# PIP Patient Information

Today's Date_____ Date of Accident _____

Legal First Name: _____MI: _____ Last Name: _____

DOB: _____Home Phone: _____Cell Phone: _____

Please check your contact preference: _____Hm _____ Cell _____Email _____ Text_____

Email: _____ Would you like to receive text message reminders? N / Y
(REQUIRED FOR PATIENT PORTAL ACCESS)

Emergency Contact: _____ Phone Number: _____

** If you are a seasonal patient please tell us when you're planning to return up north : _____

Primary Address: Secondary Address: (optional)

_____ _____

_____ _____

_____ _____

Please indicate if you want all correspondence to be marked "Confidential". Y / N

Social Security #:_____ Marital Status: S M W D Spouse:_____

Language: _____English _____ Spanish _____ other: _____

Race: _____ White _____American Indian or Alaska Native _____ Asian _____Native Hawaiian/Other Pacific Islander
_____ Black or African American _____ Hispanic or Latino _____ Decline to Answer _____Other_____
Ethnicity: _____ Hispanic or Latino _____Not Hispanic or Latino _____ Decline to Answer

# Auto Insurance Information

***IF THERE ARE NO PIP BENEFITS, AN ATTORNEY LETTER OF PROTECTION IS REQUIRED***

Are you the policy holder? Y N If no, who is policy holder: Spouse Parent Employer Other
Policy Holder's Name:_____ _____ Policy Holder's Date of Birth: _____
Auto Insurance Company: _____ Claim# _____
Adjuster's Name: _____ Adjuster's Phone # _____
Attorney: _____ Attorney phone number: _____

*Please provide a copy of your insurance cards and complete the following information.*

Do you have group health insurance coverage? Y N If yes, please complete the following:
Policy Holder's Name:
First Name: _____ M.I. _____ Last Name: _____
Patient's Date of Birth: _____ Patient's date of birth _____
Group Health Member ID: _____

**For all pip cases your auto insurance is primary and group health policy can be billed once all benefits are exhausted.**

_____ (initial) **MISSED APPOINTMENT FEE:**

Our doctors treat patients that are in pain and we have to turn away people if there is no availability. When an appointment is missed, you are taking away the opportunity for others to be treated. It is our office policy that you must call no later than 12 hours before your scheduled appointment. Please note, missed appointment on a legal case show non compliance to the doctor's treatment plan. *If a voicemail is left to cancel an appointment you will not be charged.*

| | Missed Appointment Fee Schedule | |
|---|---|---|
| | 30mins or more with Doctor (Exams, NCR, Acupuncture,) | **$60.00** |
| | 10-20mins with Doctors (Manipulations, Review of Findings, Rehab) | **$25.00** |
| | 30min Massage | **$25.00** |
| | 60min Massage | **$40.00** |

# Patient History

Are you seeing anyone else for other problems or health conditions? □ Yes □ No
Please list the problem/s, date problem/s began, and Provider/s treating you for the condition/s:

_____

_____

Past Health History

| Have you... | Yes | No | If yes, include date & provider seen |
|---|---|---|---|
| ...been diagnosed with Diabetes? Type I____or Type II_____ | □ | □ | _____ |
| ...been treated for hypertension? | □ | □ | _____ |

Do you smoke? □Never □Former Smoker □Current/Every Day Smoker □Current Some Day Smoker

Do you have medication allergies? If so please list Type of Allergy and Reaction.

_____

_____

Medications

What medications are you currently taking? Include vitamins, herbs, minerals...
List Date Started, Brand Name, Generic Name, Strength, Dosage, Frequency, Duration, Quantity,
Please be as specific as possible. (Provide list if not enough space)

| | | |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

# Assignment & Release

## Insurance Information

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this doctors office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees or outstanding balances for services I have received will be immediately due and payable.

**Patient's/Parent's/Guardian's Signature:** _____ **Date** _____

## Consent of Professional Services and Release of Information

I herby authorize and release the doctor and whomever he/she may designate as his/her assistants, to administer treatment, physical examination, x-ray studies, laboratory procedures, chiropractic care or any clinic services that he/she deems necessary in my case; I furthermore authorize him/her to disclose all or any part of my patient record to any person or corporation which is or may be liable under a contract to this office or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to hospital or medical service companies, insurance companies, worker's compensation carriers, welfare funds, or the patient's employer.

