MVA

Name____DOB________________ DOA______________

Address____ Phone__________________

Email________________________________Attorney______________Ins Company______________

□ **Male** □ **Female** **Height** _________ **Weight** ________

Are you: □ Right handed □ Left handed □ Ambidextrous (both)

What is your nationality? ____________________

What is your Primary Language: ______________________ **What is your secondary language:** ________________

Which language do you feel more comfortable speaking? ________________________

ACCIDENT DETAILS:

Were you the: □ Driver □ Passenger □ Back Passenger □ Pedestrian (not in car)

Were you wearing seat restraints? □Full lap and shoulder □Lap only □Shoulder only □Not wearing seatbelt

What was your vehicle doing just prior to the accident?

□ Stopped at a red light □ Making a turn □ Going through and intersection □ Changing lanes

□ Other: ____________________________

Traveling at an approximate speed of: ____________________ **mph**

Who hit who? □ You were struck by another car □ You struck the other car

What type of vehicle struck you? ____________________

In your own words, please explain how the accident happened: ______________________________

____

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Where was your vehicle impacted? (Check all that apply)

□Front □ Back □ Driver's side □ Passenger's side □ Front Drive's side □ Front Passenger's side

□ Back driver's side □ Back Passenger's side □ Front and Back

Did your vehicle airbags deploy? □ Yes □ No

Did you lose consciousness at the time of accident? □ Yes □ No

Did police arrive? □ Yes □ No **Was a Police Report taken?** □ Yes □ No

Did you receive medical attention at the scene of the accident? □ Yes □ No

Were you transported to the ER? □ Yes □No If yes, by who: ____________________________

Did you seek medical attention after the accident? □ Yes □ No

If yes, where and by whom: ____

Have you seen a Chiropractor since the accident? □ Yes □ No

If yes, what kind of treatment did you have? ____

How many weeks of treatment have you had? ____________ How many times a week do you go? ______________

How much have you improved since starting treatment? ___________%

Were X-rays taken? □Yes □ No Office: __________________ **MRI?** □Yes □ No Office: __________________

Body part? ____________________________ **Body part?** ____________________________

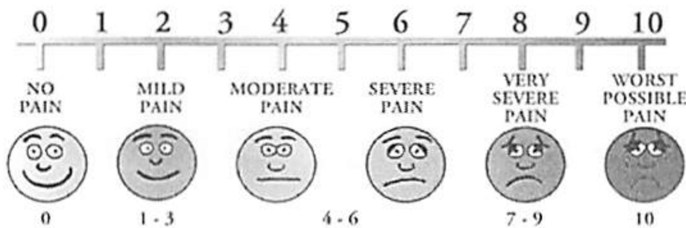
____
Patient Signature

Body Part: Mark ONLY injured parts	Frequency See definitions below:	Pain Quality Dull/Stabbing/Sharp/ Throbbing/Aching	Severity of Pain Using the pain scale below:	Pain Radiation: Does your pain radiate anywhere?	Numbness/Tingling Down upper extremities/ lower extremities?
Neck					
Shoulder (L/R)					
Mid Back					
Lower Back					
Knee (L/R)					
Other(s)					

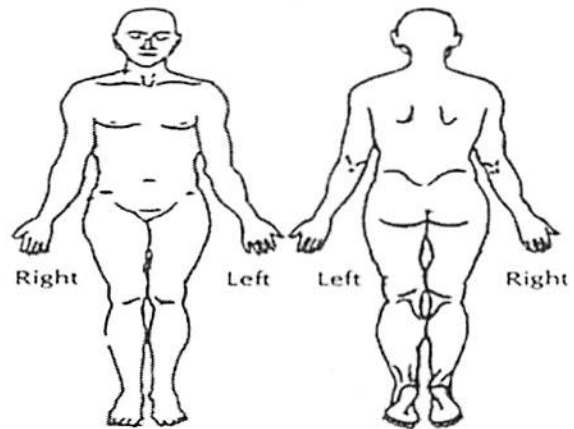
Frequency Definition:

