Manatee Wellness & Chiropractic Centers

8792 East S.R. 70, Suite 101, Bradenton, FL 34202
Phone (941) 756-4362 Fax (941) 755- 4652

8405 US-301, Suite 104, Parrish, FL 34219
Phone (941) 803 - 4474 Fax (941) 755- 4652

Today's Date:_____

PATIENT INFORMATION:

Patient's Full Name:_____ Birthdate:_____ Age:_____ Sex: M/F
Address:_____ City:_____ State:_____ Zip Code:_____
Home Phone:_____ Cell Phone:_____ Social Security #:_____
Email:_____ Height:_____ Weight:_____
Emergency Contact:_____ Relationship:_____ Emergency Contact #:_____
How did you hear about us (Circle): Website Phone Book Google Maps Office Sign Social Media
Referring Friend:_____ Cell Phone Service Provider:_____

EMPLOYMENT INFORMATION:

Employment Status (circle): Retired Employed PT Student FT Student Other_____
Employer:_____ Occupation:_____
Employer Address:_____ City:_____ State:_____ Zip Code:_____
Work Phone:_____ Hours Worked Per Week:_____

SPOUSE INFORMATION:

Name:_____ Birthdate:_____ Age:_____
Employer:_____ Occupation:_____
Work Phone:_____ Cell Phone: _____

SOCIAL HISTORY:

Do You Smoke? Y/N # of Cigarettes/Day?_____ Do You Drink Alcohol? Y/N # of Drinks/Day?_____
Do You Exercise: Y/N How Often?_____

HEALTH HISTORY:

Has any member of your immediate family had any of the following (X)?

Disease	Father	Mother	Brother	Sister	Grandmother	Grandfather
Alcoholism						
Diabetes						
Cancer (Name Type)						
Heart Disease						
High Blood Pressure						
Stroke						
Arthritis						
Depression						
Thyroid Disease						
Osteoporosis						

Do you have a history of the following (circle):

Arthritis	Y/N	Kidney Stones	Y/N	Frequent Urination	Y/N
High Blood Pressure	Y/N	Nausea	Y/N	Blurred Vision	Y/N
Poor Circulation	Y/N	Hernia	Y/N	Heart Burn	Y/N
Loss of Bladder Control	Y/N	Weight Loss/Gain	Y/N	Dizziness	Y/N
Shortness of Breath	Y/N	Osteoporosis	Y/N	Hearing Loss	Y/N
Difficulty Walking	Y/N	Headaches	Y/N	Ringing in Ears	Y/N
Insomnia	Y/N	Fatigue	Y/N	Diarrhea	Y/N

List any hospitalizations and dates:_____
List any injuries/accidents and dates:_____
List any major surgeries and dates:_____
Taking medications? Y/N If so, please list:_____
Taking over the counter medication? Y/N If so, please list:_____

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AUTOMOBILE ACCIDENT QUESTIONNAIRE

Patient Name: _____ Date: _____
Auto Insurance Name: _____ Claim# _____

1. Date of accident: _____
2. Location of accident (City/State): _____
3. Briefly describe how the accident occurred: _____

_____

_____

4. Were you the driver? No / Yes If a passenger, were you in the front or back seat? _____
5. Make and model of the car you were driving? _____
6. Make and model of the other car involved in the accident? _____
7. Were you wearing your seatbelt? No / Yes
8. Did the airbags deploy? No / Yes
9. Did you know the crash was about to happen? No / Yes Did you brace yourself for the impact? No / Yes
10. Did you get cut or scraped anywhere? No / Yes Describe _____
11. Did you get bruised anywhere? No / Yes Describe _____
12. Did you have any immediate pain? No / Yes Describe _____

_____

13. Did you hit your head? No / Yes Did you lose consciousness? No / Yes
14. Did the police investigate the accident? No / Yes Did an ambulance arrive? No / Yes
15. Did you go to the hospital by ambulance? No / Yes What hospital? _____
16. Were you transported on a backboard? No / Yes Did you wear a neck collar? No / Yes
17. At the hospital: Were you examined? No / Yes

