BAYWEST MEDICAL

PIP W/C Slip/Fall LOP

NPR

Patient Name: _____ Date: _____

Social Security #: _____ DOB: _____ Sex: M F

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Cell #: _____ Email Address: _____

Marital Status: Married Divorced Single Widowed

Spouses name: _____ Phone #: _____

Name of closest relative/friend not living with you: _____ Phone #: _____

Name of Primary Care Physician: _____ Phone #: _____

Is this accident **WORK**, **AUTO OR PERSONAL INJURY** related? (Circle all that apply) **Date of Injury:** _____

If work related, what is the employers name: _____ Phone #: _____

Was this incident reported to your employer? YES NO

If yes, who was it reported to? _____ Phone# : _____

Is there an attorney involved? YES NO

Attorney Name: _____ Phone #: _____

Have you reported the accident/injury to your insurance company? YES NO

Name of Insurance Carrier: _____

Name of Insured: _____

The relationship to the Insured (Circle): Self Spouse Parent Employee Other: _____

Claim #: _____

Does patient Reside with Insured: YES NO

Does the patient own a vehicle in the State of Florida? YES NO

Did the accident occur in the State of Florida? YES NO If not, where? _____

Privacy Notice

(as required by HIPPA)

ALL CUSTOMER HEALTHCARE INFORMATION WILL BE KEPT PRIVATE

BAYWEST MEDICAL, LLC may be required to use information in the following ways:

- **T**reatment. We may utilize or possibly disclose your health information to your healthcare provider only in order to assist in our supplying of medical products and/or equipment and in the treatment of your condition.
- **P**ayment. We may be required to disclose your health information in order to collect payment from third parties for services rendered or supplies provided.
- **D**elivery Reminders. BAYWEST MEDICAL, LLC may need to use your personal information in order to be able to contact you.
- **R**elease of Information to Family/Friends. We may need to provide information to an Individual if you are being cared for by a family member or friend.
- **D**isclosures Required by Law. Our organization will disclose health information when we are required by federal state or local law.
- **P**ublic Health Risks, Health Oversight Activities, Workers Compensation.
- **L**awsuits Law Enforcement, Threats to Health and Safety, Military, National Security.

Your Rights Regarding Your Identifiable Health Information:

- **C**onfidential Communications. You have the right to request that our organization communicate with you about you and your health. In addition you may request that this communication take place in a confidential environment. This request must be given in writing.
- **R**equesting Restriction. You may request a restriction in the use or disclosure of your personal health information to individuals involved in our dispensing of medical supplies. This request must be given to us in written form.
- **I**nspection and Copies. You have the right to request a copy of the identifiable health information that we may utilize for your care. This request must be provided in writing.
- **A**mendment. You may request that we amend your information if you think that we have incorrect information in our records. This request must be provided in writing.
- **A**ccounting of Disclosures. All of our patients have the right to request a list of any disclosures our organization makes of your personal information (such as to your medical doctor or to our technician).
- **Y**ou have a right to a copy of this notice.
- **Y**ou have the right to file a complaint if you believe your privacy rights have been violated.

Jennifer Nichols is the compliance officer for BAYWEST MEDICAL, LLC and can be reached at **727-372-0091**.

Initials_____ I have received a copy of BayWest's Privacy Notice.

BayWest Medical

Accident Details/Injury Questionnaire

Please complete all that apply
For Auto Accidents, W/C, Slip/Fall

Today's Date _____ Patient Name: _____

Please explain in full detail how this accident happened: _____

_____

What body parts were injured? _____

Have you ever had these complaints before? YES NO If yes, when: _____

Is this your first accident? YES NO If no, please explain: _____

Have you lost any time from work as a result of the accident? YES NO

Have you returned to work? YES NO On what date? _____

Please complete for Auto-Related Injuries:

What was the date and time of the accident? _____

Which direction were you heading? (Please circle) North South East West

On which street/intersection? _____

Which direction was the other party heading? (Please circle) North South East West

On which street/intersection? _____

_____

What type of vehicle were you driving? _____

What type of vehicle struck you? _____

Were the police notified? YES NO Is there a police report? YES NO Who was cited? _____

On which side were you struck (Please circle): Rear Front Left Right

Were you the...(Please circle): Driver Front Passenger Back Seat Other, pls explain: _____

Did you feel pain immediately after the accident? YES NO If Yes, please explain: _____

Were you wearing your seatbelt? YES NO Were you ever rendered unconscious? YES NO

Did the airbag deploy? YES NO Were you treated at the accident site? YES NO

Did you seek treatment after the accident? YES NO Where? _____

What treatment was given? _____

Are you currently under another providers care for this accident (please list all)? YES NO

