BACK IN LINE
CHIROPRACTIC CENTER

Automobile Accident form

Patient name: _____ Date: _____/_____/_____

Social Security # _____/_____/_____ Date of Birth: _____/_____/ _____

Date of injury: _____/_____/_____ Time of injury: _____OAM OPM

Location of accident: _____

Were you the O Driver O Passenger O Pedestrian? Estimated damage to vehicle: _____

Do you have automobile personal injury insurance coverage? O Yes O No

Insurance company: _____ Policy # _____

Adjustor Name: _____ Phone: _____

Claim #: _____ Coverage Limit: $_____

O YES O NO Have you reported this injury to your car insurance company?

O YES O NO Did the police come to the scene and make a report?

O YES O NO Was anyone issued a citation?

O YES O NO Were you seen by a paramedic? O YES O NO Went to emergency room?

O YES O NO Do you have an attorney for this case? Name/address/phone:

_____

_____

Where was your car hit? O Front O BACK O Driver's side O Passenger's side
O YES O NO Was you car moving? MPH _____ O YES O NO Was the other car moving? MPH ____

Please describe the accident: _____

_____

_____

At the time of impact your vehicle was:

O Stopped O Slowing down O Gaining Speed O Moving steady

At the time of impact, the other vehicle was:

O Stopped O Slowing down O Gaining Speed O Moving steady

During and after the crash, your vehicle:

O Kept going straight, not hitting anything

O Kept going straight, hitting the car in front

O Was hit by another vehicle

O Spun around, not hitting anything

O Spun around, hitting another car

O Spun around, hitting object or other car

Describe yourself during the crash: (check only areas that apply to you)

O You were unaware of the impending collision

O You were aware, and relaxed before the collision

O You were aware of the impending collisions and braced yourself

O Your body, torso, and head were facing straight ahead.

O You had your head and/or torso turned at the time of collision: O Left O Right

O You were intoxicated (Alcohol/other substance) at the time of crash

O You were wearing a seatbelt. If yes, does it have a shoulder harness? O YES O NO

O You were holding on to the steering wheel at the time of impact.

Indicate if your body hit something or was hit by any of the following:

Please draw lines and match the left column to the right column.

Head	Windshield	O YES O NO Did you lose consciousness?
Face	Steering Wheel	
Shoulder	Side Door	
Neck	Dashboard	
Chest	Car Frame	
Hip	Another Occupant	
Knee	Seat	
Foot	Seat Belt	

How did you feel after the accident? _____

Check symptoms you have noticed since the accident:

☐ Headache	☐ Irritability	☐ Numbness in Toes	☐ Cold Feet
☐ Neck Pain	☐ Chest Pain	☐ Shortness of breath	☐ Ringing in Ears
☐ Neck Stiffness	☐ Dizziness	☐ Fatigue	☐ Loss of Balance
☐ Sleeping Problems	☐ Head seems heavy	☐ Depression	☐ Fainting Spells
☐ Mid Back Pain	☐ Lower Back Pain	☐ Pins & Needles in arms	☐ Tension
☐ Numbness in Hand	☐ Nervousness	☐ Pins & Needles in legs	☐ Loss of Smell
☐ Loss of Taste	☐ Loss of Memory	☐ Cold Hands	☐ Sciatic Pain
☐ Bleeding (location) _____		☐ Stitches (location) _____	
☐ Lower Back Stiffness	☐ Lower Extremity Pain (location) _____		
☐ Upper Extremity Pain (location) _____		☐ Missed days from work (#) _____	

Check if any of the following vehicle parts broke, bent, or were damaged in your car:

O Windshield O Seat frame O Knee bolster O Steering Wheel O Side/rear window

O Dashboard O Mirror O Other: _____

Rear-end collisions only: (Answer this section if you were hit from the rear)
Does your vehicle have:
O Moveable head restraints O Fixed, non-moveable head restraints O No head restraints
Please indicate how your head restraint was positioned at the time of the crash:
O At the top of the back of your head O Midway height of the back of your head
O Lower height of the back of your head O At the back of your neck
O At the level of your shoulder blades (Upper back) below your neck

All types of collisions:

O YES O NO Did any of the front of your side structures, such as side door, dashboard, or floor board of your car, dent inward during the crash?

