AUTOMOBILE ACCIDENT QUESTIONAIRE

BROOKSVILLE CHIROPRACTIC

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

Patient Name _____ Date of Birth _____ Chart # _____

Date of Accident _____ Time of Accident _____A.M./P.M.
Patient's auto insurance carrier _____ Policy # _____ Claim # _____

*Please **circle** the correct statement below.
Were you the: driver , passenger , pedestrian , other _____
If you were NOT the driver, Name of the driver of the vehicle in which you were injured _____
Insurance company of driver _____ Policy #_____

At the time of impact you were: parked , moving , stopped at traffic light/stop sign , other _____
Street that accident occurred _____ Nearest cross street _____
City and State that the accident occurred _____
Direction your vehicle was heading: North , South , East , West
Direction other vehicle involved in accident was heading: North , South , East , West
What was your vehicle point of impact? Rear , Front , Driver's side , Passenger's side , other _____
Did your vehicle strike another vehicle? YES , NO
Your location in the vehicle: Front seat , Back seat , Third row , other _____
Were you using your seat belt? YES , NO
As a result of the accident, were traffic citations issued to you? YES , NO
To the driver of the other vehicle YES , NO . Or the driver of the vehicle in which you were injured YES , NO
Were police notified? YES , NO
Were you knocked unconscious? YES , NO If so, for how long?_____
Did airbags deploy? YES , NO

Where did you feel pain IMMEDIATELY following the accident? _____
Did you receive care at the accident scene? YES , NO
Where were you taken following the accident? _____
How did you get there? Ambulance , Car
What treatment was given (x-rays, CT scan, MRI, medication)? _____
Was any other physician consulted since the time of the accident? YES , NO
If so, what was the doctor's name: _____
What was your diagnosis? _____
What treatment was given? _____
How often did you see this doctor? _____
Have you EVER had ANY previous trauma (motor vehicle accidents, work injury…)? YES , NO
If so, please describe (when, did you receive treatment…)_____
_____
Have you EVER had complaints in the currently involved areas? YES , NO
If so, please describe _____

Before this injury were you capable of working on an equal basis with others your age? YES , NO
Are your work activities restricted as a result of this accident? YES , NO
Have you lost any days of work? YES , NO Dates_____

Since the time of the injury, are your complaints: Getting Worse, Same, Improving

Have you been contacted by an insurance adjuster or company representative regarding this claim? YES , NO

Name of adjuster _____

Have you retained an attorney regarding this accident? YES , NO

Name of Attorney _____ Phone number of Attorney _____

Explain in detail how your accident happened:_____

Brooksville Chiropractic Inc.
813 S. Broad Street
Brooksville, Fl. 34601
P:352-799-3433
F:352-799-3320

Chart#_____

PATIENT INFORMATION

Full Name:_____ Birth Date:_____ Gender: M / F

Address:_____City:_____State:____Zip:_____

Email address :_____

Home Phone:_____ Evening/Cell:_____
Work Phone:_____ SS#_____-___-_____

Marital Status: S M W D Sep Spouse Name:_____Birth Date:_____

Are You A Minor Y / N Are You A Student Y / N

Your Employer:_____Your Occupation:_____
Employer Address:_____

Spouse Employer:_____Spouse Occupation:_____

Insurance (Please allow our staff to photocopy your health insurance cards)

Name of Primary Insurance:_____ID#:_____

Name of Insured if Different from Patient:_____Date of Birth:_____

Relationship to Patient:_____

Name of Seconday Insurance:_____ID#:_____

- I authorize payment of medical benefits to this office.
- I will allow this office to treat me, with other health care providers present, and to record my medical information, including consultation and examination, for documentation purposes, if necessary.
- There will be a $25.00 charge for any Returned/NSF checks and missed appointments.
- We utilize Capital Accounts for any Delinquencies.

Patient's Signature:_____ Date:_____
Spouse / Guardian's Signature:_____ Date:_____
(Authorization expires 3 years from date above)

Brooksville Chiropractic Inc.
813 S. Broad St.
Brooksville, Fl. 34601
(352)799-3433

Patient DOB: _____
Patient MR#: _____

CASE HISTORY

Full Name:_____Date:_____

Present Injury/Illness
Please list below complaint(s) you have in order of importance. Also the length of time you have had these complaint(s).

