ANDERS CHIROPRACTIC & SPORTS PERFORMANCE

Application for Treatment Involving Accident of Trauma

Marc Anders, D.C., CCSP

Today's Date:_____

Name:_____ DOB:_____ Sex: M____ F_____

Address:_____ City/State:_____ Zip Code:_____

Home Phone:_____ Alt. Phone #_____ SS#_____

Marital Status: M S Spouses Name: _____

Patient's Occupation:_____

Employed by:_____

Employer Address:_____

Nearest Relative **not living with you:**_____ Relationship:_____

Phone Number:_____

Primary Care Physician:_____

Current Medications:_____

History of the Accident or Injury

Date of Accident or Injury:_____

Please describe how the accident or injury occurred:_____

If this was a motor vehicle accident, what was the year, make and model of the vehicle you were in at the time of the accident? Year_____ Make_____ Model_____

Who owns the vehicle?_____ Is this a lease car?_____

How many people were in the car at the time of the accident, including yourself?_____

What was YOUR position in the vehicle at the time of the accident? Driver__ Front Passenger__

Sitting behind the driver (left rear)____ Behind front passenger (right rear)____ Other_____

Please describe_____

At the time of the accident were you wearing a lap belt & shoulder harness? Yes_____ No_____

Does the vehicle have air bags? Yes_____ No_____ Did the air bags deploy? Yes_____ No____

Did you see the accident about to happen? Yes_____ No_____ Describe_____

Where was your vehicle struck? Front____ Back____ "T-Boned"____ Lft Side____ Rt Side____

Did your car strike another vehicle, pole, ditch, or other object after initial impact Yes___ No___

If yes, please explain_____

Patient Name:_____

Did you strike any object or parts of the car during the accident? No____ Yes_____

If yes, please describe_____

Were you dazed or confused after the accident? Yes_____ No_____ For how long?_____

Did you lose consciousness after the accident? Yes_____ No_____ For how long?_____

Does your car have headrests? Yes___ No___ Did you make a police report? Yes____ No_____

Injuries/Symptoms IMMEDIATELY after accident:_____

Any changes to your symptoms later that day, the following day or week?_____

Please describe your major problem or complaint today?_____

Did you receive emergency treatment in a Hospital Emergency Room? Yes_____ No_____

How did you get to the Emergency Room? Ambulance_____ Private Car_____ Other_____

Hospital Name_____ ER Doctor's Name_____

Have you had any previous TRAUMAS, ACCIDENTS, OR FALLS which may be caused by or contributing to the above problems? Yes_____ No_____ Month/Year_____/_____

If yes, please explain_____

SINCE THE ABOVE ACCIDENT have you had any accidents or falls which may be contributing to your condition? Yes___ No___ If yes, please explain_____

For females: Is there any chance you are pregnant? Yes____ No_____ Unsure_____

Were you pregnant at the time of the accident? Yes_____ No_____

Has the accident caused any of the following? Please check all that apply:

_____ Headache	_____ Head seems heavy	_____ Neck Pain
_____ Pins & Needles (arms)	_____ Pins & Needles (legs)	_____ Stiff Neck
_____ Sleeping Problems	_____ Back Pain	_____ Muscle Weakness

Are your symptoms worse in the morning or night?_____

What have you done at home to treat these problems?_____

Does anything relieve the pain or stiffness? (i.e. rest, lying down, heat, ice etc.)_____

Does anything make the pain worse? Yes_____ No_____ Describe_____

Patients Name:_____

What is the frequency of the pain(s)? Constant_____ Frequent_____ (Occurs between 50-75% of the time when awake) Occasional_____ (Occurs between 25-50% of the time when awake) Intermittent_____ (Occurs les than 25% of the time when awake)