□100% - Continuous □90% - Constant □75% - Frequent □50% - Intermittent □25% - Occasional

↓ **Severity of Pain**



← **Place an X on the body parts you are having pain**



Activities of Daily Living:

Sleeping:	□No Difficulties	□Some Difficulties	□Moderate Difficulties	
Bathing:	□No Difficulties	□Some Difficulties	□Moderate Difficulties	□Unable, need assistance
Dressing:	□No Difficulties	□Some Difficulties	□Moderate Difficulties	□Unable, need assistance
Walking:	□No Difficulties	□Some Difficulties	□Moderate Difficulties	□Unable, need assistance
Driving:	□No Difficulties	□Some Difficulties	□Moderate Difficulties	□Unable, need assistance
Cooking:	□No Difficulties	□Some Difficulties	□Moderate Difficulties	□Unable, need assistance

Past Medical History

□Heart Problems □PaceMaker or Stents □High Blood Pressure □Kidney Problems □Thyroid Problems
□Anemia □Diabetes □Seizures □Anxiety/Depression □Osteoporosis □Insomnia □ Stomach/Bowel
□Bleeding Problems/Clotting Problems □High Cholesterol □Headaches □Asthma/Emphysema/Sleep Apnea □ Arthritis
□ Other ________________ □Cancer/History of Cancer (what type) ________________ □NONE OF THE ABOVE

Have you ever had prior surgeries? □Yes □ No

1.Date__________ Procedures______________________________ 2.Date__________Procedures______________________

3.Date__________ Procedures______________________________ 4.Date__________ Procedures______________________

Have you had any PAST Accidents ? □Yes □ No **Type of accident** □Motor Vehicle □Slip & Fall □At Work

If yes, **what year?**________________ **what did you injure?**______________________________

Did you receive treatment for it? □ Yes □ No If yes, What kind of treatment? ______________________

____
Patient Signature

Prescription Medications/ Over the Counter/ Vitamins ☐N/A

Name of Medication	Dosage (mg)	Times per day

Are you ALLERGIC to any medications? ☐Yes ☐ No

Medication Allergy	Reaction

Are you ALLERGIC to LATEX or RUBBER? ☐ Yes ☐ No Reaction: ______________________________

PERSONAL DETAILS:

What is your occupation? How long have you been employed there?

What is your marital status? ☐ Single ☐ Married ☐ Divorced ☐ Widow ☐ Other

Do you have any children? ☐ Yes ☐ No If yes, How many? __________

Are you currently pregnant? ☐ Yes ☐ No If so, how far along are you? _________

Do you consume any tobacco/nicotine? ☐ Yes ☐ No

Do you consume Alcohol? Never Socially Occasionally other__________________

Any use of illicit drugs? ☐Yes ☐No If so, What kind of drugs?

REVIEW OF SYSTEMS: Please Check All That Apply

General: ☐Fever ☐Chills ☐Loss of Appetite ☐Sleep Disturbance ☐Unexplained Weight Loss/Gain ☐Night Sweats

EENT: ☐Blurry Vision ☐Double Vision ☐Wear Glasses ☐Sore Throat ☐Nasal congestion/Sinus Issues ☐Hearing Loss

Respiratory: ☐Cough ☐COPD ☐Wheezing ☐Recurrent Upper Respiratory Infections ☐Shortness of Breath

Endocrine: ☐Excessive Thirst ☐Temperature Intolerance ☐Feeling Tired/Fatigue ☐Hot Flashes

Cardiovascular: ☐Chest Pain ☐Irregular Heart Beat ☐Heart Attack ☐Heart Failure ☐Palpitations ☐Varicose Veins

Gastrointestinal: ☐Abdominal Pain ☐Nausea/Vomiting ☐Heartburn ☐Blood in Stool ☐Diarrhea/Constipation ☐Rectal Bleeding

