KINDLE CHIROPRACTIC CARE
101 NE THIRD AVENUE, SUITE 1500
FT. LAUDERDALE, FL 33301
954-495-4449 PHONE

I. PATIENT INFORMATION:

Today's Date: _____/_____/_____

Patient Last name: _____ **Middle Int.** _____
First name: _____
Patient address: _____
City, State, Zip: _____
Home phone #: _____ **Work phone #:** _____
Cell phone #: _____
Email address: _____
Date of birth: ____/____/_____ Age: _____ **Social security number:** ____-____-____
Sex: Male Female **Marital status:** Married Single Divorced Widowed
Patient Occupation: _____
Employer name: _____
Employer address: _____
City: _____ State: _____ Zip code: _____
Emergency contact name: _____
Phone number: _____ Relation to patient: _____
Reason for visit: _____
Date of accident: _____/_____/_____
Areas of pain: _____
Have you had these symptoms before? **Yes** **No**
If so, when was the last time and did you get treatment for it? _____
_____
Are you currently treating with another doctor? **Yes** **No**
If so, with whom are you treating with? _____
Have you lost time from work: **Yes** **No** Date Stopped Work: _____/_____/_____
Date Returned to Work: _____/_____/_____

II. INSURANCE INFORMATION:

PLEASE PRESENT YOUR INSURANCE CARD(S) & DRIVER'S LICENSE TO THE FRONT DESK TO BE COPIED. (IF YOU WERE INVOLVED IN AN AUTO ACCIDENT PLEASE CONFIRM WITH THE FRONT DESK WHICH INSURANCE CARRIER IS PRIMARILY RESPONSIBLE FOR YOUR CLAIM.)1

Your Auto Insurance Information:

Name of insurance carrier: _____

Phone number: _____

Policy number: _____ **Claim number**: _____

Name of policy holder, if different than patient: _____

Date of birth of policy holder: ____/____/____ S.S.#: _____-_____-_____

Relationship to patient: _____

Health Insurance Information:

Name of insurance carrier: _____

Phone number: _____

Policy number: _____ **Group number**: _____

Name of policy holder, if different than patient: _____

Date of birth of policy holder: ____/____/____ S.S.#: _____-_____-_____

Relationship to patient: _____

III. ATTORNEY INFORMATION: *(If applicable)*

Name of Firm: _____

Name of Attorney: _____

Address: _____

Phone number: _____ Fax number: _____

IV. HEALTH HISTORY: *(Please fill in all circles that are applicable.)*

Are you taking any of the following medications?

○ Nerve Pills	○ Pain Killers (Including aspirins)	○ Muscle Relaxers
○ Stimulants	○ Blood Thinners	○ Tranquilizers
○ Insulin	○ Other(s)_____	

How much of each pill are you taking?_____

Have you ever had any of the following diseases / medical condition(s)?

○ Heart Attack	○ Heart Surgery / Pacemaker	○ Heart Murmur
○ Mitral Valve Prolapse	○ Congenital Heart Defect	○ Artificial Valves
○ Stroke	○ Alcohol / Drug Abuse	○ Venereal Disease
○ Hepatitis	○ HIV +/ AIDS	○ Shingles
○ Cancer	○ Frequent Neck Pain	○ Emphysema / Glaucoma
○ Anemia	○ High / Low Blood Pressure	○ Psychiatric Problems
○ Rheumatic Fever	○ Severe / Frequent Headaches	○ Kidney Problems
○ Ulcers / Colitis	○ Fainting / Seizures / Epilepsy	○ Sinus Problems
○ Asthma	○ Diabetes	○ Tuberculosis
○ Difficulty Breathing	○ Chemotherapy	○ Lower Back Problems
○ Artificial Bones / Joints	○ Arthritis	

Do you smoke? **Yes** **No** How Much? _____ How Many Years? _____

Are you wearing: ○ Heel Lifts ○ Sole Lifts ○ Inner Soles ○ Arch Supports

For Women: Are you taking Birth Control? **Yes No**
Are you Pregnant? **Yes No** How Far Along? _____

What is the age of your mattress? _____ Is it comfortable? **Yes No**
List any other serious medical condition(s) you have or have had: _____

_____

_____
List any allergies: _____
List previous surgeries / treatments with dates: _____

_____
List any past serious accidents with dates & details: _____

_____
Has anyone in your family suffered from any serious diseases / medical conditions?_____
If Yes, please explain:_____
Additional Comments: _____

