Injury Questionnaire

PATIENT INFORMATION:

Name: ______________________________________ SS#: ________-______-_______ Sex at Birth: Male/Female
DOB: _______ /_______/_______ Home Telephone: ______-______-_______ Cell Telephone: ______-______-_______
Address: ____City: ______________ State: _____ Zip Code: _________
Email Address________________________ **Preferred method of communication for patient reminders** (Circle): Email/Phone/Mail
Marital Status: Single, Married, Divorced, Widowed **Preferred Language:** __________________

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / Other / I Decline to Answer
Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer
Primary Care Physician: ____________________________________ Phone: ________-________-________
Can we contact your doctor regarding your care in our office? Yes / No
Occupation: _________________________ Employer: ______________ Work Telephone: ______-______-________
Types of tasks performed/common movements: ____

Spouses Name: ________________________________ # of children? _____ Children's ages? __________
Emergency Contact Name: _________________________ Relationship: ____________ Phone: _________________

Are you currently under drug and/or medical care? ❑ Yes ❑ No If yes, explain
____

Reason for visit today: (Conditions, Symptoms, or anything you would like to discuss)
____
____

ACCIDENTS:

Have you had an auto accident? ☐ 0-6mo ☐ 6 mo-1 yr. ☐ 1-3yrs ☐ 3+yrs ☐ Never
Have you had a recent fall/other accident? ☐ 0-6mo ☐ 6 mo-1 yr. ☐ 1-3yrs ☐ 3+yrs ☐ Never
Have you ever received chiropractic care? ☐ Yes ☐ No How Many_________ Last Visit_________________
Have you ever received physical therapy? ☐ Yes ☐ No Last Visit? _____________________________________

INSURANCE: ***** PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S) *****

Car Insurance Carrier: _________________________ Policy #:___________________ Claim #:_________________
Adjustor Name: ______________________________ Phone #: ____________________
Do you have health insurance? ☐ Yes ☐ No Name of Carrier: _________________ ID Number_________________
Do you have a secondary insurance? ☐ Yes ☐ No Name of Carrier: ________________ID Number________________

Assignment and Release (insured patients)

I certify that I (or my dependent) have insurance coverage with ____________________________________ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN PRACTICE, Bare Center for Chiropractic Wellness and Integrative Healthcare and Physical Medicine, INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

SIGNATURE (X) ____ **DATE** _________________________

☐ ***I choose to decline receipt of my clinical summary after every visit. (These summaries are often blank as a result of the nature & frequency of care)*** **SIGNATURE (X)** ___________________________________ **DATE** __________________________

ACCIDENT INFORMATION: **Patient Name:**_______________________________________ Date of Accident: ____________

Where (Street/Intersection): ____

Were any tickets issued and to whom? ____

Were you the: ☐ Driver ☐ Front Seat Passenger (Right) ☐ Back Seat LEFT Passenger ☐ Back Seat RIGHT Passenger

Did you see the accident coming? ☐ Yes ☐ No Did you brace? ☐ Yes ☐ No Which way was your head turned? ___________

Did the impact to your vehicle come from the: ☐ Front ☐ Rear ☐ Left Side ☐ Right Side?

Did the air bag deploy? ☐ Yes ☐ No Did you hit anything inside the vehicle? ☐ Yes ☐ No If yes, describe: _______________

Were you restrained/ wearing a seat belt? ☐ Yes ☐ No Lap Belt ☐ Yes ☐ No Shoulder belt ☐ Yes ☐ No

Did you experience immediate pain? ☐ Yes ☐ No Did the ambulance/paramedics arrive at the scene? ☐ Yes ☐ No

Were you taken to the hospital? ☐ Yes ☐ No Did you drive to the hospital? ☐ Yes ☐ No Which hospital? _______________

Were x-rays taken? ☐ Yes ☐ No MRI? ☐ Yes ☐ No CT? ☐ Yes ☐ No Did they prescribe medication? ☐ Yes ☐ No

Are you currently taking medication? ☐ Yes ☐ No If yes, please name all: ____

Please describe the accident in your own words: ____

FIRST (MAJOR) COMPLAINT: ____

Date when symptoms first appeared: ___________________________ Have you had this condition before? _____________

Did it begin Gradual? ☐ Yes ☐ No Sudden? ☐ Yes ☐ No How long has it been going on? ________________________________

What makes symptoms increase? ____

What relieves symptoms? ____

Type of pain: ☐ Sharp ☐ Dull ☐ Aching ☐ Burning ☐ Throbbing How much of your day is pain? ☐10% ☐25% ☐50% ☐100%

Pain Intensity (circle): NONE 0 1 2 3 4 5 6 7 8 9 10 SEVERE

Does pain radiate into your (circle): L R Shoulder/Arm/Hand L R Buttox/Leg/Foot Does not radiate

SYMPTOMS: Please check if you have experienced any of the following since this accident.

