THE CHIROPRACTIC PLACE

TERMS OF ACCEPTANCE

CHIROPRACTIC INFORMED CONSENT
(ACCIDENT / INJURY)

Patient (print name): _____ Date of Accident: _____

When a patient seeks chiropractic health care and we agree to provide this care, it is essential for both to be working toward the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method with which it will be obtained. This prevents any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustment of the spine.

Health: A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity (*Dorland's Medical Dictionary*).

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses. This misalignment results in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any diseases or condition other than vertebral subluxation; however, if, during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. Our ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate healing mechanism. Our only method is specific adjusting to correct vertebral subluxation.

Your orthopedist, family practitioner, or past chiropractor may have discussed with you various modalities of pain relief: drugs, surgery, physical therapy, manipulation, etc. We want to make you aware of how care works in this office, and what is available today thanks to progress in spinal health care.

Adults: Chiropractic treatment can be successful at any age. The longer the subluxation has been there and the more damage that has been done, the longer it will take to correct and stabilize, and the more often you will need adjustments in order to maintain a healthy spine and nervous system.

Kids: Children's spines are very fragile, and improper alignment as a child can lead to permanent spinal impairment as they grow. Children get quick and profound results for a number of conditions clearly related to subluxation; therefore, it is best to check children for subluxation and begin any necessary treatment as young as possible.

Duration of Care: While pain relief may take only a few visits, getting well takes time. Depending on the patient's age, subluxation severity and lifestyle, adjustment and rehabilitative schedules for correction can range from weeks to years. Following correction, the doctor will make a recommendation for retainer care and lifetime maintenance.

As a rule, informed and cooperative patients can achieve positive chiropractic results. Thus, the following information is routinely supplied to all who consider chiropractic treatment. While recognizing the benefits of a

healthy nervous system, you should also be aware that, like all areas of the healing arts, response to treatment and results cannot be guaranteed.

Family Check-Up: Spinal conditions are often silent and can go unnoticed by family and doctors for years. While we do not ask anyone to get care against their will, we do recommend that all families receive a spinal check-up to discover whether significant spinal health issues exist.

Corrective Care: Tremendous progress has been made in the rehabilitating and correction of spinal problems. Where in the past, chronic spinal structural problems could not be reversed or corrected, today they can. Your doctor can outline a course of treatment that goes beyond simple pain relief and into what it will take to actually correct or optimize the normal position of your spine and central nervous system.

Wellness Care: Spinal neglect is common, it has become an epidemic in our society. Getting back to maintenance is the ultimate goal of chiropractic. The gold standard for health care is to ensure the reduction of subluxation in the spine and then to maintain this for a lifetime.

I understand the doctor's objectives pertaining to my care in this office. I, therefore, accept chiropractic care on this basis.

Signature: _____ Date: _____

Consent to evaluate and adjust a minor child

I, (print) _____, being the parent or legal guardian of

(print) _____, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care, including X-rays, if deemed necessary.

_____ Date: _____

Signature of parent/legal guardian

[For Women Only] Pregnancy Release

This is to certify that, to the best of my knowledge, I am not pregnant. The above doctor and his/her associates (when applicable) have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual period: _____

Signature: _____ Date: _____

THE CHIROPRACTIC PLACE

POLICIES

1. Please note our typical fees for your initial visit (motor vehicle accident and/or personal injury):

Consultation:	Always Complimentary
Examination:	$85.00 - $420.00
Treatment:	$30.00 - $200.00
TOTAL:	**$115.00 - $620.00**

2. All charges are payable when services are rendered, unless prior arrangements have been made.

Patient Signature: _____ Date: _____

Guardian Signature Authorizing Care: _____ Date: _____

In Case of Emergency, Notify: (print) _____

Relationship: _____

Address: _____

_____

_____

Phone Number: _____

By my signature, I understand that HIPAA Notice of Privacy Practices policies are posted, and a copy is available to me for review at any time.