Have you lost any time from work as a result of this accident? Yes_____ No_____

If yes, how many days?_____ Do you have any work restrictions? Yes_____ No_____

Explain_____

Please describe your primary job duties at work:_____

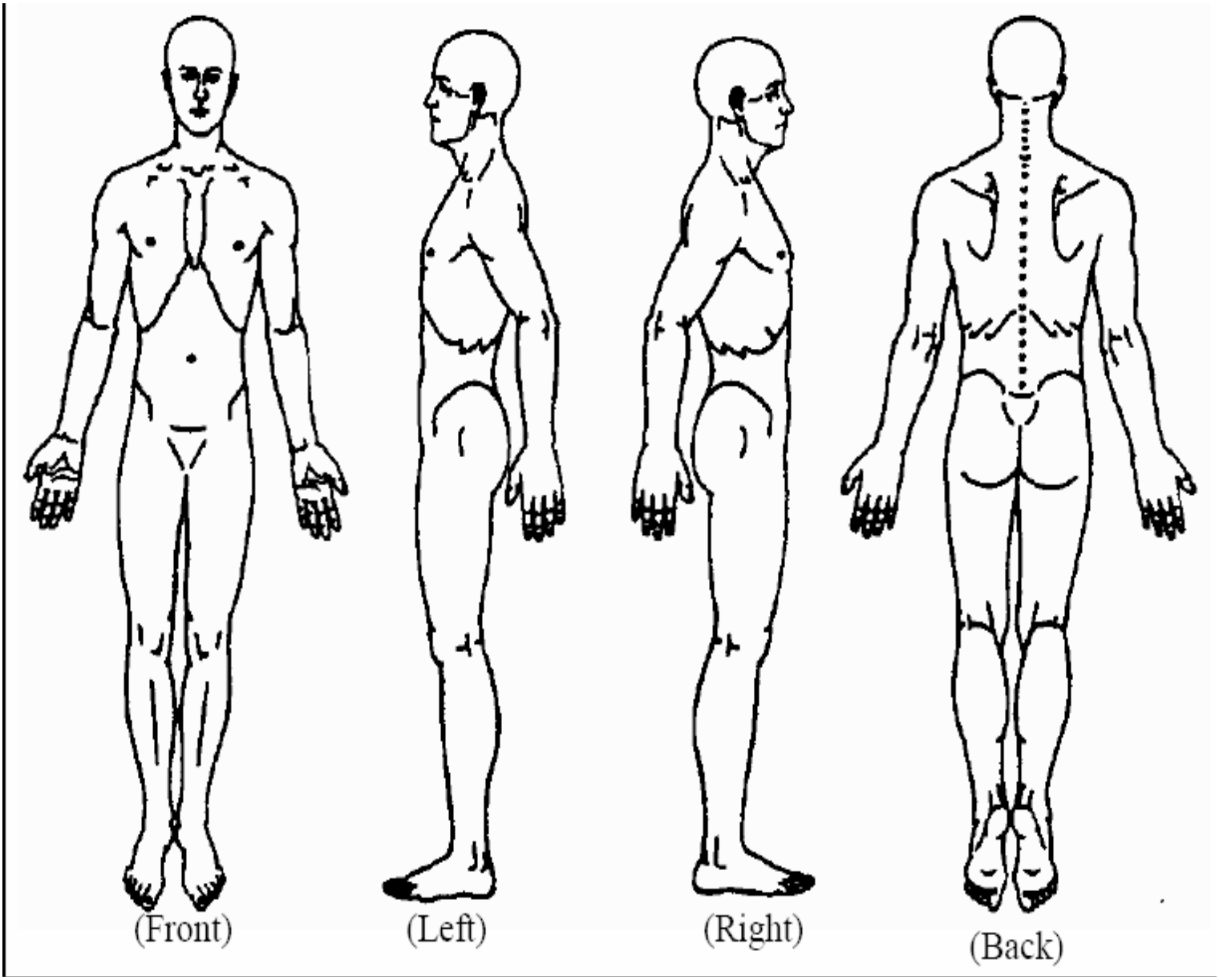
Have your injuries caused any restrictions or difficulties with any or your usual daily activities? Yes_____ No_____ If yes, please describe_____

What has been the emotional impact of this accident and your injuries on you?

_____

PAIN DRAWING

Name_____ **Date**_____



Mark as follows:

A - Ache **B - Burning** **N - Numbness** **P - Pins & Needles**

S – Stabbing **O – Other – Describe**_____

Patient Name_____

How will payment be made? Cash___ Check___ Credit Card____ Health Ins.___ Auto Ins.___ Other____ Are you covered by Medicare_____

I hereby attest that the above information is true and accurate to the best my knowledge. I hereby authorize the doctor or his representatives to examine and treat me for my injuries and related illnesses, as they deem appropriate. I understand that fees for Professional services from Anders Chiropractic & Sports Performance are due and payable at the time of the visit, unless other arrangements have been made. I understand that copies of my office records are available and may be obtained by filling out and signing the appropriate medical record release form, and that there may be a fee for this service, not to exceed the usual and customary rates.

I understand and agree that health and accident policies are an arrangement between the insurance carrier and myself. Furthermore, I understand that as a courtesy Anders University Chiropractic and Wellness Center will assist me in submitting my bills to my insurance carrier and in making collection from the insurance company, and that any amount authorized to be paid directly to Anders Chiropractic & Sports Performance, will be credited to my account upon receipt. However, by affixing my signature below I agree that I am personally responsible for full payment of all goods and services rendered to me through this clinic, regardless of the type and amount of insurance reimbursement provided for these services from third party payers.

Patient Signature_____ Date_____

Patient Name_____ Signature of parent for minor_____

INFORMED CONSENT

Medical doctors, chiropractic doctors, osteopaths, and physical therapists that perform manipulation are required by law to obtain your informed consent before starting treatment.

