

FLORIDA SPINE GROUP ACCIDENT QUESTIONNAIRE

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.**

Name _____ Sex _____ Marital Status _____ DOB _____ Home Phone _____

Address _____ City _____ State _____ Zip _____ Cell # _____

Occupation _____ Who referred you to our office? _____

SSN _____ Business Phone _____ Company Name _____ Location _____

Spouse _____ Spouse SSN _____ Spouse Employer _____ Location _____

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 injuries as you know them: _____

Did you require post accident hospitalization? Yes No

Check the symptoms you have noticed since the accident:

- | | | | |
|--|---|--|-------------------------------------|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Depression | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Stomach Upset | <input type="checkbox"/> Sensitivity to Light | <input type="checkbox"/> Buzzing in Ears | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Head Seems too Heavy | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Feet Cold |
| <input type="checkbox"/> Neck Stiff | <input type="checkbox"/> Pins and Needles in Arms | <input type="checkbox"/> Ears Ring | <input type="checkbox"/> Hands Cold |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Pins and Needles in Legs | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Back Pain |
| <input type="checkbox"/> Flushed | <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Constipation | <input type="checkbox"/> Tension |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |

Symptoms other than above: _____

Where were you taken after the accident? _____

Hospitalized? Yes No If yes, admitted? _____ How Long? _____

Name of Hospital _____

Name of Doctors _____

What treatment was given? _____

Was there 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 the accident are your symptoms Improving? Getting Worse? Same?

Driver of other vehicle (if any)

Name _____ Insurance Company _____ Policy # _____

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

Name _____ Insurance Company _____ Policy # _____

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)

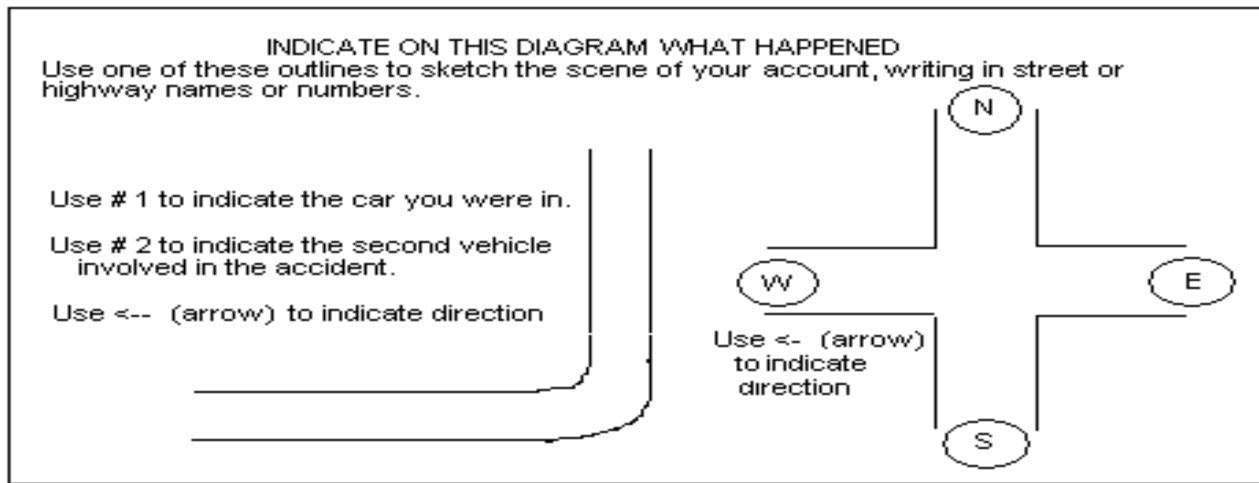
Other vehicle was headed North East South West on _____ (Street or highway)

Were police notified? Yes No

Were you knocked unconscious? Yes No If so, how long? _____

Were you struck from Behind Front Left Side Right Side

You were Driver Passenger Front Seat Back Seat Using Seat Belts Other Protective Devices



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

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES of:

**Ted H. Perkins, D.C., P.A., d/b/a Florida Spine Group
780 U.S. Hwy #1, Suite 201, Vero Beach, FL 32962**

I hereby acknowledge that I have received and had an opportunity to ask questions concerning the above named practice's Notice of Privacy Practices.

In addition, I have read and agree to all the above Financial Policies and Notices.

Date

Print Patient's Name or Representative

X

Signature of Patient or Representative

Date

Witness Florida Spine Group

**FLORIDA SPINE GROUP
PERSONAL INJURY ASSIGNMENT OF BENEFITS**

I, the undersigned insured or beneficiary of an insurance policy, irrevocably assign to (**Ted H. Perkins, D.C., P.A. DBA Florida Spine Group**) whatever rights I have under any policy of insurance and under Florida law, including, without limitation, any and all claims for attorney's fees, costs, interest and /or damages pursuant to Florida Statute 624.155. This Assignment of Benefits (AOB) includes an assignment of any potential claim for common law or statutory bad faith. If the Insurer disputes the validity of this AOB, then the insurer is instructed to notify the provider in writing within 10 days of receipt of this document. Failure to do so shall result in the provider relying on this AOB for direct payment and could constitute a waiver by the insurer to contest the validity of this document. I do hereby confirm that this AOB is irrevocable and instruct any insurance company or other collateral source for which I am entitled to benefits to pay for monies owed as a result of medical services rendered by **Florida Spine Group** to promptly make payment in the name of and directly to **Florida Spine Group**.

