Lane Family Chiropractic

Consultation Sheet

Patient name _____ Date _____

1st Complaint _____ Intensity (1/10) _____

2nd Complaint _____ Intensity (1/10) _____

3rd Complaint _____ Intensity (1/10) _____

Radicular Symptoms _____

Intermitted/Constant _____

Onset _____

_____

_____

Aggravations _____

Past Treatment of complaints _____

_____

_____

Medical/history illness _____

_____

Medication _____

_____

Work Status _____

Dr's Comments _____

_____

Dr. Thomas M. Lane, D.C. _____

Date of accident: _____

Car Insurance: _____

Phone #: _____ Fax: _____

Policy #: _____

Claim #: _____

Claim Address: _____

Adjuster: _____ Phone: _____

Benefits: _____

CHIROPRACTIC REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

_____

Employer/School Phone (____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

2 INSURANCE INFORMATION

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

3 PHONE NUMBERS

Cell Phone (____) _____ Home Phone (____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone (____) _____ Work Phone (____) _____

4 ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No Date _____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable) _____

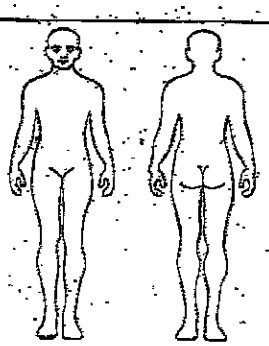
5 PATIENT CONDITION

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

6 HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes	☐ No	Chicken Pox	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Rheumatoid Arthritis	☐ Yes	☐ No
Alcoholism	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Measles	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Allergy Shots	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Migraine Headaches	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Miscarriage	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Anorexia	☐ Yes	☐ No	Fractures	☐ Yes	☐ No	Mononucleosis	☐ Yes	☐ No	Suicide Attempt	☐ Yes	☐ No
Appendicitis	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Multiple Sclerosis	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Goiter	☐ Yes	☐ No	Mumps	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Gonorrhea	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Bleeding Disorders	☐ Yes	☐ No	Gout	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Tumors, Growths	☐ Yes	☐ No
Breast Lump	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Parkinson's Disease	☐ Yes	☐ No	Typhoid Fever	☐ Yes	☐ No
Bronchitis	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	Pinched Nerve	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Bulimia	☐ Yes	☐ No	Hernia	☐ Yes	☐ No	Pneumonia	☐ Yes	☐ No	Vaginal Infections	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Herniated Disk	☐ Yes	☐ No	Polio	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Cataracts	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Prostate Problem	☐ Yes	☐ No	Whooping Cough	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No	Prosthesis	☐ Yes	☐ No	Other _____		
			Kidney Disease	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No	_____		

EXERCISE
- ☐ None
- ☐ Moderate
- ☐ Daily
- ☐ Heavy

WORK ACTIVITY
- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ Heavy Labor

HABITS
- ☐ Smoking — Packs/Day _____
- ☐ Alcohol — Drinks/Week _____
- ☐ Coffee/Caffeine Drinks — Cups/Day _____
- ☐ High Stress Level — Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date _____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

7 MEDICATIONS

_____

_____

_____

Pharmacy Name _____

Pharmacy Phone (____) _____

ALLERGIES

VITAMINS/HERBS/MINERALS

Vehicle Accident Information

PATIENT INFORMATION

Date:

Patient Name: | Date of Accident: | Time of Accident:

Please describe the accident in your own words:

Were you the: ☐ Driver ☐ Passenger (☐ Front or ☐ Back) ☐ Pedestrian

How many people were in the accident vehicle?

ACCIDENT SITE

Street/Road Name:

City/State:

Nearest Intersection:

Driving conditions: ☐ Dry ☐ Wet ☐ Icy ☐ Other

Which direction were you heading:

How fast were you travelling: mph

YOUR VEHICLE

Make/Model:

Were you wearing a seatbelt? ☐ Yes ☐ No
If yes, was it: ☐ Lap ☐ Shoulder ☐ Both

Was the vehicle equipped with airbags? ☐ Yes ☐ No
If yes, did they inflate properly? ☐ Yes ☐ No

Did your seat have a headrest? ☐ Yes ☐ No
If yes, what position was it in? ☐ Low ☐ Mid ☐ High

OTHER VEHICLE (if applicable)

Make/Model:

Which direction was it travelling?

