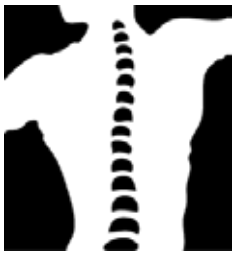
# DeLand Chiropractic & Spinal Decompression

## New Patient Application



The information that you will provide on this form will play a key role in determining your ability to be accepted as a patient in this office. Your qualification as a patient is determined by the nature of your injury, the doctor's ability to treat your condition, your commitment to getting well, your family and/or spousal support, your ability to pay for recommended care, and your willingness to make sacrifices to ensure your proper healing. Please be sure that you answer all questions. Thank you – Dr. Gordon's Staff.

**Name: _____ Sex: Marital Status:**
**Address: _____ City:_____**
**State: _____ Zip Code: _____ Date of Birth: _____ SSN: _____**
**Home Phone: _____ Work Phone: _____ Cell Phone:_____**
**Employer: _____ Occupation: _____**
**Age:_____ Email:_____ Hobbies:_____**
**Name Of Your Medical Doctor And May We Contact Them?:_____**
**Race: _____ Ethnicity: _____ Are You Pregnant?**
**How Did You Hear About Our Clinic: _____ Preferred Language:_____**
**Emergency Contact Name & Phone #: _____ Relation:_____**

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**What Is Your Chief Complaint?**

**_____**
**Date Of Your Injury? _____ Work Related? Auto Accident Related?**
**Have Had Chiropractic Care Before? How About Acupuncture?**

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**Do You Smoke Cigarettes? Currently: Formerly: Never___**
**Do You Drink Alcohol? If Yes, How Often?_____ How Much? _____**
**Do You Use Recreational Drugs? What Type?_____**

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**Do You Have A <u>Family History</u> Of: (check all that apply)**

**Heart Disease Arthritis Hypothyroid Diabetes ( Type I Type II) Seizures**
**Stroke Osteoporosis Rare Genetic Disease (type) _____**
**Cancer (type) _____**

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**Do <u>You</u> Have A Past Medical History Of: (check all that apply)**

| | | | |
|---|---|---|---|
| **Lower Back Pain** | **Stroke** | **Thyroid Disease** | **Diabetes ( Type I II)** |
| **Sciatic Pain** | **Birth Control Pills** | **Auto Accidents** | **Hormone Replacement** |
| **Hypertension** | **Head Trauma** | **Heart Attack** | **Osteoporosis** |
| **Neck / Back Trauma** | **Blood Clots** | **Balance Problems** | **Dizziness** |
| **Cancer (type)_____** | | **Numbness On ½ Of Your Face or Body** | |

**Will you be filing through insurance? If yes, please provide insurance company name and member ID number. If not, please move on to the next page.**

**Insurance Co. _____ Member ID _____**

**Please List Any Allergies, Surgeries, Accidents, Falls, Pregnancies, Or Hospitalizations:**

**List All Medications & Dietary Supplements That You Are Taking (List Dosage & Frequency):**

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**When discussing possible treatment options, do you prefer: _____**

**Our team has four goals that drive our practice and quality of care. All are important to us, but out of these values, which would be your priority for today's visit? _____**

**Are you willing to do your part to help us achieve your goal? _____**

**Looking at this list, would any of these be a possible barrier to you when considering treatment?**
**___Fear ___Time ___Budget ___Trust**

**IF YOU HAVE ANY QUESTIONS OR CONCERNS WITH THE INFORMATION BELOW, IT IS YOUR RESPONSIBILITY TO ADDRESS THOSE CONCERNS WITH THE DOCTOR.**

**Informed Consent, Financial Responsibility, and Assignment of Benefits:**

**As with all medical or chiropractic treatments, I acknowledge and understand that there are inherent risks to receiving care including but not limited to sprains, strains, fractures, dislocations, muscle pain, bruising, and stroke. Statistically, these risks are extremely rare and uncommon (1 in 1 – 5 million in the case of strokes), especially when compared to those risks related with alternative treatment options for my condition including the use of over the counter analgesics, prescription drugs, and surgery. Due to that fact, I will not hold the physician or staff responsible for those risks listed above. In addition, I understand that the risk and danger of allowing my condition to go untreated may lead to further deterioration of my condition with possible serious and/or permanent consequences to my health. I acknowledge and understand that the use of certain prescription medications (i.e. birth control pills, hormone replacement, aspirin, Coumadin), illicit drug or alcohol use, and cigarette smoking may increase these risks and inhibit proper healing. I also understand that if I am accepted as a patient, and if I receive care, that I am the ultimate responsible party on my account regardless of the actions of any 3rd party carrier (insurance company). I agree that should my account become delinquent, I will be responsible for all collection costs, including but not limited to the outstanding balance, attorney fees, court costs, collection agency fees, and interest at the rate of 18% per annum(1.5% per month). By signing below, I also agree to allow the doctor to share any and all medial reports and findings with my primary care physician, and I allow the doctor to use my name and case history in monthly newsletters and/or patient testimonial booklets. Lastly I understand that any physician at DeLand Chiropractic & Spinal Decompression cannot evaluate, examine, x-ray, diagnose, or treat me for my presenting condition without my signature below. By signing below I acknowledge that I have weighed the risks versus benefits of treatment, and I give the doctor consent to treat me for my condition.**

**Print Name:_____ Date:_____**

**Signature: _____**

**PAIN DISABILITY QUESTIONNAIRE**

Patient Name _____Date_____

Instructions: These questions ask your views about how your pain now affects how you function in every day activities. Please answer every question and mark the ONE number on EACH scale that best describes how you feel.