    Were x-rays taken? No / Yes

    Was a CT scan performed? No / Yes

    Was any laboratory work performed? No / Yes

    Were you given prescriptions? No / Yes What kind? _____
19. Were you admitted to the hospital? No / Yes Or were you released to see your own doctor? No / Yes
21. Have you been examined or treated by any other physician since the accident? No / Yes
22. What treatments have you received since the accident? _____

Patient Health Questionnaire - PHQ

Patient Name _____ *Date* _____

1. *Describe your symptoms* _____

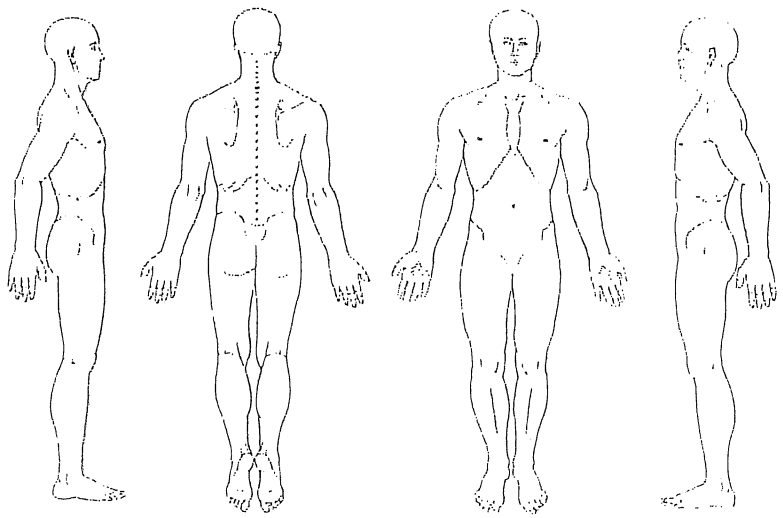
_____

a. *When did your symptoms start?* _____

b. *How did your symptoms begin?* _____

2. *How often do you experience your symptoms?*
   - ① Constantly (76-100% of the day)
   - ② Frequently (51-75% of the day)
   - ③ Occasionally (26-50% of the day)
   - ④ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. *What describes the nature of your symptoms?*
   - ① Sharp
   - ② Dull ache
   - ③ Numb
   - ④ Shooting
   - ⑤ Burning
   - ⑥ Tingling

4. *How are your symptoms changing?*
   - ① Getting Better
   - ② Not Changing
   - ③ Getting Worse

5. *During the <u>past 4 weeks</u>:*

   a. *Indicate the average intensity of your symptoms*

   None ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Unbearable

   b. *How much has pain interfered with your normal work (including both work outside the home, and housework)*

   ① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

6. *During the <u>past 4 weeks</u> how much of the time has your condition interfered with your social activities?*
   (like visiting with friends, relatives, etc)

   ① All of the time ② Most of the time ③ Some of the time ④ A little of the time ⑤ None of the time

7. *In general would you say your overall health right now is...*

   ① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

8. *Who have you seen for your symptoms?*

   ① No One ② Other Chiropractor ③ Medical Doctor ④ Physical Therapist ⑤ Other

   a. *What treatment did you receive and when?* _____

   b. *What tests have you had for your symptoms and when were they performed?*

   ① Xrays *date:* _____ ③ CT Scan *date:* _____

   ② MRI *date:* _____ ④ Other *date:* _____

9. *Have you had similar symptoms in the past?* ① Yes ② No

   a. *If you have received treatment in the past for the same or similar symptoms, who did you see?*

   ① This Office ② Other Chiropractor ③ Medical Doctor ④ Physical Therapist ⑤ Other

10. *What is your occupation?*

    _____

    ① Professional/Executive ② White Collar/Secretarial ③ Tradesperson ④ Laborer ⑤ Homemaker ⑥ FT Student ⑦ Retired ⑧ Other

    a. *If you are not retired, a homemaker, or a student, what is your current work status?*