☐ Low Back Pain
☐ Pain between Shoulder Blades
☐ Neck Pain
☐ Difficulty talking
☐ Tension/Headaches
☐ Changes in Vision
☐ Difficulty swallowing
☐ Tension Across Top of Shoulders
☐ Numbness/Tingling in Arms/Hands
☐ Numbness/Tingling in Legs/Feet
☐ Dizziness
☐ Pain in the legs/feet/buttox
☐ Pain in the hand/arm/shoulders
☐ Difficulty with balance
☐ Tired/Fatigued
☐ Difficulty Sleeping
☐ Ringing in Ears
☐ Brain Fog
☐ Nausea
☐ Vomiting
☐ Other: ________________________

PREVIOUS ACCIDENT HISTORY: Have you ever been involved in another motor vehicle accident? ☐ Yes ☐ No

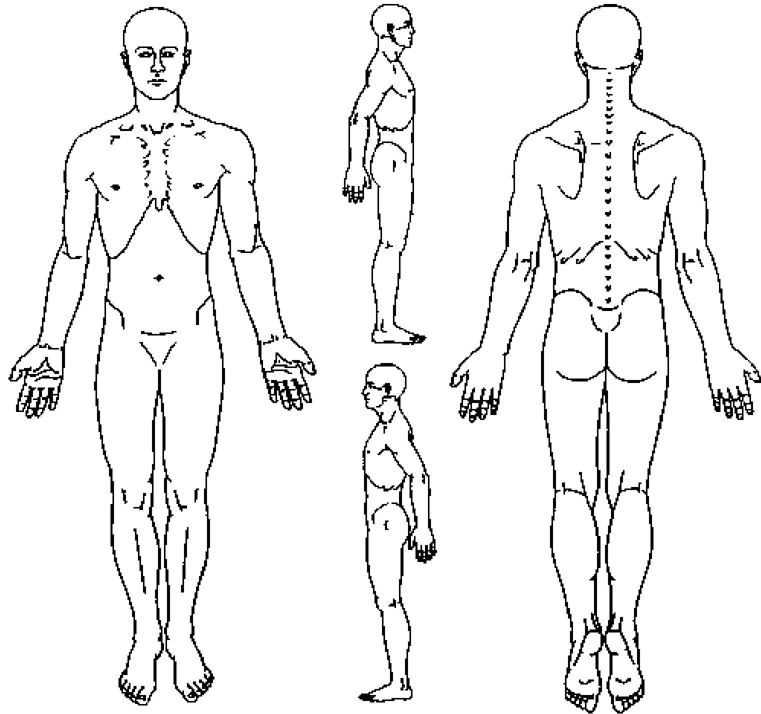
If yes, please describe and give dates: ____

PATIENT HEALTH HISTORY

Please check to indicate if you are currently experiencing any of the following conditions and then circle problematic areas on body to right:

☐ Neck Pain/Stiffness
☐ Back Pain/Stiffness
☐ Arm/Hand Pain
☐ Leg/Knee Pain
☐ Headaches
☐ Night Pain
☐ Depression
☐ Cold Extremities
☐ Nervousness
☐ Sleeping Difficulties
☐ Jaw Problems
☐ Loss of Smell
☐ Fainting
☐ Dizziness
☐ Stomach Problems
☐ Asthma
☐ Swollen Joints
☐ Mood Changes
☐ Foot Trouble

☐ Pins/Needles in Arms
☐ Pins/Needles in Legs
☐ Light Bothers Eyes
☐ Weight Change + / -
☐ Loss of Memory
☐ Nausea
☐ Loss of Taste
☐ Fatigue
☐ Chest Pain
☐Tension
☐ Fever
☐ Cold Sweats
☐ Constipation/Diarrhea
☐ Allergies
☐ Shortness of Breath
☐ Blurred/Double Vision
☐ Bowel/Bladder Changes
☐ Trouble Concentrating
☐ Loss of Balance



Please check if you have ever had any of the following:

