TLC Family Medical & Wellness Center

7026 Palisade Dr.
Port Richey, Fl 34668
(727)869-7399

13315 Cortez Blvd
Brooksville, Fl 34613
(352)596-1900

PIP / LOP Patient Application Form

Welcome to our clinic. We specialize in assisting our patients in achieving their highest level of health through our spinal and postural correction programs. Our approach is very different and more complete than other rehabilitative programs, which allows us to achieve superior correction as compared to other systems.

Please fill out the following information completely so the Doctor can let you if we can accept your case. Please feel free to ask any questions if you need assistance. We look forward to serving you.

_____

Patient Name

_____

Patient Signature

_____

Date

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Electronic Health Records Intake Form

In compliance with Medicare requirements for the Government EHR incentive program

First Name: _____ Last Name: _____

Email address: _____

Preferred method of communication: ☐ Email ☐ Phone ☐ Text ☐ Mail

DOB: ____/____/_____ Gender: ☐ Male ☐ Female Preferred Language: _____
(MM) (DD) (YYYY)

CMS requires providers to report both Race and Ethnicity

Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ White or Caucasian
☐ Native Hawaiian or Pacific Islander ☐ Other: _____ ☐ I decline to answer

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ I decline to answer

Are you currently taking any medications? ☐ Yes ☐ No (Please include regularly used over-the-counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg 2x daily)

Do you have any medication allergies? ☐ Yes ☐ No

Medication Name	Reaction	Onset Date	Additional Comments

☐ I choose to decline receipt of my clinical summary after every visit (These summaries are often blank as a result of the nature and frequency of Chiropractic care)

Patient Signature: _____ Date: _____

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Please list all **past** surgeries and associated dates:

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____
5. _____ _____
6. _____ _____

Please list any **previous** accidents and injuries, with associated dates:

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____
5. _____ _____
6. _____ _____

Please list any **prior** health health conditions not mentioned:

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____
5. _____ _____

Health Lifestyle

Do you exercise? ☐ Yes ☐ No How often? ☐ 1x ☐ 2x ☐ 3x ☐ 4x ☐ 5x Per: ☐ Week ☐ Month

Smoker status? ☐ Every day smoker ☐ Occasional smoker ☐ Former Smoker ☐ Never smoked

If a smoker, what is your daily usage? ☐ <5 daily ☐ 5-10 daily ☐ 11-15 daily ☐ 15-20 daily ☐ >1 pack daily

Do you drink alcohol? ☐ Yes ☐ No What and how much?: _____

Do you drink coffee? ☐ Yes ☐ No How many cups per day? _____

Do you drink soda? ☐ Yes ☐ No How many 12oz servings per day? _____

Do you drink water? ☐ Yes ☐ No How much per day? _____

Do you eat fruits and vegetables? ☐ Yes ☐ No How many servings per day? _____

Do you take any supplements? (ie: vitamines, minerals, herbs) ☐ Yes ☐ No

Please list: _____

_____

Patient Signature: _____ Date: _____

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Case History

Name: _____ Age: _____ Today's Date: _____

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

Phone (Home): _____ Sex: _____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Social Security #: _____ Drivers License #: _____ State: _____

Occupation: _____ Employer: _____ Phone (Work): _____

Insurance Company: _____ Insurance Contact #: _____

Insured's Name (if different from Patient): _____ Insured's Date of Birth: _____

Insured's ID # or SS #: _____ Issuing State: _____

Spouse's Name: _____ Spouse's contact #: _____

Present condition due to an injury? ☐ Yes ☐ No ☐ On the Job ☐ Auto Accident ☐ Other _____

Has the accident been reported? ☐ Yes ☐ No ☐ To Employer? ☐ Auto Carrier? ☐ Other _____