    ① Full-time ② Part-time ③ Self-employed ④ Unemployed ⑤ Off work ⑥ Other

Patient Signature _____ *Date* _____

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CONSENT TO TREAT

Having been accepted as a patient at Manatee Wellness & Chiropractic Centers, (hereafter also called the office), I understand and agree to the following conditions of acceptance:

CONSENT TO TREATMENT: I hereby request and consent to the performance of procedures, which may include, but is not limited to, spinal and extremity manipulation, massage, electrical muscular stimulation, ultrasound, and/or therapeutic modalities by either Dr. Amanda Mitchell D.C., Dr. Justin Mitchell D.C., Dr. Yessica Rosales D.C, and/or other licensed doctors or therapists who, now or in the future, treat me while employed by or associated with Manatee Wellness & Chiropractic Centers. I have had an opportunity to discuss with the doctor and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and/or other procedures. I understand and am informed that in the practice of chiropractic there are some risks to treatments including, but not limited to, fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests. I have read or have had read to me, the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

NOTIFICATION OF CHANGES: I will immediately notify the office of changes in my health status, home and work telephone numbers, mailing address, insurance benefits, attorney representing me in a personal injury lawsuit, and any information I have given on the patient intake forms.

RELEASE OF INFORMATION: To the extent necessary to determine liability for payment and obtain reimbursement, I authorize the office to furnish, upon written request authorized by me, any information in my medical record including photographs or computer images to any and all persons or organization which are or may be liable for all or any portion of my medical charges at the office. I authorize the office to release any information pertinent to my case to any insurance company or their representative involved in this case.

FILING INSURANCE CLAIMS: As a courtesy and at my request for the office to accept delayed payment for my care, the office will submit insurance claim forms for payment of my medical benefits. I authorize the office to submit claims for each service rendered and charge usual, reasonable and customary charges in this area for each service.

ATTORNEY LIEN: In the event I receive medical payment benefits, no-fault benefits, health and accident benefits, workers compensation benefits, or other reimbursement from any settlement, judgment or verdict on my behalf, I hereby authorize and direct my attorney to first pay the office the amount due for services rendered before any other disbursements are made from any funds received by the attorney's office on my behalf. This attorney lien is binding on any and all attorneys involved in my case prior to and subsequent to the date of this agreement with the office. I may only revoke this lien by a certified letter received at the

office.

GUARANTEE OF PAYMENT: I understand and agree I am personally responsible for all services received at the office, and promise to pay regardless of my health insurance benefits and/or possible future payment from any judgment or verdict on my behalf. I understand if my account at this office is past 60 days overdue, it may be subject to a 1.5% per month (18% per year) finance charge. If the defaulted amount is referred to a collection agency and/or for legal action I agree to pay for reasonable court costs and other costs of collection.

ASSIGNMENT OF BENEFITS

For good and valuable consideration, including the agreement of Manatee Wellness & Chiropractic Centers to accept this assignment in lieu of demanding full payment for services from the undersigned on the date each service is rendered, the undersigned patient executes this document hereby assigning to Manatee Wellness & Chiropractic Centers the right to receive insurance benefits directly from any insurance company that may be obligated to provide insurance benefits, to me or on my behalf, for services rendered by Manatee Wellness & Chiropractic Centers.

Any insurance company that may be obligated to pay any insurance benefits to me, or on my behalf, for the aforesaid accident for services provided by Manatee Wellness & Chiropractic Centers, is hereby directed to issue payment for those benefits directly to and payable to Manatee Wellness & Chiropractic Centers.

I also authorize and assign to Manatee Wellness & Chiropractic Centers the right to file suit and pursue all legal remedies to obtain payment for services provided to me by Manatee Wellness & Chiropractic Centers. This authorization to file suit is an assignment of my cause of action to obtain payment for services provided to me by Manatee Wellness & Chiropractic Centers and includes the assignment to pursue declaratory relief or any other legal remedies.

