Robert S. Weatherwax, D.C.
165 Sabal Palm Drive, Ste. 95
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PATIENT DEMOGRAPHIC INFORMATION

Full Name: _____ Today's Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of birth: _____ Social Security #: _____ Sex: _____ Male _____ Female

Cell Phone: _____ Home Phone: _____ Email: _____

Choose one: ____ Married ____ Single ____ Divorced ____ Minor ____ Separated ____ Partnered

Spouse's full name: _____ Spouse's contact #: _____

Whom may we thank for referring you to us? _____

IN CASE OF EMERGENCY, CONTACT: _____ Relationship: _____

Cell Phone: _____ Home Phone: _____ Email: _____

EMPLOYMENT INFORMATION

Employer: _____ Occupation: _____

Work Phone: _____ Job requirements/duties: _____

Address: _____ City: _____ State: _____ Zip: _____

AUTO INSURANCE

Is this injury related to an auto accident? ___ Yes ___ No If so, insurance company: _____

Claims address: _____ City: _____ State: _____ Zip: _____

Adjuster's name: _____ Policy: _____ Claim #: _____

Adjuster's phone #: _____ Adjuster's fax #: _____

HEALTH HISTORY

List any previous surgeries and major illnesses: _____

List any injuries- falls, head injuries, broken bones, and dislocations: _____

_____

Current medications: _____

Current Vitamins, Herbs or Minerals: _____

_____

Are you pregnant? ____ Yes ____ No Do you smoke? ____ Yes ____ Do you drink alcohol? ____ Yes ____ No

List any allergies: _____

Family history (i.e. Diabetes, Cancer, Heart Disease): _____

_____

Pervious Chiropractic care? ____ Yes ____ No If yes, Doctor's name: _____

PATIENT CURRENT COMPLAINT

Describe area(s) of complaint- When/How did this condition develop? _____

_____

Rate this pain on a scale from 1 (least pain) to 10 (severe pain): _____ Have you had this condition before? _____

Activity Level: ___ None ___ Light ___ Daily ___ Heavy Type of activity: ___ Running ___ Swimming ___ Biking ___ Other

Type of pain: ___ Sharp ___ Numb ___ Dull ___ Shooting __ Throbbing __ Aching __ Tingling __ Cramping __ Burning __ Other

Is this condition getting better, worse, or staying the same? _____

How often does this pain occur? _____ Is pain constant or does it come and go? _____

What aggravates your symptoms? _____

Is there anything that makes the pain feel better? _____

Does pain radiate down arms or legs? __ Yes __ No Does it interfere with: __ Work __ Sleep __ Daily Routine __ Recreation

Have you lost days from work? __ Yes __ No If so, what days? _____

What treatment have you already received for this condition? ____ Medication ____ Surgery ____ Physical Therapy ____ None

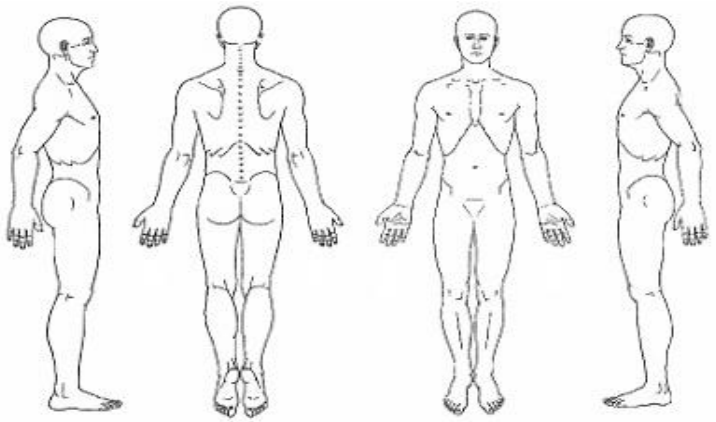
Name & contact # of other doctors who have treated this condition: _____

Fees are payable that the time examinations & treatments are received, unless other arrangements are made in advance. It is not our policy to release X-rays or MRI's that are ordered by our doctor. The films must remain at our location as part of your permanent record. We will be happy to provide you with a copy of the printed report. If the films are required by another physician or other source, copies can be made by a reputable company of our choice, but costs vary. We will be happy to give you an estimate of the cost at the time of your request. At least two weeks' notice, as well as payment in full is required when requesting films. Please sign below acknowledging that you have read and understood the information contained herein and that it has been explained to you. We are here to serve YOU, ask any questions you may have and our staff will assist you.