**Patient's/Parent's/Guardian's Signature:** _____ **Date** _____

## HIPAA KNOWLEDGEMENT

Our office complies with HIPAA regulations and it is our duty to make all patients aware medical information is confidential. Please sign if you agree/ understand with the statement below
I acknowledge that a copy of the Notice of Privacy Practices was available and that I have read it or declined the opportunity to read it. I understand that this form will be placed in my patient chart and maintained for six years.

_____ _____

**Patient Signature** DATE

## HEALTH HISTORY

What treatment have you already received for your current condition?

☐ Medications ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Services ☐ None

**DID YOU SEEK TREATMENT WITHIN 14 DAYS OF THE ACCIDENT? WHERE?**

_____

Do you have any radiology films or reports that can be obtained? Where? _____

Do you have any recent Lab reports that can be obtained? Where? _____

Are you currently pregnant? _____ Due Date: _____

PLEASE CHECK ANY OF THE FOLLOWING CONDITIONS THAT APPLY TO YOUR HEALTH HISTORY.

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | AIDS/HIV | | Emphysema | | Migraine Headaches | | Scarlet Fever |
| | Alcoholism | | Epilepsy | | Miscarriage | | S.T.D |
| | Allergy Shots | | Fractures | | Mononucleosis | | Stroke |
| | Anemia | | Glaucoma | | Multiple Sclerosis | | Suicide Attempt |
| | Anorexia | | Gonorrhea | | Mumps | | Thyroid Problems |
| | Appendicitis | | Gout | | Osteoporosis | | Tonsillitis |
| | Arthritis | | Heart Disease | | Pacemaker | | Tuberculosis |
| | Asthma | | Hepatitis | | Pinched Nerve | | Tumors, Growths |
| | Bleeding Disorder | | Herniated Disk | | Parkinson's Disease | | Typhoid Fever |
| | Breast Lump | | Hernia | | Pneumonia | | Ulcers |
| | Bronchitis | | Herpes | | Polio | | Vaginal Infections |
| | Cancer | | High Cholesterol | | Prosthesis | | Whooping Cough |
| | Chemical Dependency | | High Blood Pressure | | Prostate Problem | Other: | |
| | Cataracts | | Kidney Disease | | Psychiatric Care | | |
| | Chicken Pox | | Liver Disease | | Rheumatic Arthritis | | |
| | Diabetes | | Measles | | Rheumatic Fever | | |

Please check what may apply.

Exercise: None Moderate Daily Heavy

Work Activity: Sitting Standing Light Labor Heavy Labor

Habits: ___Smoking ---------- How many packs/day _____

___ Alcohol ---------- Drinks/Week _____

___ Coffee/Caffeine Drinks------ Cups/Day _____

___ High Stress Level---------- Reason_____

## Patient Condition

Reason for visit: _____

When did your symptoms appear? _____ Is this condition getting worse? _____

How often do you have this pain? _____

Does it interfere with your __ work __ Sleep __ Daily Routine ___ Recreation

Activities or movements that are painful to perform.