Signature: _____ Date: _____

Claim #: _____ Last Name: _____

THE CHIROPRACTIC PLACE

PERSONAL INJURY ASSIGNMENT OF BENEFITS

The Chiropractic Place
7051 Cypress Terrace Suite 106
Fort Myers, FL 33907

I, [print name] _____, assign all of the rights and benefits of any applicable personal injury protection, medical payments, or other coverage provided by any insurance policy issued pursuant to Florida Statutes §627.730-§627.7405, to THE CHIROPRACTIC PLACE, for services and supplies provided to me related to personal injuries I suffered in an automobile accident which occurred on _____.

I agree to pay any co-payment, deductible, medical payments, or other insurance coverage not covered by the applicable personal injury protection. This assignment includes, but is not limited to:

- All rights to collect benefits directly from any insurance carrier obligated to provide benefits for services and supplies I have received;
- All rights to take legal or other action against any insurance carrier obligated to provide benefits if for any reason the insurance carrier fails to pay any benefits due; and
- All rights to recover attorney fees, legal assistant fees, costs, and any interest on fees and costs, for any legal or other action taken by THE CHIROPRACTIC PLACE as my assignee.

This is an assignment of rights only, and is not a delegation of any of my duties under the subject insurance policy.

I agree that THE CHIROPRACTIC PLACE may retain any attorney it chooses to bring legal action against any insurance carrier obligated to provide benefits for services and supplies I have received, and that the attorney chosen may be different than any attorney I may have handling any claim I may have for personal injuries.

I have been given a copy of this assignment to retain for my records; I have read this assignment and I am satisfied that I fully understand the purpose and implications of executing this assignment and do so freely and voluntarily.

_____ _____
Patient/Guardian Signature Date

The undersigned, as authorized representative of THE CHIROPRACTIC PLACE accepts the assignment of benefits as set forth above.

_____ _____
Provider Signature Date

 Claim #: _____ Last Name: _____

POLICYHOLDER INFORMATION

7051 Cypress Terrace Suite 106
Fort Myers, FL 33907
(239) 887-3066

Patient/Policy Holder: _____

SS#: _____ Date of Birth: _____

Phone Numbers: (c) _____ (h) _____

Email: _____

Address: _____

_____

_____

Date of Accident: _____

Auto Insurance Co.: _____

Claim/Policy ID#: _____

Claim Adjuster: _____

I, _____, authorize the release of insurance benefits information/verification to THE CHIROPRACTIC PLACE.

Please provide this information via telephone contact and/or fax.

_____ _____

Patient /Policy Holder Signature Date

 Claim #: _____ Last Name: _____

THE CHIROPRACTIC PLACE

NOTICE OF DOCTOR'S LIEN

The Chiropractic Place
7051 Cypress Terrace Suite 106
Fort Myers, FL 33907

Patient (print name): _____ Date of Accident: _____

I do hereby authorize THE CHIROPRACTIC PLACE to furnish you, my attorney, with a full report of the doctor's 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 provider such sums as may be due and owing them for the healthcare service rendered me both by reason of this accident and by reason of any other bills that are due their office and to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect and fully compensate said provider.

And I hereby further give a lien on my case to said doctor against any and all proceeds of my settlement, judgment, or verdict which may be paid to you, my attorney, or myself, as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said provider for all healthcare bills submitted by them for service rendered me and that this agreement is made solely for said provider's additional protection and in consideration of their 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.

I agree to promptly notify said doctor of any change or addition of attorney(s) used by me in connection with this accident, and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted attorney(s).

Please acknowledge this letter by signing below and returning to the provider's office. I have been advised that if my attorney does not wish to cooperate in protecting the provider's interest, the provider will not await payment and may declare the entire balance due and payable.

_____ _____
Patient Signature Date

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold sums from any settlement, judgment, or verdict, as may be necessary to adequately protect and fully compensate said provider above-named. Attorney further agrees that in the event this lien is litigated, that the prevailing party will be awarded attorney fees and costs.