How fast was it travelling? mph

POLICE

Was police at the site of the accident? ☐ Yes ☐ No

Were there any witnesses? ☐ Yes ☐ No

Was a police report filed? ☐ Yes ☐ No

Was a traffic violation issued? ☐ Yes ☐ No
If yes, to whom?

IMPACT

Did your car collide with another vehicle? ☐ Yes ☐ No

Did your car collide with a structure? ☐ Yes ☐ No
If yes, explain:

Did any part of your body strike anything in the vehicle?
☐ Yes ☐ No
If yes, explain:

Was impact from: ☐ Front ☐ Rear ☐ Left ☐ Right
☐ Other If other:

At the time of impact were you:
☐ Looking straight ahead ☐ Looking to the right
☐ Looking to the left ☐ Looking down
☐ Looking up

Were both hands on the steering wheel? ☐ Yes ☐ No
If no, which hand was on the wheel? ☐ Left ☐ Right

Was your foot on the brake?
☐ Yes (☐ Left or ☐ Right) ☐ No

PATIENT CONDITION

Were you unconscious immediately after the accident? ☐ Yes ☐ No If yes, for how long?

Describe how you felt immediately after the accident: _____

TREATMENT

Did you go to the hospital as a result of the accident? ☐ Yes ☐ No

When did you go? ☐ Immediately after the accident ☐ Next Day ☐ 2 days or more after the accident

How did you get to the hospital? ☐ Ambulance ☐ Private transportation

Name of hospital:

Name of doctor:

What was diagnosis? _____

What treatment was given? _____

Were X-rays taken? ☐ Yes ☐ No If Yes, what area(s) of body were x-rayed? _____

SYMPTOMS/INJURIES

Have you been able to work since this injury? ☐ Yes ☐ No If no, how many work days have you missed?

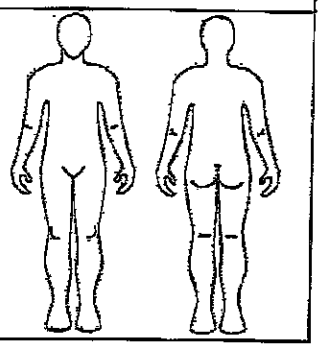
Prior to the injury were you able to work on an equal basis with others your age? ☐ Yes ☐ No

Have you had any of the following symptoms since your injury (check all that applies):

☐ Arm/shoulder pain	☐ Ear ringing	☐ Jaw problems	☐ Shortness of breath
☐ Back pain	☐ Fatigue	☐ Leg pain	☐ Sleep difficulty
☐ Back stiffness	☐ Feet/toe numbness	☐ Memory loss	☐ Stomach upset
☐ Chest pain	☐ Hand/finger numbness	☐ Nausea	☐ Tension
☐ Dizziness	☐ Headaches	☐ Neck pain	☐ Vision blurred
☐ Ear buzzing	☐ Irritability	☐ Neck stiff	

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale of 1 (least pain) to 10 (severe pain)

Type of Pain:

☐ Sharp	☐ Dull	☐ Throbbing	☐ Numbness
☐ Aching	☐ Shooting	☐ Burning	☐ Tingling
☐ Cramps	☐ Stiffness	☐ Swelling	☐ Other

If Other, please specify:

How often do you have this pain?

Is it constant or does it come and go?

Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Movements that are painful to perform:

☐ Sitting ☐ Standing ☐ Walking
☐ Bending ☐ Lying Down

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line)

1. 3. 2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH. # ( )

a. b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB 0938-0999 FORM CMS-1500 (08/05)

WCMS-1500CS

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SECOND FOLD

FIRST FOLD WHCGF-10-ENV / WHGF-10-ENV-SIS

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.

Comprehensive Exam, Adjustments, Ems, US, Hot/Cold packs, Massage Therapy, Therapeutic Exercises, Stretches, ADL, Home Supplies, X-rays, Report of findings.

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(11)(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.

OIR-B1-1571
Pub. 1/2004

Assignment of benefits form, authorization to provide copy of updated un-redacted personal injury protection payout sheet and escrow instruction.