__ Sitting __ Standing __ Walking __ Bending __ Lying Down

******MARK ON THE BODY WHERE YOUR PAIN IS.******

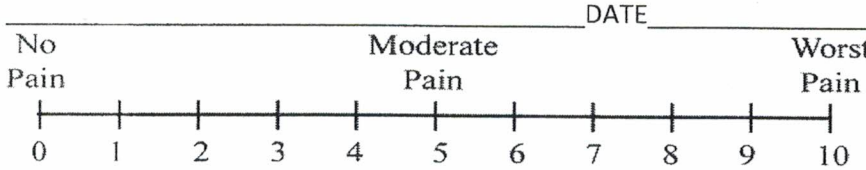
**PLEASE LIST ANY FALLS , ACCIDENTS, HEAD INJURIES,BROKEN BONES, SURGERIES.**

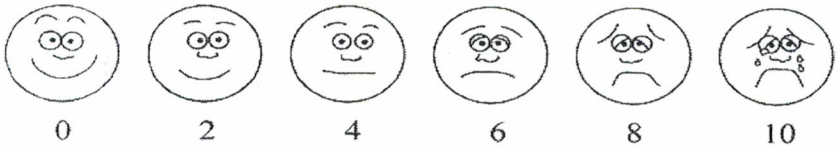
_____ DATE_____

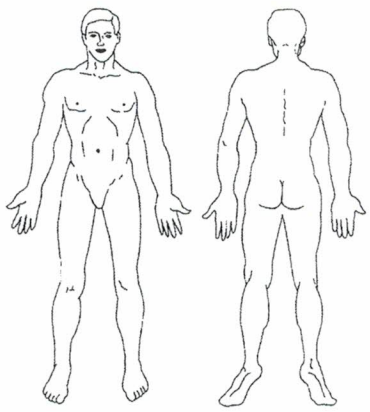
_____ DATE_____

_____ DATE_____

_____ DATE_____



# Neck Disability Index

This questionnaire is designed to help us better understand how your neck pain affects your ability to manage everyday -life activities. Please mark in each section the **one box** that applies to you. Although you may consider that two of the statements in any one section relate to you, please mark the box that **most closely** describes your present -day situation.

## Section 1 - Pain Intensity

- ❑ I have no pain at the moment.
- ❑ The pain is very mild at the moment.
- ❑ The pain is moderate at the moment.
- ❑ The pain is fairly severe at the moment.
- ❑ The pain is very severe at the moment.
- ❑ The pain is the worst imaginable at the moment.

## Section 2 - Personal Care

- ❑ I can look after myself normally without causing extra pain.
- ❑ I can look after myself normally, but it causes extra pain.
- ❑ It is painful to look after myself, and I am slow and careful.
- ❑ I need some help but manage most of my personal care.
- ❑ I need help every day in most aspects of self -care.
- ❑ I do not get dressed. I wash with difficulty and stay in bed.

## Section 3 – Lifting

- ❑ I can lift heavy weights without causing extra pain.
- ❑ I can lift heavy weights, but it gives me extra pain.
- ❑ Pain prevents me from lifting heavy weights off the floor but I can manage if items are conveniently positioned, ie. on a table.
- ❑ Pain prevents me from lifting heavy weights, but I can manage light weights if they are conveniently positioned.
- ❑ I can lift only very light weights.
- ❑ I cannot lift or carry anything at all.

## Section 4 – Work

- ❑ I can do as much work as I want.
- ❑ I can only do my usual work, but no more.
- ❑ I can do most of my usual work, but no more.
- ❑ I can't do my usual work.
- ❑ I can hardly do any work at all.
- ❑ I can't do any work at all.

## Section 5 – Headaches

- ❑ I have no headaches at all.
- ❑ I have slight headaches that come infrequently.
- ❑ I have moderate headaches that come infrequently.
- ❑ I have moderate headaches that come frequently.
- ❑ I have severe headaches that come frequently.
- ❑ I have headaches almost all the time.

## Section 6 – Concentration

- ❑ I can concentrate fully without difficulty.
- ❑ I can concentrate fully with slight difficulty.
- ❑ I have a fair degree of difficulty concentrating.
- ❑ I have a lot of difficulty concentrating.
- ❑ I have a great deal of difficulty concentrating.
- ❑ I can't concentrate at all.

## Section 7 – Sleeping

- ❑ I have no trouble sleeping.
- ❑ My sleep is slightly disturbed for less than 1 hour.
- ❑ My sleep is mildly disturbed for up to 1-2 hours.
- ❑ My sleep is moderately disturbed for up to 2-3 hours.
- ❑ My sleep is greatly disturbed for up to 3-5 hours.
- ❑ My sleep is completely disturbed for up to 5-7 hours.

## Section 8 – Driving

- ❑ I can drive my car without neck pain.
- ❑ I can drive as long as I want with slight neck pain.
- ❑ I can drive as long as I want with moderate neck pain.
- ❑ I can't drive as long as I want because of moderate neck pain.
- ❑ I can hardly drive at all because of severe neck pain.
- ❑ I can't drive my care at all because of neck pain.

