

Whom may we thank for referring you to this office? _____

NEW PATIENT APPLICATION FOR CARE AT **New Smyrna Beach Chiropractic**

Today's Date: _____

HRN: _____

PATIENT DEMOGRAPHICS

Name: _____ Birth Date: ____ - ____ - ____ Age: _____ ☐ Male ☐ Female

Address: _____ City: _____ State: ____ Zip: _____

E-mail Address: _____ Home Phone: _____ Mobile Phone: _____

Marital Status: ☐ Single ☐ Married Do you have Insurance: ☐ Yes ☐ No Work Phone: _____

Social Security #: _____ Driver's License #: _____

Employer: _____ Occupation: _____

Spouse's Name _____ Spouse's Employer _____

Number of children and ages: _____

Name & Number of Emergency Contact: _____ Relationship: _____

HISTORY of COMPLAINT

Please identify the condition(s) that brought you to this office: Primary: _____

Secondary: _____ Third: _____ Fourth: _____

On a scale of **1 to 10** with **10** being the worst pain and **zero** being no pain, rate your above complaints by **circling the number**:

Primary or chief complaint is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Second complaint is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Third complaint is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Fourth complaint is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

When did the problem(s) begin? _____ When is the problem at its worst? ☐ AM ☐ PM ☐ mid-day ☐ late PM

How long does it last? ☐ It is constant **OR** ☐ I experience it on and off during the day **OR** ☐ It comes and goes throughout the week

How did the injury happen? _____

Condition(s) ever been treated by anyone in the past? ☐ No ☐ Yes **If yes, when:** _____ **by whom?** _____

How long were you under care: _____ What were the results? _____

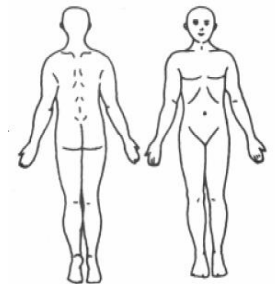
Name of Previous Chiropractor: _____ ☐ N/A

PLEASE MARK the areas on the Diagram with the following **letters** to describe your symptoms:

R = Radiating **B** = Burning **D** = Dull **A** = Aching **N** = Numbness **S** = Sharp/Stabbing **T** = Tingling

What relieves your symptoms? _____

What makes your symptoms feel worse? _____



LIST RESTRICTED ACTIVITY:

CURRENT ACTIVITY LEVEL

USUAL ACTIVITY LEVEL

_____:	_____	_____
_____:	_____	_____
_____:	_____	_____
_____:	_____	_____

Is your problem the result of ANY type of accident? ☐ Yes, ☐ No

Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

PAST HISTORY

Have you suffered with any of this or a similar problem in the past? ☐ No ☐ Yes **If yes**, how many times? _____ When was the last episode? _____ How did the injury happen? _____

Other forms of treatment tried: ☐ No ☐ Yes **If yes**, please state **what** type of treatment: _____, and who provided it: _____ **How long ago?** _____ What were the results. ☐ Favorable ☐ Unfavorable → please explain. _____

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:

If you have ever been diagnosed with any of the following conditions, please indicate with a **P** for in the **Past**, **C** for **Currently** have or **N** for **Never** have had:

____ Broken Bone ____ Dislocations ____ Tumors ____ Rheumatoid Arthritis ____ Fracture ____ Disability ____ Cancer
____ Heart Attack ____ Osteo Arthritis ____ Diabetes ____ Cerebral Vascular ____ Other serious conditions: _____

PLEASE identify ALL PAST and any CURRENT conditions you feel may be contributing to your present problem:

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
INJURIES	→		
SURGERIES	→		
CHILDHOOD DISEASES	→		
ADULT DISEASES	→		

SOCIAL HISTORY

1. **Smoking:** ☐ cigars ☐ pipe ☐ cigarettes How often? ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

2. **Alcoholic Beverage:** consumption occurs ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

3. **Recreational Drug use:** ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

4. **Hobbies -Recreational Activities- Exercise Regime:** How does your present problem affect? (See ADL form)