Health Report

Reason for seeking care: _____

List any other doctors seen for this: _____

List any diagnosis: _____

Have you had similar accidents or injuries before? ☐ Yes ☐ No Explain: _____

List names of relatives that have had a smiliar problem: _____

Have you or any relatives received chiropractic treatment previously? ☐ Yes ☐ No

If yes, please explain: _____

Have you been treated by a physician in the last year for any reason? ☐ Yes ☐ No

If yes, please explain: _____

If you listed any medications on EHR page, please list each condition those medications are prescribed for: _____

_____

_____

Do you exercise? ☐ Yes ☐ No How often? ☐ 1x ☐ 2x ☐ 3x ☐ 4x ☐ 5x Per: ☐ Week ☐ Month

Smoker status? ☐ Every day smoker ☐ Occasional smoker ☐ Former Smoker ☐ Never smoked

If a smoker, what is your daily usage? ☐ <5 daily ☐ 5-10 daily ☐ 11-15 daily ☐ 15-20 daily ☐ >1 pack daily

Do you drink alcohol? ☐ Yes ☐ No What and how much?: _____

Do you drink coffee? ☐ Yes ☐ No How many cups per day? _____

Do you drink soda? ☐ Yes ☐ No How many 12oz servings per day? _____

Do you drink water? ☐ Yes ☐ No How much per day? _____

Do you eat fruits and vegetables? ☐ Yes ☐ No How many servings per day? _____

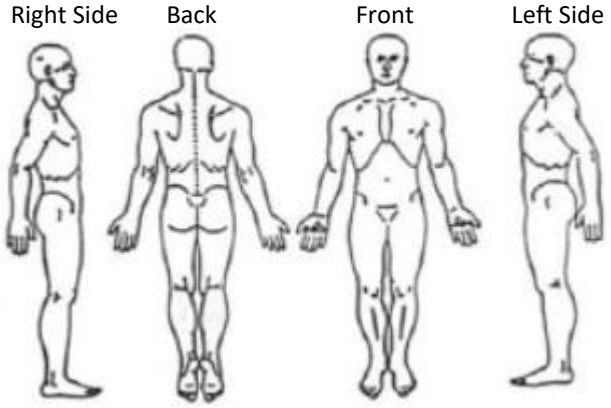
Do you take any supplements? (ie: vitamines, minerals, herbs) ☐ Yes ☐ No Please list:_____

_____

Circle your current degree of pain: 0 1 2 3 4 5 6 7 8 9 10+

Using the symbols below, mark on the diagram where you feel pain:

Numbness	===
Dull Ache	000
Burning	xxx
Sharp, Stabbing	///
Pins, Needles	+++
Other	???



What activities exacerbate (irritate) your symptoms? _____

_____

Is this condition worse during certain times of the day? _____

Is this condition interfering with ☐ Work ☐ Sleep ☐ Daily Routine

☐ Other _____

Is this condition progressively getting worse? ☐ Yes ☐ No

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Please mark each item below for each condition/ symptom you currently have or previously had:

General Symptoms:
- ☐ Convulsions
- ☐ Dizziness
- ☐ Fainting
- ☐ Headache
- ☐ Nervousness
- ☐ Numbness
- ☐ Wheezing

Muscles & Joints:
- ☐ Low Back Problems
- ☐ Pain Between Shoulders
- ☐ Neck Problems
- ☐ Arm Problems
- ☐ Leg Problems
- ☐ Swollen Joints
- ☐ Painful Joints
- ☐ Stiff Joints
- ☐ Sore Muscles
- ☐ Weak Muscles
- ☐ Walking Problems
- ☐ Sprains/ Strains
- ☐ Broken Bones

Cardiovascular:
- ☐ High Blood Pressure
- ☐ Heart Attack
- ☐ Pain Over Heart
- ☐ Poor Circulation
- ☐ Heart Trouble
- ☐ Rapid Pulse
- ☐ Slow Pulse
- ☐ Stroke
- ☐ Swelling in Ankles
- ☐ Varicose Veins

