATES ALONE
4. CHIROPRACTIC DOES NOT SEEK TO REPLACE OR COMPETE WITH OTHER SPECIFIC HEALTH CARE PROFESSIONALS. THEY RETAIN RESPONSIBILITY FOR CARE AND MANAGEMENT OF MEDICAL CONDITIONS. WE DO NOT OFFER ADVICE REGARDING TREATMENT PRESCRIBED BY OTHERS.
5. YOUR COMPLIANCE WITH THE DOCTOR'S RECOMMENDATIONS IS ESSENTIAL TO ACHIEVING THE MAXIMUM HEALTH BENEFITS
6. WE INVITE YOU TO SPEAK FRANKLY TO THE DOCTOR ON ANY MATTER RELATED TO YOUR CARE AT THIS FACILITY, ITS NATURE, DURATION, OR COST, WHAT WE WORK TO MAINTAIN AS A SUPPORTING, OPEN ENVIRONMENT

BY SIGNING BELOW, I AM STATING THAT I HAVE FULLY READ AND UNDERSTAND THE ABOVE STATEMENTS

Signature____Date____________________

INFORMED CONSENT FOR CHIROPRACTIC CARE

CHIROPRACTIC CARE, WHILE OFFERING CONSIDERABLE BENEFITS, MAY ALSO PROVIDE SOME LEVEL OF RISK. IN EXTREMELY RARE CASES, INJURY HAS BEEN ASSOCIATED WITH CHIROPRACTIC CARE. THESE CASES INCLUDE: STRAIN/SPRAIN INJURIES, IRRITATION OF EXISTING DISC CONDITION, AND FRACTURES, ETC. ONE OF THE RAREST COMPLICATIONS ASSOCIATED WITH CHIROPRACTIC WHICH OCCURS AT A RATE BETWEEN ONE INSTANCE PER ONE MILLION TO TWO MILLION CERVICAL SPINE ADJUSTMENTS MAY BE A VERTEBRAL INJURY THAT COULD LEAD TO A STROKE.
PRIOR TO RECEIVING CHIROPRACTIC CARE IN THE OFFICE, A HEALTH HISTORY AND PHYSICAL EXAMINATION WILL BE COMPLETED TO ASSESS YOUR SPECIFIC HEALTH AND SPINAL NEEDS. THESE PROCEDURES WILL ASSIST US IN DETERMINING IF CHIROPRACTIC CARE IS NECESSARY OR IF FURTHER EXAMINATION IS NEEDED. IN ADDITION, THEY WILL HELP US DETERMINE IF THERE IS ANY REASON TO MODIFY YOUR CARE OR PROVIDE YOU WITH A REFERRAL TO ANOTHER HEALTH CARE PROVIDER. ALL RELEVANT FINDINGS WILL BE REPORTED TO ALONG WITH A CARE PLAN PRIOR TO BEGINNING CARE.

I UNDERSTAND THERE ARE RISKS ASSOCIATED WITH CHIROPRACTIC CARE AND GIVE CONSENT TO THE EXAMINATION THE DOCTOR DEEMS NECESSARY AND CHIROPRACTIC CARE, INCLUDING SPINAL ADJUSTMENTS, AS REPORTED FOLLOWING MY ASSESSMENT

Name____________________**Signature**____________________**Date**____________________

Guardian Signature (For Minor) ____________________**Office Staff Signature**____________________

ABUNDANCE CHIROPRACTIC NOTICE OF PRIVACY PRACTICE AGREEMENT

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your Personal Health Information. In addition, we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as dictated by our office policy, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled 'HIPAA' on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page to our front desk receptionist. Keep this page for your records.