V. AUTO ACCIDENT INFORMATION: ***(If applicable)***

Date of Accident: _____ **Time of Accident:** _____ **AM / PM**
Was a Police Report Made: **Yes No** Who was ticketed: _____
You Were: ○ Driver ○ Passenger ○ Front Seat ○ Back Seat ○ Pedestrian
The vehicle's owner was: ○ Self ○ Immediate Family ○ Friend
Location of Accident: City _____ State ___
You Were Traveling or Stopped Facing: ○ North ○ South ○ East ○ West
How did the Accident Occur: ○ Stopped at red light
○ Hit and Run
○ Stopped waiting to turn: ○ Right ○ Left
○ Car ran stop sign / red light
○ Lost control of Car
○ Other: _____
Part of the car impacted: ○ Right ○ Left ○ Front ○ Rear
Were you wearing you seatbelt / shoulder harness? **Yes No**
Objects you struck in the car: ○ Steering Wheel / Column ○ Dashboard
○ Rearview Mirror ○ Door: **Left / Right**
○ Roof of Car ○ Windshield
○ Headrest ○ Other: _____
Part of Body you struck: ○ Head ○ Face ○ Chest ○ Arms ○ Legs ○ Knee
○ Other, please explain: _____

Were you rendered Unconscious, Cut, or Bleeding? **Yes No** If yes, please explain:

_____

Was this a work-related accident? **Yes** **No**
Did you feel immediate pain? **Yes** **No** If yes, please explain: _____

_____

_____

Have you experienced any of the following symptoms since the Accident?

○ Headaches	○ Pins / Needles in Arm(s)	○ Abdominal Pain	○ Neck Pain
○ Bruises/ Cuts	○ Pins / Needles in Leg(s)	○ Mid Back Pain	○ Low Back Pain
○ Memory Loss	○ Radiating Arm Pain	○ Chest Pain	○ Dizziness
○ Nervousness	○ Radiating Leg Pain	○ Blurred Vision	○ Ears Ringing
○ Anxiety	○ Other: _____		

After the accident, did you go: ○ Home ○ Hospital ○ Work ○ Other
If other, please explain: _____

VI. FOLLOW UP CARE:

Taken to Hospital: ○ Ambulance ○ Friend ○ Relative ○ Self ○ Home First
If not same day as the accident, when did you go to the hospital? _____/_____/_____
Name of Hospital: _____
Were you seen in the Emergency room? **Yes** **No** Were you admitted? **Yes** **No**
If admitted, how long did you stay? _____
Name of admitting Doctor? _____

Procedures done in the Emergency room:

○ Examination	○ X-Rays	○ Stitches	○ Prescriptions
○ Therapy	○ Casts	○ Splints	○ Cervical Collar
○ Back Support	○ Blood Tests	○ Other_____	

After being released from the hospital you:

○ Returned to Bed ○ Returned to Work ○ Other
If Other, please explain:_____

Where any other doctors visited:

○ Same Day ○ Next Day ○ Within a few Days ○ Other_____
Who did you visit? Dr._____
Specialty: ○ Family Doctor ○ Chiropractor ○ Orthopedist ○ Osteopath
○ Neurologist ○ Other _____
What did the doctor do?

○ Examination	○ Injections	○ X-Rays	○ Prescriptions
○ Traction	○ Physiotherapy	○ Blood Tests	○ Cervical Collar
○ Back Support	○ Other_____		

If Physiotherapy was rendered, for how long? _____
Where did you receive these treatments? (part of body) _____

How long were under the care of a physician? _____
Are you still under his/her care? **Yes** **No**

Have you been referred to any other physicians? **Yes** **No** If yes, please explain: _____

_____

Additional Comments: _____

_____

Please Read Carefully & Initial in provided space:

(If you're under 18 please have parent or guardian read, ***initial, and sign*** *in the shaded spaces provided below)*

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

_____ I authorize *KINDLE CHIROPRACTIC CARE* (hereafter referred to as "Your Company" to fill out and submit all necessary insurance claim forms).

_____ I authorize Your Company to furnish all information you may have regarding my condition while under your observation or treatment, including the history obtained, X-rays and physical findings, diagnosis and prognosis in accordance with the Automobile No-Fault Insurance Act.