The undersigned patient hereby assigns the benefits of insurance and any and all causes of action to this medical provider, Lane Family Chiropractic under the applicable policy of automobile insurance for services rendered to the undersigned patient by Lane Family Chiropractic, and covered by the personal injury protection (PIP) and/or medical payment coverage and in accordance with Florida Statue section 627.736. The undersigned further agrees to pay any applicable deductible or co-payment not covered by the PIP insurance coverage. Additionally, upon forwarding payment for any medical services and/or supplies, I direct my applicable personal injury protection and/or medical payments insurance carrier to provide my medical provider with a copy of an updated un-redacted complete PIP payout sheet upon request along with a copy of the application policy of insurance and declarations page. I hereby instruct my insurance carrier to escrow the exact amount of any disputed medical bills owed to the medical provider. Should this escrow request not be honored by the insurance carrier, this medical provider place the carrier on notice that it will seek payment of the disputed bills above the policy limits should the benefits be subsequently exhausted. This request for a reserve can be amended by me in writing, in event I have a wage loss claim and direct my insurance to pay this first.

Signature of patient

Date

Lane Family Chiropractic

Our financial policy

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professionalism. Please ask if you have any questions about our fees, financial policy, is your responsibility.

-All patients must complete our "patient information form" before seeing the doctor.
-If you do not have insurance or do not provide us with your insurance information, payment will be due at the time service is rendered.
-We accept Cash, Checks, and Visa/Master card

Adult patients
Adult patients are responsible for full payment at time of service.

Minors accompanied by an adult
The adult accompanying a minor and his/her parents (guardian) are responsible for full payment at the time of service.

Regarding Insurance
If you have insurance we will help you receive maximum benefits. We cannot guarantee insurance coverage on your first visit. We suggest YOU call your insurance company BEFORE making an appointment to verify chiropractic benefits.

On subsequent visits we MAY accept your insurance if you obtain approval from our office staff prior to the date of service. If we accept your insurance, you must pay your co-pay or percentage of charges at the time of service (some procedure require 50% payment). If your insurance company has not paid the FULL BALANCE with 45 days you have 15 days to pay the balance. Late payment charges are added to unpaid accounts after 60 days from the time of service. If your insurance company pays more than the balance due; we will send a refund check to you immediately.

Insurance is a contract between you and your insurance company. We will inform you if we are a party to your insurance contract, and will handle your claims according to our agreement with the insurance company, if one exists. We file insurance claims as a COURTESY to our patients. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary charges", etc., other than to supply actual information as necessary. You are responsible for the timely payment of your account.

Medicare/Medicaid/Worker's Compensation
If you are covered by Medicare, Medicaid, Worker's Compensation, or any other government sponsored program, please discuss your payment situation with our office staff prior to date of service. Medicare patients must pay at time of services. If you choose we will file your Medicare claim for you for your reimbursement.

Missed appointments
Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of $35.00. Please help us serve you better by keeping scheduled appointments.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

Responsible Party Signature:_____ Date: _____

VERIFICATION OF NON PREGNANCY

By my signature on this form I,_____ do hereby state that, to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at the time of my signature below.

Signature:_____ Date:_____

Witness:_____

CONSENT TO TREAT MINOR CHILD

I hereby authorize Dr. Thomas M. Lane and/or whomever he may designate as Doctor and assistants to examine and administer treatment as they deem necessary to my child_____.

Signed in _____, Florida on this _____day of_____, 20___.

Signature:_____

Relationship to Child_____

Witness: _____

TREATMENT WITHOUT X-RAYS

I_____ have requested treatment without x-rays in consideration of the foregoing, I hereby release and forever discharge the aforesaid Dr. Thomas Lane from any and all responsibility of liability of any kind, nature or character whatsoever from the beginning of the world to this day. This transaction is consumed at my specific request.

_____ _____

Signature of Patient Date

_____

Witness

Patient Name: _____

Health Care Authorization Form

The patient identified above authorizes Lane Family Chiropractic to use and/or disclose protected health information in accordance with the following:

- I give permission to Lane Family Chiropractic to use my address, phone number, and clinical records to contact me with birthday cards, holiday related cards, recall cards, testimonials, appointment reminders, telephone calls and information about treatment alternatives or other health related information.
- I give permission to Lane Family Chiropractic to treat in an open door room. I am aware that the other persons in the office may over hear some of my protected health information during the course of the care. Should I need to speak with the doctor at any time in private, the doctor will provide a room for these conversations.
- By signing this form you are giving Lane Family Chiropractic permission to use and disclose your protected health information in accordance with the directives listed above.

