PERSONAL INJURY QUESTIONNAIRE

Name____ Today's Date: _______________

Address/City/State/Zip____

Phone #___________________________________E-Mail ______________________________

Date of Birth: ___/___/___ Marital Status: M / W / D / S Spouse's Name _________________

Who can we thank for referring you to our office? ____________________________________

Employer _________________________________ Phone #____________________________

Address/City/State/Zip____

Date of Injury_________________ Location____

Your Auto Ins. Co._________________ Policy#_________________ Claim # ______________
Adjuster Name________________________ Phone # _________________ Fax # ___________

Driver/Other Party_________________ Ins.Co._______________ Policy#_________________

Is there an attorney involved? ( )Yes ( ) No
If yes, Name____ Phone#_________________
Address____

Were there any witnesses? ( ) Yes ( ) No
If yes, Name(s):

Nature of Accident
What time of the day did your accident take place? ____________________________________
What type of vehicle were you in? ____
What type of vehicle did the other party have? ____
Were you ( ) Driver ( ) Passenger ( ) Front Seat ( ) Back Seat
Number of people in your vehicle? ____________ Other Vehicle________________________
Were you struck from: ( ) Behind ( ) Front ( ) Left Side ( ) Right Side
Were you knocked unconscious? ( ) Yes ( ) No
Were the police notified? ( ) Yes ( ) No

In your own words, please describe the accident in detail:
____
____

Did you have any physical complaints BEFORE THE ACCIDENT? ( ) Yes ( ) No
If yes, please describe in detail: ____
____

Describe how you felt: ____

____

____

During the accident: ____

____

Later that day: ____

____

Next Day: ____

____

What are your PRESENT complaints and symptoms?

____

____

____

Do you have any congenital (from birth) factors or any previous illnesses which relate to this accident?
( ) Yes ( ) No If yes, please explain:

____

____

Have you been in any previous accidents? ( ) Yes ( ) No If yes, please explain including dates, type of accident, and injuries sustained:

____

____

Did you go to the hospital or any other doctors after the accident? ( ) Yes ( ) NO ____________

____

If yes, please list names, address and the type of treatment you received: ____________________

____

Since the injury occurred, are your symptoms: ( ) Improving ( ) Getting worse ( )Same

Have you lost time from work as a result of this accident? ( ) Yes ( ) No If yes, last day worked:____________

Are you being compensated for your lost time? ( ) Yes ( ) No

What type of compensation are you receiving? ____

Do you notice any activity restrictions as a result of this injury? ( ) Yes ( ) No

If yes, please explain: ____

____

____

Do you have any other pertinent information to provide, relating to this injury?_______________

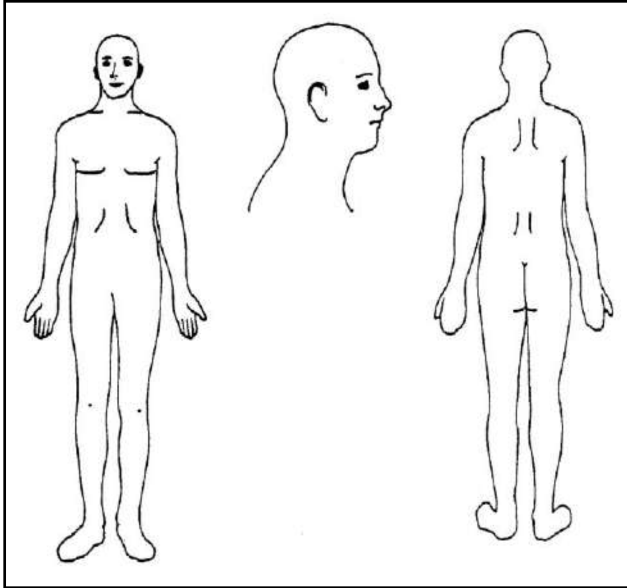
____

____

Patient Signature: __________________________________ Date: ____________________

Name ________________________________

PLEASE MARK AN X ON THE DIAGRAM BELOW WHERE YOUR PROBLEMS ARE



What hurts and how long has it hurt?

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

When do you think these problems originally started?

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

List other Chiropractic or Medical Doctors you have consulted for these conditions.

Medications:__________________________
____
Surgeries:____________________________
____
Auto Accident:________________________
Falls/ Injuries_________________________

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

Hobbies____
____

Check any of the following you have had in the six months:

( ) Headaches / Migraines
( ) Frequent Nausea/ Vomiting
( ) Vision Problems
( ) Ears (Pressure/ Infection/ Ringing)
( ) Dizziness /Vertigo
( ) Heart (Palpitation / Disease)
( ) Lung Problems / Congestion
( ) Blood Pressure Problems
( ) Ankle Swelling
( ) Prostate/ Sexual Dysfunction
( ) Menstrual Cycle Dysfunction
( ) Sinus Congestion/ Allergies

( ) Numbness /Tingling/ Weakness
( ) Throat (Swallowing/Sore)
( ) Abdominal Cramps
( ) Constipation/ Diarrhea
( ) Acid Reflux
( ) Poor / Excessive Appetite
( ) Excessive Thirst
( ) Painful / Excessive Urine
( ) Discolored Urine
( ) Diabetes
( ) Cancer