Psychological: ☐Depression ☐Anxiety ☐Trouble Concentrating

Hematologic/Lymphatic: ☐Swollen Glands ☐Blood Clotting ☐Easy Bruising ☐Bleeding Tendencies ☐Prone to infections

Genitourinary: ☐Painful Urination ☐Urinary Frequency ☐Loss of Urinary Control ☐Difficulty Urinating

Skin: ☐Skin Rash ☐Itching ☐Lump or Masses ☐Discoloration of the Skin

Musculoskeletal: ☐Joint Pain ☐Joint Swelling ☐Back Pain ☐Limitation of Motion ☐Neck Pain ☐Pain with Walking

Neurological: ☐Tremors ☐Dizzy Spells ☐Numbness/Tingling ☐Headaches ☐Feeling Weak ☐Convulsion/Seizure

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Patient Signature

PATIENT – ATTORNEY

MEDICAL LIEN AGREEMENT

I, ____ do hereby authorize Stanger Healthcare Center to furnish my attorney, with prepaid copies of medical records relevant to my injury or accident for which he/she is representing me.

I further authorize and direct my attorney to pay directly to Stanger Healthcare Center such sums of monies as may be due and owing to them, (a) for medical services rendered to me for the injury and/or, (b) for any other services, supplies, or reports, and/or (c) legal medical (i.e. impairment rating reports, attorney-physician conferences, and depositions) and to withhold such sums from any settlement or judgment as may be necessary to adequately protect and pay for my treatment. I hereby grant a lien on my claim against any and all proceeds of any settlement or judgment which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated for/or other related services.

I fully understand that I am directly and fully responsible to the above health care provider for all medical bills submitted by them for services rendered to me and that this agreement is made solely for their additional protection and in consideration of the services provided. I further understand that such payment is not contingent on any insurance company's determination, with the exception of a recognized workers compensation case, as to the appropriateness of services rendered and/or fees charged.

By my signature below, I hereby waive and/or relinquish my right to contest and/or otherwise make any legal objections as to the appropriateness of this agreement and that my attorney has advised me of same. I understand that this agreement shall be governed by the laws of the State of Florida.

Patient Signature: ______________________________ Print/Type: ____________________________

ATTORNEY AGREEMENT AND ACCEPTANCE

The undersigned being the attorney for the above client (patient), does hereby agree to observe all the terms of the above agreement to withhold such sums from any settlement or judgment as may be necessary to adequately protect the above listed health care providers and to promptly pay such sums to them upon receipt of payment of any settlement or judgment without demand.

Date: ________________

____

Attorney's Signature

Print/Type ______________________ State Bar No. __________________

Address ____

ASSIGNMENT OF INSURANCE BENEFITS, RELEASE, & DEMAND ***Insurer and Patient Please Read the Following in its Entirety Carefully!***