1. **_____How long?_____**
2. **_____How long?_____**
3. **_____How long?_____**

Is your condition(s) related to an accident: __YES __NO
Date of accident:_____Type of accident: __Auto __Work Related__Other_____
Have you had any previous Trauma or Accidents? When _____

What makes your complaint feel worse? _____
What makes your complaint feel better? _____

Have you seen any other health care provider for you present condition? __YES __NO
Who? _____
Current Medications _____ ( ) None
Allergies _____ ( ) None

Have you ever been treated by a chiropractor? __YES __NO
Are you or could you be pregnant? __YES __NO 1st day of last menstrual period _____

Do you use __Alcohol __Tobacco __Other Substances: _____ ( ) None

Are you experiencing or do you have any of the following?

__ A sore that won't heal	**__ Difficulty swallowing**	**__ Persistant cough/hoarseness**
__ Any bleeding/discharge	**__ Lump/thickening anywhere**	**__ Wart/mole changes**
__ Bladder/bowel problems	**__ Night pain**	**__ Weight loss without trying**
		__ None of the above

<u>Review of Systems</u>
In addition to the symptom(s)/dysfunction(s) listed above, are you experiencing any of the following?
Neuromusculoskeletal System

__ Anxiety	**__ Facial drooping**	**__ Loss of balance**	**__ Seizures**
__ Atrophy	**__ Headache**	**__ Memory loss**	**__ Sensory changes**
__ Concussion	**__ Joint deformity**	**__ Mood swings**	**__ Speech problems**
__ Depression	**__ Joint locking**	**__ Muscle weakness**	**__ Stiffness**
__ Tremors	**__ Joint swelling**	**__ Numbness**	**__ Difficulty walking**
__ Dizziness	**__ Lack of coordination**	**__ Popping noises**	**__ Twitches**
__ Vision trouble	**__ Limited range of motion**	**__ Extremity deformity**	**__ Psychiatric disorders**
			__ None of the above

Cardiovascular System

__ Ankle Swelling	**__ Chest pain**	**__ Jaw pain**	**__TIA**
__ Blood clots	**__ Dizziness**	**__ Known vascular disease**	**__ Previous stroke**
__ Fainting	**__ Carotid blockage**	**__ Mitral valve prolapse**	**__ Shortness of breath**
__ Hypertension	**__ Changes in skin color**	**__ Phlebitis**	**__ Varicose veins**
			__ None of the above

<u>Past History</u>
List any surgeries you have had (including appendix, tonsils, and wisdom teeth)
1. _____Date_____ 3. _____Date_____
2. _____Date_____ 4. _____Date_____

Have you ever been hospitalized in addition to surgeries? __YES __NO
If so, when and for what reason? _____
Have you ever been diagnosed with any condition? (diabetes, heart trouble, cancer, stroke, rheumatoid, etc.)
__YES __NO _____
Do you have a family history of any disease? (diabetes, heart trouble, cancer, stroke, rheumatoid, etc.)

__Yes __NO _____

Are you currently under a doctor's care for conditions other than ones you are seeking care for today?

__YES __NO _____

Updated 9/09

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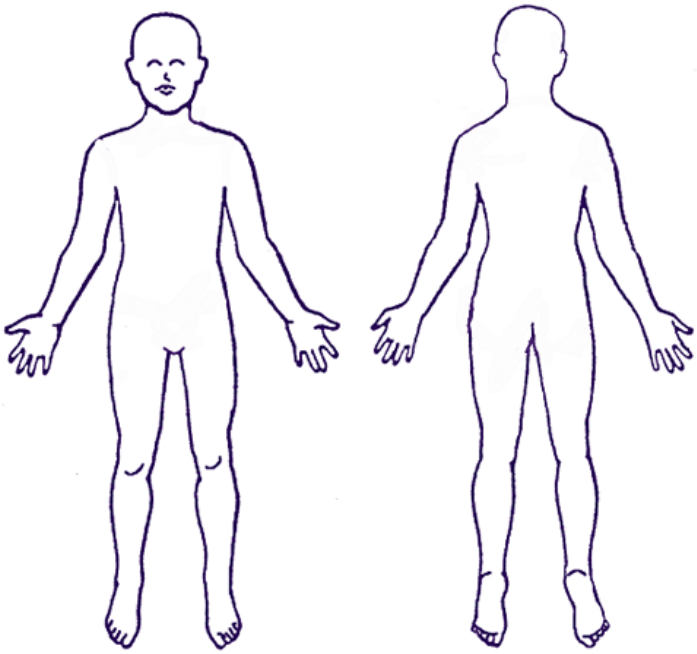
PAIN DRAWING

