Automobile Accident Questionnaire

Please answer all questions completely

Dear Patient: This information is considered confidential. We need this information because we care enough to want to know, and your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. Thank you.

Name_____ Sex_____ Marital Status_____ Date of Birth_____ Age_____
Address_____ City_____ State_____ Zip_____
Home Phone_____ Cell_____ Work_____ email_____
Soc. Sec. #_____ Occupation_____
Who referred you to us?_____

Please explain in detail how your accident happened_____
_____
_____
_____

Were you knocked unconscious? _____ If yes, for how long?_____ Were you _____driver ____passenger
Were you ____ Front Seat _____ Back Seat _____ Using seat belt _____Airbags Deployed

Major Complaints_____
_____
_____

Where did you feel pain immediately after the accident?_____
Where were you taken after the accident?_____
Name of Doctor/Hosptial_____
Treatment_____ X-Rays_____Yes _____No
Length of time under his/her care?_____ Results_____
Fractures_____ Surgeries_____
Have you ever had complaints in the involved area(s) before?_____
Name/Phone of Primary Physician_____
Medications (present)_____
Mediations (previous)_____

Past medical history_____
_____

Before the injury were you capable of working on an equal basis with others your age? ____Yes ____No If no, what were the complaints?_____
Are your work and/or daily activities restricted as a result of this accident? ____Yes ____No
Since this injury are your symptoms ____Improving ____Getting Worse ____ Same

Insurance Co_____ Phone Number_____
Date of Accident_____Adjuster's Name_____ Claim Number_____
Attorney Name_____ Phone Number_____

Laura A. Weller, D.C., P.A. 2090 MLK Street North, St. Petersburg, Fl. 33704 727-894-7528

HEALTH QUESTIONNAIRE PLEASE CHECK ALL THAT APPLY

MUSCULO-SKELETAL SYSTEM

_____ Low back problems
_____ Pain between shoulders
_____ Neck problems
_____ Arm problems
_____ Leg problems
_____ Swollen joints
_____ Painful joints
_____ Stiff joints
_____ Sore muscles
_____ Weak muscles
_____ Walking problems
_____ Ruptures
_____ Broken bones

GENITO-URINARY SYSTEM

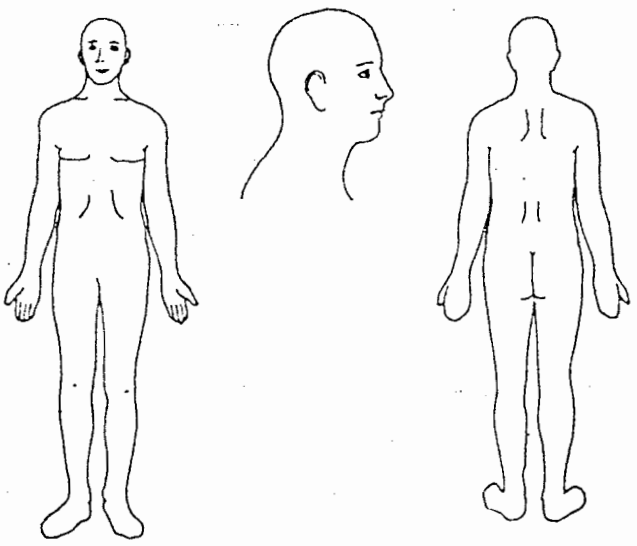
_____ Bladder trouble
_____ Excessive urination
_____ Scanty urination
_____ Painful urination
_____ Discolored urine

FEMALE

_____ Vaginal discharge
_____ Vaginal bleeding
_____ Vaginal pain
_____ Breast pain
_____ Lumps on breast

Are you pregnant?
_____ Yes _____ No

Please mark your areas of pain on the figures below.