I, the undersigned patient/insured knowingly, voluntarily and intentionally assign the rights and benefits of my automobile insurance, also known as Personal Injury Protection (hereafter PIP) and Medical Payments policy of insurance to the above health care providers (Stanger Healthcare Center). I understand it is the intention of the provider to accept this assignment of benefits in lieu of demanding payment at the time the services are rendered and that this document will allow the provider to file suite against an insurance company for payment of the insurance benefits. I understand the provider may file a lawsuit against my insurer for payment and if the provider's bills are paid or applied to a deductible I agree this will serve as a benefit to me and I authorize and request such litigation. This assignment of benefits includes the cost of transportation, medications, supplies, overdue interest and any potential claim common law or statutory bad faith/unfair claims handling. If the insurer disputes the validity of this assignment of benefits then the insurer is instructed to notify the provider in writing within five days of receipt of this document. Failure to inform the provider shall result in a waiver by the insurer to contest the validity of this document. The undersigned directs the insurer to pay the healthcare provider directly without reductions & without including the patient's name on the check. To the extent the PIP insurer contends there is a material misrepresentation on the application for insurance resulting in the policy of insurance is declared voided, rescinded or canceled, I, as the named insured under said policy of insurance, hereby assign the right to receive the premiums paid for my PIP insurance to this provider and to file suit for recovery of the premiums. The insurer is directed to issue such a refund check payable to this provider only. The insured and the provider hereby contests and objects to any reductions or partial payments. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by the provider shall be done so under protect, at the risk of the insurer, and the deposit shall not be deemed a waiver or agreement by the provider to accept a reduced amount as payment in full. The insurer is hereby placed on notice that this provider reserves the right to seek the full amount of the bills submitted. If the insurer schedules a defense examination or examination under oath (hereinafter "EUO") the insurer is hereby INSRTUCTED to send a copy of said notification to this provider. The provider or the provider's attorney is expressly authorized to appear at any EUO or IME set by the insurer. The assignment applies to both past and future medical expenses and is valid even if undated. A photocopy of this assignment is to be considered as valid as the original. I agree to pay any applicable deductible, copayments, for services rendered after the policy of insurance exhausts and for any other services unrelated to the automobile accident.

Release of Information: I hereby authorize this provider to: furnish an insurer, an insurer's intermediary, the patient's other medical providers, and the patient's attorney via mail, fax, or email, with any and all information that may be contained in the medical records; to obtain insurance coverage in writing and telephonically from the insurer; request from any insurer all explanation of benefits (EOBs) for all providers and non-redacted PIP payout sheets; obtain any written and verbal statements the patient or anyone else provided to the insurer, obtain copies of the entire claim file and all medical records, including but not limited to, documents, reports, scans, notes, bills, opinions, X-rays, IMEs and MRIs, from any other medical provider or any insurer. The provider is permitted to produce my medical records to its attorney in connection with any pending lawsuits. I permit a copy of this authorization to be used in place of original. Regulations pertaining to Medicare benefits also apply.

Demand: Demand is hereby made for the insurer to pay all bills within 30 days without reductions and to mail the latest non-redacted PIP payout sheet and the insurance coverage declaration sheet to the above provider within 15 days. The insurer is directed to pay the bills in the order they are received. However, if a bill from this provider and a claim from anyone else is received by the insurer on the same day the insurer is directed to not apply this provider's bill to the deductible. If a bill from this provider and claim from anyone else is received by the insurer on the same day then the insurer is directed to pay this provider first before the policy is exhausted. In the event the provider's medical bills are disputed or reduced by the insurer for any reason, or amount, the insurer is to: set aside the entire amount disputed or reduced; escrow the full amount at issue, and not pay the disputed amount to anyone or any entity, including myself, until the dispute is resolved by Court. Do not exhaust this policy. The insurer is instructed to inform, in writing, the provider of any dispute.

Certification: I certify that: I have read and agree to the above; I have not been solicited or promised in exchange for receiving health care; I have not received any promises or guarantees from anyone as to the results that may be obtained by any treatment or service; and I agree the provider's prices for medical services, treatment and supplies are reasonable, usual and customary. Caution: Please read before signing. Please ask to view a copy of our charges. If you do not completely understand this document please ask us to explain it to you. If you sign below we will assume you understand and agree to the above. Patient's Name______________________ Patient's

Signature____________________________________ (Please Print) (If patient is a minor, signature of parent/guardian)

Consent to Treatment:

