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.**

INITIAL EVALUATION

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.

Pensacola Chiropractic and Dry Needling

Authorization for Release of Records

Date_____

I hereby authorize the release of my medical records and request that they be transferred from:

From: _____

Phone#:_____ Fax #:_____

Address: _____

City: _____State _____Zip _____

TO: Pensacola Chiropractic and Dry Needling
24 N. Tarragona Street
Pensacola, Florida 32501
Phone 448-240-2902
pensacolachiropractic@gmail.com

Records to be Disclosed:

_____

_____

Patient's Name: _____

DOB: _____ Date of Records_____

Patient's Signature_____

Confidentiality Statement:
This Electronic Message contains information from Shores Chiropractic & Wellness and is confidential or privileged. The information is intended to be for the use of the individual or entity named above. If you are not the intended recipient, be aware that any disclosure, copying, distribution or use of the contents of this message is prohibited. If you have received this electronic message in error, please notify us immediately by telephone at 850-819-8083.

Pensacola Chiropractic and Dry Needling

Patient Information

Name:_____ Sex:_____ Date:_____

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

Phone:(Primary):_____ (Secondary):_____ Email:_____

Date of Birth:_____ Age:_____ Social Security #:_____

Occupation:_____ Employer's Name:_____

Emergency Contact:_____ Phone:_____ Relationship:_____

Previous Chiropractic Care:_____ Date of Last Treatment: _____

Would you be willing to accept text reminders of upcoming appointments? Circle one: YES NO

History of Present Illness

Primary complaint:_____ When did symptoms begin?_____

Describe the pain. (Circle all that apply): Dull Aching Sharp Shooting Burning Throbbing Deep Stabbing Nagging

Does this complaint radiate, travel or shoot to any areas of your body? If so, where? Arm L or R Leg L or R

Grade the intensity/severity (0-10) of your pain: (No complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible pain)

How frequent is the complaint present?_____ Does the pain wake you up at night?_____

Does anything aggravate your symptoms?_____

Does anything make your complaint better?_____

List any doctors/treatment you have seen for this condition:_____

Secondary complaint:_____ When did symptoms begin?_____

Describe the pain. (Circle all that apply): Dull Aching Sharp Shooting Burning Throbbing Deep Stabbing Nagging

Does this complaint radiate, travel or shoot to any areas of your body? If so, where? Arm L or R Leg L or R

Grade the intensity/severity (0-10) of your pain: (No complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible pain)

How frequent is the complaint present?_____ Does the pain wake you up at night?_____

List any doctors/treatment you have seen for this condition:_____

Patient Signature: _____ Date: _____

Pensacola Chiropractic and Dry Needling

Previous Health History

Current and Past Medical History

Please list any current medical conditions you have:_____

Please list any previous medical conditions you have:_____

Please list any previous injury or traumas:_____

Do you have any medical/surgical implants?_____

Females only: Is there a chance you may be pregnant?_____If yes, how far along?_____

Family History

List any medical conditions of your mother:_____

List any medical conditions of your father:_____

Surgical History

Surgery	Year

Social History

Do you drink Alcohol?	YES	NO	Average consumption: _____
Do you drink Caffeinated products?	YES	NO	Average consumption: _____
Do you smoke cigarettes?	YES	NO	Daily use in packs per day: _____
Are you a former smoker?	YES	NO	Estimated quit date: _____
Do you exercise?	YES	NO	How many times a day?