☐ ADD/ADHD
☐ Aids/HIV
☐ Alcoholism
☐ Allergy Shots
☐ Anemia
☐ Anorexia
☐ Appendicitis
☐ Arthritis
☐ Asthma/Wheezing
☐ Bad Breath/Bad Taste
☐ Bleeding Disorders
☐ Blood Pressure: High or Low (circle)
☐ Breast Lump
☐ Broken Bones
☐ Bronchitis
☐ Bulimia

☐ Cancer
☐ Cataracts
☐ Chemical Dependency
☐ Chicken Pox
☐ Colon Trouble
☐ Contacts/Glasses
☐ Diabetes
☐ Dry Skin
☐ Ear Infections
☐ Epilepsy
☐ Fractures
☐ Gall Bladder
☐ Glaucoma
☐ Goiter
☐ Gonorrhea
☐ Gout
☐ Heartburn

☐ Heart Attack
☐ Heart Problems
☐ Hemorrhoids
☐ Hepatitis
☐ Hernia
☐ Herniated Disc
☐ Herpes
☐ High Cholesterol
☐ Hormone Imbalance
☐ Insomnia
☐ Kidney Problems
☐ Liver Disease
☐ Measles
☐ Menopausal Prob.
☐ Migraines
☐ Miscarriage
☐ Mononucleosis

☐ Mouth Sores or Bleeding Gums
☐ Multiple Sclerosis
☐ Mumps
☐ Nosebleeds
☐ Osteoporosis
☐ Pacemaker
☐ Parkinson's Disease
☐ Pinched Nerve
☐ Pneumonia
☐ Polio
☐ Prostate Problems
☐ Prosthesis
☐ Psychiatric Care
☐ Rheumatoid Arthritis
☐ Rheumatic Fever
☐ Scarlet Fever
☐ Sexual Difficulty

☐ Stroke
☐ Suicide Attempt
☐ Thyroid Problems
☐ TMJ Pain
☐ Tonsillitis
☐ Tremors
☐ Tuberculosis
☐ Tumors/Growths
☐ Typhoid Fever
☐ Ulcers
☐ Vaginal Infections
☐ Venereal Disease
☐ Whooping Cough
☐ Other: ___________
____
____
____

Are you currently under drug and/or medical care? ☐ Yes ☐ No If yes, explain
____
____

Reason for visit today: (Conditions, Symptoms, or anything you would like to discuss)
____
____

SIGNATURE (X) ____________________________________ **DATE** ______________________

3773 S. Pine Ave. Ocala, FL 34471 Ph: (352) 369-6325 F: (352) 369-6329

Personal Medical History: (Circle if applies)

Diabetes	High Blood Pressure	Pacemaker
Heart Disease	Stroke	Fibromyalgia
Thyroid	Other:____	

Family History: (Circle if applies and list the family member and the type of condition if applies)

Inflammatory Arthritis	Heart Disease	Cancer
Stroke	Diabetes	

Other: ____

History of Trauma:

Auto (Date) _____________________________	Slip/Fall (Date):_______________________________________
Auto (Date):______________________________	Sport:____
Auto (Date): _____________________________	Work:____
Other:___________________________________	Other:____

Please list any surgeries and/or hospitalizations you have had (type & date):

____

____

____

ALLERGIES: **(Please place a check mark next to any known allergy that you have)**

___ Milk ___Eggs ___Peanuts ___Almonds ___Cashews ___Walnuts ___ Fish ___ Shellfish ___Soy ___Wheat ___ Gluten ___Penicillin ___Sulfa Drugs ___Tetracycline ___Codeine ___NSAIDS ___Phenytoin ___Carbamazepine ___Mildew ___Mold ___ Dust ___Fungus ___Mites ___Tree Pollen ___Grass Pollen ___Weed Pollen ___Insects ___Dog Dander ___Cat Dander ___Latex ___Other Animal Dander ___

OTHER: _________________/__________________/________________/__________________ (please fill in)

Medications:____

____

____

Supplements:

____

____

Hobbies: ____

Have you had to give up your hobbies or modify performing them due to your pain? (Please Circle) Yes / No

Prior Chiropractic Experience: ____

How Does Your Pain Impact Your Activities of Daily Living?