O YES O NO Did the side door touch your body during the crash?
O YES O NO Were your hands on the steering wheel or dashboard during the crash?
O YES O NO Did your body slide under the seat belt?
O YES O NO Was a door of your vehicle damaged to the point where you could not open the door?

Emergency Department

O YES O NO Did you go to the emergency department after the accident?
What is the name of the hospital? _____ (time/date) _____
O YES O NO Did another person drive you to the hospital? O YES O NO Overnight stay?
O YES O NO Did the emergency Dr. take any X-Rays?
O Skull O Neck O Mid back O Low Back O arm/leg O Other_____
O YES O NO Did the emergency Doctor prescribe you any pain medication?
O YES O NO Did the emergency Doctor prescribe you any muscle relaxants?
O YES O NO Did you have any cuts/lacerations? O YES O NO Did they require stitches?
O YES O NO Were you given a collar or neck brace to wear?

When did you first notice any pain after the injury?
O Immediately O _____ hours after injury O _____ Days after injury

If you did not see a doctor for the first week after the injury, indicate why: (Check all the apply)
O No pain was noticed O No appointments available
O No transportation O Work/school schedule did not permit

If you did not see a doctor for the first month after the injury, indicate why: (Check all the apply)
O No pain was noticed O No appointments available
O No transportation O Work/school schedule did not permit
O I thought pain would go away O I had no insurance or money
O I self-treated with over-the-counter drugs O Took hot showers, used ice and heat
Have you been unable to work since injury? O YES (___ Partially ___ Completely) O NO
Please list date(s) off work: ___/___/____ to ___/___/____

ASSIGNMENT OF BENEFITS / ERISA AUTHORIZED REPRESENTATIVE FORM

Financial Responsibility

I have requested professional services from Back In Line Chiropractic Center ("Provider") on behalf of myself and/or my dependents, and understand that by making this request, I am responsible for all charges incurred during the course of said services. I understand that all fees for said services are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement unless other arrangements have been made in advance.

Assignment of Insurance Benefits

I hereby assign all applicable insurance benefits to which I and/or my dependents are entitled to Provider. I certify that the insurance information that I provided to Provider is accurate as of the date set forth below and that I am responsible for keeping it updated.

I hereby authorize Provider to submit claims, on my, and/or my dependent's behalf, to the benefit plan (or its administrator) listed on the current insurance card I provided to Provider, in good faith. I also hereby instruct my benefit plan (or its administrator) to pay Provider directly for services rendered to me or my dependents. To the extent that my current policy prohibits direct payment to Provider, I hereby instruct and direct my benefit plan (or its administrator) to provide documentation stating such non-assignment to myself and Provider upon request. Upon proof of such non-assignment, I instruct my benefit plan (or its administrator) to make out the check to me and mail it directly to Provider.

I am fully aware that having insurance does not absolve me of my responsibility to ensure that my bills for professional services from Provider are paid in full. I also understand that I am responsible for all amounts not covered by my insurance, including co-payments, co-insurance, and deductibles.

Authorization to Release Information

I hereby authorize Provider to: (1) release any information necessary to my insurance benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

ERISA Authorization

I hereby designate, authorize, and convey to Provider to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan, as my Authorized Representative: (1) the right and ability to act on my behalf in connection with any claim, right, or cause in action that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act on my behalf to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right to act on my behalf in respect to a benefit plan governed by the provisions of ERISA as provided in 29 *C.F.R.* §2560.5031(b)(4)) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines.

A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

_____ _____

Patient Date

_____ _____

Policyholder/Insured 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 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. This means that no person has initiated contact with me and/or persuaded me to use the doctor or licensed professional, clinic, or medical institution that provided the services.
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.

