**** PLEASE READ BEFORE PROCEEDING

- Please fill out this packet completely. Fill in every line with as much detail to your knowledge.
- Please Sign and Date every sheet where highlighted.
- Consult the front desk if you have any questions or concerns to what you're signing.

It is our goal to provide outstanding care. Our mission at North Tampa Spine & Joint Center is to exceed your every expectation in health care.

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Personal Injury Questionnaire

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

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

Are Text Reminders ok?_____ Cell Phone: _____ Date of Birth:_____

Emergency Contact:_____ Contact Number:_____ Relationship:_____

I will be paying today by: __Cash __Check __Credit Card Social Security # _____

Email:_____ Occupation:_____

Previous Chiropractic Care? Y / N Name of Previous Chiropractor:_____

Last Chiropractic Treatment? _____ Primary Care Physician: _____

What type of care are you interested in? ☐ Pain relief only ☐ Healing condition ☐ Optimizing your health

What is your **long term goal** from treatment (ex. play round of golf):_____

Is today's visit due to a work related injury? Yes / No Is today's visit due to an auto accident? Yes / No

(If yes to either question above, check with the receptionist, additional information is needed.)

(Patients Auto Insurance Co)_____ Phone:_____

Mailing Address: _____ City:_____ State: ____ Zip:_____

Policy #_____ Claim #_____

Adjuster: _____ Phone#_____ Ext_____ Fax _____

*Name of Driver of Other Vehicle*_____ *Phone #* _____

Mailing Address: _____ *City:*_____ *State:* ____ *Zip:*_____

*Other Driver Insurance Co*_____ *Policy #:*_____

*Insurance Adjuster:*_____ *Phone #* _____*Ext*_____ *Fax #*_____

Patient Signature_____

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1. What was the date of the accident?_____
2. What time did the accident occur?_____
3. How many vehicles were involved in the accident?_____
4. What was the estimated damage to the vehicle you were in? _____
5. What state did the accident occur in? _____
6. What city did the accident occur in? _____
7. What street or intersection you were on when the accident occurred? _____
8. What direction were you traveling in? _____
9. What type of impact was the auto accident? _____
10. Did your vehicle hit anything after the accident? if yes, please describe

    _____

11. Where were you sitting in the vehicle during the accident? _____
12. Did you know the accident was coming?_____
13. What type of vehicle were you in? _____
14. What type of vehicle impacted yours? _____
15. At the time of the impact, how fast was your vehicle moving? _____
16. At the time of impact, how fast was the other vehicle moving? _____
17. During and after the crash what happened to your vehicle? (check all that apply)
    - ☐ kept going straight
    - ☐ kept going straight hitting a car in front
    - ☐ was hit by another vehicle
    - ☐ spun around
    - ☐ spun around and hit a stationary object
    - ☐ hit a stationary object
18. Did you lose consciousness during the accident? ☐ yes ☐ no
19. How was your head positioned during the accident? _____
20. How was your torso positioned during the accident? _____
21. How were your hands positioned during the accident? _____
22. Did your head hit anything during the accident? ☐ no ☐ yes, please describe_____
23. Did your face hit anything during the accident? ☐ no ☐ yes, please describe_____
24. Did your shoulders hit anything during the accident? ☐ no ☐ yes, please describe_____
25. Did your neck hit anything during the accident? ☐ no ☐ yes, please describe_____

Patient Signature_____

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26. Did your chest hit anything during the accident? ☐ no ☐ yes, please describe._____

27. Did your hips hit anything during the accident? ☐ no ☐ yes, please describe_____

28. Did your knees hit anything during the accident? ☐ no ☐ yes, please describe_____

29. Did your feet hit anything during the accident? ☐ no ☐ yes, please describe_____

30. What kind of headrest was in your vehicle?
    - ☐ movable fixed headrest
    - ☐ non-movable fixed headrest
    - ☐ no headrest