Patient Name:_____
Date:_____

Please mark the areas where you feel the following sensations:

DULL = D	BURNING = B
NUMBNESS = N	TINGLING = T
ACHE = A	SHARP = S



Indicate severity of pain by marking an X on the appropriate number:
(0 means no pain- 10 means worst possible pain)

How bad is your Neck Pain? 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

How bad is your Back Pain? 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

How bad is your Arm Pain? 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

How bad is your Leg Pain? 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Chart # _____
Date of Birth _____

Brooksville Chiropractic, Inc
813 South Broad St
Brooksville, FL 34601

Agreement to Office Policies:

By initialing the statements listed below, I acknowledge that I have read, understand and agree to abide by the policies of this office:

_____I agree to follow the doctor's appointment schedule.

_____I understand that it is my responsibility to inform the office of any address or telephone number changes.

_____I understand that my payment is due at the time of service (Self-pay, co-payments, and deductibles)

_____I understand that refunds will be issued within 4-6 weeks from the date requested, if there are no pending insurance claims.

_____I understand the Cancellation Policy. It states that if I have a scheduled appointment that I will not be able to make, it is my responsibility to call and reschedule the appointment with 24 hours notice. Failure to do this will result in a service charge of $25, which will be billed to me directly, and is not payable by insurance, lien, worker's comp,

_____I understand that a returned check will result in a $25 service charge and all future payments will only be accepted in the form of cash or credit card.

_____I understand that there is a $25 charge for the completion of paperwork (disability, FMLA, etc).

_____I agree to follow all other recommendations made by the doctor(s), including the proper use of spinal supports, doing my exercises as prescribed, etc.

_____I agree to make a personal financial agreement and promptly fill out all necessary medico legal and insurance forms to aid in the timely payment for my care.

_____I understand that Brooksville Chiropractic offers a time of service discount. In order to be eligible for this discount, two requirements must be met: payment must be made in full at the time of service, and Brooksville Chiropractic will not file any insurance claim.

_____I have received a copy of Brooksville Chiropractic's Notice of Privacy Practices.

If I elect to use my health care coverage:

Brooksville Chiropractic will file my insurance claim as a courtesy; however, I am ultimately responsible for understanding my insurance policy. The office has a relationship with me, the patient, not my insurance company. Although Brooksville Chiropractic does attempt to verify my chiropractic benefits with my insurance policy, I realize this is only an estimate of my coverage based on the information given to Brooksville Chiropractic at the time of inquiry. If a service is not covered and needs to be performed, I am responsible for these fees at the time of service. I understand that if my insurance company has not paid my claims within sixty (60) days, a copy of that unpaid claim will be given to me and I will be responsible to follow up on the status of payment. I will also inform Brooksville Chiropractic of any changes to my insurance policy so my coverage can be re-verified prior to my appointment.

Brooksville Chiropractic realizes that temporary financial problems may affect timely payment of you account. If such problems do arise, we urge you to contact us promptly for assistance in the management of your account. If you have any questions about the above information, please do not hesitate to ask us. **WE are here to help YOU**!

_____

_____

Patient Signature Date

Brooksville Chiropractic, Inc.

813 S. Broad St

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Phone: 352-799-3433

Fax: 352-799-3320

Consent to Treat Notice

I _____ hereby request and consent to the performance of chiropractic treatments and other chiropractic/medical procedures, including various forms of physical therapy and diagnostic x-rays by Brooksville Chiropractic, Inc. This consent is extended to other licensed chiropractic physicians, chiropractic assistants, or licensed massage therapists, who now or in the future, are employed by, working with or associated with this office.

I certify that I have had the opportunity to discuss, with the doctor of chiropractic and/or other office personnel, the nature and purpose of the care that is being provided. I understand that the results are not guaranteed. Further, I have been informed and I understand that, as in the practice of any of the healing arts, in the practice of chiropractic, there are some risks to treatment, including, but not limited to,

fractures, disc injuries, strokes, dislocations, and sprains. I also understand that the doctor, who has explained all of these things to me, is not expected to be able to anticipate and explain all risks and complications. I will rely on the doctor to exercise appropriate judgement during the course of care, based on the facts known at this time, and in my best interest.

My signature below certifies that I have read, or have had read to me the above consent. I also certify that I have had the opportunity to ask questions and options to care have been explained. By signing this consent form, I agree to the care being provided to me for the entire course of treatment for m present condition(s) and for any future condition(s) for which I seek treatment.