The undersigned licensed medical professional 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. I have **explained** the services rendered 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.

Insured Person (patient receiving treatment) or Guardian of Insured Person:

Name *(PRINT or TYPE)* _____ Signature _____ Date _____

Licensed Medical Professional Rendering Treatment *(Signature by his or 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.

OIR-B1-1571
10/03

BACK IN LINE CHIROPRACTIC CENTER
6991 W. BROWARD BLVD PLANTATION, FL 33317
954-584-BACK (2225)

LETTER OF PROTECTION

TO: Attorney: _____

_____

_____

RE: PATIENT: _____

I do hereby authorize the above doctor and corporations 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 involved.

I hereby authorize and direct you, my attorney to pay directly to the above referenced doctor and corporations such sums as may be due and owing them for medical 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 insurance payments from whatever source, settlement, judgment, or verdicts may be necessary to adequately protect said doctor and corporations. I herby further give a lien on my case to said doctor and corporations against any and all proceeds of any insurance payments from whatever source, settlement, judgment of verdict which may be paid to you, my attorney, of myself as the result of the injuries for which I have been treated of injuries in connection therewith.

I fully understand that I am directly fully responsible to said doctor and corporations for all medical bills submitted by them for service rendered me and that this agreement is made solely for said doctors and the named corporations additional protection in consideration of their awaiting payment, I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

In the intent of the undersigned that this assignment is irrevocable and shall apply to the previously described cause of action whether of not the undersigned should engage co-counsel of substitute attorneys at any future time and in that event, the undersigned further agrees to immediately advise the doctor's office and corporations in writing of such substitution at the time said substitution or agreement of co-counsel should occur.

PATIENT'S SIGNATURE: _____ DATE: _____

The undersigned, being attorney of record for the above patient, and in consideration of the doctor's agreement to testify, provide medical reports or be disposed, does hereby agree to observe all the terms of the above and agrees to withhold such sums from any insurance from whatever source, settlement, judgment or verdict as may be necessary to adequately protect said doctor and corporations above named and to pay any of the above charges directly to the doctor and corporations within a reasonable time (not more than 10 days after receipt by the undersigned).

The patient's attorney further agrees to immediately notify the doctors' office and corporation in writing should there occur a substitution of counsel, referral to another attorney or law firm, and retention of co-counsel or should the attorney/client relationship be terminated or modified

In the event it becomes necessary for the doctor or any above named corporation to enforce the terms of this agreement against the undersigned then and in that event , said corporation and/or doctor shall be entitled to recover all costs incurred including attorney's fees for services rendere in connection with any enforcement of breach of this agreement, including appellate proceedings and post judgment proceedings.

ATTORNEY SIGNATURE: _____ DATE: _____

PRINT NAME: _____

BACK IN LINE
CHIROPRACTIC CENTER

PATIENT DISCLOSURE AND ACKNOWLEDGEMENT FORM

☐ Office Visit	☐ Electrical Stimulation	☐ Laser
☐ Manual Therapy	☐ Cervical Traction	☐ Traction
☐ Therapeutic Exercises	☐ X-rays	☐ Scan
☐ Therapeutic Ultrasound	☐ Gait Training	☐ Other _____
☐ Massage Therapy	☐ Functional Activities	☐ Other _____
☐ Hot/Cold Pack	☐ Balance Work	☐ Other _____
☐ Whirlpool	☐ Ball Work	☐ Other _____

1. I acknowledge that I received the treatment(s) listed above.
2. I acknowledge that I have the right and affirmative duty to confirm that services listed were rendered.
3. I was not solicited by this medical facility or any of it's employees to seek medical treatment for injuries sustained as a result of this accident.
4. I understand that if the insured notifies the insurer in writing of any billing errors, the insured may be entitled to a certain percentage of the reduction in the amounts being paid by the insured's motor vehicle insurer.
5. The services being provided to me for which my Doctor intends to bill my insurance have been explained. I have had the opportunity to have any questions answered to my satisfaction.
6. I hereby acknowledge having been informed of the above and have consented to the treatment and billing for the treatment proposed by my provider.