Home/Recreational:____

____

____

Work:____

____

____

SIGNATURE (X) ____________________________________ **DATE** ______________________

Social History:

Do you exercise: ❑ Frequently ❑ Moderately ❑ Occasionally ❑ None

Have you had to give up exercising or modify because of your pain? Yes / No

Do your work activities mostly involve: ❑ Sitting ❑ Standing ❑ Light Labor ❑ Heavy Labor

Hours per day spent: Sitting ___________ Standing ____________

Do you sleep on your: ❑ Back ❑ Side ❑ Stomach Do you use a cervical pillow? ❑ Yes ❑ No

What is your daily/weekly intake of the following?

Caffeine_________ cups/day Alcohol ________ drinks/week Cigarettes ____ packs/day

- **I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health. I will give complete and accurate information during my exam.**

SIGNATURE (X) ____ DATE __________________________

X-ray Questionnaire: For women only

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Name: ____________________________________ Date of last menstrual period: ___________________

☐ There is a possibility that I may be pregnant at this time. ☐ Yes, I am definitely pregnant

☐ No, I am definitely not pregnant at this time ☐ I request that x-ray films not be taken because:

_______________________________ ____

SIGNATURE (X) _______________________________________ DATE ___________________________

FOR MINORS:

I, ____________________________ being the parent or legal guardian of _________________________,

(Print Guardian Name) (Print Minor's Name)

have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive treatment. **Patients under the age of 16 must be accompanied by a parent/guardian.**

______________________________ ____________________________ ______________________

PRINT NAME **SIGNATURE** **DATE**

NEUROLOGICAL/ MRI/ VASCULAR PATIENT QUESTIONNAIRE

NAME ____ **DATE** ______________

For any YES answer, please explain under comment and notify the Doctor:

1. Do you suffer from neck pain with pain in your shoulder, arms or hands? NO YES
   Comment: ____

2. Do you have weakness, numbness or burning in your shoulder, arms or hands? NO YES
   Comment: ____

3. Do your hands or arms fall asleep regularly? NO YES
   Comment: ____

4. Do you have reduced feeling (sensation) or swelling in your hands or arms? NO YES
   Comment: ____

5. Do you suffer from a loss of handgrip strength? NO YES
   Comment: ____

6. Do you suffer from back pain with pain in your buttocks, legs or feet? NO YES
   Comment: ____

7. Do you have weakness, numbness or burning in your buttocks, legs or feet? NO YES
   Comment: ____

8. Do your legs or feet fall asleep regularly? NO YES
   Comment: ____

9. Do you have reduced feeling (sensation) or swelling in your legs, feet? NO YES
   Comment: ____

10. Do you suffer from cold hands or feet? NO YES
    Comment: ____

11. Have you tried any medications such as anti-inflammatory? NO YES
    If yes, what kind of medication? ____

12. Have you tried any Physical Therapy or Chiropractic treatments before? NO YES
    If yes: When? For how long? What kind? ____

13. Have you had an MRI? NO YES
    If yes: When? Who ordered it? What was it ordered for? ____
    ____

14. Have you used any splint or braces or other prescribed treatment by an MD? NO YES
    If yes: When? What kind? Who ordered it? ____
    ____

15. If you have tried any treatment or medications, did this make your problem better? NO YES
    Comment: ____

NOTE: Your health information will be kept strictly confidential. Any information that we collect about you on this form will be kept confidential in our office. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.

PAIN DISABILITY QUESTIONNAIRE

Patient Name ____________________________________ Date____________________

Instructions: These questions ask your views about how your pain affects how you function in everyday activities. Answer every question and mark the ONE number on EACH scale that best describes how you feel.

1. Does your pain interfere with your normal work inside and outside the home?
Work normally — Unable to work at all
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

2. Does your pain interfere with personal care (such as washing, dressing, etc.)?
Take care of myself completely — Need help with all my personal care
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

3. Does your pain interfere with your traveling?
Travel anywhere I like — Only travel to see doctors
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

4. Does your pain affect your ability to sit or stand?
No problems — Can not sit/stand at all
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

5. Does your pain affect your ability to lift overhead, grasp objects, or reach for things?
No problems — Can not do at all
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

6. Does your pain affect your ability to lift objects off the floor, bend, stoop, or squat?
No problems — Can not do at all
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

7. Does your pain affect your ability to walk or run?
No problems — Can not walk/run at all
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

8. Has your income declined since your pain began?
No decline — Lost all income
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

9. Do you have to take pain medication every day to control your pain?
No medication needed — On pain medication throughout the day
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

10. Does your pain force your to see doctors much more often than before your pain began?
Never see doctors — See doctors weekly
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