Additional Information: _____

Medication List

MEDICATION	STRENGTH/DOSE	DATE STARTED

Patient Signature: _____Date: _____

Please Circle ALL That Apply

GENERAL SYMPTOMS
Headache
Fever
Chills
Sweating
Fainting
Dizziness
Loss of Sleep
Fatigue
Nervousness
Loss of Weight
Allergy
Wheezing
Neuralagia
Numbness or Pain in
Arms, Hands or Legs

GASTROINTESTINAL SYMPT.
Poor Appetite
Difficult Digestion
Excessive Hunger
Belching of Gas
Nausea
Vomiting
Vomiting of Blood
Pain Over Stomach
Distention of Abdomen
Constipation
Diarrhea
Liver Trouble
Gall Bladder Trouble
Jaundice
Colitis

E.N.T.
Failing Vision
Nearsightedness
Farsightedness
Crossed Eyes
Eye Pains
Deafness
Earache
Noises
Nose Bleeds
Nasal Obstruction
Sore Throat
Hay Fever
Asthma
Dental Decay
Gum Trouble
Frequent Colds
Enlarged Thyroid
Nasal Drainage
Tonsillitis
Sinus Infection
Enlarged Glands

CARDIO-VASCULAR
Rapid Beating Heart
Slow Beating Heart
High Blood Pressure
Low Blood Pressure
Pain Over Heart
Previous Heart Attack
Hardening of Arteries
Swelling of Ankles
Poor Circulation
Previous Stroke

MUSCLE & JOINT SYMP.
Neck Pain
Low Back Pain
Swollen Joints
Tremors
Foot Trouble
Painful Tail Bone
Hernia
Spinal Curvature
Poor Posture

RESPIRATORY
Chronic Cough
Spitting up Phlegm
Spitting up Blood
Chest Pain
Difficult Breathing

GENITOURINARY SYMPT.
Frequent Urination
Painful Urination
Bloody Urine
Kidney Infection or Stones
Bed Wetting
Inability to Control Urine
Prostate Trouble

SKIN
Skin Eruptions
Itching
Bruising
Dryness
Sensitive Skin
Varicose Veins
Hives or Allergy

FOR WOMEN ONLY
Painful Menstrual Periods
Hot Flashes
Irregular Cycle
Cramps or Backache
Menopausal Symptoms

Patient Signature: _____ Date: _____

Concussion Symptom Checklist

Patient Name: _____ **Today's Date:** _____ **Hours of Sleep** Last Night: _____

Grade the following **22 symptoms with a score of 0 through 6.**

Note that these symptoms may not all be related to a concussion.

	None	Mild		Moderate		Severe	
Headache	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
"Pressure in head"	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Neck Pain	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Nausea or Vomiting	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Dizziness	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Blurred Vision	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Balance Problems	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Sensitivity to light	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Sensitivity to noise	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Fatigue or low energy	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Feeling slowed down	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Feeling like "in a fog"	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Difficulty concentrating	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Difficulty remembering	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Drowsiness	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Trouble falling asleep	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
"Don't feel right"	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Confusion	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
More emotional than usual	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Irritability	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Sadness	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Nervous or Anxious	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
TOTAL SUM OF EACH COLUMN	0						
TOTAL SYMPTOM SCORE *(Sum of all column totals)*							

Do symptoms worsen with physical activity? Yes ☐ No ☐ Not Applicable ☐

Do symptoms worsen with thinking/cognitive activity? Yes ☐ No ☐ Not Applicable ☐

Activity Level: Over the past two days, compared to what I would typically do, my level of activity has been _____% of my normal level.

X_____

Signature of Patient / Parent or Guardian

Rev 12/2020

Pensacola Chiropractic and Dry Needling

Informed Consent

Informed Consent To Chiropractic Examination, Diagnostic Procedures, Chiropractic Adjustments and Care

I hereby request and consent to the performance of: physical examinations and evaluations required to be performed to diagnose my condition(s), of chiropractic adjustments and other chiropractic procedures, including various modes of physical medicine, any associated nutrition supplements, home healthcare products, on me (or on the patient named below for whom I am legally responsible) by or under the supervision of the doctor of chiropractic named below and/or other licensed doctors of chiropractic: who now or in the future treat me while employed by **Pensacola Chiropractic and Dry Needling**, working, or associated with, or serving as back-up for the doctor of chiropractic named below, including those working at any of the listed **Pensacola Chiropractic and Dry Needling.**

I have had an opportunity to discuss with the Doctor of Chiropractic named below and/or with other office or clinic personnel, the nature and purpose chiropractic adjustments and other procedures as well as home healthcare products and nutrition supplementation, I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fracture, disc injuries, strokes, dislocations, sprains, swelling and bruising. 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 judgement during the procedure which the doctor feels at the time, based upon the facts then known, what is in my best interests.