1. Does your pain interfere with your normal work inside and outside the home?

Work Normally — Unable to work at all

0 1 2 3 4 5 6 7 8 9 10

2. Does your pain interfere with personal care (such as washing, dressing, etc.)?

Take care of myself completely — Need help with all my personal care

0 1 2 3 4 5 6 7 8 9 10

3. Does your pain interfere with your traveling?

Travel anywhere I like — Only travel to see doctors

0 1 2 3 4 5 6 7 8 9 10

4. Does your pain affect your ability to sit or stand?

No problems — Can not sit/stand at all

0 1 2 3 4 5 6 7 8 9 10

5. Does your pain affect your ability to lift overhead, grasp objects or reach for things?

No problems — Can not do at all

0 1 2 3 4 5 6 7 8 9 10

6. Does your pain affect your ability to lift objects off the floor, bend, stoop or squat?

No problems — Can not do at all

0 1 2 3 4 5 6 7 8 9 10

7. Does your pain affect your ability to walk or run?

No problems — Can not walk/run at all

0 1 2 3 4 5 6 7 8 9 10

8. Has your income declined since your pain began?

No decline — Lost all income

0 1 2 3 4 5 6 7 8 9 10

9. Do you have to take pain medication every day to control your pain?

No medication needed — Need medication throughout the day

0 1 2 3 4 5 6 7 8 9 10

10. Does your pain force you to see doctors much more often than before your pain began?

Never see doctors — See doctors weekly

0 1 2 3 4 5 6 7 8 9 10

11. Does your pain interfere with your ability to see the people who are important to you?

No problem — Never see them

0 1 2 3 4 5 6 7 8 9 10

12. Does your pain interfere with recreational activities and hobbies?

No interference — Total interference

0 1 2 3 4 5 6 7 8 9 10

13. Do you need the help of your family and friends to complete everyday tasks?

Never need help — Need help all the time

0 1 2 3 4 5 6 7 8 9 10

14. Do you now feel more depressed, tense, or anxious than before your pain began?

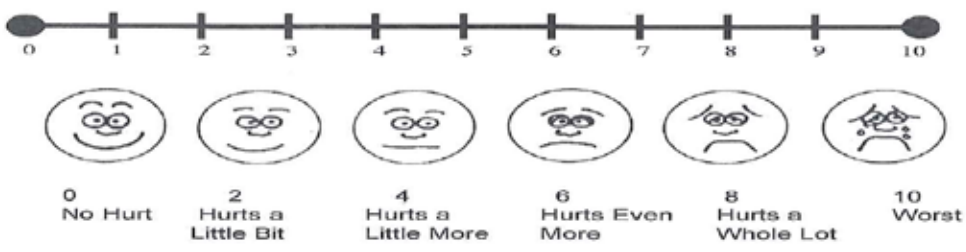
No depression/tension — Severe depression/tension

0 1 2 3 4 5 6 7 8 9 10

15. Are there emotional problems caused by your pain that interfere with your family, social and or work activities?

No problems — Severe problems

0 1 2 3 4 5 6 7 8 9 10



## ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
## DELAND CHIROPRACTIC & SPINAL DECOMPRESSION

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.

By checking the lines below I authorize being contacted for practice reminders, birthday greetings or promotions by: Mail ☐ Email ☐ Telephone ☐ Text Message ☐

By checking the box below I authorize the doctor to personally discuss with me products and services that may benefit my health or condition. ☐

_____ _____

Patient Name (please print) Date

_____

Name of Parent, Guardian or Patient's legal representative

_____

Signature of Patient, Parent, Guardian or Patient's legal representative

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.

## HIPAA Compliant Authorization for Release of Patient Information

Patient Information

Name:_____ Date of Birth: _____

Section II: Authorization for Release of Patient Information: I, or my authorized representative, hereby authorize _____ (name of entity holding the requested records) and their respective employees, agents and subcontractors to disclose my Personal Health Information (PHI) and Insurance Record to: Deland Chiropractic & Spinal Decompression.

Section III – Specific Information to be Released:

☐ Please release my Medical Record from (insert date) _____ to (insert date) _____.

☐ Please release my entire Medical Record, including patient histories, office notes (excluding psychotherapy notes; including test results, radiology studies, films, referrals, consults, billing records, insurance records sent by other health care providers.