FAMILY HISTORY:

1. Does anyone in your family suffer with the same condition(s)? ☐ No ☐ Yes

If yes whom: ☐ grandmother ☐ grandfather ☐ mother ☐ father ☐ sister(s) ☐ brother(s) ☐ son(s) ☐ daughter(s)

Have they ever been treated for their condition? ☐ No ☐ Yes ☐ I don't know

2. **Any** other hereditary conditions the doctor should be aware of? ☐ No ☐ Yes: _____

I hereby authorize payment to be made directly to [New Smyrna Beach Chiropractic Clinic, PLC](#) for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to [New Smyrna Beach Chiropractic Clinic, PLC](#) for any and all services I receive at this office.

Patient or Authorized Person's Signature

Date Completed

Doctor's Signature

Date Form Reviewed

PATIENT'S NAME: _____ HR#: _____ Date: _____

ACTIVITIES OF LIFE

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITIES:	EFFECT:			
Carry Children/Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sit to Stand	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Climb Stairs	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Pet Care	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Extended Computer Use	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Lift Children/Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Read/Concentrate	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Getting Dressed	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Shaving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sexual Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sleep	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Yard work	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Washing/Bathing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sweeping/Vacuuming	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dishes	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Laundry	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Garbage	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Other: _____	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform

List Prescription & Non-Prescription drugs you take: _____

Patient signature: _____ Today's Date: __/__/__

Health History Questionnaire

(PLEASE MARK ALL PAST/PRESENT CONDITIONS AS THIS SECTION IS VERY IMPORTANT)

Please **CIRCLE** any conditions you **currently** have and place an "X" on the line if you have had this condition in the **past**.

General

- ☐ Chronic Fever
- ☐ Chills
- ☐ Night Sweats
- ☐ Loss of Sleep
- ☐ Chronic Fatigue
- ☐ Nervousness
- ☐ Weight Loss/Gain
- ☐ Allergies
- ☐ Bleeding Problems
- ☐ Anemia
- ☐ Diabetes
- ☐ Cancer
- ☐ Thyroid Disease
- ☐ High Cholesterol
- ☐ Osteoporosis
- ☐ Alcoholism
- ☐ Drug Abuse

Cardiovascular

- ☐ Irregular Heartbeat
- ☐ High Blood Pressure
- ☐ Pain in Chest
- ☐ Heart Disease
- ☐ Ankle Swelling
- ☐ Varicose Veins
- ☐ Stroke
- ☐ Heart Attack
- ☐ Heart Murmur

Neurological

- ☐ Weakness
- ☐ Twitching
- ☐ Tremors
- ☐ Chronic Headaches
- ☐ Fainting
- ☐ Dizziness
- ☐ Convulsions
- ☐ Epilepsy
- ☐ Numbness/Tingling
- ☐ Arm/Leg Pain
- ☐ Mental Disorder

Eyes, Ears, Nose, Throat

- ☐ Poor Vision
- ☐ Pain in eye(s)
- ☐ Deafness/Difficulty Hearing
- ☐ Nosebleeds
- ☐ Nose Problems
- ☐ Sinus Problems
- ☐ Hoarseness
- ☐ Difficulty Swallowing
- ☐ Dental Problems
- ☐ Recurrent Ear Infections

Genitourinary

- ☐ Frequent Urination
- ☐ Painful Urination
- ☐ Blood in Urine
- ☐ Urinary Infection
- ☐ Kidney Disease
- ☐ Inability to Control Urine
- ☐ Difficulty Starting Urine Flow
- ☐ Frequent Night Urination
- ☐ Breast Lumps or Pain
- ☐ Venereal Disease
- ☐ Sexual Dysfunction
- ☐ Kidney Stone