31. Where was the headrest positioned on your head? _____

32. Did you have your seatbelt on during the accident? ☐ yes ☐ no

33. Did you slide out of your seatbelt during the accident? ☐ yes ☐ no

34. What was damaged in your vehicle? (Check all that apply)

☐ windshield	☐ rear bumper	☐ mirror
☐ steering wheel	☐ front bumper	☐ knee bolster
☐ dashboard	☐ trunk	☐ back right door
☐ seat frame	☐ front left door	☐ completely totaled
☐ side window	☐ front right door	
☐ rear window	☐ back left door	

35. Choose the items that dented inward:
    ☐ floor boards ☐ side door ☐ dashboard

36. Choose the doors that would not open as a result of the accident.
    ☐ front left ☐ front right
    ☐ rear left ☐ rear right

37. Did you go to the hospital? ☐ yes ☐ no -- If no, why not (do not answer 38-43)

    _____

38. How did get to the hospital? _____

39. What was the name of the hospital? _____

40. Were you hospitalized overnight? _____

41. Circle what you were prescribed at the hospital
    ☐ pain medication ☐ muscle relaxers ☐ neck brace

42. Did you receive any stitches for any cuts at the hospital? _____

43. Were x rays, MRI's, or CT's taken at the hospital? If yes, which area was taken?

    X-Rays: _____

    MRI's/CT's: _____

North Tampa
Spine & Joint Center

Chief Complaint_____

When did symptoms begin?_____ Have you had this problem before?_____

Was the Onset: ☐ Gradual ☐ Sudden Since its Onset, has it gotten: ☐ Worse ☐ Better

Describe what caused the pain:_____

Have you detected any possible relationship of your current complaint with any of the following?

☐Muscle Weakness ☐Bowel/Bladder problems ☐Digestion ☐Cardiac/Respiratory ☐Other:_____

Have you tried any self-treatment or taken any medication (over the counter or prescription)? ☐Yes ☐No

If Yes, Explain:_____ Results:_____

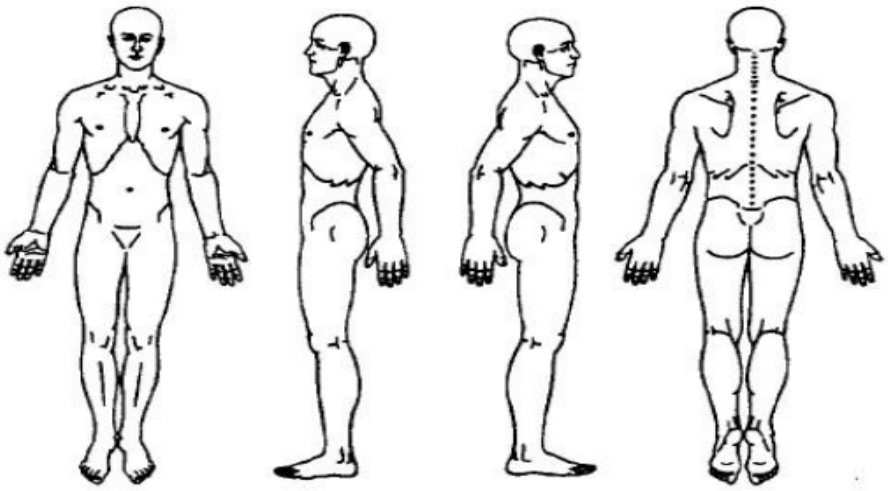
List Medications:_____

Currently Pregnant? ☐Yes ☐No Are you currently taking anti-coagulant or blood thinning meds? ☐Yes ☐No

PAIN CHART

Please Mark Areas of Pain using these Codes!

+++	Burning
###	Dull/Ache
***	Numbness/Tingling
===	Throbbing
000	Stabbing/Sharp



(Front) (Left) (Right) (Back)

SEVERITY OF PAIN

List region of pain and *circle the number*, which represents the intensity of your pain.