Manatee Wellness & Chiropractic Centers accepts the aforesaid assignment and hereby notifies any insurer issuing payment that Manatee Wellness & Chiropractic Centers objects to any "repricing" or reduction of billed amounts unilaterally made by any insurer. Any such reduced payments issued by any insurer are accepted under protest and without waiving any right of the provider to pursue all legal remedies against the insurer.

AUTHORIZATION FOR DISCLOSURE OF INSURANCE DECLARATIONS PAGE: I, the patient and insured, further authorize and direct any insurance company that may be obligated to pay any insurance benefits to me, or on my behalf, to provide to Manatee Wellness & Chiropractic Centers a copy of any declarations page of any insurance policy that may provide any insurance benefits to me for the aforesaid accident.

AUTHORIZATION FOR DISCLOSURE OF INSURANCE PAYMENT RECORD: I further authorize and direct any insurance company that may be obligated to pay any insurance benefits to me, or on my behalf, to provide to Manatee Wellness & Chiropractic Centers a copy of any ledger or payment record of payments made under any insurance coverage available to me, without redacting the names of any other medical provider or entity to whom insurance benefits have been paid and without redacting the amount of any insurance benefits that have been paid.

DIRECTION NOT TO EXHAUST BENEFITS BY PAYMENT OF OTHER CLAIMS: I further authorize and direct any insurance company that may be obligated to pay any insurance benefits to me, or on my behalf, to not exhaust insurance benefits or coverage until all claims submitted by Manatee Wellness & Chiropractic Centers have been paid in full, or at 80% if the insurance policy is limited to pay 80% coverage of medical claims. If any insurance company obligated to pay any insurance benefits to me, or on my behalf, has denied payment of a claim submitted by Manatee Wellness & Chiropractic Centers, or made payment to Manatee Wellness & Chiropractic Centers at an amount lesser than the amount billed, or lesser than 80% of the amount billed if my coverage is limited to 80% for medical claims, I direct the aforesaid insurance company to hold in escrow the amount in dispute, and if other claims would exhaust benefits I direct the aforesaid insurance company to hold in escrow the disputed amount and to not exhaust benefits or coverage by payment of the amount I have hereby requested be held in escrow. I further authorize and direct the aforesaid insurance company to notify Manatee Wellness & Chiropractic Centers that benefits have been exhausted except for the amount held in escrow, to enable Manatee Wellness & Chiropractic Centers to attempt to resolve the disputed claim in a manner acceptable to Manatee Wellness & Chiropractic Centers.

DIRECTION TO INSURER TO MAINTAIN CONFIDENTIALITY: I further direct any insurance company that may be obligated to pay any insurance benefits to me, or on my behalf, to maintain the privacy and confidentiality of my medical records. I do not authorize any insurer to provide my medical records to anyone without first obtaining a written authorization from me to provide the medical records to any other entity.

AUTHORIZATION FOR RELEASE OF RECORDS TO PROVIDER: I hereby authorize any insurance company that may be obligated to pay any insurance benefits to me, or on my behalf, to release a copy of my complete medical records in possession of such insurer to Manatee Wellness & Chiropractic Centers upon the request of Manatee Wellness & Chiropractic Centers. This authorization includes the authorization to release to Manatee Wellness & Chiropractic Centers a copy of any medical examination or evaluation of me requested by any insurance company.

DIRECTION TO INSURER TO PROVIDE TO PROVIDER ADVANCE NOTICE OF IME OR EUO: I further authorize and direct any insurance company that may be obligated to pay any insurance benefits to me, or on my behalf, to provide at least 15 days advance notice to Manatee Wellness & Chiropractic Centers of any physical examination or examination under oath of myself that any insurance company may schedule.

Please read this document completely before signing. If you do not completely understand this document or have any questions about this document, please ask us to explain it to you. If there is any portion of this document that you do not wish to authorize, we will remove that portion from this document. Your signature below is your agreement that you fully understand this document and you fully agree to the terms of this document.