Musculoskeletal

- ☐ Neck Stiffness/Pain
- ☐ Pain Between Shoulder Blades
- ☐ Low Back Pain
- ☐ Swollen Joints
- ☐ Stiff/Painful Joints
- ☐ Muscle Aches/Soreness
- ☐ Spinal Curvature
- ☐ Arthritis
- ☐ Knee Pain
- ☐ Shoulder Pain
- ☐ Wrist/Hand Pain
- ☐ Ankle/Foot Pain
- ☐ Radiating Pain into Arms
- ☐ Radiating Pain into Legs
- ☐ Disc Herniation
- ☐ Disc Bulge

Gastrointestinal

- ☐ Poor Appetite
- ☐ Poor Digestion
- ☐ Belching or Gas
- ☐ Chronic Nausea
- ☐ Vomiting Blood
- ☐ Pain Over Abdomen
- ☐ Ulcer
- ☐ Black/Bloody Stool
- ☐ Liver Problems
- ☐ Gallbladder Problems
- ☐ Jaundice
- ☐ Hernia
- ☐ Chronic Diarrhea
- ☐ Chronic Constipation
- ☐ Hemorrhoids
- ☐ Appendicitis

Skin

- ☐ Itchy/Dry/Flaky
- ☐ Bruise Easily
- ☐ Change in Mole
- ☐ Skin Cancer
- ☐ Rashes
- ☐ Abnormal Scars
- ☐ Inability to Stop Bleeding

Habits/Exercise

- ☐ Smoking
_____ pks/day
- ☐ Alcohol
_____ drinks/wk
- ☐ Exercise
_____ times/wk
- ☐ Caffeinated Drinks
_____ drinks/day
- ☐ Water
_____ cups/day
- ☐ Recreational Drug Use

Respiratory

- ☐ Difficulty Breathing
- ☐ Chronic Cough
- ☐ Coughing up Phlegm
- ☐ Coughing up Blood
- ☐ COPD
- ☐ Asthma
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Emphysema

Other

- ☐ Memory Loss
- ☐ Concentration Loss
- ☐ Convulsions
- ☐ Vertigo
- ☐ Fibromyalgia
- ☐ Aneurysm
- ☐ HIV/AIDS
- ☐ Recent Unintentional
weight loss

MALE ONLY

- ☐ Testicular Swelling
- ☐ Prostate Problems
- ☐ Undescended Testicle
- ☐ Painful Intercourse

FEMALE ONLY

- ☐ Excessive Menstruation
- ☐ Painful Menstruation
- ☐ Irregular Cycle
- ☐ Painful Intercourse
- ☐ Hot Flashes

Please list all other past medical diagnosis: _____

QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name _____

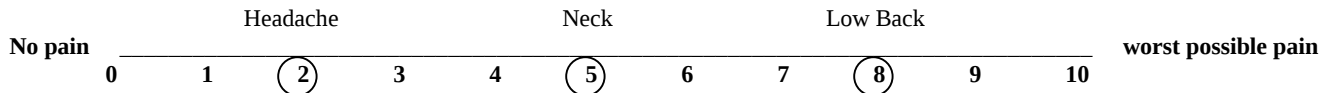
Date _____

Please read carefully:

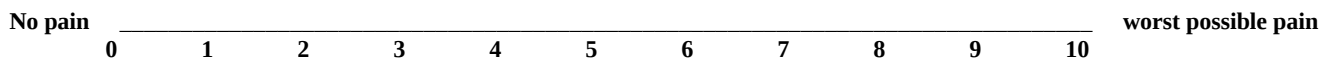
Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

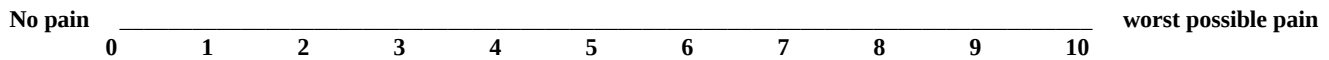
Example:



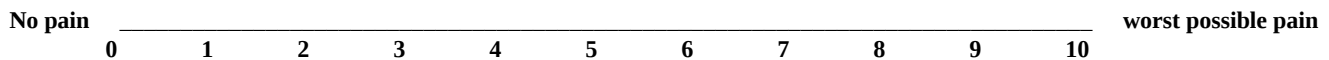
1 – What is your pain RIGHT NOW?