_____ _____
Attorney Signature Date

_____
Attorney Office and Address

 Claim #: _____ Last Name: _____

THE CHIROPRACTIC PLACE

AUTOMOBILE ACCIDENT CASE HISTORY

This is a comprehensive case history of your car accident. Fill this out completely. For each question, please select the response(s) that most accurately describe(s) what occurred to you during the accident. **In some questions, more than one (1) response may be necessary to explain what happened.**

1. DATE OF ACCIDENT: _____

2. TIME OF ACCIDENT: _____ AM / PM

3. PLACE OF ACCIDENT (CITY / STATE): _____

4. MAKE and MODEL OF **YOUR** CAR: _____

5. MAKE and MODEL OF **OTHER** CAR: _____

6. ROAD CONDITIONS AND VISIBILITY AT TIME OF ACCIDENT:
____Dry ____Wet ____Snowy ____Icy ____Road under construction
____Good visibility ____Poor visibility

7. WHERE WERE YOU SEATED IN THE VEHICLE?
____Driver ____Front Passenger ____Behind the driver ____Behind the passenger

8. WERE YOU:
____Restrained with shoulder harness and lap belt
____Restrained with lap belt only
____Restrained with the shoulder harness only
____Not restrained at all

9. SPEED OF YOUR CAR AT THE TIME OF COLLISION:
____My car was at a complete stop
____My car suddenly came to a complete stop
____My car was gradually slowing down, coming to a stop with a speed of _____mph
____I was going the speed limit for the road I was on, which was _____mph
____I was travelling at approximately _____mph.

10. SPEED OF THE OTHER VEHICLE(S) AT THE TIME OF THE COLLISION:
____There was no other car involved except my own
____The speed of the other car was unknown
____The speed of the car was _____ mph
____The car behind me was at a complete stop and was suddenly struck and pushed forward by another car going _____ mph.

11. YOUR BODY POSTURE AT THE TIME OF THE COLLISION:
____Seated in an upright position and looking straight ahead
____Seated in a slouched position and looking straight ahead
____Seated in an upright position and looking to the right / left

____Seated in a slouched position and looking to the right / left
____Head and torso twisted to the right / left to check kids in the back seat
____Sleeping in the front seat and body posture was unknown
____Sleeping in the back seat and body posture was unknown
____Arm / wrist position prior to impact: ___ On steering wheel ___Arm out of window
___Arms relaxed at side
____Other_____

12. WAS THE IMPACT:
____Sudden and unexpected
____I saw it coming and braced for impact

13. I BRACED FOR IMPACT WITH:
____My arms against the dashboard
____My arms extended against the steering wheel
____I did not brace for impact because it was sudden and unexpected.

14. WAS THE IMPACT:
____Rear impact
____Front impact
____Head-on impact
____Side impact to the ___Driver side ___Passenger side
____Lost control of the vehicle and went into: ___Ditch ___Tree ___Utility pole ___Another car
___Concrete median ___Grass median
____Vehicle was struck by an animal: ___Deer ___Cow ___Horse ___Dog

15. UPON IMPACT, THE CAR WAS:
____Pushed forward into the intersection _____ amount of feet
____Pushed forward into the intersection _____ amount of feet and then struck on the
___right / ___left side by another vehicle
____Pushed forward into the car in front of me
____Pushed forward but did not strike car in front of me
____Stayed stationary
____Spun around to the ___right / ___left
____Spun around to the ___right / ___left and struck a ___Tree ___Utility pole ___Ditch
___Another car ___Concrete / Grass median ___Other
____Spun around to the ___right / ___left and rolled _____time(s)
____Other: _____

16. UPON IMPACT, I WAS:
____Jerked forward then backward in my seat
____Jerked backward then forward in my seat
____Jerked left to right in my seat
____Jerked right to left in my seat
____Air bag deployed striking me in the head / face and I was pushed backwards / forward
____Air bag deployed striking me in the chest and I was pushed backwards / forward
____My ___arms ___Shoulders ___Wrists
were jammed against the
___Steering wheel ___Dashboard ___Back of seat ___Vehicle door
____My knees struck the dashboard
____My knees struck the seat in front of me

____I cannot recall the specifics of the crash
____Other: _____

17. FOLLOWING THE IMPACT, MY:
____Chest struck the steering wheel
____Chest struck the steering wheel and my face / head struck the windshield
____Head struck the steering wheel
____Head struck the windshield
____Head struck the dashboard
____Head struck the side window
____Head struck the back of the passenger / driver seat (for back passenger)
____Head struck the headrest
____Head struck and went over the top of the headrest
____Top of my head struck the roof of the car