Expiration

The authorization shall expire on the following date: _____

Right to Revoke Authorization

You have the right to revoke this authorization, in writing, at any time. However, your written request to revoke authorization is not effective to the extent that we have provided services or taken action in reliance on your authorization.
You may revoke this authorization by mailing or hand delivering a written notice to the Privacy Official of Lane Family Chiropractic. The written notice must contain the following: your name, Social Security number, date of birth, a clear statement of your intent to revoke the authorization, the date of our request and your signature.
This revocation is not effective until it is received by the Privacy Official.
This authorization is requested by Lane Family Chiropractic for its own use/disclosure of PHI. (Minimum necessary standards apply.)
You have the right to sign this authorization. If you refuse to sign this authorization, Lane Family Chiropractic will not refuse to provide treatment.

_____ _____

Patient Signature Date

Acknowledgement of Receipt of Notice of Privacy Practice

I understand and have been provided with a Notice of Information Practice that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

_____ _____

Patient Signature Date

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as a cervical arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with the potential lead to a stroke. This occurs in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with spine stroke is exceedingly rare and is estimated to be related in one million to one in two million cervical adjustments.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other options about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient name: _____ Signature: _____ Date: _____

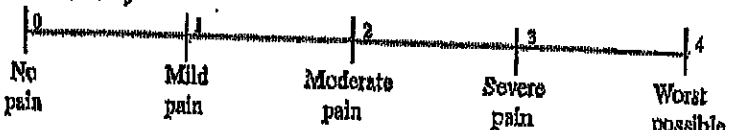
Witness name: _____ Signature: _____ Date: _____

Functional Rating Index

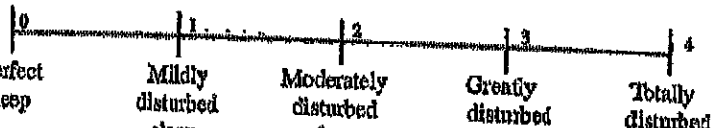
For use with Neck and/or Back Problems only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.
For each item below, **please circle the number which most closely describes your condition right now.**

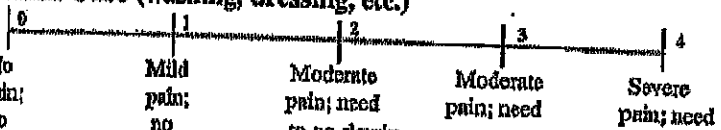
1. Pain Intensity



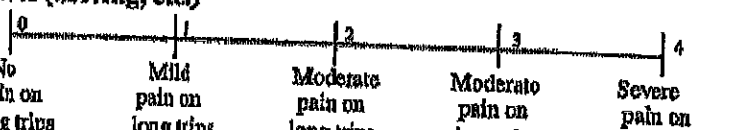
2. Sleeping



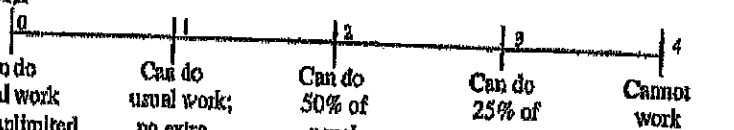
3. Personal Care (washing, dressing, etc.)



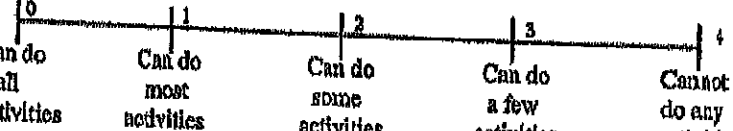
4. Travel (driving, etc.)



5. Work

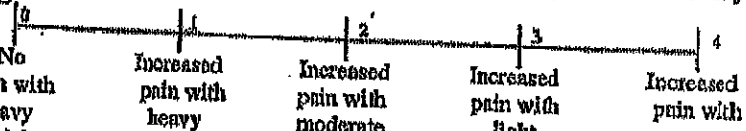


6. Recreation

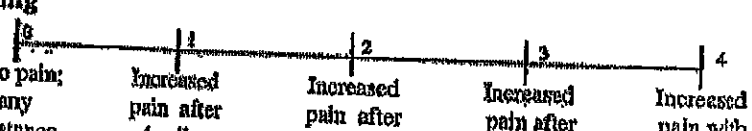


7. Frequency of pain

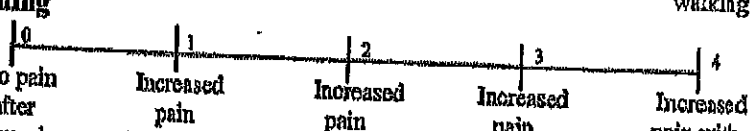
8. Lifting



9. Walking



10. Standing



Total Score_____

Name _____
PRINTED

_____
Signature

_____
Date

DIAGNOSTIC IMAGING CONSULTANTS

Rudy N. Heiser, DC, MS, DACBR, Richard A. Leverone, DC, DACBR, FICC
Terry Sandman, DC, MPH, DACBR, A. Scott Thorpe, DC, DACBR