11. Does your pain interfere with your ability to see people who are important to you as much as you would like?
No problem — Never see them
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

12. Does your pain interfere with recreational activities and hobbies that are important to you?
No interference — Total interference
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

13. Do you need the help of your family and friends to complete everyday tasks (including both work outside the home and housework) because of your pain?
Never need help — Need help all the time
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

14. Do you now feel more depressed, tense, or anxious than before your pain began?
No depression/tension — Severe depression/tension
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

15. Are there emotional problems caused by your pain that interfere with your family, social and or work activities?
No problems — Severe problems
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

Please total your numbers from above here: TOTAL:______/ 150

With Permission from: Anagnostis C et al: The Pain Disability Questionnaire: A New Psychometrically Sound Measure for Chronic Musculoskeletal Disorders. Spine 2004; 29 (20): 2290-2302.

TERMS OF ACCEPTANCE AND CONSENT FOR CARE

We will attempt to identify and diagnose any ailments you may have that may be corrected through physical medicine, massage therapy, chiropractic care, and/or active/passive rehabilitation. If any condition or disease appears to be present out of our scope of practice, we will refer you to an appropriate physician to diagnose and/or treat that condition.

Consent to Treat: I request and give consent to my physician to provide and perform such medical/ surgical care, tests, procedures, drugs and other services and supplies as are considered necessary or beneficial by my physician for my health and well being. I acknowledge that no representations, warranties, or guarantees as the results or cures have been made to me or relied upon me.

Consent to Testing: I am fully aware that the physician may order testing that he/she deems appropriate in my treatment. I am aware Integrative Healthcare and Physical Medicine plays a large role in verifying insurance benefits on my behalf, and although most testing is verified, it is my responsibility to know my insurance coverage. If I refuse any diagnostic testing/ labs/ urine screening, I understand that the physician has the right to terminate the patient / physician relationship at any time.

H.H.S: Pursuant to the Health Insurance Portability and Accountability Act of 1996, I acknowledge that a copy of the NOTICE OF PRIVACY PRACTICES is available to me immediately upon request.

Medicare Certification: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize my physician who treats me, to release information from my medical record to the Social Security Administration and / or the Medicare program or its intermediaries of carriers. I request that payment of authorization benefits be made directly to my physician treating me, on my behalf.

Chiropractic Care: The primary focus of chiropractic care is the detection and correction of vertebral subluxation. This is the misalignment of one or multiple spinal bones with interference to the nervous system. Any interference to the nervous system may or may not cause various different symptoms.

Through specific chiropractic adjustments, we reduce and/or correct these subluxations. It may be necessary to examine an individual each time a new injury occurs and often x-rays are necessary to maintain the utmost safety when dealing with your body. The risks of physical medicine, chiropractic care or massage therapy are minimal when dealing with a licensed professional; however, if you have concerns about these risks, please discuss them with the doctor prior to the examination.

Soreness: I am aware that like exercise it is common to experience muscle soreness in the first few treatments.

Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare.

Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disk, or other abnormality is detected, this office will proceed with extra caution.

Physical Therapy Burns: Some therapies used in this office generate heat & may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase of pain and possible blistering. This should be reported to the doctor. Tests have been performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in one million to once in ten million treatments. Once in a million is about the same chance as getting hit by lightening. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death.

I also understand that the fee paid for treatment x-rays is for analysis only. The file itself is the property of this office. Once films are taken, they cannot be released, but may be copied. There is a fee for copying of the xrays this is $25.00.

Also, for your protection, portions of our office where patients do not disrobe are under video surveillance, specifically, but not limited to, the front desk check-out stations.

I have read and I accept the terms above and understand them fully. I hereby give consent to Integrative HealthCare & Physical Medicine, Ocala and Bare Center for Chiropractic Wellness to evaluate me to determine my condition and treat me for such conditions. I also understand that I may at any time discontinue with the exam and/or x-rays or any treatment if I so choose.

I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered to me will be immediately due and payable. I agree that I will be responsible for all attorney and legal fees if legal action becomes necessary to collect this amount.

I, ____ have read and fully understand the above statements.

