AUTO ACCIDENT QUESTIONAIRE

Core Chiropractic and Wellness, L.L.C.

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:_____

Updated 9/2009

Core and Chiropractic and Wellness, L.L.C.
5323 Main Street
New Port Richey, FL 34652
P:727-807-7020
F:727-807-7021

Chart#_____

PATIENT INFORMATION

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

Address:_____City:_____State:____Zip:_____

Email address :_____

Home Phone:_____Cell#:_____**Cell Provider**:_____
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)

Core Chiropractic and Wellness, L.L.C.
5323 Main St.
New Port Richey, FL 34652
(727) 807 7020

Patient DOB: _____

CASE HISTORY

Full Name:_____Date:_____

History of 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 _____

When is your condition most severe? _____
When is your condition least severe? _____
What makes your condition feel worse? _____
What makes your condition feel better? _____

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

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

Review of Systems

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

Past History

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 _____

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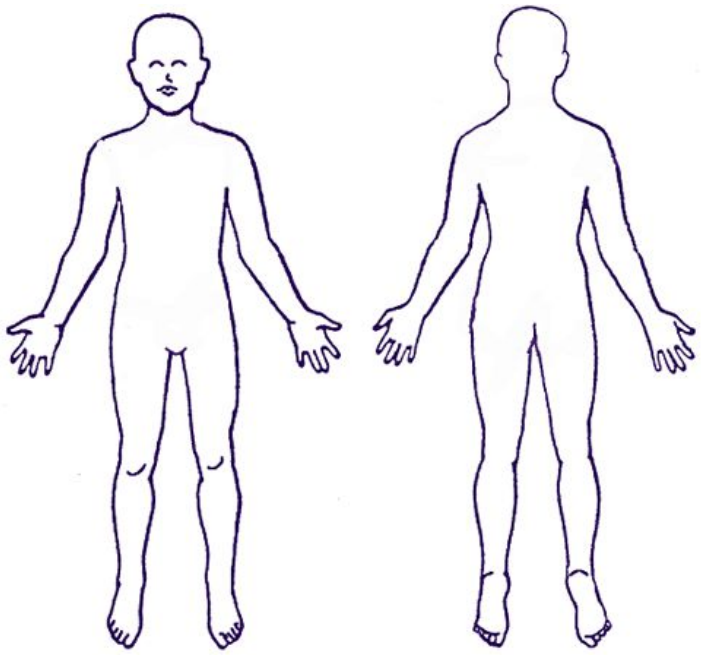
5323 Main Street
New Port Richey, FL *34652*
Phone: *727-807-7020*
Fax: *727-807-7021*

PAIN DRAWING

Patient Name:_____ Date:_____

Please mark the areas where you feel the following sensations:

PAIN = P	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 _____

Core Chiropractic and Wellness, L.L.C.
5323 Main Street
New Port Richey, FL *34652*

Agreement to Office Policies:

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

_____I agree to follow the doctor's appointment schedule. I understand that I will be expected to make up any ssed appointments. All missed appointments must be made up within seven(7) days.

_____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 urance claims.

_____I understand the Cancellation Policy. It states that if I have a scheduled appointment that I will not be able to

ke, it is my responsibility to call and reschedule the appointment with 24 hours notice. Failure to do this will result 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 epted 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 understand that this office will use Capital Accounts for any delinquencies. I will also be responsible for y costs incurred in collection of said balance, which may include collection agency, court costs, and attorney fees.

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

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

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

_____I understand that until a relationship is established between Core Chiropractic and Wellness and myself, ecks will not be accepted. We gladly accept cash, credit or debit cards.

_____**I understand that I may be responsible for a $10.00 cost for personal use electrodes for the Electric uscle Stimulation Unit, if the doctor's determine that I will benefit from this treatment. This charge is not mbursable by health insurance.**

_____I have received a copy of Core Chiropractic and Wellness Notice of Privacy Practices.

If I elect to use my health care coverage:

e Chiropractic and Wellness will file my insurance claim as a courtesy; however, I am ultimately responsible for understanding my urance policy. The office has a relationship with me, the patient, not my insurance company. Although Core Chiropractic and Wellness does mpt to verify my chiropractic benefits with my insurance policy, I realize this is only an estimate of my coverage based on the information en to Core Chiropractic and Wellness at the time of inquiry. If a service is not covered and needs to be performed, I am responsible for e 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 aid claim will be given to me and I will be responsible to follow up on the status of payment. I will also inform Core Chiropractic and lness of any changes to my insurance policy so my coverage can be re-verified prior to my appointment.