I_____, Do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Physical therapy and exercises may also be used. Although spinal and extremity manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware the there are possible risks and complications associated with these procedures as follows:

Soreness/Bruising: I am aware that like exercise it is common to experience muscle soreness and occasionally bruising 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 disc, or other abnormality is detected, this office will proceed with extra caution.

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 a million to once in ten million treatments. Once in a million is about the same chance as getting hit by lightning. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol® causing death.

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

TREATMENT RESULTS

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits. I realize that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures. I agree to the performance of these procedures by my doctor and such other persons of the doctor's choosing.

ALTERNATIVE TREATMENTS AVAILABLE

Reasonable alternatives to these procedures have been explained to me including, rest, home applications of therapy, prescription or over-the counter medications, exercises and possible surgery.

Medications: Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.

Rest/Exercise: It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of limited value but are not corrective of injured nerve and joint tissues.

Surgery: Surgery may be necessary for joint instability or serious disc rupture. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery.

Non-treatment: I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

I have read or had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.

To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

_____ Signature of Patient Date_____

_____Signature of Witness Date_____

LIMITED POWER OF ATTORNEY

I hereby give limited power of attorney to Anders Chiropractic & Sports Performance and Dr. Marc Anders to endorse/sign my name on any checks for payment of medical service received or services provided by said office and grant a lien to said medical services provider for any proceeds or insurance benefits payable under my policy. A photocopy of this instrument shall be considered as effective and valid as the original.

Patient Name:_____

Patient Signature:_____ Date:_____

Witness:_____

If you are represented by an attorney, please complete the information requested below:

AUTHORIZATION TO COMMUNICATE WITH MY RETAINED ATTORNEY

___ Yes ____ No I authorize verbal and written communication with attorney
___ Yes ____ No I authorize sending records to my attorney

Patient Name:_____

Date Injury:_____

Name of Attorney:_____

Address:_____

_____

Patient Signature:_____ Date:_____

Expiration Date/Event for Authorization:
____ When treatment/billing has concluded with our office.
____ When case is closed

I authorize the doctor's office to discuss case-related issues by telephone, fax, and written communication, including sending reports, with my retained attorney for a claim resulting from a motor vehicle accident for as long as this specific injury-related case is open. Your attorney will want to have copies of your medical records sent and your authorization is required. Our office is required by the Federal HIPPA Laws to have your signed and dated permission before sending reports or communication with your attorney. This authorization may be revoked by you at any time, by advising our office (privacy officer) of this revocation in writing. If you choose to not sign this authorization, this will not have any adverse effect on your treatment, eligibility for benefits, enrollment or payment.

ANDERS CHIROPRACTIC &
SPORTS PERFORMANCE

NOTICE TO ALL PATIENTS

Welcome to our facility and practice! The following is important information regarding our patient policies. These policies aid us in ensuring proper care and customer service. If you have any questions or concerns, please do not hesitate to contact our staff.

- Please sign in upon entering the facility for your scheduled appointment, and check out with our receptionist prior to leaving.

- Payment is due at the time services are rendered unless prior arrangements have been made. Please be prepared to pay by credit card, check, or cash for each office visit if necessary.

- In order to provide all of our patients with proper care, it is imperative you are no more than 15 minutes late for your scheduled appointment. If you will be later than 15 minutes, please call the clinic and we will try to work you in at another time or you may have to reschedule your appointment. Please understand you may not receive some of the originally scheduled treatments if you are worked in.

- Failure to notify the clinic of cancellation of your scheduled therapy appointment at least 24 hours in advance will result in a $25.00 charge billed to you personally.

- You will be announced by the receptionist at your scheduled appointment time and a therapist will come to greet you. Please remain in the lobby area until a therapist is present. This ensures your safety in our facility.

- We value your time. Let us know in advance if you have a limited amount of time for our session and we will try to accommodate you.

Thank you for your patience and cooperation.

_____ _____

Patient Signature Date

Anders Chiropractic
&
Sports Performance
11873 High Tech Ave. Ste A
Orlando, Florida 32817
PH# (407) 249-3300 FAX# (407) 249-3322

ASSIGNMENT OF BENEFITS

I, _____, in exchange for medical services, assign all rights, title, and interest from any and all automobile insurance policies, which provide medical benefits or no-fault benefits to MEDICAL PROVIDER for services rendered to me by MEDICAL PROVIDER related to injuries I suffered in an automobile accident, which occurred on _____. Additionally, I agree to fully cooperate with MEDICAL PROVIDER and do nothing to impair its rights, title, and interest under the policy. I further authorize my insurance company to release any information that MEDICAL PROVIDER deems necessary for the pursuit of its claim for benefits under any policy of insurance.

_____ _____
Patient Signature **Date**

The undersigned, as authorized representative of MEDICAL PROVIDER accepts the assignment of benefits as set forth above.