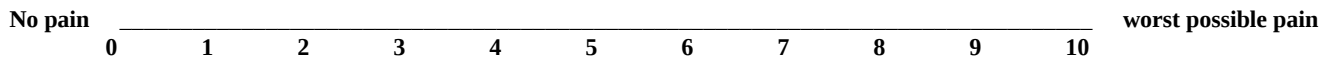
2 – What is your TYPICAL or AVERAGE pain?



3 – What is your pain level AT ITS BEST (How close to “0” does your pain get at its best)?



4 – What is your pain level AT ITS WORST (How close to “10” does your pain get at its worst)?



OTHER COMMENTS:

Examiner _____

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

Informed Consent

REGARDING: Chiropractic Adjustments, Massage Therapy, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care and massage therapy, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments, massage therapy and, all other procedures provided at [New Smyrna Beach Chiropractic Clinic, PLC](#) have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____/_____/____  *Witness Initials*
Patient or Authorized Person's Signature **Date**

REGARDING: X-rays/Imaging Studies

FEMALES ONLY → *please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.*

☐ The first day of my last menstrual cycle was on ____ - ____ - ____ (Date)

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____/_____/____  *Witness Initials*
Patient or Authorized Person's Signature **Date**

New Smyrna Beach Chiropractic - NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **Personal Health Information**. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as **dictated by our office policy**, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled **'HIPAA'** on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

PERMITTED DISCLOSURES:

1. Treatment purposes - discussion with other health care providers involved in your care.
2. Inadvertent disclosures - open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes - to process a claim or aid in investigation.
5. Emergency - in the event of a medical emergency we may notify a family member.
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement - to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons - discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders - **we may call your home and leave messages** regarding a missed appointment or apprise you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice.
3. To request mailings to an address different than residence.
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance.
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). **X-rays** are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call [Dr. Amanda Prokop, Compliance Officer](#) at (386)423-5259. If [she](#) is unavailable, you may make an appointment with our receptionist to see [her](#) within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201

Patient initials: _____-retaining page 1 of 2

New Smyrna Beach Chiropractic Clinic, PLC **NOTICE REGARDING YOUR RIGHT TO PRIVACY** continued...

I have received a copy of New Smyrna Beach Chiropractic Clinic, PLC Patient Privacy Notice. I understand my rights as well as the practice's duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

Patient's Name

DOB

HR#

Patient's Signature

Date

Witness

Date

**Medical Information Release Form
(HIPAA Release Form)**

Name: _____ Date of Birth: _____

Release of Information:

☐ I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

☐ Spouse _____

☐ Child(ren) _____

☐ Other _____

☐ Information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

Messages:

Please call ☐ my home ☐ my work ☐ my mobile number: _____

If unable to reach me:

☐ you may leave a detailed message

☐ please leave a message asking me to return your call

☐ _____

The best time to reach me is (day) _____ between (time) _____

Signed: _____ Date: _____

Witness: _____ Date: _____

New Smyrna Chiropractic
Automobile/PI Accident or Work Comp Questionnaire

Patient's Name _____

Date of Birth _____

HR#: _____

Dear Patient:

This information is considered confidential. Your answers will help us determine if chiropractic care can help your condition. We will not accept your case if we do not believe your condition will respond satisfactorily to care. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. Thank you.

Please answer all questions completely.