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1307 W. FLETCHER AVE. TAMPA, FL 33612
PH: (813) 968-4293 Fax: (813) 968-3182
Films/Date Exposed *Medical History*

****Please print and complete form with patient's signature****

Patient Name _____ Date of Birth _____ Sex ___M___F
Address _____ City/State/Zip _____
Phone _____ SS# _____ Case/Acct# _____

BILL: ____ PIP ____ Health/Other Ins. ____DR. ____Atty. ____Patient

Primary Insurance: _____ Phone _____
Adjuster _____ ID/Claim# _____
Address _____ Insured _____
City/State/Zip _____ Date of Injury____/____/____

Attorney: _____ Phone _____
Address _____ City/State/Zip _____

****

ASSIGNMENT, LIEN AND AUTHORIZATION/INSURANCE BENEFITS

For and in consideration of receiving services by "Assignee" and for other good and valuable consideration, I hereby agree to the following: I authorize assignee to release any information pertinent to my case to any insurance company, adjuster, or attorney to facilitate collection under this Assignment, Lien, Reservation of Benefits and Authorization.

ASSIGNMENT OF BENEFITS, RESERVATION AND REQUEST TO ESCROW ANY DISPUTED BENEFITS:

I HEREBY ASSIGN MY insurance benefits and any and all causes of action available under my policy of automobile insurance to, DIAGNOSTIC IMAGING CONSULTANTS OF ST. PETERSBURG, P.A d/b/a DIAGNOSTIC IMAGING CONSULTANTS hereinafter, collectively referred to as the Assignee. Additionally, both the assignee and the undersigned patient acknowledge they are foregoing or assuming certain rights under this agreement that they would not otherwise have under normal circumstances, and as such, agree the same serves as additional consideration for this assignment of benefits to the provider/assignees. In the event my insurance company, obligated to make payments to me upon charges made by assignee for services, refuses to make or reduces such payments and in order to maximize the benefits available under my policy coverage, I hereby request the insurance company (assuming there is coverage remaining at the time the company receives the Assignees' bill and if the company fails to pay Assignee the full amount of the bill(s) submitted), to avoid exhaustion of coverage while Assignee pursues its rights under this Agreement, both parties to this agreement (the Assignee and I) further authorize, direct, notice and request the Insurance Company to set aside and place in escrow an amount equal to the full amount of any such denial or reduction, and to hold that amount in escrow until the dispute is resolved in the appropriate forum.

IN THE EVENT MY insurance company obligated to make payments to me upon the charges made by Assignee for their services refused to make such payments, upon demand by me or Assignee, I hereby assign and transfer to Assignee any and all causes of action that I might have or that might exist in my favor against such company and authorize Assignee to prosecute said cause of action either in my name or in Assignee name and further I authorize Assignee to compromise, settle or otherwise resolve said claim or cause of action as they see fit.

I AUTHORIZE ASSIGNEE to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under this Assignment, Lien and Authorization. I agree that the above mentioned Assignee be given Special Power of Attorney to endorse/sign my name on any and all checks and claim forms for payment of my bill.

I UNDERSTAND THAT I remain personally responsible for the total amounts due the Assignee for their services as insurance coverage may only pay a certain percentage of the bill; as, I may have an insurance deductible or my insurance benefits may exhaust or otherwise be limited. I further understand and agree that this Assignment, Lien and Authorization does not require Assignee to await payments and they may demand payments from me immediately upon rendering services at their option, although the Assignee agrees to first demand immediate payment from the insurance company as their first means of pursuing payment for services rendered. Also, I understand that if this account is assigned to an attorney for collection and/or suit, the assignee shall be entitled to reasonable attorney fees and costs of collection. I also understand that, if any bad check is written, I agree to pay for those added costs.

Dated this _____ day of _____, 20 ___.

Patient Signature _____ **Printed Name** _____ **Witness** _____

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