_____ I understand that Your Company requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with Your Company's business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account. We have the right to collect your deductible and co-insurance.

_____ I understand that Your Company reserves the right to alter, add, or omit any of the agreements set forth on this form as deemed necessary, and without notice.

Please check one of the two following statements:

_____ I, **DO,** authorize *KINDLE CHIROPRACTIC CARE* with the right to mail and or call my residence or work with correspondence.

_____ I, **DO NOT,** authorize *KINDLE CHIROPRACTIC CARE* with the right to mail and or call my residence or work with correspondence.

I understand that any attempt to defraud any insurance company or other person, by intentionally concealing or providing false information for the purpose of misleading, thereto commits a fraudulent insurance act, which is a criminal offense.

In witness whereof the undersigned have hereunto read, understood, and agreed to all of the terms and conditions set forth above, this _____ day of _____, 20____.

_____ _____

Witness to Responsible Party's Signature **Responsible Party's Full Printed Name**

_____ _____

Responsible Party's Signature **Responsible Party's S.S. #**

Consent

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 carry out the instructions of such physician.

Release of information: 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 of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by telephoning our main office at 954-495-4449. You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

Verification of non-pregnancy (female patients only): 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 this particular time. Date of last menstrual period _____.

_____
Print Patient's name

_____
Patient's signature

_____
Other than patient, print name and relationship

_____
Witness

KINDLE CHIROPRACTIC CARE
Notice of Information Practices

Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on medical records for treatment.

Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical records for treatment.

You may inspect and receive copies of your records within 30 days a request to do so. There may be a reasonable cost-based fee for photocopying, postage and preparation.

You may request changes to your records. Our practice has the right to accept or deny your request.

We maintain a history of protected health information disclosures that is accessible to you.

In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office.

You may file a complaint about privacy violations by contacting our Office Manager at 954-495-4449.

Name _____ Phone #_____

The effective date of this Notice of Information Practices is _____.

Thank you

KINDLE CHIROPRACTIC CARE
Letter of Protection

Patient Name: _____

I do hereby authorize the above center to furnish you, my attorney with a full report of my case history, examinations, diagnosis, treatment, and prognosis of myself in regard to my accident / injury which occurred on _____/_____/_____.

I hereby give a lien to said physician on any settlement, claims, judgment, or verdict as a result of said accident / injury and to authorize you, my attorney to pay directly to the doctor such sums as may be due and owing them for services rendered me, and to withhold such sums from settlement claim, judgment or verdict as may be necessary to protect said physician.

I fully understand that I am directly responsible to said doctor for all bills submitted by them for services rendered me, and that this agreement is made solely for said physician's additional protection and in consideration for his awaiting payment.

I further understand that such payment is not contingent on any settlement, claim, judgment, or verdict by which I may eventually recover said fee.

I understand that at anytime I may inquire as to the charges and payments on my account and that this information will be given in full, in writing within 5 business days.

Dated: _____/_____/_____ Patient's signature: _____

The undersigned being attorney of record, or duly authorized representative of the attorney, for the above named patient does hereby acknowledge receipt of the above lien. Who does agree to honor the same to protect adequately said physician.

_____/____/_____
Dated

_____
Attorney signature

_____
Printed Attorney name

KINDLE CHIROPRACTIC CARE
101 NE THIRD AVENUE, SUITE 1500
FT. LAUDERDALE, FL 33301
954-495-4449 PHONE

KINDLE CHIROPRACTIC CARE
Power of Attorney to Endorse Checks

KNOW ALL MEN BY THESE PRESENT: That the undersigned has made constituted and appointed, and by these presents does hereby make, constitute and appoint the clinic of *KINDLE CHIROPRACTIC CARE* and of its duly authorized agents and employees as and to be the undersigned's true and lawful Attorney for and in the undersigned's name, place and stead to endorse any and all checks, drafts or money orders which are made payable to the undersigned alone or to the undersigned and the said clinic *KINDLE CHIROPRACTIC CARE*, which checks, drafts or money orders are to pay for the services rendered by *KINDLE CHIROPRACTIC CARE* clinic at the request or with the knowledge and approval of the undersigned and or the maker of the check, draft or money order.

The undersigned by these presents does thus give and grant unto the said clinic *KINDLE CHIROPRACTIC CARE* as attorney the full power and authority to do and perform all and every act and thing whatsoever requisite and necessary to be done in and about the premises as fully to all intents and purposes as the undersigned might or could do to personally present in so far as the endorsing and cashing of said checks are concerned.