Ear/ Nose, Throat:
- ☐ Earache
- ☐ Ear Noises
- ☐ Enlarged Thyroid
- ☐ Frequent Colds
- ☐ Hay Fever
- ☐ Nasal Blockage
- ☐ Nose Bleeds
- ☐ Pain Behind Eyes
- ☐ Poor Vision
- ☐ Sinusitis
- ☐ Sore Throat
- ☐ Tonsilitis

Gastro-Intestinal:
- ☐ Belching/ Gas
- ☐ Colon Problems
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive Hunger/ Thirst
- ☐ Gall Bladder
- ☐ Hemorrhoids
- ☐ Liver
- ☐ Nauseau
- ☐ Abdominal Pain
- ☐ Ulcer
- ☐ Poor Appetite
- ☐ Poor Digestion
- ☐ Vomiting/ Blood
- ☐ Black Stool
- ☐ Bloody Stool
- ☐ Weight Loss/ Gain

Respiratory:
- ☐ Asthma
- ☐ Chronic Cough
- ☐ Difficulty Breathing
- ☐ Spitting Blood
- ☐ Spitting Phlegm

Genito-Urinary:
- ☐ Blood in Urine
- ☐ Frequent Urination
- ☐ Kidney Infection
- ☐ Painful Urination
- ☐ Prostate Problems
- ☐ Loss of Bladder Control

Skin or Allergies:
- ☐ Boils
- ☐ Bruising Easily
- ☐ Dryness
- ☐ Eczema/ Rash/ Dermatitis
- ☐ Hives
- ☐ Itching
- ☐ Sensitive Skin
- ☐ Allergy _____

For Women Only:
- ☐ Birth Control
- ☐ Hormone Replacement Therapy
- ☐ Cramps/ Backaches
- ☐ Excessive Flow
- ☐ Hot Flashes
- ☐ Irregular Cycle
- ☐ Miscarriage
- ☐ Painful Periods
- ☐ Vaginal Discharge
- ☐ Breast Pain
- ☐ Currently Pregnant

I hereby certify that the answers given on this form are accurate to the best of my knowledge, and understand it is my responsibility to inform this office of any changes in my health. I agree to allow this office to examine me for further evaluation relative to my treatment.

Patient Signature: _____ Date: _____

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Terms of Acceptance

Procedures and Payment Policy

When a person seeks chiropractic care and rehabilitative health care, and is accepted for such care, it is essential for both parties to be working towards the same objective. It is important that each person understand both the objective and the method(s) that will be used to obtain this objective. By signing this form, you acknowledge that you have read, understand, and consent to the terms herein.

Procedures

- No Charge Consultation: This is a brief meeting between you and the Doctor to determining if you may benefit from the care we provide. There is no financial obligation in connection with this service.
- Clinical Exam: After your consultation, if the Doctor believes you will likely benefit from the care we provide, a thorough orthopedic, neurologic, and chiropractic clinical exam will be recommended.
- X-Rays: Based on the exam findings, the Doctor may recommend selected x-rays be taken to aid in comprehensive diagnosis of your condition(s).
- Included in the cost of the clinical exam is a report of findings. This is where the Doctor presents his findings regarding your diagnostic testing. The Doctor will also explain what he feels would be the best and fastest approach to improve your health, based on your condition.
- Treatments may include: Spinal and extraspinal adjustments, joint manipulation, intersegmental traction, electric muscle stimulation, curve restoration traction, core muscle training, posture correction exercises, scoliosis correction therapy, cold laser therapy, rehabilitation therapy, spinal decompression, massage/ manual therapy, ice (cryotherapy), neuromuscular re-education, custom orthotics, analgesic rubs/ creams/ sprays, and nutritional recommendations and supplements.