_____ _____

Patient's signature Date

_____

Patient's name

_____ _____

Provider's Signature Date

BACK IN LINE
CHIROPRACTIC CENTER

PATIENT INFORMATION

First Name _____ Last Name _____

Gender ___ M ___ F (Are you pregnant?) ____ Date of Birth ___/ ___/ _____ Age _____

Home Address _____

City _____ State _____ Zip Code _____

Phone (Cell) _____ (Home): _____

Email _____S.S # (last 4-digits)_____

Would you like to receive text alerts about future appointments? ___ Yes ___No

If yes, who is your cellphone provider? _____

I authorize being contacted for practice reminders by ___mail ___email ____ voicemail

Employer _____

Address _____

City _____ State _____ Zip Code _____

Emergency Contact _____ Phone _____

Whom may we thank for referring you? _____

FINANCIAL RESPONSIBILITY

____ Self-Pay ____ Insurance

Insurance Company _____ I.D. # _____

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Back in Line Chiropractic Center Inc., all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid by insurance or not. I hereby authorize Back in Line Chiropractic Center Inc. To release all information necessary to ensure payment of benefits. I authorize the use of this signature on all insurance submissions. Also, deductibles any other applicable fees are to be paid at time of service.

_____ _____

Responsible Party Signature (Relationship) Date

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_____ _____

Patient Date

_____ _____

BACK IN LINE CHIROPRACTIC CENTER

PATIENT HISTORY

1. What is your major symptom/problem? _____

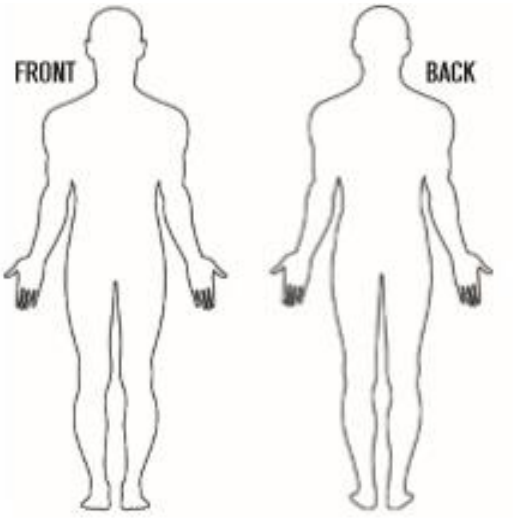
   _____

2. When did the symptom appear? _____
3. Have you noticed any visceral or neurological problems since the condition occurred? (for example: high blood pressure, loss of balance, numbness, etc.)

   _____

4.	Symptom/Complaint Areas (check all that apply)	Type of pain	Pain Rating 1-min 10-max	Frequency % (0-100%)
	Headaches			
	Neck Pain			
	Shoulder(s) Pain			
	Arm(s) Pain			
	Elbow(S) Pain			
	Upper Back Pain			
	Mid Back Pain			
	Lower Back Pain			
	Hip(s) Pain			
	Sciatica Pain			
	Knee(s) Pain			
	Ankle(s) Pain			
	Feet Pain			
	Other			

5. In the figure below, circle the specific area(s) where you are experiencing pain, discomfort or limited range of motion.



Type of Pain: A. Sharp B. Dull C. Throbbing

D. Numbness E. Aching F. Stiff G. Burning

H. Radiating I. Burning J. Tingling

Activities or movements that are perform: __work __Sleep __Drive __Sitting __Standing __Walking __Bending ___ Other _____

BACK IN LINE
CHIROPRACTIC CENTER

MEDICAL HISTORY

1.List any and all surgery (s) and dates _____

_____

2.Recent falls or accidents _____

3.Broken bones, dislocation or fractures _____

4.Current medications (prescription or over the counter) _____

_____

5.Current Vitamin/Minerals or Herbal Supplements

_____

6.**List any allergies** _____

7.Last time you saw a chiropractor _____ Dr. _____

8.Please indicate any conditions you or a family member have had in the past with (X) for yourself or (F) for family member.