18. Were you able to exit the vehicle on your own?
____Yes ____No
If no, how did you exit the vehicle? _____

19. IN WHICH OF THE FOLLOWING BODY REGIONS DID YOU EXPERIENCE PAIN **IMMEDIATELY** AFTER THE ACCIDENT (**DESCRIBE** SYMPTOMS):
____Neck _____
____Upper/mid back _____
____Lower back _____
____Shoulders/Arms _____
____Elbow/wrist/hand _____
____Hip/knee/ankle/foot/legs _____
____Chest/Abdomen _____

20. IN WHICH OF THE FOLLOWING BODY REGIONS DID YOU EXPERIENCE PAIN **A FEW HOURS** AFTER THE ACCIDENT (**DESCRIBE** SYMPTOMS):
____Neck _____
____Upper/mid back _____
____Lower back _____
____Shoulders/Arms _____
____Elbow/wrist/hand _____
____Hip/knee/ankle/foot/legs _____
____Chest/Abdomen _____
____Extremity numbness/tingling _____

21. IN WHICH OF THE FOLLOWING BODY REGIONS DID YOU EXPERIENCE PAIN OR SYMPTOMS BEGINNING **THE NEXT DAY OR WITHIN THE NEXT 2 WEEKS AFTER** THE ACCIDENT (**DESCRIBE** SYMPTOMS):
____Neck_____
____Upper/mid back_____
____Lower back _____

____Shoulders_____

____Elbow/wrist/hand_____

____Hip/knee/ankle/foot_____

____Chest/Abdomen_____

____Extremity numbess/tingling_____

22. DID YOU EXPERIENCE ANY OF THE FOLLOWING SYMPTOMS AFTER THE ACCIDENT:

___Blackouts ___Disorientation / Confusion ___Visual problems ___Speech problems
___Breathing difficulty ___Loss of consciousness ___Headaches ___Dizziness
___Lightheadedness ___Ringing in the ears (tinnitus)____Numbness/Tingling

23. WHAT TYPE OF TREATMENT HAVE YOU RECEIVED SINCE THE ACCIDENT:

____No treatment to date since the accident
____Saw paramedics at scene of the accident and no other treatment since then
____Saw paramedics and transported to emergency room
____Placed in a neck collar, on a backboard and transported to the ER
____After the accident, I was taken by another person to the ER
____At the ER, I was examined, released with medication and instructed to follow-up if pain continued
____At the ER, I was examined, x-rayed, released with medication and instructed to follow-up if pain
____At the ER, I was examined, x-rayed, released with medication and referred to a specialist
____Seen by my family physician_____days after the accident
____Seen by my family physician and referred to a medical specialist (ortho / phys med / etc)
____Other:_____

24. SINCE THE ACCIDENT, WHICH OF THE FOLLOWING ACTIVITIES CAUSE YOU TO EXPERIENCE A WORSENING OF YOUR CONDITION:

___Driving a car ___Reading ___Working on a computer ___Lifting
___Leaning ___Stooping ___Squatting ___Personal care
___Up / Down stairs ___Walking / running ___Any motion of injured area ___Bending
___Use of arms overhead ___Home activities / chores ___Recreational Activities
___Caring for children / family

25. WORK/SCHOOL STATUS FOLLOWING THE CAR ACCIDENT:

____I have not missed any work / school since my accident
____I have missed _____ day(s) of work / school since my accident
____I returned to work/school on ____/____/____
____Due to my injuries, I have not been able to return back to work / school