(PRINT NAME)

SIGNATURE (X) ____________________________________ **DATE** ______________________

Special Financial Information Section

Many insurance companies require physicians to attempt to collect any unpaid portion of the annual deductible and/or co-payment and/or regular treatment fees from the patient. However, certain conditions may permit a physician's office to waive (partially or fully) the collection of these amounts. One of the conditions is the patient's financial hardship. Based upon discussions with me, this office has determined that due to my financial hardship, I am unable to pay (partially or in full) the deductible and/or the co-payment and/or regular treatment fees. If I were forced to pay the annual deductible and/or the co-payment and/or the regular treatment fees, I would not be able to receive the necessary treatment for my health condition(s). Due to these circumstances, this office is waiving (partially or in full) my obligation for payment of charges for the services rendered in this office. However, if based upon future discussions with me regarding my financial situation, this office determines that my situation has improved enough to enable me to fully pay the annual deductible and/or co-payment and/or regular treatment fees, this office will require payment of charges incurred at that time.

______________________________ ______________________________ ____________________

Print Name Signature Date

PRIVACY REPORT

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient at Integrative Healthcare & Physical Medicine, Ocala and Bare Center for Chiropractic Wellness, we may use or disclose personal and health related information about you in the following ways:

- Your personal health information, including your clinical records, may be disclosed to another healthcare provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- Your healthcare records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of your services.
- Your name, address, phone number, and healthcare records may be used to contact you regarding appointment reminders, information about alternative to your present care, or other health related information that may be of interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Furthermore, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in the following circumstances:

- If we are providing healthcare to you based on the orders of another healthcare provider.
- If we provide healthcare services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain our consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care. If we are ordered by the courts or another appropriate agency.

This practice is a multi specialty practice with multiple providers, you may at anytime be treated by any and/or all of them. In this situation it is possible to be provided, be billed, and receive records from either BARE CENTER FOR CHIROPRACTIC WELLNESS or INTEGRATIVE HEALTHCARE AND PHYSICAL MEDICINE, OCALA. I give both entities permission to request records, perform services and bill out for services received by me.

Any use or discloser of your protected health information, other than as outlined above, will only be made upon your written authorization.

We normally provide information about your health to you in person at the time you receive care from us. We may also mail information to you regarding your healthcare or about the status of your account. If you would like to receive this information at an address other than your home or if you would like the information in a different form, please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition you have the right to request an amendment to your health information. Requests to inspect, copy or amend our health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply to all of your information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-discloser by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to: Dr. Preston Bare. If you would like further information about our privacy policies and practices please contact: Dr. Preston Bare
This notice is effective as of January 1, 2018. This notice, and any alterations or amendments made hereto will expire seven (7) years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

____________________	____________________	____________
Print Name	Signature	Date

HIPAA-COMPLIANT
AUTHORIZATION TO RELEASE PATIENT INFORMATION
PURSUANT TO 45 C.F.R. §164.508

Patient's Full Name: _______________________________________ Date:______________________

Patient SSN: ___ ___ ___ - ___ ___ - ___ ___ ___ ___ Date of Birth: ______________

I authorize the following organization, individual, or entity to disclose protected health information identified below:

Name:____

Address:____

Phone #: _____________________________________ Fax #: _______________________________

Information Requested: The Patient identified above authorizes the disclosure of all protected medical information in any form (including oral, written and electronic) to the Requestors listed below, and Requestors' re-disclosure of the data and information to its agents, consultants, counsel, and whomever Requestors deems reasonable and necessary to further the administration of the Requestor's suggested treatment and care of the Patient. Patient expressly requests that all covered entities under HIPAA identified above shall disclose full and complete protected health information concerning the Patient, relating to the time period beginning on _____________________ and ending on _____________________, inclusive. This includes, but is not limited to, the following:

- All medical records, including, but not limited to: inpatient & emergency room treatment; all clinical charts, reports, documents, correspondence, test results, statements, questionnaires/histories, examination reports, office and doctor's handwritten notes, and records received from other physicians or health care providers
- All laboratory, histology, cystology, pathology, radiology, CT scan, MRI, echocardiogram reports
- All radiology films
- All pharmacy prescription records.

The Patient hereby authorizes the above information be released or disclosed to:

Integrative Healthcare & Physical Medicine, Ocala **Ph. (352) 369-6325**
Bare Center for Chiropractic Wellness
3773 S. Pine Ave. Ocala, FL 34471 **Fax (352) 369-6329**

I understand the following:

- I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
- I understand that, after information is released under this authorization, it may be re-disclosed by the recipient, and if re-disclosed, the information will no longer be protected by federal or state privacy rules.
- I understand that I am entitled to receive a copy of this authorization.
- My treatment, payment for treatment and enrollment or eligibility for benefits cannot be conditioned on the signing of this authorization.
- This authorization will expire one (1) year from the date signed below.