PERMITTED DISCLOSURES:

1. Treatment purposes- discussion with other health care providers involved in your care
2. Inadvertent disclosures- open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes- to process a claim or aid in investigation
5. Emergency- in the event of a medical emergency we may notify a family member
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement – to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons –discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders -we may call your home and leave messages regarding a missed appointment or apprize you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice
3. To request mailings to an address different than residence
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain one copy of your records at no charge, when timely notice is provided (72 hours). X-rays are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call Dr. Andres Julia at (727) 201-2271 if he is unavailable, you may make an appointment with our receptionist to see him within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights 200 Independence Ave. SW Room 509F HHH Building Washington DC 20201

I have received a copy of Chiropractic's Patient Privacy Notice. I understand my rights as well as the practices duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this 'Notice of Privacy Practice" at an time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

Patient Name____ DOB__________________________

Patient Signature____Date___________________________

Witness____Date___________________________

JDD,DC 5/2011

X-RAY AUTHORIZATION

AS YOUR HEALTHCARE PROVIDER, WE ARE LEGALLY RESPONSIBLE FOR YOUR CHIROPRACTIC RECORDS. WE MUST MAINTAIN A RECORD OF YOUR X-RAYS IN OUR FILES

X-RAYS ARE UTILIZED IN THIS OFFICE TO HELP LOCATE AND ANALYZE VERTEBRAL SUBLUXATIONS. HEALTH HISTORY AND EXAMS WILL ALLOW THE DOCTOR TO DETERMINE IF X-RAYS ARE NECESSARY FOR YOUR CASE. THESE X-RAYS ARE NOT USED TO INVESTIGATE FOR MEDICAL PATHOLOGY. THE DOCTOR(S) OF ABUNDANCE CHIROPRACTIC DO NOT DIAGNOSE OR TREAT MEDICAL CONDITIONS. HOWEVER, IF ANY ABNORMALITIES ARE FOUND, WE WILL BRING IT TO YOUR ATTENTION SO THAT YOU CAN SEEK PROPER MEDICAL ADVICE.

AT YOUR REQUEST, WE WILL PROVIDE YOU WITH A COPY OF YOUR X-RAYS

THE FEE FOR COPYING YOUR X-RAYS ON A DISC IS $15.00 WHICH MUST BE PAID IN ADVANCE.

BY SIGNING BELOW, I AM AGREEING TO THE ABOVE TERMS AND CONDITIONS

Signature____**Date**__________________________________

FEMALE PATIENTS ONLY: TO THE BEST OF MY KNOWLEDGE, I BELIEVE I AM NOT PREGNANT AT THE TIME X-RAYS ARE TAKEN AT ABUNDANCE CHIROPRACTIC

Signature____**Date**___________________________

Abundance Chiropractic
Dr. Andres Julia
4431 Park Blvd. N, Pinellas Park, FL 33781

No Fault State - Florida

Practice Member Name: ____

Date of Accident: __________ **Time of Accident:** ____________ **City:** ____________________ **State:** ______

Claim # ______________________ **Adjusters Name:** ____________________ **Phone #** ____________________

Insurance Company Name: __________________________

Attorney Name: ____________________________ **Phone #** ____________________

Please contact YOUR car insurance company and obtain the following information.

Is this an open and billable medical claim? YES NO

Do you have uninsured motorists policy on your insurance? Yes No
If so, what's the limit? _________________

Is there a deductible &/or coinsurance on the policy? Deductible $__________ Coins __________%

Is there a medical pay maximum on the policy? $2,000 $2,500 $5,000 $10,000

If medical pay applies, has any of it been used? Yes $__________ No

Is there a direct number to call for claims status? Yes No

If Yes, Phone #: ______________________________

Auto Insurance Company Name & Mailing Address to Submit Claims:
____
____
____

Fax # to Submit Claims: ______________________________

3rd Party Information:

Insurance Company: ____ Phone #: ___________________________

Is there Bodily Injury Coverage? YES NO

- If Yes How Much? $_________________

Additional Notes:____

Information Obtained By: ______________________________ Date: ___________________________

Abundance Chiropractic
Dr. Andres Julia
4431 Park Blvd. N, Pinellas Park, FL 33781

DOCTOR'S LIEN

I hereby authorize and instruct my attorney &/or insurance carrier, __________________________ to pay **Abundance Chiropractic** directly for the full amount of services rendered by **Abundance Chiropractic** in relation to my personal injury treatment arising from my accident on or about __________________________ once a settlement or verdict is reached and those funds are made available or disbursed.