26. PERSONAL MEDICAL HISTORY **PRIOR** TO THE ACCIDENT (CHECK IF APPLIES AND **DESCRIBE**):

____Hospitalization_____

____Auto Accident_____

____Work Accident _____

____Surgery _____

27. Please check any of the following if they applied to you within the last 12 months ***prior*** to the accident		
General	**Muscle / Joint**	**Skin**
□ Allergies	□ Arthritis / rheumatism	□ Boils
□ Depression	□ Bursitis	□ Bruise easily
□ Dizziness	□ Foot trouble	□ Dryness
□ Fainting	□ Muscle weakness	□ Hives or allergies
□ Fatigue	□ Low back pain	□ Itching
□ Fever	□ Neck pain	□ Rash
□ Headaches	□ Mid back pain	□ Varicose veins
□ Loss of sleep	□ Joint pain	
□ Mental illness		**Cardiovascular**
□ Nervousness	**Gastrointestinal**	□ High blood pressure
□ Tremors	□ Abdominal pain	□ Low blood pressure
□ Weight loss / gain	□ Colitis / Crohn's	□ Hardening of the arteries
	□ Colon trouble	□ Irregular pulse
Eye, Ear, Nose & Throat	□ Constipation	□ Pain over heart
□ Colds	□ Diarrhea	□ Palpitation
□ Deafness	□ Difficult digestion	□ Poor circulation
□ Ear ache	□ Diverticulosis	□ Rapid heart beat
□ Eye pain	□ Bloated abdomen	□ Slow heart beat
□ Hoarseness	□ Excessive hunger	□ Swelling of ankles
□ Nasal obstruction	□ Gallbladder trouble	
	□ Hernia	**Women only:**
Respiratory	□ Liver trouble	□ Irregular cycle
□ Chest pain	□ Nausea	□ Pain / Cramps
□ Chronic cough	□ Pain over stomach	□ Difficulty getting pregnant
□ Difficulty breathing	□ Poor appetite	
□ Hay fever	□ Vomiting	
□ Shortness of breath		
□ Spitting up phlegm / blood		
□ Wheezing		
Past or Present History		
□ Alcoholism	□ Eczema	□ Miscarriage
□ Anemia	□ Edema	□ Multiple sclerosis
□ Appendicitis	□ Emphysema	□ Mumps
□ Arteriosclerosis	□ Epilepsy	□ Nose bleeds
□ Asthma	□ Goiter	□ Numbness/tingling
□ Bronchitis	□ Gout	□ Pace maker
□ Cancer	□ Heart burn	□ Sinus infection
□ Chicken pox	□ Heart disease	□ Sore throat
□ Cold sores	□ Hepatitis	□ Stroke
□ Diabetes	□ High cholesterol	□ Thyroid disease
□ Osteoporosis	□ HIV/AIDS	□ Tonsillitis
□ Pneumonia	□ Influenza	□ Tuberculosis
□ Polio	□ Malaria	□ Ulcers
□ Rheumatic fever	□ Measles	□ Vision problems

 Claim #: _____ Last Name: _____

28. Do you have an attorney on this claim? ____Yes ____No

If yes, who? Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

29. Are you on any medications? If so, please list them below:

_____

_____

30. Employer: _____ Position: _____

Address: _____

31. Who is your primary care physician?

Name: _____ Address: _____

Phone Number: _____ _____

32. Please complete the pain diagram to the right. Also, write anything else you would like us to know about your pain in the lines below.

_____

_____

_____

_____

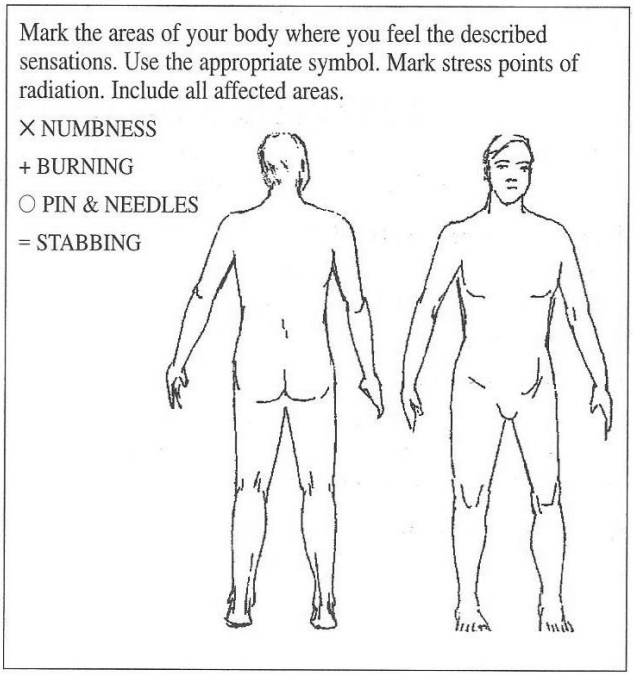
_____

_____

_____

_____

_____



Signature: _____ Date of Accident: _____