Payment Policy

- Payment is expected at the time of service, unless prior arrangement has been made between you and the office.
- Health/ Automobile Insurance
    - Your insurance coverage is a contract between you and your insurance company. We will gladly help you verify benefits of your particular coverage; however, we cannot take responsibility for what your insurance does or does not cover. Ultimately, all services rendered to you are charged directly to you, and you are responsible for any and all payment aside from benefit coverage approved by your insurance carrier.
    - We will file your insurance claim for you and do everything we can to ensure you receive proper reimbursement, if applicable.
    - If your policy has a deductible feature, it is due at the time of service.
    - We will do our very best to answer any questions you may have in regard to your insurance.
- There will be a $25 charge on all returned checks (plus the original amount of the check)

_____ _____

Patient Signature Date

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Informed Consent

Signing below indicates a request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various methods of physiotherapy and, if necessary, diagnostic x-rays on me by the Doctor of Chiropractic and/ or by any other office or clinic personal.

Possible Risks

I understand and am informed that, as in all healthcare, in the practice of Chiropractic medicine there are some risks to treatment. These risks include but may not be limited to: stiffness, soreness, muscle strain, ligament sprain, fracture, disc injury, dislocation, paralysis, and stroke. The ancillary procedures could produce skin irritations, burns, or minor complications.

Probability of Risks Occurring

The risk of complications due to Chiropractic treatment have been described as rare, about as often as complications are seen from the taking of a single Aspirin tablet. The risk of cervicobrachial injury or stroke has been estimated at one in one million to one in twenty million, and can be reduced even further by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered rare.

Other Treatment Options that Could Be Considered

- Over-the-counter analgesics. The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- Medical care, typically anti-inflammatory drugs, tranquilizers, steroids, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- Hospitalization in conjunction with medical care adds risk of virulent communicable disease in a significant number of cases.
- Surgery in conjunction with medical care adds the risk of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Consent

I acknowledge I have discussed, or have had the opportunity to discuss, with my Chiropractor the nature and purpose of Chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of this Informed Consent waiver. I consent to the chiropractic treatments offered or recommended to me by my Chiropractor. I intend this consent to apply to all my present and future chiropractic care.

_____ _____

Print Patient Name Date

_____

Sign Patient Name

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Notice of Privacy Practices

Authorization for Use or Disclosure of Protected Health Information

We keep a record of the health care services provided to you. You may ask to see a copy of that record. We will not disclose your records to others unless you direct us to, or unless the law compels or requires us to. You may see your record or get more information about it by contacting one of our offices. We may use your health information in the following ways:

- We may share your health information to run our office, collect payment, treat you, thank you for referring others, discuss your case with your family, include you in health care classes, help you collect from your insurance company, inform you about other services, or provide assistance with your diagnoses or treatment from another provider or radiologist.
- We may use your health information for health and safety reasons, court hearings and filings, reporting to law officials, and for reporting victims of abuse.
- We may call you by name in the reception area when the doctor is ready to see you.
- A postcard may be mailed to the address provided by you.
- When telephoning your home, we may leave a message on your answering machine or whomever answers when we call.
- We may include a photo of you on our referral wall.

You have the right to- request a copy of your records, ask to limit the information we share, amend your health information, or request a list of whom we share your records with. You have the right to revoke this authorization in writing at any time, except to the extent that the information has been released in reliance upon this authorization. Our office follows legal and ethical standards pursuant to HIPAA compliance at all times regarding your protected health information.
Please advise our management if you believe your privacy rights have been violated.

By signing below, you consent to our use and disclosure of your protected healthcare information as indicated above and as required by law, and you acknowledge that you have read, understand, and agree to our Notice of Privacy Practices.

_____ _____

Patient Name (Print) Patient Name (Sign)

_____

Date

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No-Call / No-Show Policy

I _____ acknowledge that TLC Family Medical & Wellness Center will charge a fee of $25 for every missed appointment that is not cancelled or rescheduled at least 24 hours in advance. This balance will accrue for each missed appointment, and the total will be forwarded to my attorney upon settlement of my case. To avoid these charges, I understand that I must call at least 24 hours in advance to cancel or reschedule any appointment that I am unable to keep.