1. Complaint:_____ No pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable
2. Complaint:_____ No pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable
3. Complaint:_____ No pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable

Office Use Only:

HT_____, WT_____, BP_____, Pulse _____, OxySat _____Prev Chiro_____Benefits _____

Patient Signature_____ Date_____

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PAST HEALTH HISTORY: would you say your health is (check one): ☐Excellent ☐Very Good ☐Good ☐Fair ☐Poor

1. Have you ever experienced your present problem before for which you are consulting us: ☐Yes ☐No

   If yes, When:_____. Was treatment provided? ☐Yes ☐No If yes, by whom:_____

2. Have you ever had a stroke or issues with blood clotting? ☐Yes ☐No If yes, when:_____

3. Have you recently experienced dizziness, unexplained fatigue, weight loss, or blood loss? ☐Yes ☐No

4. Have you ever had any major illnesses, injuries, broken bones, hospitalizations, accidents, or surgeries? ☐Yes ☐No

Date	Injury/Fracture/Illness/Surgery	Treatment	Results

SOCIAL HISTORY

Recreational Activities (Hobbies):_____

☐Yes ☐No Do you exercise?_____ times per week.

☐Yes ☐No Do you smoke?_____packs per day.

☐Yes ☐No Do you consume alcohol? How many drinks per week?_____

☐Yes ☐No Do you use tobacco? What/How much per day?_____

☐Yes ☐No Do you get adequate sleep? If no, Explain:_____

☐Yes ☐No Is your life stressful? If yes, Explain:_____

☐Yes ☐No Do you use recreational drugs? If yes, Explain:_____

Do you or have you ever had any problems with the following areas? (please mark **Y** or **N** in each of the following:)

1. _____Eyes
2. _____Ears, Nose, Mouth, Throat
3. _____Heart
4. _____Lungs/Breathing
5. _____Digestion/Bowels
6. _____Urinary
7. _____Muscles Pain or weakness
8. _____Nerves
9. _____Joints/Bones
10. _____Skin
11. _____Internal Organs
12. _____Blood
13. _____Allergies

Please explain any (yes) answers in space below:

_____

_____

_____

_____

_____

Family Health History (indicate which family member)

☐ Heart Disease_____ ☐ Cancer_____

☐ Diabetes_____ ☐ Arthritis_____

☐ Other _____

Patient Signature_____ Date_____

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

*DO NOT SIGN UNTIL YOU HAVE REVIEWED THE LAMINATED COPIES GIVEN WITH PACKET!

_____Patient Name (**please print**) Date_____

_____ (if a minor) Parent, Guardian or Patient's Legal representative

_____ **Signature**

CONSENT TO TREAT

I have read or had read to the Informed Consent to treat, alternative treatments, and treatment results of a chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING I have made my decision voluntarily and freely.
*DO NOT SIGN UNTIL YOU HAVE REVIEWED THE LAMINATED COPIES GIVEN WITH PACKET!

_____ Signature of Patient Date_____

_____Signature of Parent or Guardian Date_____

AUTHORIZATION AND ASSIGNMENT & OFFICE POLICIES

I acknowledge that I have read and agree to the Authorization and Assignment. I understand it is my duty to pay all debts in full to North Tampa Spine & Joint Center.
*DO NOT SIGN UNTIL YOU HAVE REVIEWED THE LAMINATED COPIES GIVEN WITH PACKET!

_____ Signature of Patient Date_____

_____Signature of Parent or Guardian Date_____

**This form will be placed in the patient's chart and maintained for six years.*

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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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ASSIGNMENT OF BENEFITS, LIENS, DIRECT PAYMENT AUTHORIZATION, AUTHORIZATION TO RELEASE INSURANCE INFORMATION, AND AUTHORIZATION TO ESCROW UNPAID MEDICAL & PIP BENEFITS – North Tampa Spine & Joint Center Inc.

INSURANCE CARRIER: _____ POLICY NUMBER: _____ DATE OF LOSS: _____

For and in consideration of North Tampa Spine & Joint Center Inc. agreeing to pursue the responsible automobile insurance carrier for payment of benefits due and not requiring prepayment for services, I hereby irrevocably assign all (absolutely all) rights and benefits to North Tampa Spine & Joint Center Inc. for Personal Injury Protection, extended Personal Injury Protection, Medical Payment Coverage, and other benefits which I may have in accordance with Florida Statute §627.736. This includes any benefits from my insurance company and any other entity which may be responsible for medical expenses incurred. I further authorize North Tampa Spine & Joint Center Inc. to collect payments & prosecute any necessary actions to collect payment for services as they see fit and allowable by law and contract. THIS DOCUMENT CONSTITUTES AN ABSOLUTE ASSIGNMENT OF RIGHTS AND BENEFITS.