Please explain in detail how your accident happened: _____

What were the time and date of present injury? _____

Where did you feel pain immediately after the accident? _____

List the extent of your injuries as you know them: _____

Did you require post-accident hospitalization? ☐ Yes ☐ No

Check symptoms you have noticed since the accident:

☐ Headache	☐ Dizziness	☐ Depression	☐ Fatigue
☐ Light Bothers Eyes	☐ Buzzing in Ears	☐ Diarrhea	☐ Neck Pain
☐ Head Seems to Heavy	☐ Memory Loss	☐ Feet Cold	☐ Neck Stiff
☐ Pins and Needles in Arms	☐ Ears Ring	☐ Hands Cold	☐ Fainting
☐ Sleeping Problems	☐ Back Pain	☐ Face Flushed	☐ Loss of Balance
☐ Pins and Needles in Legs	☐ Constipation	☐ Tension	☐ Nervousness
☐ Numbness in Fingers	☐ Loss of Smell	☐ Fever	☐ Irritability
☐ Numbness in Toes	☐ Loss of Taste	☐ Chest Pain	☐ Cold Sweats
☐ Shortness of Breath	☐ Stomach Upset		

Symptoms other than above: _____

Where were you taken after the accident? _____

Hospitalized? ☐ Yes ☐ No If yes, admitted? _____ How long? _____

Name of Hospital: _____

Name of Doctor(s): _____

What treatment was given? _____

Patient's Name _____

Date of Birth _____

HR#: _____

Was any other doctor consulted after your accident? ☐ Yes ☐ No

If so, what was the doctor's name? _____ D.C., M.D., D.O., D.D.S.

What was the diagnosis? _____

What treatment was given? _____

How often did you see the doctor? _____

How long did you see the doctor? _____

Have you ever had any complaints in the involved area before? ☐ Yes ☐ No

If so, what were the complaints? _____

Before the 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

Since this injury are your symptoms ... ☐ Improving? ☐ Getting worse? ☐ Same?

Driver of other vehicle (if any):

Name _____ Insurance Company _____ Policy No. _____

Driver of vehicle in which you were injured (if applicable):

Name _____ Insurance Company _____ Policy No. _____

Name of your insurance adjustor _____

Have you retained an attorney? ☐ Yes ☐ No

If so, his/her name and address _____

You were heading North/ East/ South/ West on _____ (street or highway)

Other vehicle was heading North/ East/ South/ West on _____ (street or highway)

Were police notified? ☐ Yes ☐ No

Were you knocked unconscious? ☐ Yes ☐ No If yes, for how long? _____

You were struck from Behind/ Front/ Left Side/ Right Side _____

You were Driver/ Passenger/ Front seat/ Back Seat/ Using seat belts _____

Patient Signature _____

Date _____

Doctor Signature _____

Date _____

**ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE PERSONAL INJURY, WORK COMP, ERISA,
AND OTHER LEGAL AND ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND /OR
HEALTH BENEFIT PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND
DESIGNATION OF AUTHORIZED REPRESENTATIVE**

Provider Name: Dr. Amanda Prokop

Clinic: New Smyrna Beach Chiropractic Clinic

Address: 1205 N. Dixie Freeway, New Smyrna Beach, FL 32168

I hereby assign and convey directly to the above-named health care provider, as my designated authorized representative, any and all medical benefits and/or any insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by the above-named health care provider, regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above-named health care provider to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the above-named health care provider any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the above-named health care provider or its attorneys in order to claim such medical benefits.

In addition to the assignment of all medical benefits and/or insurance reimbursement above, I also assign and/or convey to the above named health care provider any legal or administrative claim or chose an action arising under any group health plan, employee benefits plan, health insurance or tort feasor insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from the above-named health care provider (including any right to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of ERISA breach or fiduciary duty claims and other legal and/or administrative claims.

I intend by this assignment and designation of authorized representative to convey to the above-named provider all of my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or mediations provided by the above-named health care provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (above-named provider) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The above-named provider as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense.

Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

Patient Signature

Date

New Smyrna Beach Chiropractic Clinic, PLC

Amanda J. Prokop D.C.