Are you pregnant? ( ) Yes ( ) No ( ) Not Sure

QUADRUPLE VISUAL ANALOGUE SCALE

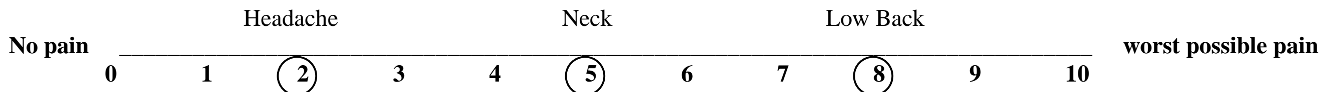
Patient Name ____ Date ___________________________

Please read carefully:

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:



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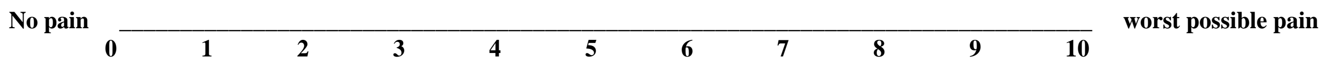
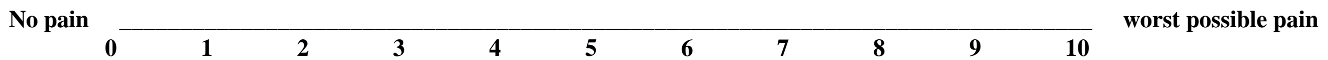
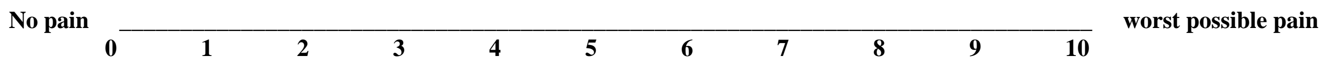
1 – What is your pain RIGHT NOW?



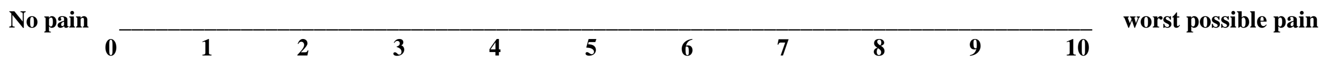
2 – What is your TYPICAL or AVERAGE pain?



3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?



4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?



OTHER COMMENTS:

____

____

____
Examiner

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

San Jose Chiropractic
Thuraia Owais, D.C.
12276 San Jose Blvd, STE 512
Jacksonville, FL 32223
(904)683-4476

35- Day Notice Treatment

Today's Date: ____________

Insurance Company: ________________________
Address: __________________________________
City, State, Zip: _____________________________

Policy Holder's Name: ________________________
Policy Number: ______________________________
Claim Number: _______________________________

Patient's Name: ______________________________

Dear insurer,
This is to inform that the above-named patient presented himself or herself to my office today for treatment. In accordance with Section 6277.736(5)(b) of the Florida Statues. I am placing you on notice of such treatment as it relates to the patient's personal injury claim with you

Date of Accident: _____________

_____________________________ _____________
Patient's Signature **Date**

_____________________________ ______________
Thuraia Owais, D.C. **Date**

Informed Consent to Chiropractic Care

Terms of acceptance for care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working toward the same objective. It is important that each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may take the decision whether to undergo chiropractic care after being advised of the known benefits, risks, and alternative.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of health.

Health is the state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity

Vertebral subluxation is the disturbance to the nervous system that occurs when one or more of the 24 vertebrae in the spinal column becomes misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic. Subluxations are correct and/or reduces by an adjustment

Adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instrument. In addition, ancillary procedures such as extremity adjustment, physiotherapy and or rehabilitation procedures maybe included.

If during the course of care we encounter non-chiropractic or usual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternative of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis

____

PRINT NAME SIGNATURE DATE

San Jose Chiropractic

Insurance Disclaimer

If you have insurance, we will, as a courtesy, bill your insurance and help you receive the maximum allowable benefit under your policy.

It is your responsibility to provide all correct and necessary insurance eligibility, identification, authorization and to notify our office of any information changes when they occur. With most insurance companies we have a short window to file your claim. If we pass this window of opportunity your policy may state that the insurance has no responsibility to pay on your claim. Unfortunately, even a preauthorization of services does not guarantee payment from your insurance carrier. Failure to provide all required information may necessitate patient payment in full for all charges. We have no control over contractual downgrades of services by your insurance company and assume no monetary liability based upon any downgrade of benefits. The insurance company will not disclose this information ahead of time. Because of the quality of our work we cannot allow insurance companies to dictate our services or the materials that we may use.

Please be aware that you as the guarantor are responsible for payment on your account in a prompt and timely manner, usually 30-45 days from date the service was rendered, whether insurance has paid or not.