_____

Print Name **Signature** **Date**

On the diagram below, please indicate the exact location you are experiencing pain **(writing space for the doctor's notes)**:



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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.
Print Patient's Name

_____

Signature of Patient or Legal Representative **Date**

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refuse to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

ASSIGNMENT OF INSURANCE BENEFITS, RELEASE, & DEMAND

I, the undersigned patient/insured knowingly, voluntarily and intentionally assign the rights and benefits of my automobile Insurance, also known as Personal Injury Protection (hereinafter PIP), and Medical Payments policy of insurance to: First Diagnostic, Inc. I understand it is the intention of the provider to accept this assignment of benefits in lieu of demanding payment at the time services are rendered and that this document will allow the provider to file suit against an insurance company for payment of the insurance benefits. I understand the provider may file a lawsuit against my insurer for payment and if the provider's bills are paid or applied to a deductible I agree this will serve as a benefit to me and I authorize and request such litigation. This assignment of benefits includes the cost of transportation, medications, supplies, overdue interest and any potential claim for common law or statutory bad faith/unfair claims handling. If the insurer disputes the validity of this assignment of benefits then the insurer is instructed to notify the provider in writing within five days of receipt of this document. Failure to inform the provider shall result in a waiver by the insurer to contest the validity of this document. The undersigned directs the insurer to pay the health care provider directly without reductions & without including the patient's name on the check. To the extent the PIP insurer contends there is a material misrepresentation on the application for insurance resulting in the policy of insurance is declared voided, rescinded, or canceled, I, as the named insured under said policy of insurance, hereby assign the right to receive the premiums paid for my PIP insurance to this provider and to file suit for recovery of the premiums. The insurer is directed to issue such a refund check payable to this provider only. Should the medical bills not exceed the premium refunded, then the provider is directed to mail the patient/named insured a check which represents the difference between the medical bills and the premiums paid.

The insurer is directed by the provider and the undersigned to not issue any checks or drafts in partial settlement of a claim that contain or are accompanied by language releasing the insurer or its insured/patient from liability unless there has been a prior written settlement agreed to by the health provider and the insurer as to the amount payable under the insurance policy. The insured and the provider hereby contests and objects to any reductions or partial payments. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by the provider shall be done so under protest, at the risk of the insurer, and the deposit shall not be deemed a waiver, accord, satisfaction, discharge, settlement or agreement by the provider to accept a reduced amount as payment in full. The insurer is hereby placed on notice that this provider reserves the right to seek the full amount of the bills submitted.

If the insurer schedules a defense examination or examination under oath (hereinafter "EUO") the insurer is hereby INSTRUCTED to send a copy of said notification to this provider. The provider or the provider's attorney is expressly authorized to appear at any EUO or IME set by the insurer. The health care provider is not the agent of the insurer or the patient for any purpose.

This assignment applies to both past and future medical expenses and is valid even if undated. A photocopy of this assignment is to be considered as valid as the original. I agree to pay any applicable deductible, co-payments, for services rendered after the policy of insurance exhausts and for any other services unrelated to the automobile accident. The health care provider is given the power of attorney to endorse my name on any check for services rendered by the above provider; and to request and obtain a copy of any statements or examinations under oath given by patient.

Release of information: I hereby authorize this provider to: furnish an insurer, an insurer's intermediary, the patient's other medical providers, and the patient's attorney via mail, fax, or email, with any and all information that may be contained in the medical records; to obtain insurance coverage information (declaration sheet & policy of insurance) in writing and telephonically from the insurer; request from any insurer all explanation of benefits (EOBs) for all providers and non-redacted PIP payout sheets; obtain any written and verbal statements the patient or anyone else provided to the insurer; obtain copies of the entire claim file and all medical records, including but not limited to, documents, reports, scans, notes, bills, opinions, X-rays, IMEs, and MRIs, from any other medical provider or any insurer.

The provider is permitted to produce my medical records to its attorney in connection with any pending lawsuits. The insurer is directed to keep the patient's medical records from this provider private and confidential and the insurer is not authorized to provide these medical records to anyone without the patient's and the provider's prior express written permission.

Demand: Demand is hereby made for the insurer to pay all bills within 30 days without reductions and to mail the latest non-redacted PIP payout sheet and the insurance coverage declaration sheet to the above provider within 15 days. The insurer is directed to pay the bills in the order they are received. However, if a bill from this provider and a claim from anyone else are received by the insurer on the same day the insurer is directed not to apply this provider's bill to the deductible. If a bill from this provider and claim from anyone else is received by the insurer on the same day then the insurer is directed to pay this provider first before the policy is exhausted. In the event the provider's medical bills are disputed or reduced by the insurer for any reason, or amount, the insurer is to set aside the entire amount disputed or reduced; escrow the full amount at issue; and not pay the disputed amount to anyone or any entity, including myself, until the dispute is resolved by a Court. Do not exhaust the policy. The insurer is instructed to inform, in writing, the provider of any dispute.