1205 N. Dixie Freeway
New Smyrna Beach, FL 32168
Phone: (386) 423-5259 Fax: (386) 423-0929

NOTICE OF INITIATION OF TREATMENT

Claim Number:

Date:

Patient Name:

Practice/Provider Name: New Smyrna Beach Chiropractic Clinic

First Treatment Date:

This document shall serve as formal notice to the insurer that the first examination or treatment of the claimant has occurred. While Florida Statute § 627.736 requires medical providers to submit bills to insurance companies within 35 days of treatment, subsection (5)(c) allows medical providers to submit bills within 75 days of treatment if this notice is provided within 21 days of the first examination or treatment. Any deficiencies to this notice are deemed waived if they are not specifically objected to in writing before the 21 day window expires.

(c) With respect to any treatment or service, other than medical services billed by a hospital or other provider for emergency services and care as defined in s. 395.002 or inpatient services rendered at a hospital-owned facility, the statement of charges must be furnished to the insurer by the provider and may not include, and the insurer is not required to pay, charges for treatment or services rendered more than 35 days before the postmark date or electronic transmission date of the statement, except for past due amounts previously billed on a timely basis under this paragraph, and except that, if the provider submits to the insurer a notice of initiation of treatment within 21 days after its first examination or treatment of the claimant, the statement may include charges for treatment or services rendered up to, but not more than, 75 days before the postmark date of the statement. The injured party is not liable for, and the provider may not bill the injured party for, charges that are unpaid because of the provider's failure to comply with this paragraph. Any agreement requiring the injured person or insured to pay for such charges is unenforceable.

New Smyrna Beach Chiropractic Clinic, PLC

Amanda J. Prokop D.C.

1205 N. Dixie Freeway

New Smyrna Beach, FL 32168

Phone: (386) 423-5259 Fax: (386) 423-0929

FINANCIAL DISCLOSURE POLICY

As a result of the changes to the 2003 Florida No Fault Statute (PIP statute) it is a third degree felony for any health care provider to agree to waive a deductible or to reduce or waive your co-payment (if applicable) as a routine business practice.

We therefore require payment of all balances due, whether co-payment or deductibles, after all attempts by us (including litigation) to collect from the PIP carrier and the at fault driver's carrier have been exhausted.

Two exceptions are permitted under the law:

1. Reduction of the balance in conjunction with a personal injury settlement.
2. Documented financial hardship.

Please speak with our billing manager if you have any questions or if your visits to our facility are due to the negligence of another party.

Patient's Signature

Date



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**.

Exam, 3-4 CMT, Trigger Point, Exercise, Heat/Ice, EMS, Tens, Strapping, Traction

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*):

Dr. Amanda Prokop, DC

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.

ASSIGNMENT OF BENEFITS

I HEREBY ASSIGN AND TRANSFER ANY AND ALL RIGHTS, BENEFITS AND CAUSES OF ACTION TO THE ASSIGNEE. This is an assignment of my rights and benefits. In the event my insurance company is obligated to make payment to me upon charges made by the Assignee for its services, and the company fails or refuses to make timely, complete payment, I authorize Assignee to prosecute said cause of action either in my name or Assignee's name and further I authorize Assignee to compromise, settle or otherwise resolve said cause of action as they see fit.

DIRECTION OF PAYMENT

I hereby authorize and direct you, my insurance company and or my attorney, to pay directly to New Smyrna Beach Chiropractic Clinic (Assignee), such sums as may be due and owing Assignee for the services rendered to me by reason of accident or illness, and by reason of any other bills that are due Assignee. I hereby authorize any insurance company to pay directly to Assignee the amount of this and/or any future bills for services rendered to me and to release any information requested that is pertinent to my case to my insurance company or attorney involved in this case.

LETTER OF PROTECTION IN FAVOR OF PROVIDER

I hereby authorize and direct that my lawyer, if I am represented by counsel, SHALL, withhold such sums from any disability benefits, medical payment benefits, no-fault benefits, or any other insurance benefits obligated to reimburse me, or, from any settlement, judgment or verdict on my behalf as may be necessary to reimburse Assignee for services provided to me. I HEREBY FURTHER GIVE AN IRREVOCABLE LIEN to said Assignee against any and all insurance benefits named herein and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by the Assignee. In the event that I do not have insurance coverage, I understand that I remain personally responsible for payment of services rendered. I also agree to pay in a current manner any difference between the total charges and the amount paid by the insurance company directly to Assignee.