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures from SHCC and their affiliated facilities. Since Chiropractic is a health care profession distinct and separate from medicine, it is important that you understand some fundamental distinctions concerning Chiropractic care. Experience shows that informed patients make better choices concerning their health care. Chiropractors do not diagnose or treat specific disease conditions such as cancer, diabetes, etc. Chiropractors are trained in the detection of Vertebral Subluxation Complex (VSC). VSC concerns the integrity of the spine, the central and peripheral nervous system, and the muscular system. Extensive scientific evidence suggests that imbalances in the musculoskeletal system can affect the ability of the nervous system to accurately transmit information to and from the muscles, organs and glands of the body. This nervous system interference decreases the body's natural recuperative ability. Chiropractic treatment in the Clinic consists of various procedures aimed at decreasing or eliminating nervous system interference and to increase the overall level of body function. You will receive nutritional recommendations if our analysis shows this would enhance your overall body function and well-being. Such advice is only a recommendation and is not to be considered treatment of a specific pathology. I have been advised that although the incidence of complications associated with chiropractic services is very low, anyone undergoing adjusting or manipulative procedures should know of possible complications which have been alleged. Those include, but are not limited to, fractures, disk injuries, strokes, dislocations, sprains, and those which relate to physical aberrations unknown or reasonably undetectable by the doctor. I have read or have had read to me and understand the above consent. I understand my condition as the doctor has explained it to me. I understand the possible risks and complications of treatment. I also understand the alternative to the proposed treatment and the doctor's opinion concerning the consequences of not receiving treatment. The doctor has explained the probability of a satisfactory response to treatment and that he cannot guarantee a successful outcome. By signing below I also authorize any holder of medical information about me to be released to HCFA and its agents any information determine coverage or medically necessary procedures for payment of any claim. I authorize SHCC to submit claims to my insurance company, my signature authorizes my information to be released to the insurer, and agency or company being billed also releasing my medical records to refer to by treating provider in an effort to provide the most efficient treatment and/or imaging.

Printed Patient Name	Patient Signature	Date Signed

Consent of Treatment of a Minor (if acquirable):

I hereby authorize SHCC to perform diagnostic tests and render chiropractic treatment to my minor child date of birth . I hereby affirm that I have the legal right to select and authorize health care services for the minor child named above. (If applicable) Under the terms and conditions of my dissolution of marriage or separation, I have the legal right to select and authorize this care for my minor child without consent of my spouse/former spouse. If my authority to authorize such care is revoked or modified, I will immediately notify this office. I understand that the practice of chiropractic medicine is not an exact science and that my child's care may involve the making of judgments based on the facts known to the doctor at the time; that it is not reasonable to expect the doctor to be able to anticipate or explain all risks and complications; that an undesirable result does not necessarily indicate an error in judgment or treatment; that no guarantee as to results has been made to or relied upon by me, and I wish to rely on the doctor to exercise judgment during the course of the procedure which he or she feels at the time, based on the facts then known, is in my child's best interests. I have also been advised that, although the incidence of complications associated with chiropractic services is very low, anyone undergoing adjustment or manipulative procedures should know of possible complications which have been alleged. These include, but are not limited to, fractures, disk injuries, strokes, dislocations, sprains and those which related to physical aberrations unknown or reasonably undetectable by the doctor. I have read or have had read to me the above consent. I have also had an opportunity to ask questions about its contents, and by signing below on behalf of my minor child, acknowledge my understanding of its contents.

Date Minor Child's Name Printed	Authorized Parent/Guardian Printed Name	
Authorized Parent/Guardian Signature	Relationship of Authority to Minor Patient	Date Signed

Consent for use and disclosure of Health Information: PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting: SHCC Front Office Staff at Phone Number: (561)-498-4300.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE: I, ______________________________, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: ______________________________ Date: ______________

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: ______________________________ Relationship to Patient: ______________

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Print Name of Patient: ______________________________ Date of Birth: ____________________

I. My Authorization:

I authorize the following using or disclosing party: *Stanger Healthcare Center* to obtain, request or disclose the following health information:

☐ - All of my health information including imaging and any health information relating to the following treatment, condition and/ or date range:

____

II. My Rights:

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Signature of Patient: ______________________________ Date: ______________

If the patient is a minor or unable to sign, please complete the following:

☐ - Patient is a minor: __________ years of age

☐ - Patient is unable to sign because: ____