Pursuant to this AOB, **Florida Spine Group** is authorized to file suit on my behalf against any insurance company that reduces or denies benefits for medical services rendered to me and to collect any damages awarded or settlement monies for services rendered, plus interest, costs, reasonable attorney's fees and a contingency fee multiplier. I understand that in any such lawsuit, my name or other identifying information will need to be included in and/or portions of my medical file attached to pleadings and/or formal discovery. I waive any confidentiality of my records and /or information but only to the extent necessary to prosecute a claim for unpaid or owed medical expenses against the insurance company or any other responsible party.

I acknowledge that **Florida Spine Group** objects to any reductions or partial payments by the Insurer. Any partial or reduced payment, regardless of the accompanying language, issued by the Insurer and deposited by **Florida Spine Group** shall be done under protest, at the risk of the insurer and the deposit shall not be deemed a waiver, accord, satisfaction, discharge, settlement or agreement by the provider to accept a reduced amount as payment in full. **Florida Spine Group** reserves the right to seek the full amount of the bill submitted from the insurance company (ies) or me. Accordingly, the insurer is hereby instructed to set aside (escrow) any and all reduced or denied benefit payments for medical services rendered by this provider and not pay the disputed amount to anyone until the dispute is resolved.

I further instruct my insurance company to cooperate with the above-captioned **Florida Spine Group** in resolving all medical billing disputes. Cooperation includes, but is not limited to, providing any and all declaration pages, PIP logs, payout ledgers, explanations of benefits, copies of checks, and any and all other documents or information to **Florida Spine Group** or its attorneys, employees or other representatives acting on behalf of **Florida Spine Group**. If the insurer schedules a defense examination, examination under oath (EUO) or Independent Medical Examination (IME) of the patient, the insurer is hereby instructed to send a copy of said notification to this provider and the provider's attorneys. The provider and/or the provider's attorneys are authorized to appear at any patient EUO or IME set by the insurer. **THIS ASSIGNMENT OF BENEFITS DOES NOT ASSIGN ANY RIGHTS OR OBLIGATIONS UNDER THE POLICY OF INSURANCE, TO SUBMIT TO AN EUO OR RECORDED STATEMENT.** I further direct and authorize you to speak to an attorney, employee or any other representative of **Florida Spine Group** or anyone acting on their behalf over the phone and provide them with any and all information you may have or documentation not previously listed above that they may request.

I, as the patient, agree to remain personally liable for the amounts billed by **Florida Spine Group** regardless of the amount paid by the insurance company, unless ordered by a court of law. I fully understand that said health care services were provided to me in consideration for an unconditional promise to pay and for me providing these instructions to my insurance company. I, as the patient, further agree to be liable for reasonable attorney's fees and costs incurred in collecting any delinquent accounts or unpaid balances. By executing this document, I am placing my insurance company (ies) on notice that the claims for medical treatment rendered by **Florida Spine Group** are related to my accident (or my covered conditions) and should be paid directly to **Florida Spine Group** pursuant to his assignment of benefits and Florida law. Any delay in paying benefits owed under the insurance policy could adversely affect me.

BY EXECUTING THIS DOCUMENT, I AM PLACING MY INSURANCE COMPANY ON NOTICE THAT THIS IS A DIRECT ASSIGNMENT OF BENEFITS PURSUANT TO FLORIDA LAW. AS THE INSURED OR BENEFICIARY OF SAID INSURANCE POLICY, I AM IRREVOCABLY ASSIGNING WHATEVER RIGHTS I HAVE UNDER MY POLICY OF INSURANCE (LESS THE DUTY TO ATTEND AN EUO) AND UNDER FLORIDA LAW TO THIS HEALTH CARE PROVIDER. A photocopy of this assignment shall be considered as effective and valid as the original.