The provider's name (s)? _____ Phone #: _____

When was the last time that you were treated for this accident? _____

SymptomSurvey

Please circle as many as apply

Patient Name _____ Date: _____

Head: **Headache Pain Level:** Mild Moderate Severe **How Often**: Daily _x Day _ x Week ____ x Month
Type of Pain: Sharp Dull **Frequency**: Constant Intermittent Staff Only
Location: Back of Head Forehead Temples Right Side Left Side Behind Eyes Frequency: %

Jaw: **Pain:** Right Left Both **Clicking/Popping:** Right Left Both Frequency: %

Neck: **Pain Location**: Right Left Both **Pain Level:** Mild Moderate Severe
Type of Pain: Sharp Stabbing Dull
Pain Increased by: Forward Movement Backward Movement Rotate Head Right Rotate Head Left
Bending Head Left Bending Head Right Frequency: %

Shoulder: **Pain Location:** Right Left Both **Pain Level**: Mild Moderate Severe
Type of Pain: Sharp Stabbing Dull **Pins and Needles**: Right Left Both Frequency: %

Upper Arm: **Pain Location**: Right Left Both **Pain Level:** Mild Moderate Severe
Type of Pain: Sharp Stabbing Dull **Pins and Needles:** Right Left Both Frequency: %

Elbow: **Pain Location:** Right Left Both **Pain Level:** Mild Moderate Severe
Type of Pain: Sharp Stabbing Dull **Pins and Needles:** Right Left Both Frequency: %

Forearm: **Pain Location:** Right Left Both **Pain Level:** Mild Moderate Severe
Type of Pain: Sharp Stabbing Dull **Pins and Needles:** Right Left Both Frequency: %

Hand/Wrist: **Pain Location:** Right Left Both **Pain Level:** Mild Moderate Severe
Type of Pain: Sharp Stabbing Dull **Pins and Needles**: Right Left Both Frequency: %

Upper Back: **Pain Location:** Right Left Both **Pain Level:** Mild Moderate Severe
Type of Pain: Sharp Stabbing Dull Frequency: %

Middle Back: **Pain Location:** Right Left Both **Pain Level:** Mild Moderate Severe
Type of Pain: Sharp Stabbing Dull Frequency: %

Low Back: **Pain Location:** Right Left Both **Pain:** Mild Moderate Severe
Type of Pain: Sharp Stabbing Dull
Pain Increased by: Forward Movement Backward Movement Rotate Torso Right Rotate Torso Left
Bending Torso Left Bending Torso Right

Hip: **Pain Location:** Right Left Both **Pain Level:** Mild Moderate Severe
Type of Pain: Sharp Stabbing Dull **Pins and Needles:** Right Left Both Frequency: %

Upper Leg: **Pain Location:** Right Left Both **Pain Level:** Mild Moderate Severe
Type of Pain: Sharp Stabbing Dull **Pins and Needles:** Right Left Both Frequency: %

Knee: **Pain Location:** Right Left Both **Pain Level:** Mild Moderate Severe
Type of Pain: Sharp Stabbing Dull **Pins and Needles:** Right Left Both Frequency: %

Lower Leg: **Pain Location:** Right Left Both **Pain Level:** Mild Moderate Severe
Type of Pain: Sharp Stabbing Dull **Pins and Needles:** Right Left Both Frequency: %

Ankle/Foot: **Pain Location:** Right Left Both **Pain Level:** Mild Moderate Severe
Type of Pain: Sharp Stabbing Dull **Pins and Needles:** Right Left Both Frequency: %

Briefly describe how your daily activities have changed due to this injury? _____

BayWest Medical

Confidential Patient Health and History

Patient Name: _____ Date: _____

Have you ever had any of the following: (Circle Y or N)