I understand that I am directly and fully responsible for all medical bills incurred at **Abundance Chiropractic** for services rendered to me with respect to any personal injury treatment. Further, I understand that I am responsible for the payment of all services rendered by **Abundance Chiropractic**, regardless of whether or not I receive any proceeds from any insurance company or third party, and that my obligation and liability to **Abundance Chiropractic** is in no way conditioned upon any settlement or verdict.

I agree to promptly notify **Abundance Chiropractic** of any changes in my representation or attorney for this accident.

By signing below, I acknowledge and agree to this lien in favor of **Abundance Chiropractic** the full amount owed for any and all services rendered to me by **Abundance Chiropractic**.

I acknowledge that **Abundance Chiropractic** is not required to permit me the option to postpone or make payments toward of services rendered, and that it is being done solely as a courtesy. As such, **Abundance Chiropractic** may, at any time, seek payment for any and all amounts owed by me while this lien is in force. Additionally, if my attorney fails to acknowledge this lien in favor of **Abundance Chiropractic**, the entire balance related to this personal injury treatment is my sole responsibility, and **Abundance Chiropractic** may demand payment immediately.

____________________________________ Print Practice Members Name

____________________________________ Practice Member Signature

____________________________________ Date

Acknowledged by Attorney this ___________ day of ______________, 20__________

____________________________________ Attorney Signature

QUADRUPLE VISUAL ANALOGUE SCALE

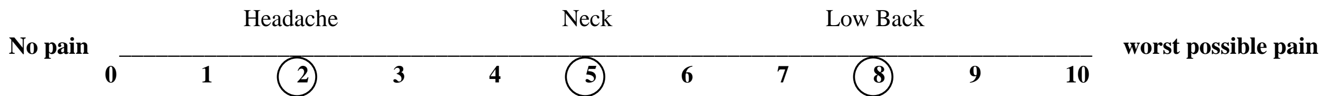
Patient Name ____ Date ______________________

Please read carefully:

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:



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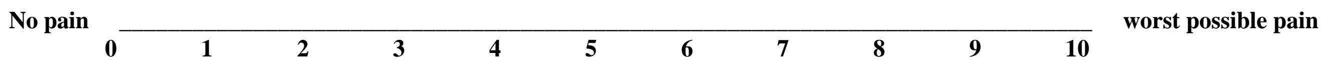
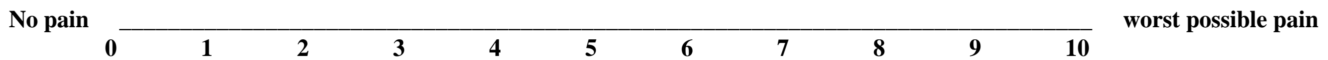
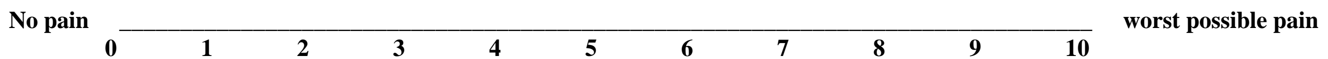
1 – What is your pain RIGHT NOW?



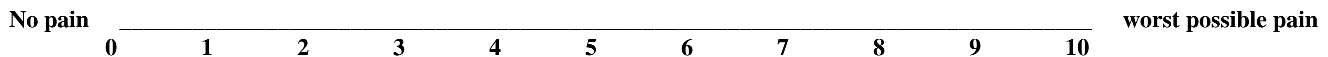
2 – What is your TYPICAL or AVERAGE pain?



3 – What is your pain level AT ITS BEST (How close to “0” does your pain get at its best)?



4 – What is your pain level AT ITS WORST (How close to “10” does your pain get at its worst)?



OTHER COMMENTS:

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Examiner

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.