I hereby further give a lien to North Tampa Spine & Joint Center Inc. against any and all insurance benefits named herein, and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by North Tampa Spine & Joint Center Inc. as a result of the above stated loss date. This document acts as an irrevocable and absolute assignment of all of my rights and benefits under all policies of insurance for which I am entitled to coverage thereupon. I agree to cooperate with North Tampa Spine & Joint Center Inc. and their attorneys (at their choosing), and to do all things reasonable to effect payment of the bills by the insurance company or other entity to North Tampa Spine & Joint Center Inc. including, but not limited to, disclosing my medical condition, being available for factual discovery or other cooperation.

This assignment concerns the bills for North Tampa Spine & Joint Center Inc. and those costs including, but not limited to, attorneys fees, other costs, and interest necessary in procuring payment from the above-named insurance company and/or other entities. This assignment is not intended to assign any other causes of action that may belong to the undersigned patient. I agree to pay any applicable deductible or co-payment not covered by any policy of insurance cited above. I understand that as a benefit and convenience to me, North Tampa Spine & Joint Center Inc. will bill and pursue collection against the insurance company or other responsible entity on my behalf. I hereby instruct and direct my insurance company to pay my benefits directly to North Tampa Spine & Joint Center Inc. at the address provided on the bill. If my current policy prohibits direct payment to doctors, then I hereby instruct and direct my insurance company or other responsible entity to make the check payable to me and mail it to North Tampa Spine & Joint Center Inc. at the address on the bill. North Tampa Spine & Joint Center Inc.'s medical care is being provided for a reasonable fee for treatment causally related to the above loss date and is medically necessary. I instruct my insurance carrier or other responsible entity to pay these bills to the full extent of my available benefits under the insurance policy and Florida law. If any portion of the charge for these services is either reduced or denied in whole or in part, my insurance company or other entity is to place funds equal to the amount of the reduced or denied charges into escrow and hold the escrowed funds until agreement or resolution of legal action by North Tampa Spine & Joint Center Inc. I further instruct my insurance company to make payment for charges submitted by North Tampa Spine & Joint Center Inc. in priority to any other requests to escrow benefits, including a request by myself to reserve benefits for pending disability claims. I hereby give North Tampa Spine & Joint Center Inc. limited power of attorney to endorse and sign my name on any draft for payment to either North Tampa Spine & Joint Center Inc. or myself if said draft represents payment for charges related to services rendered by North Tampa Spine & Joint Center Inc.

I further direct my insurance carrier or responsible other entity to provide information to North Tampa Spine & Joint Center Inc. which is otherwise available to me including but not limited to a copy of any applicable insurance policy, declaration page, all applicable endorsements, transcripts and/or copies of any recorded statements, examinations under oath and requests for same, independent medical evaluations and requests for same, peer review reports and listing of all PIP benefits paid to date which shall include when claim were made, when the claims were received, the payment or denial of each claim, the amount of the deductible and the claims applied thereto, and whether benefits have been exhausted and the amount of PIP benefits available, commonly known as a "PIP log". This request includes the name of other medical providers to whom payments have been made under my policy of insurance. This agreement is intended to serve as an assignment of rights and benefits under my policy of insurance in favor of North Tampa Spine & Joint Center Inc. If any language within this agreement has the effect of invalidating this agreement, that language shall be deemed void and the remainder of the assignment shall maintain full force and effect. A photocopy of this assignment shall be considered as effective and valid as the original.

_____ _____ _____

Patient Signature Date Patient Name

If patient is incapacitated or under the age of 18, please indicate the patient name, guardian name and relation to patient, and obtain guardian signature.

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North Tampa
Spine & Joint Center

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

DATE: _____

I HEREBY REQUEST THAT MY MEDICAL RECORDS FROM:

_____

BE RELEASED TO:

Dr. Travis Mohr
Phone: 813-983-7921
Fax: 813-333-2788

North Tampa Spine & Joint Center
17429 Bridge Hill Court
Tampa, FL 33647

I ASK THAT MY RECORDS BE:

- ❑ Mailed
- ❑ Faxed

This authorization is given pursuant to Florida Statute 456.057 and HIPAA regulations. I understand that Florida Statute 456.057 (12) makes clear that any third party to whom records are disclosed is prohibited from further disclosing any information in the medical record without the expressed written consent of the patient or the patient's legal representatives.