Certification: I certify that: I have read and agree to the above; I have not been solicited or promised anything in exchange for receiving health care; I have not received any promises or guarantees from anyone as to the results that may be obtained by any treatment or service; and I agree the provider's prices for medical services, treatment and supplies are reasonable, usual and customary.

Caution: Please read before signing. Please ask to view a copy of our charges. If you do not completely understand this document please ask us to explain it to you. If you sign below we will assume you understand and agree to the above.

Patient's Name (please print) **Patient's Signature or Legal Guardian** **Date**

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Authorization to Release, Request, or Obtain Confidential Information

By signing this authorization, I authorize First Diagnostic, Inc. to use and/or disclose certain protected health information, (PHI), about me to or for the party or parties listed below.

I, _____, Date of Birth: _____, SSN: _____
Hereby authorize First Diagnostic, Inc. to [ ] Obtain [ ] Release medical information via, mail, facsimile, or other appropriated source

[ ] To [ ] From _____
(Person(s) of Entity(s) to receive/release requested information)

_____
(Address) (City, State, Zip) (Phone number) (Fax)

I. The individually identifiable health information to be obtained/released is: (Please place a check in the appropriate space(s)).
__ Dr. Weatherwax's Office Notes __ Financial Information __ Entire Medical chart (specify if cover to cover)
__ Massage / Physical Therapy notes __ Medication List(s)
__ X-ray, Laboratory or other Diagnostic Reports _____
__ Emergency Room Records from _____ (Dates)
__ Inpatient Records _____ (Dates)
__ Only the Records from _____ to _____ (Dates)
__ Only information related to (Specify) _____
__ Other (Specify) _____

Additional information to obtain/release: (Please place a check in appropriate space(s)).

II. The Purpose or need for the disclosure of information:
____ Continuity Medical Care ____ Legal Case ____ Personal use ____ Other, please explain_____

III. This authorization will expire on _____ (please indicate expiration date or specific event).
(If authorization is not revoked and no expiration/event is noted it will terminate 1 year form the date of signature below.)

IV. I understand that I have the right to revoke this authorization at any time and must do so in writing. I understand that the revocation will not apply to protected health information (PHI) that has already been disclosed in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer the right to contest a claim under my policy. My written revocation must be submitted to First Diagnostic, Inc.'s private officer at the address noted on this authorization.

I understand that First Diagnostic, Inc. may not condition treatment, payment, enrollment or eligibility for benefits on this signed authorization.

I understand that the release, use, or disclosure of my protected health information (PHI) carries with it the potential for re-disclosure by the recipient and the PHI may not be protected by the federal HIPPA privacy rule.

I understand I have the right to refuse this authorization and that the facility named above is released from all legal liability that may arise from the release or receipt of the information requested.

_____
(Signature of Patient of Legal Guardian) **(Relationship of Patient)** **(Date Signed)**

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AGREEMENT & LIEN TO FIRST DIAGNOSTIC, INC

I hereby give a lien and letter of protection to **First Diagnostic, Inc.** on any settlement, claim, judgement or verdict as a result of said accident/illness and to authorized and direct you as the holder of this document to guarantee and to pay directly to **First Diagnostic, Inc.** such sum as may be due and owing **First Diagnostic, Inc.** for services rendered and to be rendered both by reason of this accident/illness and by reason of other bills incurred by **First Diagnostic, Inc.**

As the holder of this document, I ask that you acknowledge receipt of this document, in writing, to **First Diagnostic, Inc.**

Please be advised accordingly, that even if you, as the holder of this document, do not desire acknowledgement receipt of this document, I direct you to honor my directions, without hesitation, for all sums owing by me. Receipt of this document by fax will verify your receipt of this document.

I acknowledge and agree that this lien and letter of protection is irrevocable until satisfaction of my financial account occurs for **First Diagnostic, Inc.** releases such lien and letter of protection.

Patient Name	**Signature**	**Date**
Attorney Name	**Signature**	**Date**
Attorney Street	**City/State**	**Zip**
Attorney phone	**Fax**	**Email**

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NOTICE OF INITIATION OF TREATMENT

Dear _____:

This letter is to inform you that our patient, _____,

is insured by your company under Policy # _____.

The above named patient began treatment at First Diagnostic Inc. on

_____. The date of accident is _____.

Thank you in advance for your assistance in this matter.

Sincerely,

Robert S. Weatherwax, DC