KINDLE CHIROPRACTIC CARE
1306 E. Broward Blvd. | Ft. Lauderdale, Florida 33301
Phone: 954-495-4449

PIP NEW PATIENT INTAKE FORM
Today's Date: _____

I. SECTION I — PATIENT INFORMATION

Personal Details

LAST NAME ✦ | FIRST NAME ✦ | MIDDLE INITIAL

DATE OF BIRTH ✦ | AGE | WEIGHT | HEIGHT

SEX:
□ Male □ Female

MARITAL STATUS:
□ Married □ Single □ Divorced □ Widowed

Contact Information

STREET ADDRESS ✦

CITY | STATE | ZIP CODE

HOME PHONE | CELL PHONE | WORK PHONE

EMAIL ADDRESS ✦

Employment

PATIENT OCCUPATION | EMPLOYER NAME

Emergency Contact

EMERGENCY CONTACT NAME ✦ | PHONE NUMBER ✦ | RELATIONSHIP TO PATIENT

Reason for Visit

PRIMARY REASON FOR VISIT / CHIEF COMPLAINT ✦

DATE OF ACCIDENT ✦ | AREAS OF PAIN

Have you had these symptoms before?

□ Yes □ No

IF YES, WHEN WAS THE LAST TIME AND DID YOU RECEIVE TREATMENT?

Are you currently being treated by another doctor?

□ Yes □ No

IF YES, WHO ARE YOU TREATING WITH?

Have you lost time from work?

□ Yes □ No

DATE STOPPED WORK **DATE RETURNED TO WORK**

II. SECTION II — INSURANCE INFORMATION

IMPORTANT: Please present your insurance card(s) and driver's license to the front desk. If you were involved in an auto accident, please confirm which insurance carrier is primarily responsible for your PIP claim.

Auto Insurance (PIP)

NAME OF INSURANCE CARRIER ✦ **PHONE NUMBER**

POLICY NUMBER ✦ **CLAIM NUMBER**

NAME OF POLICY HOLDER (IF DIFFERENT FROM PATIENT)

DATE OF BIRTH OF POLICY HOLDER

RELATIONSHIP TO PATIENT

Attorney Information (If Applicable)

NAME OF FIRM **NAME OF ATTORNEY**

ADDRESS

PHONE NUMBER **FAX NUMBER**

III. SECTION III — HEALTH HISTORY

Please check all conditions you have or have had:

- ☐ Arthritis
- ☐ Asthma
- ☐ Back Pain
- ☐ Blood Clots
- ☐ Cancer
- ☐ Cardiovascular Disease
- ☐ Depression / Anxiety
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy / Seizures
- ☐ Fibromyalgia
- ☐ Headaches / Migraines
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Multiple Sclerosis
- ☐ Neck Pain
- ☐ Numbness / Tingling
- ☐ Osteoporosis
- ☐ Scoliosis
- ☐ Spinal Stenosis
- ☐ Stroke
- ☐ Thyroid Disorder
- ☐ Vertigo

LIST ANY OTHER SERIOUS MEDICAL CONDITIONS:

KNOWN ALLERGIES

PREVIOUS SURGERIES / TREATMENTS (WITH DATES):

PAST SERIOUS ACCIDENTS (WITH DATES AND DETAILS):

FAMILY MEDICAL HISTORY — HAS A FAMILY MEMBER SUFFERED FROM ANY SERIOUS DISEASE OR CONDITION? IF YES, PLEASE EXPLAIN:

IV. SECTION IV — AUTO ACCIDENT INFORMATION

DATE OF ACCIDENT ✦

TIME OF ACCIDENT (AM / PM)

Was this a work-related accident?

☐ Yes ☐ No

Was there any bleeding?

□ Yes □ No
IF YES, PLEASE EXPLAIN:

Did you feel immediate pain?
□ Yes □ No
IF YES, PLEASE DESCRIBE:

Symptoms Since the Accident — Check All That Apply

□ Blurred Vision	□ Chest Pain	□ Confusion / Memory Loss
□ Dizziness	□ Fatigue	□ Headaches
□ Hip Pain	□ Jaw Pain (TMJ)	□ Lower Back Pain
□ Mid-Back Pain	□ Muscle Spasms	□ Nausea
□ Neck Pain	□ Numbness / Tingling	□ Radiating Arm Pain
□ Radiating Leg Pain	□ Ringing in Ears	□ Shoulder Pain
□ Sleep Disturbance	□ Upper Back Pain	□ Weakness
□ Whiplash Symptoms	□ Wrist / Hand Pain	

HAVE YOU SEEN A PHYSICIAN FOR THIS INJURY? IF YES, WHO?