## Section 9 – Reading

- ❑ I can read as much as I want with no neck pain.
- ❑ I can read as much as I want with slight neck pain.
- ❑ I can read as much as I want with moderate neck pain.
- ❑ I can't read as much as I want because of moderate neck pain.
- ❑ I can't read as much as I want because of severe neck pain.
- ❑ I can't read at all.

## Section 10 – Recreation

- ❑ I have no neck pain during all recreational activities.
- ❑ I have some neck pain with all recreational activities.
- ❑ I have some neck pain with a few recreational activities.
- ❑ I have neck pain with most recreational activities.
- ❑ I can hardly do recreational activities due to neck pain.
- ❑ I can't do any recreational activities due to neck pain.

Patient Name _____ Date _____

Score _____ [50] Benchmark -5 = _____

# Oswestry Low Back Pain Scale

**Please rate the severity of your pain by circling a number below:**

***No pain*** | 0 1 2 3 4 5 6 7 8 9 10 | ***Unbearable pain***

**Name** _____ **Date** _____

**Instructions:** Please circle the **ONE NUMBER** in each section which most closely describes your problem.

**Section 1 – Pain Intensity**
0. The pain comes and goes and is very mild.
1. The pain is mild and does not vary much.
2. The pain comes and goes and is moderate.
3. The pain is moderate and does not vary much.
4. The pain comes and goes and is severe.
5. The pain is severe and does not vary much.

**Section 2 – Personal Care (Washing, Dressing, etc.)**
0. I would not have to change my way of washing or dressing in order to avoid pain.
1. I do not normally change my way of washing or dressing even though it causes some pain.
2. Washing and dressing increase the pain but I manage not to change my way of doing it.
3. Washing and dressing increase the pain and I find it necessary to change my way of doing it.
4. Because of the pain I am unable to do some washing and dressing without help.
5. Because of the pain I am unable to do any washing and dressing without help.

**Section 3 – Lifting**
0. I can lift heavy weights without extra pain.
1. I can lift heavy weights but it gives extra pain.
2. Pain prevents me lifting heavy weights off the floor.
3. Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.
4. Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
5. I can only lift very light weights at most.

**Section 4 – Walking**
0. I have no pain on walking.
1. I have some pain on walking but it does not increase with distance.
2. I cannot walk more than 1 mile without increasing pain.
3. I cannot walk more than ½ mile without increasing pain.
4. I cannot walk more than ¼ mile without increasing pain.
5. I cannot walk at all without increasing pain.

**Section 5 – Sitting**
0. I can sit in any chair as long as I like.
1. I can sit only in my favorite chair as long as I like.
2. Pain prevents me from sitting more than 1 hour.
3. Pain prevents me from sitting more than ½ hour.
4. Pain prevents me from sitting more than 10 minutes.
5. I avoid sitting because it increases pain immediately.

**Section 6 – Standing**
0. I can stand as long as I want without pain.
1. I have some pain on standing but it does not increase with time.
2. I cannot stand for longer than 1 hour without increasing pain.
3. I cannot stand for longer than ½ hour without increasing pain.
4. I cannot stand for longer than 10 minutes without increasing pain.
5. I avoid standing because it increases the pain immediately.

**Section 7 – Sleeping**
0. I get no pain in bed.
1. I get pain in bed but it does not prevent me from sleeping well.
2. Because of pain my normal nights sleep is reduced by less than one-quarter.
3. Because of pain my normal nights sleep is reduced by less than one-half.
4. Because of pain my normal nights sleep is reduced by less than three-quarters.
5. Pain prevents me from sleeping at all.

**Section 8 – Social Life**
0. My social life is normal and gives me no pain.
1. My social life is normal but it increases the degree of pain.
2. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
3. Pain has restricted my social life and I do not go out very often.
4. Pain has restricted my social life to my home.
5. I have hardly any social life because of the pain.

**Section 9 – Traveling**
0. I get no pain when traveling.
1. I get some pain when traveling but none of my usual forms of travel make it any worse.
2. I get extra pain while traveling but it does not compel me to seek alternate forms of travel.
3. I get extra pain while traveling which compels to seek alternative forms of travel.
4. Pain restricts me to short necessary journeys under ½ hour.
5. Pain restricts all forms of travel.