Heart Disease	Y	N	Hepatitis A, B,	Y	N	Mumps	Y	N
Diabetes	Y	N	or C Lung	Y	N	Chickenpox	Y	N
Prolapsed Mitral Valve	Y	N	Rheumatic Fever	Y	N	Whooping Cough	Y	N
Glaucoma	Y	N	Arthritis	Y	N	Scarlet Fever	Y	N
Tuberculosis	Y	N	HIV / AIDS	Y	N	Diphtheria	Y	N
Bronchitis	Y	N	Kidney Disease	Y	N	Smallpox	Y	N
Liver Disease	Y	N	Thyroid Disease	Y	N	Venereal Disease	Y	N
Measles	Y	N	Ulcers	Y	N	Anemia	Y	N
Stroke	Y	N	Mental/Psychiatric Disorder	Y	N	Bladder Infection	Y	N
Heart Attack	Y	N	Heart Murmur	Y	N	Migraine Headaches	Y	N
Pacemaker	Y	N	Colitis	Y	N	Polio	Y	N
Metal Implants	Y	N	Epilepsy	Y	N	Hernia	Y	N
Swollen Ankles	Y	N	Artificial Prosthesis	Y	N	Blood or Plasma Transfusions	Y	N
Sinusitis	Y	N	Hearing Loss	Y	N	Back Trouble	Y	N
Asthma	Y	N	Pregnant	Y	N	High Blood Pressure	Y	N
Hemorrhoids	Y	N	Cancer	Y	N	Low Blood Pressure	Y	N
Hives or Eczema	Y	N	Mono	Y	N	Date of Last Chest X-ray		

Previous Hospitalizations/Surgeries/Serious Illness (Please explain) _____

_____

Please list any and all **ALLERGIES**: _____

Please list any medications that you take (prescription and over the counter) : _____

_____

Patient social history:

Use of alcohol: Never Rarely Moderate Daily

Use of tobacco: Never Rarely Moderate Previously, but quit: (date) _____ Current packs/day: _____

Use of Drugs: Never Type/Frequency: _____

Excessive exposure to(at home or at work): Fumes Dust Solvents Airborne Particles Noise

Family Medical History:

	Age	Diseases	If Deceased, Cause of Death
Father			
Mother			
Siblings			
Siblings			
Spouse			
Children			
Children			

Authorization to Release Healthcare Information

Patient Name: _____

Date of Birth: _____

Last 4 SSN: _____

I request and authorize All Health Care Providers to release healthcare information of the patient named above to:

Name: BayWest Medical

Address: 5633 State Road 54

City: New Port Richey State: FL Zip Code: 34652

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

Patient Signature: _____ Date Signed: _____

Assignment of Benefits/Policy Rights

Patient Name: _____

Policy Owner's Name: _____

Insurance Carrier Name: _____

Claim #: _____

Date of Accident/Injury: _____

PATIENT: I, the undersigned patient, understand and agree that **BayWest Medical** (including any other subsidiaries, all its corporative, elected and appointed representatives and officials, or its assigns), requires payment at the time services are rendered, in consideration of Provider agreeing to not require at the time services are rendered, hereby assign the rights and benefits of insurance of the applicable personal injury protection, medical payments, and/or other insurance which may be available to pay Provider on my behalf to the said Provider. This assignment is for services and/or supplies rendered for treatment of personal injuries sustained in an automobile accident or incident on the above referenced date to me, the undersigned patient, who is covered by Personal Injury Protection (PIP) coverage or other insurance coverage under the above named Policy Owner's name, in accordance with Florida Statute 627.736.5. The undersigned is responsible for any applicable deductible or co-payment not covered by the said P.I.P. or other insurance policy rights, which I am assigning hereby, are to be covered through a policy of insurance with the company commonly known as the above referenced insurance company, under the above referred policy or claim number.

The assignment is intended to transfer all of the patient's rights to collect benefits from the said insurance company, including, but not limited to, all rights to collect benefits directly from the insurance company for services that I have received and all rights to proceed against the insurance company which is obligated to provide benefits in any action including legal suit if for any reason the insurance company fails to make payments of benefits to which I am due. This Assignment further includes the right to collect payment for the reasonable costs connected with copying and mailing records to the insurer at the insurer's request and in accordance with Florida Statute 627.736 (6). This assignment also includes any right to recover attorney's fees and costs for any such action brought by the Provider as patient's assignee. I agree that the said Provider may select any attorney it wishes and understand and agree that the attorney selected by them may be different than the attorney handling my P.I.P./Bodily Injury claim or case. In the event of litigation or arbitration, I agree to cooperate with he said Provider and in any manner reasonably required. I understand that this cooperation may include giving sworn testimony at deposition, trial of the case, or any other proceeding that may be reasonably required and I also agree to execute any releases, settlement papers, and settlement checks. I further agree not to compromise or extinguish the value of this Assignment by taking a position inconsistent with the said Provider's pursuit of payment.

The Assignment of Rights and Benefits is intended to become effective immediately and binding upon the said insurance carrier upon my execution. I hereby instruct the said insurance carrier that in the event the subject medical benefits are disputed for any reason, including medical reasonableness and/or necessity, that the amount of benefits claimed by the said Provider be placed in escrow and not disbursed until the dispute is resolved. As part of this Assignment of Rights and Benefits, I further instruct the insurance carrier to notify the Provider immediately of any dispute as to payment so that it may exercise its legal rights. I have read and understand the information herein, and it is true to the best of my knowledge and belief.