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

_____ _____

Printed patient name Date

_____ _____

Patient signature (or guardian's signature) Date

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ACUPUNCTURE CONSENT

"Acupuncture" means the stimulation of a certain point or points near the surface of the body by the insertion of special needles. The purpose of acupuncture is to prevent or modify the perception of pain and is thus a form of pain control. In addition, through the normalization of physiological functions, it may also serve in the treatment of certain diseases or dysfunctions of the body. Acupuncture includes the techniques of electro-acupuncture (the therapeutic use of weak electric currents at acupuncture points), mechanical stimulation (stimulation of an acupuncture point or points on or near the surface of the body by means of apparatus or instrument), and moxibustion (the therapeutic use of thermal stimulus at acupuncture points by burning Artemisia alone or Artemisia formulations).

The potential risks: slight pain or discomfort at the site of needle insertion, infection (rare), bruises, weakness, fainting, nausea, and aggravation of problematic systems existing prior to acupuncture treatment.
The potential benefits: acupuncture may allow for the painless relief of one's symptoms without the need for drugs, and improve balance of bodily energies leading to the prevention of illness, or the elimination of the presenting problem.
Use of Disposable Needles: To reduce the possibility of infection from acupuncture, all needles are pre-sterilized, one-time-use needles made of surgical stainless steel needles. After each treatment they are disposed of as medical waste, needles are never reused. Additionally, Dr. Mitchell has had training in and follows the procedures of Clean Needle Technique and Universal Precautions.

I understand that Dr. Mitchell has recommended acupuncture treatment for me in the capacity of a pain mediator to reduce my symptoms. No cure or promises regarding my reaction to the treatment have been made or implied. I request and consent to the performance of the acupuncture procedure. I understand that I am free to withdraw my consent and that I may stop treatment or any procedure at any time. I understand that my signature in this form indicates that I have read and understand the preceding information regarding my treatment. I understand that if I have any questions about this information, I should ask my doctor. I, hereby release Dr. Mitchell and Manatee Wellness & Chiropractic Centers from any and all liability that may occur in connection with the above-mentioned procedures, except for failure to perform the procedures with appropriate medical care.

"With this knowledge, I voluntarily consent to the above procedures."

Patient Name:_____ Date:_____

Signature of Patient:_____

Signature of Representative (if minor):_____

Relationship to Patient:_____

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AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name:
Social Security Number:
Birthdate:

I hereby authorize the Person/Organization providing the information to release medical information about me to Manatee Wellness & Chiropractic Centers.

Dates Of Service Needed: From:_____ To: _____

Person/Organization Providing The Information	Person/Organization Receiving The Information
Name:	**Name:** Manatee Wellness & Chiropractic Centers
Address:	**Address:** 8792 East State Road 70, Suite 101 Bradenton, FL 34202-3705
Phone:	**Phone:** 941-756-4362
Fax:	**Fax:** 941-755-4652

Specific Description of Information Needed:

___X-Ray Reports ___MRI Reports ___CT Reports
___EMG Reports ___Progress Notes ___All Records

- I am aware that such records may contain information related to mental health, substance abuse (both alcohol and drug), and sexually transmissible diseases (including test results related to HIV/AIDS), and I specifically authorize the release of such information pursuant to this authorization.
- I understand that I may revoke the authorization at any time in writing. I further understand that any such revocation will not apply to any information already released under this Authorization. I understand that I am under no obligation to sign this Authorization, and that my ability to obtain treatment from Manatee Wellness & Chiropractic Centers will not depend in any way on whether I sign this authorization.
- I understand that I have a right to request a copy of this Authorization.

By signing below, I authorize the release of my medical information as described above.

Patient Signature:_____ Date:_____

Representative Signature (if minor):_____ Date:_____

Relationship to Patient:_____

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
Amanda Mitchell	Amanda Mitchell	

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.

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Date: _____

To My Attorney: _____

_____

_____

Re: Letter of Protection

Dear _____;

Please provide at your earliest convenience a Letter of Protection to Manatee Wellness & Chiropractic Centers confirming that the fees / services will be protected at the time of settlement / adjudication of my case.

Thank you for your assistance in this matter.

Sincerely,

_____
Patient Signature

_____
Patient Name