Patient's Signature: ____ Date:______________________

Witness: ____ Date:______________________

IF THIS AUTHORIZATION IS SENT BY FAX, IT IS INTENDED ONLY FOR THE USE OF THE PERSON OR OFFICE TO WHOM IT IS ADDRESSED, AND CONTAINS PRIVILEGED OR CONFIDENTIAL INFORMATION PROTECTED BY LAW. ALL RECIPIENTS ARE HEREBY NOTIFIED THAT INADVERTENT OR UNAUTHORIZED RECEIPT DOES NOT WAIVE SUCH PRIVILEGE, AND THAT UNAUTHORIZED DISSEMINATION, DISTRIBUTION, OR COPYING OF THIS COMMUNICATION IS PROHIBITED. IF YOU HAVE RECEIVED THIS FAX IN ERROR, PLEASE DESTROY THE ATTACHED DOCUMENT(S) AND NOTIFY THE SENDER OF THE ERROR BY CALLING (352) 369-6325. IF YOU DO NOT RECEIVE ALL OF THE PAGES, OR IF YOU HAVE ANY PROBLEMS WITH THIS TRANSMISSION, PLEASE CALL (352)369-6325.

Integrative Healthcare & Physical Medicine
Bare Center for Chiropractic Wellness
3773 S. Pine Ave. Ocala, FL 34471
352.369.6325

INSTRUCTION AND ATTORNEY'S LETTER OF PROTECTION

SENT (VIA FAX) TO ATTORNEY: _________________________________FAX # (____)

Patient / Client Name: ____ Date of Loss: ____/____/____

Provider:

I, the undersigned patient, in consideration for my being treated without being required to pay cash in advance of treatment, hereby instruct my attorney to execute this irrevocable Attorney's Letter of Protection in favor of Provider to ensure that Provider is paid in full for any and all treatment, supplies, and services provided by them to me, or on my behalf, for the consequences of the accident that took place on or about the Date of Loss described above. Payment is to be derived from the proceeds of any settlement or funds received by me, or in my beneficial interest, from any source, as compensation for any damages I may have sustained from the consequences of the events that occurred on or about the Date of Loss described above. **Please execute and return this Attorney's Letter of Protection to Provider immediately upon your receipt of it.**

I further authorize my attorney to enter into a different Attorney's Letter of Protection acceptable to my attorney and Provider, but if no agreement for a different Attorney's Letter of Protection is made, then I instruct that this Attorney's Letter of Protection shall be the Attorney's Letter of Protection in force and instruct my attorney to comply with its terms and conditions.

I further instruct that my instructions to attorney herein are irrevocable and shall and are transferable to any future attorney of mine in the event that I change my legal representation in regard to the damages contemplated herein.

The terms of this Attorney's Letter of Protection included but not limited to the following:

- If the bills protected by this letter are for treatment of an auto accident, then in regard to PIP covered charges, this letter of protection is valid for outstanding PIP covered charges, only if PIP is appropriately billed and pursued by Provider pursuant to F.S.627.736 (5) (b).
- If the bills and costs protected by this letter are not payable under PIP, the amount due shall be 100% of billed charges including transportation costs.
- This letter of protection shall not be assignable or transferable to another provider.
- Upon request and periodically, Provider will forward updated bills and medical records to the patient or to the patient's attorney and not to the Patient, unless requested otherwise in writing.
- Provider will refrain from any and all collection efforts during litigation.
- Should Provider not agree to the sums available for payment to Provider, and then Patient's attorney shall post funds, in an amount no less than the disputed charges, in the registry of the court for appropriate judicial determination.
- Provider is acting in reliance on the terms of this agreement for the provision of treatment and services contemplated herein.
- The terms contained herein are accepted as adequate consideration for this agreement by the signatories below.

Agreed and understood by the undersigned on the dates shown below:

____________________________	____________________________	_____/_____/_____
Patient's Printed Name	Patient's Signature	Date
____________________________	____________________________	_____/_____/_____
Provider's Authorized Agent, Printed	Provider's Authorized Agent, Signature	Date
____________________________	____________________________	_____/_____/_____
Printed Name of Attorney	**Signature of Attorney**	**Date**

WHEN SIGNED PLEASE FAX TO: 352.369.6329

PIP LOG ACKNOWLEDGEMENT

The State of Florida Requires that a PIP Log is maintained while you are receiving care at Integrative Healthcare and Physical Medicine Ocala for injuries sustained in a Motor Vehicle Accident dated_________________________________.