_____	_____	_____
Patient/Responsible Party Signature	Print Patient/Responsible Party Name	Date

Provider: The undersigned, on behalf of the above-referred provider, hereby accepts assignment of the insurance right and benefits for the services rendered to the above-referenced patient, and to be paid directly to the above referenced Provider under the above referenced patient's P.I.P. or other insurance coverage with the above referenced insurance carrier and in accordance with Florida Statute 627.736 et. Seq.

_____	_____
Authorized Agent/Representative	Date

Office Financial Policy

Patient Name: _____

Basic Policy:
Payment for service is due in full at the time that service is provided in our office.

For Patients With Insurance:
We bill most insurance carriers for you, assuming that you provide the correct insurance information. As the patient/responsible party, you should be aware of your plan limitations and benefits. Copays and deductibles are due at the time of service. We do not routinely research why an insurance carrier has not paid or why it has paid less than was anticipated. However, if you need help understanding your explanation of benefits from your insurance carrier, we will be happy to explain it to you to the best of our ability. It is not the responsibility of this office to obtain authorizations or verifications of coverage. Ultimately, any remaining unpaid balance is the responsibility of the patient/responsible party.

Non-Covered Services:
Any services/supplies not covered by your insurance carrier (at the time of service/when supplies are given) will require payment in full at the time of service or upon notice of insurance carrier denial. It is not the responsibility of this office to confirm or verify your insurance coverage. Please know what your plan limitations are.

Personal Injury Cases:
This office will bill for any auto accident or other liability or lawsuit related cases as a courtesy to you. It is your responsibility to provide us with the car insurance carrier name and corresponding information prior to your visit in order to obtain proper authorization. Understand that only injuries which have a direct correlation to the personal injury case shall be handled in this manner. Any treatment received which is not related shall be dealt with separately and shall remain your responsibility.

Workers Compensation:
If your injury is work related, it is your responsibility to provide us with the case number and carrier name prior to your visit in order to obtain proper authorization. We will be happy to bill your workers compensation insurance company as a courtesy to you. Understand that only injuries which has a direct correlation to the work-related injury shall covered by your workers compensation insurance company. Any treatment received which is not related shall be dealt with separately and shall remain your responsibility.

Missed Appointments:
In fairness to other patients and our physicians, we require at least a 24-hour notification of an appointment cancellation.

Assignment of Insurance Benefits (Health Insurance):
Patients with insurance please read and sign below that you understand and agree with the following statement:

Authorization to Administer Treatment:
I hereby give permission to the physician and staff at BayWest Medical to administer treatment, prescribe testing procedures indicated by the physician, as he/she may deem necessary in the diagnosis and/or treatment of my condition.

Authorization to Release Medical Information:
This authorization or photocopy hereof will authorize BayWest Medical to furnish all information on record regarding my condition while under observation or treatment, including the history obtained, x-rays and physical findings, diagnosis and prognosis. This authorization also allows any and all records to be released to BayWest Medical.

Authorization to Send/Receive Text Messaging: I hereby give permission to the physician and staff at BayWest Medical to utilize my cell phone number to send texts for the purpose of reminding me of upcoming appointments and general communications.

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plans, to BayWest Medical. This assignment will remain in effect until revoked by me in writing.
A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges which remain unpaid by insurance. I hereby authorize said assignee to release all information necessary to secure payment.

I have read, understood, and agreed to the above financial policies for payment of professional fees.

Signature: _____ Date: _____
Policy Holder/Responsible Party

Standard Disclosure and Acknowledgement Form

Personal Injury Protection - Initial Treatment or Service Provided

CLAIM # _____

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:

_____	_____	_____
Patient Name ***(PRINT or TYPE)***	***Patient*** **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**):*

Scott Coletti, D.C. / Dan MacDougall, D.C.		
Doctor's Name *(PRINT or TYPE)*	**Doctor's** 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.

BayWest Medical, LLC
5633 State Rd 54
New Port Richey, FL 34652
727-372-0091
727-372-0192

Disclosure and Informed Consent Treatment Protocols

In this office, we utilize trained staff personnel to assist the doctor with portions of the physical examination, X- ray taking, Cold Laser Protocols, Stretching and Exercising instructions, etc.