_____ _____
Patient Signature Date

_____
Staff Signature

X-ray/ Diagnostic Testing Consent

During the examination the Doctor may feel that additional scans and diagnostic tests will be needed in order to further assess and diagnose your condition. We would like to make you aware that, in those cases, additional x-rays and/ or diagnostic tests may be required in order to accurately diagnose your condition and administer treatment. In order to perform x-rays on any patient, our office requires consent for such tests to be performed.

Please choose one:

- ☐ I understand that my Doctor may need x-rays or diagnostic tests in order to diagnose my condition and I give my consent for all necessary scans and tests.
- ☐ I understand that my condition may require my Doctor to take x-rays to further diagnose my symptoms. I choose not to consent to additional scans or diagnostic tests at this time, and release the Doctor and Family Chiropractic Health Centers of all liabilities that may arise.

_____ _____
Patient Signature Date

_____ _____
Staff Signature Date

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PIP/ MVA Questionnaire

Date of Accident _____

What type and size vehicle were you driving?

☐ Bicycle ☐ Moped
☐ Car ☐ Mini ☐ Small ☐ Midsize ☐ Large
☐ SUV ☐ Small ☐ Medium ☐ Large ☐ Very Large
☐ Pickup Truck ☐ Small ☐ Large ☐ Very Large
☐ Tractor Trailer ☐ With Load ☐ Without Load ☐ Unknown if loaded

Your position in vehicle: ☐ Driver ☐ Front Passenger ☐ Rear Left ☐ Rear Middle ☐ Rear Right
Were you seated in a: ☐ Booster Seat ☐Car Seat

What type and size of the other driver's vehicle?

☐ Bicycle ☐ Moped
☐ Car ☐ Mini ☐ Small ☐ Midsize ☐ Large
☐ SUV ☐ Small ☐ Medium ☐ Large ☐ Very Large
☐ Pickup Truck ☐ Small ☐ Large ☐ Very Large
☐ Tractor Trailer ☐ With Load ☐ Without Load ☐ Unknown if loaded

Were you wearing your seatbelt? ☐ Yes ☐ No

Did your airbag deploy? ☐ Yes ☐ No

Did your seat break in the impact? ☐ Yes ☐ No

Your headrest position relative to your head? ☐ Low ☐ Mid ☐ High ☐ Headrest not present

Did your head hit the headrest? ☐ Yes ☐ No

Your head position at impact? ☐ Ahead ☐ Down ☐ Left ☐ Right ☐ Over left shoulder ☐ Over right shoulder

Did the impact cause any body part to strike any object in the car? ☐ Yes ☐ No
If yes, what part of body? ☐ Back of head/ neck ☐ Front of head ☐ Left side of head ☐ Right side of head
☐ Left chest/ flank ☐ Left Shoulder ☐ Left arm ☐ Left Leg ☐ Left Foot ☐ Left knee
☐ Right chest/ flank ☐ Right Shoulder ☐ Right arm ☐ Right leg ☐ Right foot ☐ Right knee

Which part of automobile? ☐ Airbag ☐ Armrest ☐ Dashboard ☐ Door ☐ Flying object(s) inside vehicle
☐ Headrest ☐ Seat ☐ Steering wheel ☐ Window

Did you receive a head injury from this accident? ☐ Yes ☐ No

Did you lose consciousness? ☐ Yes ☐ No

Where was your vehicle impact location? ☐ Front right ☐ Front left ☐ Front center ☐ Right rear ☐ Left rear
☐ Rear end ☐ Right side (passenger's side) ☐ Left side (driver's side)

Your direction of travel? ☐ Backing up ☐ Moving forward ☐ Stopped ☐ Turning left ☐ Turning right ☐ Unknown
Your estimated speed at time of impact? ☐ Unknown ☐ Not moving ☐ <15mph ☐ 16-25mph ☐ 26-40mph
☐ 40-65mph ☐ >65mph