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

_____ _____

ient Signature Date

Core Chiropractic and Wellness, L.L.C.
5323 Main Street
New Port Richey, FL *34652*
Phone*: 727-807-7020*
Fax*: 727-807-7021*

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 Core Chiropractic and Wellness 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 judgment 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.

_____ Vivian Montemayor, D.C._____
Patient or Representative Signature Doctor's Name

_____ _____
Witness's Signature Doctor's Signature

_____
Date

Release of Protected Health Information
Authorization Form

Core Chiropractic and Wellness, L.L.C.
5323 Main Street
New Port Richey, FL 34652
Phone: 727-807-7020
Fax: 727-807-7021

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 Core Chiropractic and Wellness 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 Core Chiropractic and Wellness 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

Core Chiropractic and Wellness, L.L.C.
5323 Main Street
New Port Richey, FL 34652
Phone: 727-807-7020
Fax: 727-807-7021

Assignment and Authorization

For good and valuable consideration, including the agreement of Core Chiropractic and Wellness, LLC. 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 Core Chiropractic and Wellness, LLC. 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 Core Chiropractic and Wellness, LLC. 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 Core Chiropractic and Wellness, LLC. is hereby directed to issue payment for those benefits directly and payable to
Core Chiropractic and Wellness, LLC.

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

Core Chiropractic and Wellness, LLC. accepts the aforesaid assignment and hereby notifies any insurer issuing payment that Core Chiropractic and Wellness, LLC. 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

Core Chiropractic and Wellness, L.L.C.
5323 Main Street
New Port Richey, FL 34652
Phone: 727-807-7020 Fax: 727-807-7021

AUTHORIZATION TO OBTAIN PIP BENEFITS PAYOUT INFORMATION AND COPY OF POLICY DELCARATION PAGE

NAME OF INSURER:_____
PIP POLICY NUMBER:_____
NAME OF INSURED:_____
DATE OF ACCIDENT:_____

I,_____hereby authorize and direct _____
to send Core Chiropractic and Wellness an accounting of payouts made under all claims submitted for payment under the above referenced policy relating to the automobile accident occurring on the above referenced date as those payouts occur.

_____ _____
Signature of Insured Date

Address of Insured: _____
Chart Number:_____
Date of Birth:_____

Core Chiropractic and Wellness, L.L.C.
Vivian Montemayor, D.C.
5323 Main Street
New Port Richey, FL 34652
Phone: 727-807-7020
Fax: 727-807-7021

Letter of Protection

I do hereby authorize Core Chiropractic and Wellness and Vivian Montemayor, 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

Core Chiropractic and Wellness, L.L.C.
Dr. Vivian Montemayor, D.C.
5323 Main Street
New Port Richey, FL 34652
727-807-7020

Promise to Pay for Treatments

I, _____, am seeking treatment from Core Chiropractic and Wellness, L.L.C. for injuries sustained in an automobile accident occurring on _____. I am responsible for paying Core Chiropractic and Wellness for that treatment and any treatments left unpaid are due and owing by me to Core Chiropractic and Wellness. I hereby promise and assure Core Chiropractic and Wellness that any payment by check or any other form from any health insurance company, automobile insurance company, or any other source as compensation or reimbursement for treatment of the aforementioned injuries by Core Chiropractic and Wellness shall be preserved and submitted to Core Chiropractic and Wellness for payment of any balance due on the aforementioned treatments.

I understand that I remain liable to Core Chiropractic and Wellness for any unpaid aforementioned treatments should I cash any check or accept any payment from any health insurance company, automobile insurance company, or any other source as compensation or reimbursement for treatment of the aforementioned injuries.

I agree to promptly advise Core Chiropractic and Wellness of receipt of any payment by check or any other form from any health insurance company, automobile insurance company, or any other source as compensation or reimbursement for treatment of the aforementioned injuries.

Signed this _____day of _____, 20__.

_____
Patient's name

_____
Patient's signature

_____
Witness signature

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.**

_____

_____

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 (15) and (16), 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.