__ AIDS/HIV __ Anemia __ Arthritis __ Cancer __Diabetes __Epilepsy __Hypertension

__Multiple Sclerosis __Parkinson's Disease __Polio __Rheumatic Fever __Tuberculosis

__Tumors __Stroke __Hear attack __Seizures __Hernia __Osteoporosis ___Other

9.Are you currently experiencing any of the following?

Difficulty __Speaking __Swallowing __Walking __Nausea/Vomiting

__Double Vision __Fainting or lightheadedness __ Rapid eye movement

__Numbness on one side of the body/face __Unusual Headaches/Migraines

_____

Signature _____ Date _____

BACK IN LINE
CHIROPRACTIC CENTER

INFORMED CONSENT

Doctors of Chiropractic who use manual therapy techniques are required to advise patients that there are or may be some risks associated with such treatment. You should note:

1.While rare, some patients may experience short-term aggravation symptoms, rib fractures or muscle and ligament strains or sprains as a result of manual therapy techniques.

2.There are reported cases of stroke associated with many common neck movements including adjustment of the upper cervical spine. Present medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical spine adjustment and the occurrence of stroke. Furthermore, the apparent association is noted very infrequently. However, you are being warned of this possible association because stroke sometimes causes some neurological impairment and may on rare occasion result in injuries including paralysis. The possibility of such injuries resulting from upper cervical spinal adjustment is extremely remote.

3.There are rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused or may be caused by spinal adjustments or chiropractic treatment.

I acknowledge I have discussed or had the opportunity to discuss with my Chiropractor the nature and purpose of Chiropractic treatment in general and my treatment (including spinal adjustment) as well as the contents of this consent.

I consent to the Chiropractic treatments recommended to me by my Chiropractor, including spinal adjustment. I intend this consent to apply to all my present and future Chiropractic care.

Dated this ____ day of _____ 20____ Doctor Initials _____

Patient Signature _____ Print Name _____

I hereby also request and consent to the performance of: (sign)

_____Acupuncture (I understand the methods may include but are not limited to: acupuncture needling, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine and nutritional counseling.

_____Massage Therapy

_____Physical Therapy

Notice: By signing this contract you are agreeing to have any issue of medical malpractice decided by neutral arbitration and you are giving up your right to a jury or court trial. Arbitration Agreement is included in your Notice of Privacy Practices Package.

Missed appointments:

Dr. Marciante strives to provide excellent service and quality care. Therefore, we feel that it's only fair for all appointments to be kept, please provide at least 24 hrs. notice of cancellation, to timely accommodate another patient. **The cancellation fee is $40.**

I agree and fully understand the missed appointment policy. _____(Initial)

Notice of HIPPA Privacy forms:

I have read Back in Line Chiropractic Center's Notice of Privacy Practices prior to signing this consent. Back in Line Chiropractic Center reserves the right to revise its notice of Privacy Practices at any time.

By signing this form, I am consenting Back in Line Chiropractic Center's use and disclosures of my PHI to carry our TPO.

Signature _____ Date _____

X-Ray Examination (for females only):

I am aware that the radiation exposure may be harmful to an unborn child. To the best of my knowledge, I am not pregnant at the time. I agree to diagnostic x-ray examinations as requested by Dr. Marciante. _____(Initial)

Photographs and Films:

I further agree to the taking of photographs, films, or other materials showing the condition of my mouth or my treatment for the purpose of documentation, my education and diagnosis, as well as for insurance purposes. _____(Initial)

The undersigned certifies that he/she has read and understands each of the above paragraphs and is the patient or responsible party with the power to execute this document and accept these terms. _____(Initial)

_____ _____

Signature of patient or responsible party/ Date Signature of witness/ Date

_____ _____

Name of patient or responsible party Name of witness