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Amount of visible damage to your vehicle? ☐ Unknown ☐ No visible damage ☐ Slight visible damage
☐ Moderate visible damage ☐ Heavy visible damage ☐ Totaled

Other vehicle's movement? ☐ Backing up ☐ Stopped ☐ Moving forward ☐ Turning left ☐ Turning right ☐ Unknown

Other vehicle's speed? ☐ Unknown ☐ Not moving ☐ <15mph ☐ 16-25mph ☐ 26-40mph
☐ 40-65mph ☐ >65mph

Estimated damage of other vehicle? ☐ Unknown ☐ No visible damage ☐ Slight visible damage
☐ Moderate visible damage ☐ Heavy visible damage ☐ Totaled

Was your vehicle towed from the scene? ☐ Yes ☐ No ☐ Unknown

Did the police arrive on scene? ☐ Yes ☐ No ☐ Unknown
Was there an accident report? ☐ Yes ☐ No ☐ Unknown

Did EMS arrive in the scene? ☐ Yes ☐ No ☐ Unknown

Did you go to the hospital or home by ambulance? ☐ Arranged for a ride home ☐ Continued on with activities
☐ Denied transportation ☐ Was driven to hospital ☐ Drove home ☐ Was transported to local hospital

Your treatment since accident? ☐ Not treated ☐ Admitted to hospital
☐ Examined ☐ Prescribed medication
☐ X-rayed ☐ Referred for further evaluation and treatment ☐ Referred to a chiropractor
☐ Referred to neurologist ☐ Referred to orthopedist ☐ Referred to primary care provider
☐ Treated by surgeon
☐ Released ☐ Released that day
☐ Treated by self at home: ☐ With heat ☐ With cold ☐ With OTC medication ☐ With rest

Discomfort at time of accident: ☐ Discomfort ☐ Aching ☐ Annoying ☐ Burning ☐ Deep ☐ Diffuse ☐ Dull
☐ Heavy ☐ Intolerable ☐ Pulling ☐ Sharp ☐ "Shock like" ☐ Stabbing ☐ "Stiffness" ☐ Throbbing
☐ "Tightness" ☐ Tingling

Where were your primary (most apparent) symptoms felt at the time of accident?
Head: ☐ Front ☐ Back ☐ Left side ☐ Right side
Cervical (Neck): ☐ Front ☐ Back ☐ Left side ☐ Right side
Thoracic (Mid back): ☐ Right ☐ Left ☐ Central
Lumbar (Low back): ☐ Right ☐ Left ☐ Central
Torso: ☐ Abdomen ☐ Chest ☐ Front of ribs ☐ Back of ribs ☐ Right side of ribs ☐ Left side of ribs
Extremities: ☐Front of right shoulder ☐ Rear of right shoulder ☐ Front of left shoulder ☐ Rear of left shoulder
☐ Front right upper arm ☐ Rear right upper arm ☐ Front left upper arm ☐ Rear left upper arm
☐ Front right elbow ☐ Rear right elbow ☐ Front left elbow ☐ Rear right elbow
☐ Front right wrist ☐ Rear right wrist ☐ Front left wrist ☐ Rear right wrist
☐ Front right hand ☐ Rear right hand ☐ Front left hand ☐ Rear right hand
☐ Front right hip ☐ Rear right hip ☐ Front left hip ☐ Rear left hip
☐ Front right thigh ☐ Rear right thigh ☐ Front left thigh ☐ Rear right thigh
☐ Front right knee ☐ Rear right knee ☐ Front left knee ☐ Rear left knee
☐ Front right leg ☐ Rear right leg ☐ Front left leg ☐ Rear right leg
☐ Front right ankle ☐ Rear right ankle ☐ Front left ankle ☐ Rear left ankle
☐ Top of right foot ☐ Bottom of right foot ☐ Right side of right foot ☐ Left side of right foot
☐ Top of left foot ☐ Bottom of left foot ☐ Right side of left foot ☐ Left side of left foot