Stroke: Stroke is the most serious problem that has been associated with Chiropractic adjustments. Stroke means that a portion of the brain does not receive enough oxygen from the blood stream. The results can be temporary or permanent dysfunction of the brain, with a very rare complication of death. In extremely rare instances Chiropractic adjustments have been associated with strokes that arise from the vertebral artery only; this is because of vertebral artery is found inside the neck vertebrae. Certain types of high velocity neck adjustments
may potentially be related to vertebral artery strokes, but no one is certain. The most recent studies (Spine, Vol. 33 No., February 2008)

Disc Herniations: Disc herniations that create pressure on the spinal nerve or on the spinal cord are frequently treated by Chiropractors and Chiropractic adjustments, traction, etc. This includes both neck and back. Yet, occasionally Chiropractic treatments (adjustments, traction, etc.) will aggravate the problem and rarely surgery
may become necessary for correction. Rarely Chiropractic adjustments may also cause worsening of a pre-existing disc problem if the disc is in a weakened condition. These problems occur so rarely that there are no available statics to quantify their probability.

Soft Tissue Injury: Soft tissues primarily refer to muscles and ligaments. Muscles move bones and ligaments limit joint movement. Rarely a Chiropractic adjustment, traction, massage therapy, etc., may tear some muscle or ligament fibers. The result is a temporary increase in pain and necessary treatments of resolution, but there are no long-term effects for the patient. These problems occur so rarely that there are no available statistics to quantify their probability.

Rib fractures: The ribs are found only in the thoracic spine or middle back. They extend from your back to your front chest area. Rarely a Chiropractic adjustment will crack a rib bone, and this is referred to as a fracture. This occurs only on patients that have weakened bones from such things as osteoporosis. Osteoporosis can be noted on your x-rays. We adjust all patients very carefully, and especially those who have osteoporosis on their x-rays. These problems occur so rarely that there are no available statistics to quantify their probability.

Soreness: It is common for Chiropractic adjustments, traction, massage therapy, passive stretching, exercises, etc., to result in a temporary increase in soreness in the region being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic change. It is not dangerous, but please tell your doctor about any soreness you experience.

Other Problems: There may be other problems or complications that might arise from Chiropractic treatment other than those noted above. These other problems or complications occur so rarely that it is not possible to anticipate and/or explain them all in advance of treatment.

Chiropractic is a system of health delivery, and therefore, as with any health care delivery system we cannot promise a cure for ANY symptom, disease, or condition because of treatment at this office. We will always give you our best care, and if results are not acceptable, we will refer you to another provider we feel will assist your situation.

If you have any questions on the above, please ask your doctor. When you have a full understanding, please initial and date below.

Patient Initials: _____ **Date:** _____

BayWest Medical, LLC
5633 State Rd 54
New Port Richey, FL 34652
727-372-0091
727-372-0192

Patient: You have the right as a patient to be informed about your condition and the recommended modalities and therapies to be used, so that you may make an informed decision whether to undergo the procedure after knowing the potential risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply to make you better informed, so you may give or withhold your consent to the recommended modalities and procedures.

I hereby request and consent to the performance of Chiropractic adjustments, Diagnostic X-rays, Cold Laser Protocols, EMS, Hydro Therapy, passive stretching, active stretching, and exercises, on me even if I have had previous auto-immune disorder(s) and /or cancer(s) (or the patient named below for whom I am legally responsible by the Doctor of Chiropractic named below and/or other licensed Doctors of Chiropractic or those working at the clinic or office who now or in the future treated me while employed by, working or associated with, or serving as a backup for the Doctor of Chiropractic named below.

I can discuss with the Doctor of Chiropractic at BayWest Medical, LLC, my diagnosis, the nature and purpose of Chiropractic adjustments and other procedures and alternatives.

I understand and have been informed that, in the practice of Chiropractic there are some risk to exam and treatment including, but not limited to: fracture, disc injuries, strokes, dislocations, sprains and increases symptoms and pain or no improvement of symptoms or pain. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I rely on the doctor to exercise judgement during the course of the procedures which the doctor feels at the time, based on the facts then known, is in my interest. I further acknowledge that no guarantees or assurances have been made concerning the results intended from the treatment.

I have read, or have had read to me the above consent. I have also had an opportunity to ask questions, and all my questions have been answered fully and satisfactorily. By signing below, I consent to the treatment plan. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

To be completed by the patient:

_____
Print Patient Name

_____
Patient Signature

_____
Date

To be completed by the patient's representative. If necessary, e.g., if the patient is a minor or physically or legally incapacitated.

_____
Print Name of Patient

_____
Print Name of Patient Representative

_____
Patient Representative Signature

As: _____
Relationship or Authority Patients Representative

_____
Date

To be completed by the Doctor or Staff

_____ _____
Witness to Patient's Signature Date

_____ _____
Translated By Date