______________________________________ __________________

Signature Date

San Jose Chiropractic
Thuraia Owais, D.C.
12276 San Jose Blvd, STE 512
Jacksonville, FL 32223
(904)683-4476

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR PRIVATE, GROUP, AND ACCIDENT HEALTH INSURANCE

I hereby instruct and direct ________________________________ (insurance company) to pay by check made out and mailed to San Jose Chiropractic.

OR

If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows: 12276 San Jose Blvd., STE 512. Jacksonville, FL 32223.

The professional and medical expense benefit allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGMENT OF RIGHTS AND BENEFTIS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay in a current manner any balance of said professional services charges over and above this insurance payment.

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

I also authorize the release of any information from my medial record, pertinent to my case, to my insurance company, adjuster, or attorney involved in this case.

Date:

________________________ ________________________

(Signature of Patient) (Witness)

________________________ ________________________

(Patient name Printed) (Signature of guardian if patient is under 18 yoa)

SAN JOSE CHIROPRACTIC

Patient Acknowledgement and/or Receipt of

Notice of Privacy Practices Pursuant to HIPAA
And Consent for Use of Health Information

Name____ Date___________________
Print Patient's Name

The undersigned does herby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersigned does herby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant To HIPAA, the HIPAA Compliance Manual, State Law and Federal Law.

Dated this _______________day of __________________________, 20______

By ____
Patient's Signature

If patient is a minor or under a guardianship order as defined by State Law:

By ____
Signature of Parent/Guardian (circle one)

12276 San Jose Blvd, Suite 512 * Jacksonville, FL 32223
904-683-4476 * www.sanjosechirojax.com

SAN JOSE CHIROPRACTIC

LIEN FOR DR. THURAIA OWAIS AND SAN JOSE CHIROPRACTIC

To: ____

____

____

RE: Medical Records and Doctor's Lien

Patient Name: ______________________________ Date of Accident: _________________

I do hereby authorize Dr. Thuraia Owais and San Jose Chiropractic to furnish you, my attorney/insurance carrier, with a full report of their case history, examination, diagnosis, prognosis and service of/to myself in regard to my accident/illness which occurred/began on _________________.

I hereby give a lien to Dr. Thuraia Owais and San Jose Chiropractic on any settlement, claim, judgment or verdict as a result of said accident/illness, and authorize and direct you, my attorney/insurance carrier, to pay directly to Dr. Owais/San Jose Chiropractic such sum as may be due and owing them for services rendered me, and to withhold such sums from such settlement, claim, judgment or verdict as may be necessary to pay Dr. Owais/San Jose Chiropractic adequately.

I agree never to rescind this document and that a recession will not be honored by my attorney. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney will honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by him.

Please acknowledge this letter by signing below and returning it to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but may declare the entire balance due and payable.

I fully understand that I am directly and fully responsible to Dr. Thuraia Owais and San Jose Chiropractic for all just bills submitted by them for services rendered me, and that this agreement is made solely for Dr. Thuraia Owais and San Jose Chiropractic's additional protection and in consideration of their awaiting payment. And I further understand that such payment is not contingent on any settlement, claim, judgment or verdict by which I may eventually recover said fee.

Dated ________________________ Patient Signature____

The undersigned attorney of record for the above patient, does hereby agree to observe all of the above terms and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor above named. Attorney further agrees that in the event this lien is litigated, the prevailing party will be awarded attorney's fees and cost.

Dated ________________________ Attorney's Signature ____________________________________

Please date and sign and return to doctor's office.

SAN JOSE CHIROPRACTIC

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations, and that it may be re-disclosed by the recipient.

Patient Name: ____
Organization Providing the Information: San Jose Chiropractic, LLC
Organization(s) or Person(s) Receiving the Information: ______________________________
____
____
Specific Description of Information Disclosed: _____________________________________
____
____
____

To the extent any of the following information is contained in the records being released, I specifically authorize the release of such information for the purposes indicated below by initialing before each category: Initials:_____ HIV/AIDS testing, test results, treatment and related information including high risk behavior documented; Initials:_____ drug and/or alcohol diagnosis, treatment, test results and reports and referral information; Initials:_____ mental health treatment information, test results and reports including psychological and psychiatric studies, reports, evaluations and referral information; and/or Initials:_____ venereal disease information.
Purpose of Disclosure:____
____
____

If this Authorization is for marketing purposes, remuneration is/is not involved (Provider circle one)

You must read and initial the following statements:

1. I understand this Authorization will expire on _____/_____/_____ (DD/MM/YR) or on the following event ___________________________________. Initials: ______
2. I understand that I may revoke this Authorization at any time by notifying **San Jose Chiropractic** in writing, but if I do, it will not have any effect on any actions **San Jose Chiropractic** took before they received the revocation.

Initials: __________

_____________________________________ _______________________________
Signature of Patient or Representative

_____________________________________ Date___________________________
Relationship to Patient

You may refuse to sign this Authorization. Your receipt of adjustments is not contingent upon signing this authorization. However, if you are requesting our submitting insurance forms on your behalf, this release must be signed before adjustments can commence.

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 (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):*

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.