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Additional/ supplemental symptoms at the time of accident? ☐ None ☐ Anxiety ☐ Breathing difficulty ☐ Chest pain ☐ Depression ☐ Disbelief ☐ Dizziness ☐ Exhaustion ☐ Facial pain ☐ Genital pain ☐ Gluteat pain (buttocks) ☐Headaches ☐ Irritability ☐ Loss of appetite ☐ Low energy ☐ Muscle spasm ☐ Numbness/ tingling ☐ Rib pain ☐ Shock ☐ Sleeping difficulty ☐ Soreness ☐ Stomach pain ☐ Stress ☐ Stunned ☐ Tightness ☐ Tiredness ☐ Upset

Status of symptoms since accident date: ☐ No change since accident ☐ More pain ☐ More stiffness ☐ Exacerbated ☐ Deteriorated daily functining at work/ home ☐ Worsened ☐ Worsened quality of life ☐ No change in daily functioning at work/ home ☐ Disappeared ☐ Improved ☐ Improved daily dunctioning at work/ home ☐ Less pain ☐ Less stiffness ☐ Lessened ☐ Somewhat resolved

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Insurance Information

Patient's Full Name: _____
Social Security # : _____
Street Address: _____
City: _____ State: _____ Zip: _____

Patient's Personal Insurance: _____
Policyholder's Name (If other than patient): _____
Policy # : _____
Insurance Company Name: _____
Insurance Contact Phone # : _____
Street Address: _____
City: _____ State: _____ Zip: _____
Claim # : _____
Attorney's Name: _____
Adjuster's Name: _____ Contact # : _____

Other Party's Insurance: _____
Other Policyholder's Name (If other than patient): _____
Policy # : _____
Insurance Company Name: _____
Insurance Contact Phone # : _____
Street Address: _____
City: _____ State: _____ Zip: _____
Claim # : _____
Attorney's Name: _____
Adjuster's Name: _____ Contact # : _____

Additional Insurance: _____
Policyholder's Name (If other than patient): _____
Policy # : _____
Insurance Company Name: _____
Insurance Contact Phone # : _____
Street Address: _____
City: _____ State: _____ Zip: _____
Claim # : _____
Attorney's Name: _____
Adjuster's Name: _____ Contact # : _____

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Back Index

ACN Group, Inc. Form BI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ **Date** _____

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.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index Score _____

TLC Family Medical & Wellness Center

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(352)596-1900

Neck Index

ACN Group, Inc. Form NI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ **Date** _____

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.

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.

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).

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.

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.

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 car 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.

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.

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.

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.

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.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Neck Index Score _____

OFFICE OF INSURANCE REGULATION
Bureau of Property & Casualty Forms and Rates

Standard Disclosure and Acknowledgement Form
Personal Injury Protection - Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

1. The services or treatment set forth below were **actually rendered.** This means that those services have **already been provided.**

_____

_____

2. I have the right and the **duty to confirm** that the services have already been provided.

3. I was **not solicited** by any person to seek any services from the medical provider of the services described above.

4. The medical provider has **explained** the services to me for which payment is being claimed.

5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to $500.

Insured Person (patient receiving treatment or services) or Guardian of Insured Person:

Name *(PRINT or TYPE)*	Signature	Date

The undersigned licensed medical professional or medical director, if applicable, affirms the statement numbered 1 above and also:

A. I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.

B. The treatment or services rendered were explained to the insured person, or his or her guardian, **sufficiently** for that person to sign this form with informed consent.

C. The accompanying statement or bill is **properly completed** in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to **truthfully, accurately**, and in a **substantially complete** manner.

D. The coding of procedures on the accompanying statement or bill is proper. This means that **no service has been upcoded, unbundled**, or constitutes an invalid **or not medically necessary diagnostic test** as defined by Section 627.732 (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.