PIP LOG & DEC SHEET REQUEST

I HEREBY AUTHORIZE THE ASSIGNEE TO REQUEST A COPY OF THE APPLICABLE INSURANCE POLICY AND DECLARATION PAGE WHICH REFLECTS THE POLICY LIMITS AVAILABLE AT THE TIME OF THIS ACCIDENT, AND THE APPLICABLE PIP LOG TO BE PROVIDED TO THIS ASSIGNEE upon request. This request is authorized pursuant to the terms of my policy as well as Florida Statutes. I hereby authorize this Assignee to request and receive a copy of my pip log periodically as they deem to be necessary.

RESERVATIONS OF BENEFITS

Be further advised that I AM HEREBY PLACING YOU ON NOTICE PURSUANT TO FLORIDA CASE LAW THAT SHOULD YOU (THE INSURANCE COMPANY/CARRIER) DENY, REDUCE OR FAIL TO PAY ANY PART OF, OR AN ENTIRE BILL WHICH WAS SUBMITTED ON MY BEHALF FROM THIS PROVIDER, I (THE ASSIGNOR) AS WELL AS THE ASSIGNEE ARE REQUESTING IN ADVANCE THAT YOU RESERVE, OR, OR "SET-ASIDE," THE AMOUNT YOU REDUCED OR DENIED UNTIL THE DISPUTE IS RESOLVED. Should you submit a check to Assignee which is less than the correct contractual amount, and contains any language referring to payment as "Full and Final Payment," I have instructed Assignee to return the check to you (the carrier) and consider the bill still due and owing (ie. a late payment as defined in F.S 627.736). Additionally SHOULD THE REMAINING AMOUNT OF MY BENEFITS APPROACH AN AMOUNT WHERE THERE WOULD BE INSUFFICIENT FUNDS TO PAY THE AMOUNT YOU REDUCED, DENIED OR FAILED TO PAY, PLEASE NOTIFY ME (THE ASSIGNOR) AND THE ASSIGNEE OF THIS FACT. Should my benefits exhaust; please notify me (the assignor) and assignee promptly.

SEVERABILITY CLAUSE

If any term or provision of this Assignment, Lien and Authorization or the application thereof to any person or circumstances shall to any extent be invalid or unenforceable the remainder of this Assignment, Lien and Authorization, or the application of such term or provision to persons or circumstances other than those as to which it is held invalid or unenforceable, shall not be affected thereby, and each term and provision of this Assignment, Lien and Authorization shall be valid and enforced to the fullest extent of the law.

Signature: _____ Date: _____

Print Name: _____ Date: _____

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LETTER TO MASSAGE THERAPY PATIENTS

Dear Valued Patients:

We understand that unanticipated events happen occasionally in everyone's life. In our desire to be effective and fair to all of our clients and out of consideration for therapists' time, we have adopted the following policies:

- **24 hour advance notice is required** when canceling an appointment. This allows the opportunity for someone else to schedule an appointment.
 - If you are unable to give your therapist a reasonable time of advance notice you will be charged **\$60.00 out of pocket** for your missed appointment. The missed services will not be submitted to insurance.
- **Arriving late** Appointment times have been arranged specifically for you. If you arrive late your session may be shortened in order to accommodate others whose appointments follow yours. Depending upon how late you arrive, your therapist will then determine if there is enough time remaining to start a treatment. Regardless of the length of the treatment actually given, you will be responsible for the "full" session; however we will do our best to satisfy the scheduled time.

Out of respect and consideration to your therapist and other customers, please plan your visit accordingly.

Thank you for your understanding and for being part of the New Smyrna Beach Chiropractic Clinic Family. Please do not hesitate to contact us with any questions.

Sincerely,
New Smyrna Beach Chiropractic Clinic

I, _____, want the services above and acknowledge and accept any out of pocket penalty associated with a missed appointment if not canceled within 24 hours.

Patient Signature

Date