GASTRO-INTESTINAL SYSTEM

_____ Poor appetite
_____ Excessive hunger
_____ Difficult chewing
_____ Difficult swallowing
_____ Excessive thirst
_____ Nausea
_____ Vomiting food
_____ Vomiting blood
_____ Abdominal pain
_____ Diarrhea
_____ Constipation
_____ Black stool
_____ Bloody stool
_____ Hemorrhoids
_____ Liver trouble
_____ Gall bladder problems
_____ Weight trouble

NERVOUS SYSTEM

_____ Numbness
_____ Loss of feeling
_____ Paralysis
_____ Dizziness
_____ Fainting
_____ Headaches
_____ Muscle jerking
_____ Convulsions
_____ Forgetfulness
_____ Confusion
_____ Depression

CARDIO-VASCULAR-RESPIRATORY

_____ Chest pain
_____ Pain over heart
_____ Difficult breathing
_____ Persistent cough
_____ Coughing phlegm
_____ Coughing blood
_____ Rapid heartbeat
_____ Blood pressure problems
_____ Heart problems
_____ Lung problems
_____ Varicose Veins

EYE, EAR, NOSE, AND THROAT

_____ Eye strain
_____ Eye inflammation
_____ Vision problems
_____ Ear pain
_____ Ear noises
_____ Ear discharge
_____ Hearing loss
_____ Nose pain
_____ Nose bleeding
_____ Nose discharge
_____ Difficult breathing thru nose
_____ Sore gums
_____ Dental problems
_____ Sore mouth
_____ Sore throat
_____ Hoarseness
_____ Difficult speech

_____
Patient's Signature

DO NOT WRITE BELOW THIS LINE

Patient accepted? Yes_____ No_____ Doctor's signature_____

ABOUT YOU

Name: _____ File #: _____

What is your current weight: _____ lbs., and height, _____ Ft. _____ In..

Please describe your condition:

_____

_____

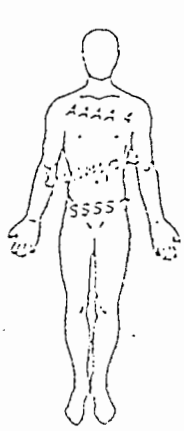
Signature: _____ Date: _____

SHOW US WHERE IT HURTS

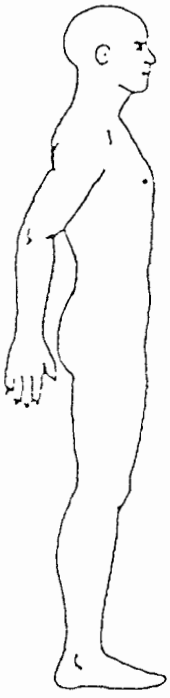
Please mark area(s) of injury or discomfort as shown in the example below. Mark all areas with the appropriate symbols and indicate the degree of pain using a scale from 1 (discomfort) to 10 (extreme pain).

Description →	Numbness	Pins & Needles	Burning	Aching	Stabbing
Symbol →	NNNN	PPPP	BBBB	AAAA	SSSS

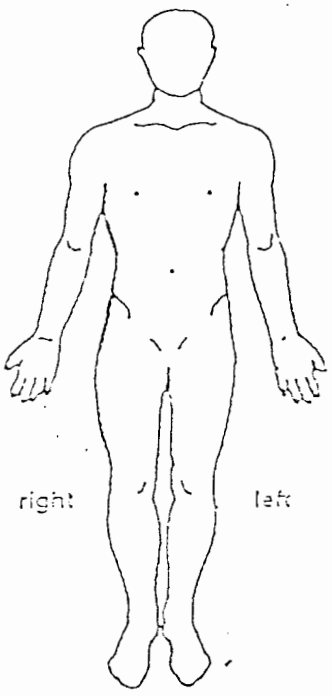
◯ Circle any area of pain not represented by a symbol.



Example

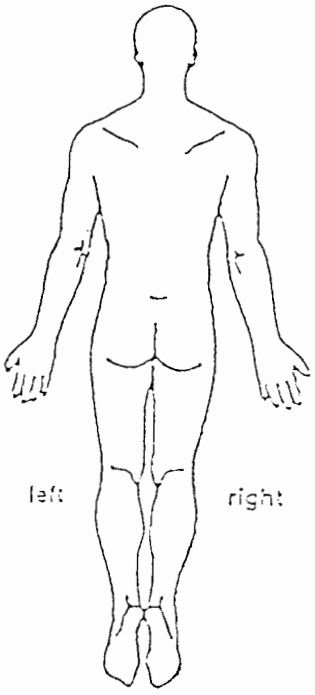


Right



right left

Front



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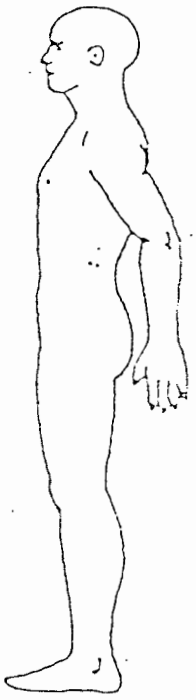
Back



Left

DOCTOR'S NOTES

_____

_____

_____

_____

_____

PLEASE RECYCLE SO THAT WE MAY PRESERVE THE HEALTH OF OUR PLANET

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

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.