I have read, or had read to me, the above consent. I have also had an 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(s) and for any future condition(s) for which I seek treatment at **Pensacola Chiropractic and Dry Needling**.

To be completed by patient:

_____

Print Patient's Name

_____

Signature of Patient

_____

Date

To be completed by patient's representative, if necessary, e.g., if patient is a minor or disabled.

Patient's name: _____

Representative's Name: _____

Signature of Representative: _____

Pensacola Chiropractic and Dry Needling

Consent for Purposes of Treatment, Payment, and Healthcare Operations

I acknowledge that the Chiropractic Office of **Pensacola Chiropractic and Dry Needling** "Notice of Privacy Practices" is available to me upon request.

I understand I have a right to review the Chiropractic Office of **Pensacola Chiropractic and Dry Needling** "Notice of Privacy Practices" prior to signing this document. The "Notice of Privacy Practices" describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations, and describes my rights and the duties of the Chiropractic Offices of Shores Chiropractic & Wellness, with respect to my protected health information. This policy is also provided on request at the main administration desk of the practice.

The Chiropractic Office of **Pensacola Chiropractic and Dry Needling** reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

PATIENT SIGNATURE _____DATE _____

Pensacola Chiropractic and Dry Needling

Release Of Records / Payment Agreement
And Assignment Of Benefits

Patient to sign prior to any medical treatment to be performed

Patient: _____

I hereby authorize: Pensacola Chiropractic and Dry Needling, my Health Care Provider/Facility, **to release any and all medical information** to the above-named insurance carrier(s), or to my designated attorney, now or in the future, and/or to my physician(s), if necessary, for the purposes of payment of my medically related outstanding debts, administration and evaluation, utilization review and financial audit. This, authorization remains valid and effective from the date of this signing until revoked in writing, to both my insurance carrier and to this provider of services. This authorization is given pursuant to Florida Statute 456.057 and HIPAA regulations. I understand that Florida Statute 456.057 (10) makes clear that any third party to whom records are disclosed is prohibited from further disclosing any information in the medical records are without the expressed written consent of the patient or the patient's legal representatives.

Payment Agreement: All professional services rendered are charged to the patient and the patient is responsible for all fees, regardless of insurance coverage. I understand I am responsible to the above -mentioned facility/provider, for charges not covered by this assignment, including deductibles & co-payment requirements by my insurance policy or certificate. I further agree that in the event of non-payment, I will bear the expenses of collection and /or court costs, and reasonable legal fees, should this be required. I understand if my commercial insurance has not paid the bill within 60 days of my visit(s), for my services received by my provider /facility, I am responsible, and I will then make whatever arrangements are necessary & available to me to pay all unpaid charges.

Assignment of Benefits: I hereby assign to Pensacola Chiropractic and Dry Needling, my health Care Provider /Facility, all money to which I am entitled for medically related expenses, received at, or through the above-mentioned facility. The payment shall not exceed my indebtedness. Any payment that facility/health care provider, received by the insurance company, beyond my indebtedness shall be refunded to me, when my outstanding bill(s) with them are paid.

I understand I may request a copy of any or all of my medical records for a reasonable fee or a fee allowed by State Statute or Workers' Compensation Statute. Any copy of this document shall be as valid as if it were the original. I have read the above authorization to release medical records, assignment of benefits, and payment agreement, and hereby acknowledge that I understand it. The payment agreement portion of this instrument may not be revoked in writing or otherwise.

PATIENT SIGNATURE _____DATE _____