SPECIFICALLY INCLUDE:

MEDICAL RECORDS: (___)
X-RAYS: (___)
OTHER:_____ (___)

PATIENT NAME *(Print Please)*_____

PATIENT NAME *(Signature Please)*_____

DATE OF BIRTH: _____ **SOCIAL SECURITY #:**_____

LOP

SENT (VIA FAX) TO ATTORNEY: _____ FAX No.: (___)_____

Patient/Client Name: _____ Date of loss: _____/___/_____

Provider: North Tampa Spine & Joint Center - 17429 Bridge Hill Ct. Tampa, FL 33647

I, the undersigned patient, hereby instruct my attorney to execute this irrevocable Attorney's Letter Of Protection, herein referred to as LOP, in favor of Provider to insure that Provider is paid in full for any and all treatment and services provided by it to me, or on my behalf, as a result of the accident that took place on or about the date of loss described above, regardless of the outcome of a trial or what a jury may award me for the injuries that I have suffered. I understand that recovery is often uncertain, owing to the strategies, tactics and opinions offered at trial by defense lawyers who are working for insurance companies with significant resources to combat the reasonable claims brought by me, the injured patient.

Unfortunately, until the at-fault driver, or his/her insurance carrier, (the at-fault insurance company), on the at-fault driver's behalf, accepts responsibility for the negligent conduct, I have no way to compensate said Provider for the care and treatment that it will provide me under this LOP. Despite the fact that the at-fault driver is insured under a policy of insurance that provides for bodily injury coverage, the at-fault insurance carrier has no fully accepted responsibility for the negligent conduct of their insured. Because of the delay on the part of the at-fault insurance carrier, I hereby request that my attorney protect and pay my outstanding charges after attorney's fees and costs, from any settlement or funds received by me, or in my beneficial interest, from any source, as compensation for any damages I may have sustained as a result of the events that occurred on or about the date of loss described above. I further authorize my attorney to enter into a different Attorney's LOP acceptable to my attorney and Provider, but if no agreement for a different Attorney's LOP is made, then I instruct that this Attorney's LOP shall be the Attorney's LOP in force and instruct my attorney to comply with its terms and conditions. I further instruct that my instructions to attorney herein are irrevocable and shall and are transferable to any future attorney of mine in the event that I change my legal representation in regard to the damages contemplated herein.

Please execute and return this Attorney's LOP to Provider immediately upon your receipt of it.

The terms of this Attorney's LOP are as follows:

- IF the bills protected by this letter are for treatment of an auto accident, then in regard to PIP covered charges this LOP is valid for outstanding PIP covered charges, only if PIP is appropriately billed and pursued by the Provider pursuant to FS627.736(5).
- This LOP shall not be assignable or transferable to another provider.
- Upon request and periodically, Provider will forward updated bills and medical records to the patient or to the patient's attorney and note to the Patient unless requested otherwise in writing.
- Provider will refrain from any and all collection efforts during litigation.
- Should Provider not agree to the sums available for payment to Provider, then Patient's attorney shall post funds, in an amount no less than the disputed charges, in the registry of the court for appropriate judicial determination.
- Provider is acting in reliance on the terms of this agreement for the provision of treatment and services contemplated herein.
- The terms contained herein are accepted as adequate consideration for this agreement by the signatories below.
- The Provider is allowed to request a copy of final settlement disbursements.
- In the event of a breach of this contract the at fault party shall be liable to absorb legal fees.

Agreed by the undersigned on the dates shown below: WHEN SIGNED PLEASE FAX TO 813-333-2788

_____	_____	_____
Patient's Printed Name	Patient's Signature	Date
_____	_____	_____
Provider's Agent, Printed	Provider's Signature	Date
_____	_____	_____
Attorney's Printed Name	Attorney's Signature	Date