Patient's Name/DOB

Signature of Policy holder or Claimant/Date

Name of Policy holder or Claimant

Acceptance of **Florida Spine Group**/Date

Patient or
Authorized
Signature

FLORIDA SPINE GROUP

Patient Name _____ Date _____

CHIROPRACTIC INFORMED CONSENT

“Chiropractic physician” as defined in Florida Statute 460.403(5)(2008). Chiropractic physicians examine, analyze, and diagnose the human living body and its disease by use of (a) any physical, chemical, electrical or thermal methods, (b) x-ray for diagnosing, (c) blood tests and (d) other chiropractic methods. See Florida Statute 460.403(3)(b)

Before you, the Patient, receive chiropractic care, it is important that you read this Consent and understand the nature and risks of chiropractic medicine. The “practice of chiropractic medicine” (or chiropractic care) involves the adjustment, manipulation and treatment of your body in which vertebral subluxations and other malpositioned articulations and structures may be interfering with the normal generation, transmission and expression of nerve impulse between the brain, organs and tissue cells, thereby causing disease. See Fla. Stat. 460.403(9)(a). Chiropractic adjustments, manipulations, and treatments are intended to restore the normal flow of nerve impulse which produces normal function and consequent health. See Fla. Stat. 460.403(9)(a)

The undersigned Patient understands and acknowledges that there are risks associated with the practice of chiropractic medicine and chiropractic care including, but not limited to ataxia, bruising, thermal injuries, dislocations/subluxations, dizziness, fracture(s), mobility disruption, paralysis, spinal injury, stroke, vision disturbances and others. The most common side effect following chiropractic manipulation/adjustment is an ache or stiffness at the site of the adjustment.

I, also hereby give authorization for **consent of treatment to Florida Spine Group** and whomever they may designate as their assistants to perform and administer therapy and treatment as they deem necessary.

I, the undersigned Patient, understand the risks and limitations associated with the practice of chiropractic medicine, including the use of chiropractic care, evaluation, diagnosis, adjustments, manipulations, physical therapy and therapeutic modalities such as heat, ice, ultrasound, stimulation, traction, muscle stimulation and others treatments by **Florida Spine Group**. **All of my questions have been answered in detail and I fully understand and certify that no guarantee or assurances have been made to the results or outcome from treatment that may or will be rendered.**

Patient or Authorized Signature X

Date

**FLORIDA SPINE GROUP
LETTER OF PROTECTION**

I, the undersigned, hereby agree that this agreement constitutes a lien against any recovery of proceeds paid by any insurance carrier or from whatever source, settlement, judgment or verdict which may be paid to my attorney or myself as a result of the injuries by reason of this accident.

I hereby authorize my attorney to discuss my case or provide **Florida Spine Group** with any information necessary to have payment paid directly to them for such sums as may be due and owing for medical services rendered to me. I, furthermore, authorize my attorney to withhold such sums from any insurance payments or from whatever source, settlement, judgment or verdict and pay **Florida Spine Group** as soon as possible for said debt.

I authorize the release of any information pertinent to my case to my insurance company, adjustor and attorney to facilitate collection. I also authorize the release of medical records to any other doctor involved in my case. Further, I hereby authorize the **RELEASE OF MEDICAL RECORDS**.

I, _____, fully understand that I am directly responsible to **Florida Spine Group** for all medical bills for services rendered to me and this agreement does not relieve me of any personal responsibility for said charges. I further understand that this agreement is made solely for the protection of said provider and such payment is not contingent on any settlement, judgment or verdict by which I may recover said fee.

I understand that this Letter of Protection is irrevocable and shall apply to any cause of action whether or not I should engage legal counsel or substitute attorney at any future time. I further understand and agree to notify **Florida Spine Group** in writing if I change or terminate attorney/client relationship.

Patient Signature

Date

Claim #

Date of Accident

ATTORNEY

I, the undersigned, being the attorney of record for the above patient, do hereby agree to observe all the terms of the above agreement and agree to withhold such sums from any insurance payments or from whatever source, settlement, judgment or verdict and pay **Florida Spine Group** as soon as possible for said debt.

I, furthermore, understand and agree to immediately notify **Florida Spine Group** in writing should there occur a substitution of counsel, referral to another attorney or law firm, retention of co-counsel or should the attorney/client relationship be terminated or modified in any manner.

NOTICE TO MY ATTORNEY OF THIS DOCTOR'S LIEN:

I, THE UNDERSIGNED, HEREBY NOTIFY MY ATTORNEY OF RECORD THAT I HAVE SIGNED AND AGREED TO THIS DOCTOR'S LIEN, and it **CANNOT BE RESCINDED, REVOKED OR ALTERED** BY ME OR ANY LEGAL REPRESENTATIVE THAT I HAVE PRESENTLY OR MAY HAVE IN THE FUTURE.

(A photocopy of this agreement shall be considered as effective and valid as the original)

Attorney Name

Attorney Signature

Date

**FLORIDA SPINE GROUP
REQUEST FOR AUTO INSURANCE INFORMATION**

**Florida Spine Group
780 US1 Suite 201
Vero Beach, FL 32962**

I hereby authorize _____
(Name of Insurance Company)
to release auto policy information including policy/claim number, PIP and medpay benefits.

In regards to the accident on: _____

Patient Name: _____

Signature of Patient: _____

Date: _____

Please indicate the following:

Deductible: _____

Benefits: _____

Medpay: _____

Insurance Company Representative Name

Please fax information to 772-778-9382

Thank you for your cooperation.