The undersigned does herby ratify and confirm any and all actions taken by the said attorney in accordance with this special power of attorney and which the said attorney shall do or cause to be done by virtue of these presents.

In witness whereof the undersigned have hereunto read, understood, and agreed to all of the terms and conditions set forth above, this _____ day of _____, 20____.

_____ Witness to Responsible Party's Signature

_____ Responsible Party's Full Printed Name

_____ Responsible Party's Signature

KINDLE CHIROPRACTIC CARE
Irrevocable Assignment of Benefits
Instructions to Insurance Carrier

PATIENT / CLAIMANT: _____
INSURANCE CO.: _____
CLAIM NUMBER: _____
POLICY NUMBER: _____
DATE OF ACCIDENT: _____

1. I hereby irrevocably assign to *KINDLE CHIROPRACTIC CARE* any and all rights and causes of action I may have under any insurance policy or collateral source agreement including but not limited to 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. You are requested to do the following during the handling of this claim:

- **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 said healthcare provider with a prompt and reasonable explanation in writing of the basis in the insurance policy, in relation to the facts of the case or applicable law, for denial of a claim or for the offer of a compromise settlement or payment or delay in payment past thirty (30) days from receipt of this notice.
- **d.** Inform the healthcare provider promptly as to what additional information is necessary for processing of the claim.
- **e.** Return all phone calls from the provider promptly.
- **f.** Provide the provider with notice of each and every Independent Medical Examination (hereafter "IME") and statement or Examination Under Oath (hereafter "EUO") which is scheduled for me.
- **g.** Provide to the medical provider with a copy of each and every IME, paper IME or paper review generated with respect to me as required by Fla. Stat. 627.736.

These payment instructions are for benefits payable to me under my current insurance policy as payment toward the total charges for professional services rendered. I as the patient have agreed to remain personally liable for the amounts billed by the healthcare provider regardless of the amount paid by the insurance company unless ordered otherwise by a court of law. I further understand that said health services are being provided to me in consideration for an unconditional promise to pay and for me providing these instructions to my insurance company as the patient further agree to be liable for reasonable attorney's fees and costs incurred in collecting any delinquent accounts or unpaid balances. A photocopy of these instructions shall be considered as effective and valid as the original.

X _____ _____
SIGNATURE OF POLICY HOLDER DATE

KINDLE CHIROPRACTIC CARE

KINDLE CHIROPRACTIC CARE
Sworn Affidavit

1. I, _____ was residing at _____
_____
as of the date of my accident. At the time of the accident, I did not own a motor vehicle for which "no-fault / personal injury protection" security was required by the Florida Automobile Reparations Act (Chapter 627 of the Florida Statutes). Furthermore, I was not a resident member of a household or residing with a relative who owned a motor vehicle requiring such security as required under Florida Law.

2. I further state that at the time the accident occurred, I was not in the scope of my employment and the injuries for which I am claiming "no fault" of benefits were not covered under any Worker's Compensation Act.

3. I further state that I am lawfully entitled to "no-fault" benefits being sought under the policy issued to _____, with the policy number _____.

4. I am also aware that under the Florida Fraud Statute that " any person who knowingly and with the intent to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information, is guilty of a felony of the third degree.

Signature _____ Date _____

STATE OF _____
COUNTY OF _____
WITNESSED _____

Subscribed and sworn before me this _____ day of _____, 20____.

Authorization for Medical Information

This authorization or photocopy hereof, will authorize you to furnish all information you may have regarding my condition while under your observation or treatment, including the history obtained, x-ray and physical findings diagnosis and prognosis. You are authorized to provide this information in accordance with the Florida "no fault" auto insurance law.

Signature Date

Authorization for Wage and Salary Information

This authorization or photocopy hereof, will authorize you to furnish all information you may have regarding my wages or salary while employed by you. You are authorized to provide this information in accordance with the Florida "no fault" auto insurance law.

Signature Date

Social Security No. _____

Receipt of Notice of Privacy Practices Written Acknowledgement Forms

I, _____have read a copy of *Kindle Chiropractic Care's* Notice of Patient Privacy Practices.

_____

Signature of Patient or Parent or Legal Guardian

_____

Date

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(14) and (15), 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.