Patient or Representative Signature	Troy M. Robinson, D.C. Doctor's Name
Witness's Signature	Doctor's Signature
Date	

Release of Protected Health Information Authorization Form

Brooksville Chiropractic, Inc.

813 S. Broad St

Brooksville, FL 34601

Phone: 352-799-3433

Fax: 352-799-3320

Patient Information:
Name: _____ Date of Birth:_____

Address:_____
Phone number:_____ SSN:_____

Information Requested From:
Facility releasing information:_____

Address:_____
Phone number:_____ Fax:_____

Information Requested:
□ Chart Abstract(Specify dictated report/office visit date or range):_____

□ Diagnostic Report(specify date and test type): _____

□ Radiology Films(specify date and type):_____

□ Exclusions:_____

PURPOSE OF DISCLOSURE:_____

I hereby release Brooksville Chiropractic, Inc and it's employees, agents, officers, and affiliates from any and all liability, responsibility, claims and damages which may result from the release of information incurred due to this authorization. I hereby authorize the use or disclosure of my individual, identifiable protected health information about me as described above. I understand that this authorization is voluntary. This release includes complete medical records/reports unless specifically listed above under exclusions. I understand that should I wish to revoke this authorization I must provide written notice to Brooksville Chiropractic, Inc. However, I understand that any action taken in reliance on this authorization can not be reversed and my revocation will not affect those actions. This authorization shall expire ninety (90) days from the date set forth below, or upon the following date, event, or condition:_____

FEES FOR COPIES: Federal law permits a fee to be charged for copying of medical records. You may be required to
pre-pay for this copies, if not then you copies will be mailed along with an invoice.

_____ _____ _____
Signature of Patient or Representative Relationship Date

_____ _____
Witness Date

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Assignment and Authorization

For good and valuable consideration, including the agreement of Brooksville Chiropractic, Inc. to accept this assignment in lieu of demanding full payment for services rendered from the undersigned on the date each service is rendered, the undersigned patient executes this document hereby assigning to Brooksville Chiropractic, Inc. the right to receive insurance benefits directly from any insurance company that may be obligated to provide insurance benefits, to me or on my behalf, for services rendered by Brooksville Chiropractic, Inc. for a motor vehicle accident that occurred on or about _____.

Any insurance company that may be obligated to pay any insurance benefits to me, or on my behalf, for the aforesaid accident for services provided by Brooksville Chiropractic, Inc. is hereby directed to issue payment for those benefits directly and payable to Brooksville Chiropractic, Inc.

I also authorize and assign to Brooksville Chiropractic, Inc. the right to file suit and pursue all legal remedies to obtain payment for services provided to me by Brooksville Chiropractic, Inc. This authorization to file suit is an assignment of my cause of action to obtain payment for services provided to me by Brooksville Chiropractic, Inc. and includes the assignment to pursue declaratory relief or any other legal remedies.

Brooksville Chiropractic, Inc. accepts the aforesaid assignment and hereby notifies any insurer issuing payment that Brooksville Chiropractic, Inc. objects to any “repricing” or reduction of billed amounts unilaterally made by any insurer. Any such reduced payments issued by any insurer are accepted under protest and without waiving any right of the provider to pursue all legal remedies against the insurer.

Please read this document completely before signing. If you do not completely understand this document or you have any questions about this document, please ask us to explain it to you. If there is any portion of this document that you do not wish to authorize, we will remove that portion from this document. Your signature below is your agreement that you fully understand this document and you fully agree to the terms of this document.

_____	_____
Patient/Guardian Signature	Date
_____	_____
Witness to Patient Signature	Date
_____	_____
Authorized Signatory for Provider	Date

Troy M. Robinson, D.C.

813 South Broad St.

Brooksville, FL 34601

Letter of Protection

I do hereby authorize Brooksville Chiropractic and Dr. Troy M. Robinson, D.C. to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was recently involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him for medical service rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment, or verdict which may be paid to you, my attorney or myself, as the result of the inquiries for which I have been treated or injuries in connection therewith.

I agree never to rescind this document and that a rescission will not be honored by my attorney. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by him.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And, I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but will require me to make payments on a current basis.

Dated _____ _____ _____

Patient Signature | Print name

Dated _____ _____ _____

Attorney Signature | Print name

Please date, sign and return one copy to the doctor's office. Also keep one copy for your records