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Hippa Release of Patient Records Authorization

I _____ hereby authorize, _____ to release a copy of all my records/reports containing proceeded information to : Dr David K. Dahmer, DC or Dr Christian Schneider DC for Date of Service:_____

The authorization is given pursuant of Florida statutes 456.051(10) makes clear that any third party to whom records are disclosed in prohibited from further disclosing any information in the records without the expressed written consent of the patient or the patient's legal representatives.

Print: Patient/Legal rep. Name: _____
Signature: Patient/Legal rep. Name: _____
Patients last 4 of SSN: _____ Patients DOB: _____
Date: _____

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To _____
_____
_____

Re: Health Reports and Doctor's Lien Name of Attorney: _____

I hereby authorize and direct my attorney, to pay directly to TLC Family Medical and Wellness Center, such sums as may be due and owing for professional services rendered to me both by reason of this accident and by reason of any other bills that are due to the provider and to withhold such sums from any settlement of judgment as is necessary to adequately protect the provider. I hereby further give a lien to the provider on any proceeds to which I may become entitled as a result of any settlement of judgment in any claim or litigation arising out of the injuries for which I have been treated of injuries in connection therewith, whether such proceeds are remitted directly to me or to you my attorney. I fully understand that I am directly responsible to the provider for all professional bills submitted by the provider for services rendered to me by the provider and that this agreement is made solely for the providers' additional protection and in consideration of the provider awaiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee. Attorney agrees to notify the doctors immediately of the name and contacting information of any attorney substituted in his or her place.

Print Name: _____ Date of Accident: _____
Sign: _____ Today's Date: _____

ACKNOWLEDGEMENT OF ASSIGNMENT & LIEN BY ATTORNEY

The undersigned being the attorney of record on his own behalf and on behalf of any other attorney or attorneys who are associated with the undersigned or who are substituted in his stead for the above patient, does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect, TLC Family Medical & Wellness Center.

Attorney Signature: _____ Date: _____

** NOTE TO ATTORNEY**
PLEASE SIGN AND RETURN ONE COPY TO THE PROVIDER'S OFFICE; KEEP A COPY FOR YOUR RECORDS

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Medical Release

Photocopy of this document shall be sufficient to authorize any person having records of medical treatment, services or supplies pertaining to me to be true copies of same to **TLC Family Medical & Wellness Center Inc.** or any insurer providing coverage to me in connection with the processing of any claims for benefits made by me or by the assignee herin. A photocopy of this document shall be as binding as an original signature page.

The undersigned does herby ratify and confirm any and all actions taken by the said attorney in accordance with this special power and which they said attorney shall do or cause to be done by virtue of these presents.

Release of information: I herby authorize this medical provider to furnish my insurance company or companies and the patient's attorney with any and all information that may be contained in my medical records, to obtain coverage information telephonically from my insurer; to request a written non redacted PIP payout sheet from the insurer; and to obtain copies of my medical records, including but not limited to, documents, reports, scans, notes, options, x-rays, anf MRI's received from any other medical provider or any insurance company. The insurer is directed to keep the patient's medical records private and confidential. The insurer is **NOT** authorized to provide these medical records to anyone, including but not limited to, third party vendors without the patient's and the provider's express written permission.

Assignment of Benefits

I, _____ Herby authorize _____

(Name of insured) (Name of Insurance Carrier)

Payable directly to: **TLC Family Medical & Wellness Center Inc.**

Payable to and mail directly to: **13315 Cortez Blvd. Brooksville, FL. 34613**

Herby IRREVOCABLY ASSIGN to **TLC Family Medical & Wellness Center Inc.** any benefits under any policy of insurance, indemnity agreement, or any other collateral source as defined in Florida Statutes for any services and/ or charges provided by **TLC Family Medical & Wellness Center Inc.** IN WITNESS WHEROF the undersigned have here unto set their hands, this _____ day of _____, 20____.

_____ _____

(Print Name) (Sign Name)