LAURA A. WELLER, D.C., P.A.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORAMTION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect _____ and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USERS AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example;

Treatment: We may use or disclose you health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with other healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payments or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or discloses permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of his Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclose of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on determination using our professional judgment disclosing only health information that is directly

relevant to the person's involvement in your healthcare. We will also use our professional judgment and out experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you$_____ for each page, $_____ per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclose Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purpose, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request thus accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure for your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communications: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must may your request in writing) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a compliant with our practice, our contact Bernadette Bell, our Privacy Office, at 2090 MLK Street North, Saint Petersburg, FL 33704. All complaints must be submitted in writing. **You will not be penalized for filing a compliant.**

Receipt of Notice of Privacy Practices
Written Acknowledgement form

Laura A. Weller, D.C., P.A.

I, _____ (Patient) have read a copy of

LAURA A. Weller, D.C.,P.A.'s Notice of Patient Privacy Practices.

_____ _____

Signature of Patient/Parent/Legal Guardian Date

I WILL BE PAYING TODAY BY:
CASH CREDIT CARD CHECK

FINANCIAL RESPONSIBILTY

ALL PATIENTS: I AGREE BE TO FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCURRED AT THIS OFFICE, INCLUDING MY INSURANCE DEDUCTIBLE, CO-PAYMENT, AND ANY SERVICES DENIED BY MY INSURANCE COMPANY.

X_____X_____
PATIENT SIGNATURE DATE

FILING INSURANCE

IF YOU ARE FILING ANY INSURANCE: I AUTHORIZE THIS OFFICE TO RELEASE ANY INFORMATION PERTINENT TO MY CASE TO ANY INSURANCE, ADJUSTER, AND ATTORNEY INVOLVED IN THIS CASE; AND HEREBY RELEASE THIS OFFICE ANY CONSEQUENCE THEREOF.

X_____X_____
PATIENT SIGNATURE DATE

ASSIGNMENT OF BENEFITS

IF YOU WOULD LIKE OUR OFFICE TO CHECK ON THE POSSIBLITY OF ACCEPTING ASSIGNMENT ON YOUR SERVICES: I HEREBY INSTRUCT AND DIRECT MY INSURANCE COMPANY TO PAY BY CHECK MADE OUT AND MAILED DIRECTLY TO DR. LAURA WELLER, D.C., P.A. THE PROFESSIONAL OR MEDICAL BENEFITS ALLOWABLE, AND OTHERWISE PAYABLE TO ME UNDER MY CURRENT INSURANCE POLICY AS PAYMENT TOWARD THE TOTAL CHARGES FOR PROFESSIONAL SERVICES RENDERED BY THIS OFFICE. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY; HOWEVER, THE PAYMENTS SHALL NOT EXCEED MY INDEBTEDNESS TO THIS OFFICE.

X_____X_____
PATIENT SIGNATURE DATE

Patient Questionnaire

I. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operation):

_____

_____

II. Please list the family members or significant others, if any, whom we may inform about your medical conditions ONLY IN AN EMERGENCY:

Name _____ Phone Number_____
Name _____ Phone Number _____

III. Please print the address of where you would like your billing statements and/ or correspondence from our office to be sent if other than your home:

_____

_____

IV. Please indicate if you want all correspondence from our office sent in a sealed envelope marked "Confidential":

YES_____ NO _____

VI. Can confidential messages (i.e., appointment reminders) be left on your telephone answering machine, voicemail or email?

YES_____ NO _____

V. Please print the telephone number where you want to receive calls about your appointments, lab and x-rays results, or other health care.

Phone number_____
Email address_____

PATIENT NAME_____(guardian if under 18)

PATIENT SIGNATURE_____ DATE_____