Each visit you will be required to sign out electronically upon leaving. This signature verifies that you are aware of all services rendered on that visit. If you prefer a print out one can be provided for you.

____________________________	________________________________	________________
Patient Name	Patient Signature	Date

Power of Attorney and Medical Release

Know by all these present that: The undersigned has made, constituted and appointed, and by these presents does herby make, constitute and appoint INTEGRATIVE HEALTHCARE & PHYSICAL MEDICINE OCALA and Bare Center for Chiropractic Wellness, and any of its duly authorized agents and employees as and to be the undersigned's true and lawful attorney-in-fact for and in the undersigned's name, place and stead to endorse any all checks, drafts or money orders which are made payable to the undersigned alone or to the undersigned and the said INTEGRATIVE HEALTHCARE & PHYSICAL MEDICINE OCALA/ Bare Center for Chiropractic Wellness, which checks, drafts or money orders are made payable for services which have been made by INTEGRATIVE HEALTHCARE & PHYSICAL MEDICINE OCALA/ Bare Center for Chiropractic Wellness, at the request or with the knowledge and approval of the undersigned and/or the maker of the check, draft or money order.

Furthermore, the undersigned allows INTEGRATIVE HEALTHCARE & PHYSICAL MEDICINE OCALA/ Bare Center for Chiropractic Wellness, or any of it's agents to sign any paper that will be necessary to enhance, expedite and/or allow payment to said provider. This may include affidavits of non-ownership of vehicles, insurance forms and other statements.

The undersigned by these presents does give and grant the said INTEGRATIVE HEALTHCARE & PHYSICAL MEDICINE OCALA/ Bare Center for Chiropractic Wellness, as attorney-in-fact the full power and authority to do and perform all and every act whatsoever requisite and necessary to be done as full as the undersigned might or could to personally present insofar as the endorsing and cashing of said checks are concerned as well as any other document.

MEDICAL RELEASE

A photocopy of this document shall be sufficient to authorize any person having records of medical treatment, services, or supplies pertaining to me to release true copies of same to INTEGRATIVE HEALTHCARE & PHYSICAL MEDICINE OCALA / Bare Center for Chiropractic Wellness, or any insurer providing coverage to me in the connection with the processing of any claim for benefits made by me or by the assignee herein. A photocopy of this document shall be as binding as an original signature page.

The undersigned does hereby ratify and confirm and all actions taken by the said attorney-in-fact in accordance with this special power and which the said attorney shall do or cause to be done by virtue of these presents.

ASSIGNMENT OF BENEFITS

I,________________________ hereby authorize and direct my automobile personal injury protection and/or medical payments insurance carrier and/or my health insurance carrier to make benefit payments otherwise payable to me for services rendered by INTEGRATIVE HEALTHCARE & PHYSICAL MEDICINE OCALA/ Bare Center for Chiropractic Wellness, but not to exceed the charges of those services, payable to and mailed directly to:

Dr. Preston Bare, D.C., B.S.
Integrative Healthcare and Physical Medicine Ocala
3773 S. Pine Ave.
Ocala, FL 34471

Furthermore, I hereby ASSIGN to INTEGRATIVE HEALTHCARE & PHYSICAL MEDICINE OCALA/ Bare Center for Chiropractic Wellness, rights and benefits under any policy of insurance, indemnity agreement, or any other collateral source as defined in Florida Statues for any service and or charges provided by INTEGRATIVE HEALTHCARE & PHYSICAL MEDICINE OCALA/ Bare Center for Chiropractic Wellness, so that they or I individually or jointly may enforce said rights and benefits for said services and/or charges but, in any event, I recognize and agree that any such charges and/or services are/or services are my personal responsibility and that I am responsible for paying such charges and/or services if not paid by my insurance company for any reason.
IN WITNESS WHEREOF the undersigned have hereunto set their hands, this ___ day of ___________, 201__.

____________________________	______________________________	________________________________
PATIENT'S NAME	PATIENT'S SIGNATURE	**Witness Signature**

*SUPERCEDES ALL PRIOR FORMS

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(14) and (15), 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):*

______________________	______________________	______________
Medical Professional 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 Pub. 1/2004