**Section 10 – Changing Degree of Pain**
0. My pain is rapidly getting better.
1. My pain fluctuates but is definitely getting better.
2. My pain seems to be getting better but improvement is slow.
3. My pain is neither getting better or worse.
4. My pain is gradually worsening.
5. My pain is rapidly worsening.

**TOTAL** _____

**ASSIGNMENT OF RIGHTS AND BENEFITS**
**WITHIN THE MEANING OF 627.736, FLORIDA STATUTES**

I, the below named patient/ insured, in consideration for being treated by **Frank Clinic of Chiropractic PA** without payment in full at the time of treatment (or in advance of treatment), hereby fully and completely assign over to **Frank Clinic of Chiropractic PA** any and all MedPay benefits and Personal Injury Protection (PIP) rights and benefits (including but not limited to the right to sue and the right to compromise claims) to which I am entitled by virtue of Florida Statute 627.736 and /or any policy of insurance providing Personal Injury Protection benefits and/or MedPay benefits. This assignment also includes and is not limited to the right to reimbursement of transportation cost and any and all rights I may have to notice of, attendance of counsel to and copies or transcripts or reports of, any EUO (Examination Under Oath) and any IME (Independent Medical Examination) scheduled or taken by any insurance carrier regarding treatment provided by **Frank Clinic of Chiropractic PA**. As additional consideration I also agree as follows:

E. I agree and stipulate that venue for any litigation involving the payment of any benefits under any policy which may cover me shall be in Pasco County, Florida.
F. I agree and stipulate that should my attorney or representative request a reduction of any costs or fees payable by me personally that my attorney or representative must provide to **Frank Clinic of Chiropractic PA**. The terms of the settlement or recovery obtained by me as well as an accurate and complete copy of the actual settlement and disbursement statement for my case.
G. I grant to **Frank Clinic of Chiropractic PA**, full power and authority to endorse and sign checks or drafts for payment of bills submitted by **Frank Clinic of Chiropractic PA**, for services rendered to me by them.
H. I authorize and direct my present or future attorneys and my Personal Injury Protection insurance carrier or carriers to release any and all medical and legal information in their possession about me to **Frank Clinic of Chiropractic PA** immediately upon demand.

If any portion of this document is deemed to be in consistent with an assignment of rights and benefits within the meaning of 627.736, Florida Statues, or said policy of insurance said portion shall be rewritten in order to conform with Florida law to give full effect to the intended purpose of this agreement , said intended purpose being to create an assignment of rights and benefits from the below named patient/ insured to Frank Clinic of Chiropractic PA.

**The undersigned has read this entire document, agrees to its terms and conditions and agrees to execute this document in duplicate and agrees that either duplicate or original document for all purposes.**

**Wherefore, the undersigned have set their hands and seals on this, the _____ day of _____, 2018.**

_____
Patient/ Insured (Signature)

_____
Authorized Agent (Signature)

_____
Patient/ Insured (Printed Name)

Kristina Robles
_____
Frank Clinic of Chiropractic PA
Authorized Agent (Printed Name)

**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.**

Exams, Manipulation, Therapy

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 |
|---|---|---|
| Dr. Mark Frank D.C | Dr. Mark Frank D.C. | |

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.


FRANK CLINIC OF CHIROPRATIC PA
38040 DAUGHERTY RD
ZEPHRYHILLS, FL 33540
PH#(813)788-0496 FAX#(813) 783-8910

# RELEASE OF MEDICAL INFORMATION

DATE: _____

TO: _____

YOU ARE HEREBY AUTHORIZED AND REQUESTED TO FURNISHED TO FRANK CLINIC ANY AND ALL MEDICAL INFORMATION, HISTORY, RECORDS DIAGNOSIS, REPORTS OR X-RAYS IN YOUR POSSESSION CONCERNING THE UNDERSIGNED.

NAME: _____

SS: _____

SIGNATURE: _____ Date of Birth: _____

(Parent or Guardian if Minor)

*Approved by:* *Mark Frank D.C* *Celeste Holstein D.C* *Chris Schriver D.C*

*Attending Physcian*

**PLEASE FAX ALL INFORMATION TO: (813) 783-8910**