Are you still under their care?
□ Yes □ No

Have you been referred to any other physicians?
□ Yes □ No
IF YES, PLEASE EXPLAIN:

V. SECTION V — PATIENT ACKNOWLEDGEMENTS & AUTHORIZATIONS

Please read carefully and initial in each box. If you are under 18, a parent or guardian must initial and sign.

Initial:	I certify all the information contained within this questionnaire is true. There are no false, misleading, or incomplete statements.

Initial:	I authorize Kindle Chiropractic Care to fill out and submit all necessary insurance claim forms.

Initial:	I authorize Kindle Chiropractic Care to furnish all information regarding my condition, including history, X-rays, physical findings, diagnosis, and prognosis in accordance with the Automobile No-Fault Insurance Act.

Initial:	I understand that Kindle Chiropractic Care requires payment in full for all services rendered at the time of visit unless other arrangements have been made. If account is not paid within 90 days and no financial arrangements have been made, I will be responsible for legal fees, collection agency fees, and other collection expenses.

Initial:	I understand that Kindle Chiropractic Care reserves the right to alter, add, or omit any agreements set forth on this form as deemed necessary, and without notice.

Correspondence Authorization — Please Select One

□ I DO authorize Kindle Chiropractic Care to mail and/or call my residence or workplace with correspondence.

Consent for Treatment

Consent for Treatment

I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician, and it is the responsibility of the staff to conduct the instructions of such physician.

Release of Information / HIPAA Notice

By signing this form, you are granting consent to Kindle Chiropractic Care to use and disclose your protected health information for the purposes of treatment, payment, and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice before signing. You have the right to revoke this consent in writing, except to the extent we have already used or disclosed your information in reliance on your consent. Our notice is subject to change; you may obtain a revised copy by calling 954-495-4449.

Verification of Non-Pregnancy (Female Patients Only)

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

DATE OF LAST MENSTRUAL PERIOD:

FRAUD WARNING

Any attempt to defraud any insurance company or other person, by intentionally concealing or providing false information for the purpose of misleading, constitutes a fraudulent insurance act, which is a criminal offense under Florida law.

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CONSENT FOR TREATMENT & PRIVACY PRACTICES

Protecting the privacy of your personal health information is important to us. Please review this notice carefully.

- Disclosure of protected health information without authorization is limited to defined situations including emergency care, quality assurance, public health, research, and law enforcement.
- Disclosures for treatment, payment, or operations are made only after obtaining your consent.
- You may inspect and receive copies of your records within 30 days of a request. A reasonable cost-based fee may apply.
- You may request changes to your records. The practice has the right to accept or deny your request.
- You may file a complaint about privacy violations by contacting our Office Manager at 954-495-4449.

Print Patient's Name

X Signature

Patient's Signature ✦

X Signature

OTHER THAN PATIENT — PRINT NAME AND RELATIONSHIP

WITNESS

POWER OF ATTORNEY TO ENDORSE CHECKS

KNOW ALL MEN BY THESE PRESENT: That the undersigned has made, constituted, and appointed Kindle Chiropractic Care and its duly authorized agents and employees as the undersigned's true and lawful Attorney to endorse any and all checks, drafts, or money orders made payable to the undersigned alone or to the undersigned and Kindle Chiropractic Care, which are to pay for services rendered by Kindle Chiropractic Care at the request or with the knowledge and approval of the undersigned.

The undersigned does hereby ratify and confirm all actions taken by said attorney in accordance with this special power of attorney. In witness whereof the undersigned have hereunto read, understood, and agreed to all terms and conditions set forth above, this _____ day of _____, 20_____.

Witness to Responsible Party's Signature

X Signature

Responsible Party's Full Printed Name ✦

X Signature

Responsible Party's Signature ✦

X Signature

IRREVOCABLE ASSIGNMENT OF BENEFITS

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PIP NEW PATIENT INTAKE FORM

Today's Date: _____

PATIENT / CLAIMANT: INSURANCE CO.: _____

CLAIM NUMBER: POLICY NUMBER: _____

DATE OF ACCIDENT:

1. I hereby irrevocably assign to Kindle Chiropractic Care all rights and causes of action I may have under any insurance policy or collateral source agreement including but not limited to the above-referenced collateral source provider.

2. Kindle Chiropractic Care and I further instruct my insurance company to cooperate with the above-captioned healthcare provider in resolving all medical billing matters, including:

a. Provide all pay-out sheets immediately upon payment of bills.
b. Investigate and pay directly to Kindle Chiropractic Care all claims within thirty (30) days after receipt of billing.
c. Provide a prompt and reasonable written explanation for denial of a claim or compromise settlement.
d. Inform the healthcare provider promptly of what additional information is necessary for processing the claim.

Patient Signature ✦

X Signature

Date

X Signature

PRINTED PATIENT NAME