_____ _____
Authorized Representative **Date**
MEDICAL PROVIDER

(To be completed by Insurance Company Representative)
Please provide the following:

Patient Name: _____

Claim #: _____ Policy #: _____

PIP$: _____ MEDPAY$: _____ DEDUCTIBLE$: _____ DEDUCT. MET$ _____

Claims Mailing Address: _____
_____

City: _____ State: _____ Zip Code: _____

Adjustor's Name: _____ Adjustor's Phone #: (____)_____ EXT. _____

Once you have completed the information, please fax it back to (407) 249-3322

HIPAA PRIVACY NOTICE

Effective April 14, 2003

This notice describes how medical information about you may be used and disclosed and how you can obtain access to this information. Please review it carefully.

Introduction

We are required by law to maintain the privacy of "protected health information." "Protected health information" includes any identifiable information that we obtain from you or others that relates to your physical or mental health, the health care you have received, or payment for your health care.

As required by law, this notice provides you with information about your rights and our legal duties and privacy practices with respect to the privacy of protected health information. This notice also discusses the uses and disclosures we will make of your protected health information. We must comply with the provisions of this notice, although we reserve the right to change the terms of this notice from time to time and to make the revised notice effective for all protected health information we maintain. You can always request a copy of our most current privacy notice from our office.

Permitted Uses and Disclosures

We can use or disclose your protected health information for purposes of treatment, payment and health care operations.

♦ Treatment means the provision, coordination or management of your health care, including consultations between health care providers regarding your care and referrals for health care from one health care provider to another. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. Therefore, the doctor may review your medical records to assess whether you have potentially complicating conditions like diabetes.

♦ Payment means activities we undertake to obtain reimbursement for the health care provided to you, including determinations of eligibility and coverage and other utilization review activities. For example, prior to providing health care services, we may need to provide to your insurance carrier (or other third party payor) information about your medical condition to determine whether the proposed course of treatment will be covered. When we subsequently bill the carrier or other third party payor for the services rendered to you, we can provide the carrier or other third party payor with information regarding your care if necessary to obtain payment.

♦ Health Care Operations mean the support functions of our practice related to treatment and payment, such as quality assurance activities, case management, receiving and responding to patient complaints, physician reviews, compliance programs, audits, business planning, development, management and administrative activities. For example, we may use your medical information to evaluate the performance of our staff in caring for you. We may also combine medical information about many patients to decide what services are not needed, and whether certain new treatments are effective.

Disclosures Related To Communications With You Or Your Family

- We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you or relate specifically to your medical care through our office. For example, we may leave appointment reminders on your answering machine or with a family member or other person who may answer the telephone at the number that you have given us in order to contact you.
- We may disclose your protected health information to your family or friends or any other individual identified by you when they are involved in your care or the payment for your care. We will only disclose the protected health information directly relevant to their involvement in your care or payment. We may also use or disclose your protected health information to notify, or assist in the notification of, a family member, a personal representative, or another person responsible for your care of your location, general condition or death. If you are available, we will give you an opportunity to object to these disclosures, and we will not make these disclosures if you object. If you are not available, we will determine whether a disclosure to your family or friends is in your best interest, and we will disclose only the protected health information that is directly relevant to their involvement in your care.

Your Rights

1. You have the right to request restrictions on our uses and disclosures of protected health information for treatment, payment and health care operations. However, we are not required to agree to your request.
2. You have the right to reasonably request to receive communications of protected health information by alternative means or at alternative locations.

ELECTRONIC TRANSFER OF PROTECTED PATIENT INFORMATION PRIVACY PRACTICE

The Anders Chiropractic and Sports Performance, LLC seeks to protect the privacy of Protected Health Information stored on computers of the Anders Chiropractic and Sports Performance, LLC or transmitted via the internet.

Only authorized employees shall have access to computers on which Protected Patient Information is stored. All computers will be protected with a password. Only authorized employees may use a password to access computers. The password will be periodically changed and changed any time an authorized employee leaves the Practice's employ.

Only the owners of the practice will be authorized to take out of the Practice's premises back up discs or flash drives onto which Protected Patient Information has been copied. The owner will take appropriate steps to protect the information on the discs or flash drives from unauthorized disclosure. Back up data will be stored in a secure place.

Any electronic claims that may be filed using software that is approved for electronic transmissions of Protected Health Information and which protects the privacy of such information as it becomes available.

The Practice will make certain that any billing services used by the Practice to electronically file claims on behalf of the Practice have a policy adopted that protects Protected Health Information and that uses software that is approved for electronic transmissions of Protected Health Information and which protects the privacy of such information.

ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

_____ _____

Patient Name (please print) Date

_____

Parent, Guardian or Patient's legal representative

_____

Signature

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.

List below the names and relationship of people to whom you authorize the Practice to release PHI.

_____ _____

_____ _____

_____ _____