☐ Other: (please explain) _____

Reason for release of information:

☐ Include: (Indicate by Initialing) _____ Alcohol/Drug Treatment _____ Mental Health Information _____ HIV-Related Information

☐ At the request of the individual

☐ Other: _____

Signature:_____ Date of Birth:_____

Section IV: I understand that Section 460.413 (1) (m), Florida Statutes, and Board of Chiropractic Medicine Rule 64B2-17.006 require chiropractic physicians to retain records and x-rays for at least four years. Therefore, a chiropractic physician receiving a request for a patient's x-ray within that four-year period must retain the x-ray and provide a copy of it in lieu of the original x-ray. I, further, understand that Section 456.057 (18), Florida Section 457.057 (16), Florida Statutes, authorizes a health care practitioner or patient records owner furnishing copies of reports or records or making the reports or records available for digital scanning pursuant to this section to charge no more than the actual cost of copying, including reasonable staff time, or the amount specified in administrative rule by the appropriate board, or the department when there is no board. The Board of Chiropractic Medicine Rule 64B-17.0055, Florida Administrative Code, authorizes chiropractic physicians to charge patients $1.00 per page for the first 25 pages, and 25 cents for each page in excess of 25 pages. The Board of Chiropractic Medicine Rule defines the reasonable costs of reproducing x-rays, and such other special kinds of records as the actual costs. The phrase reasonable cost; means the cost of the material and supplies used to duplicate the record, as well as the labor costs and overhead costs associated with such duplication. The Board of Chiropractic Medicine Rule 64B-17.0055, Florida Administrative Code, authorizes chiropractic physicians to charge people who are not patients authorized to seek copies of my patient records $1.00 per page. I understand that the HIPAA regulations authorize the practice to charge the cost of labor and hardware onto which the records are electronically copied unless the Board of Chiropractic Medicine sets lower costs. I understand that there is no cost for transmitting the electronic records by email.
This authorization will be in effect for five years from the date signed, unless you indicate a shorter period below:
Date or event on which this authorization will expire: _____.
If an authorized representative is making this request, please provide your information below and attach certifying documentation of your status as the authorized representative, such as a Power of Attorney or Guardianship papers.
AUTHORIZED REPRESENTATIVE
By signing this form, I am confirming that it accurately reflects my wishes. In addition, I have kept a copy of this form for my records.

_____ _____
Signature of Member or Authorized Representative Date

Name: _____

Relationship to Patient (if applicapable):_____

DeLand Chiropractic & Spinal Decompression
Dr. Jeremy M. Gordon & Dr. Michael Munson

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DeLand, FL 32720

Phone (386)734-9995
Fax (386)734-9949

*Nutritional Counseling* *DRX Spinal Decompression* *Chiropractic* *Acupuncture* *Comprehensive Blood Analysis*

**ASSIGNMENT, LIEN AND AUTHORIZATION OF BENEFITS**

I,_____, hereby authorize and direct you, my insurance company, and/or attorney, to pay directly to DeLand Chiropractic and Spinal Decompression such sums as may be due and owing this office for services rendered me, both by reason of accident or illness, and by reason of any other bills that are due this office, to withhold such sums from any disability benefits, medical payments benefits, "no-fault benefits", health and accidental benefits, workmen's compensation benefits, or any other insurance benefits obligated to reimburse me or from my settlement, judgment or verdict on my behalf as may be necessary to adequately project this office. I hereby further give a lien to said office against any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness from which I have been treated by this office. Signature of this document authorizes the release of any medical or other information necessary to process this claim, and I request payment of government benefits and authorize payment of medical benefits to the undersigned physician or durable medical goods supplier for goods or services provided. This is to act as an assignment of my rights and benefits to the extent of the office's services provided.

In the event my insurance company which is obligated to make payments to me for the charges incurred at this office refuses to make such payments, upon demand of this office, I hereby assign and transfer to this office any and all causes of action that I might have or that might exist in my favor against such company and authorize this office to prosecute said cause of action either in my name or in the office's name and further I authorize this office to compensate settle or otherwise resolve said claim or cause of action as they see fit.

DeLand Chiropractic and Spinal Decompression accepts the aforesaid assignment and hereby notifies any insurer issuing payment that DeLand Chiropractic and Spinal Decompression objects to any repricing or reduction of billed amounts unilaterally made by any insurer. Any such reduced payments issued by any insurer are accepted under protest and without waving any right of the provider to pursue all legal remedies against the insurer.

I, _____, understand that I remain personally responsible for the total amounts due the office for their services that are not paid by the insurance company.

I, _____, authorize the office to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under this assignment, lien and authorization. I agree that the above-mentioned office be given power of attorney to endorse/sign my name on any and all checks for payment of my doctor (medical) bill.

Please read this document completely before signing. If you do not understand this document or have any questions about this document, please ask us to explain it to you. If there is any portion of this document that you do not wish to authorize, we will remove that portion from this document. Your signature below is your agreement you fully understand this document and you fully agree to the terms of this document.

_____ _____

***Patient or guardian's signature*** ***Date***

_____ _____

***Witness to patient or guardian's signature*** ***Date***

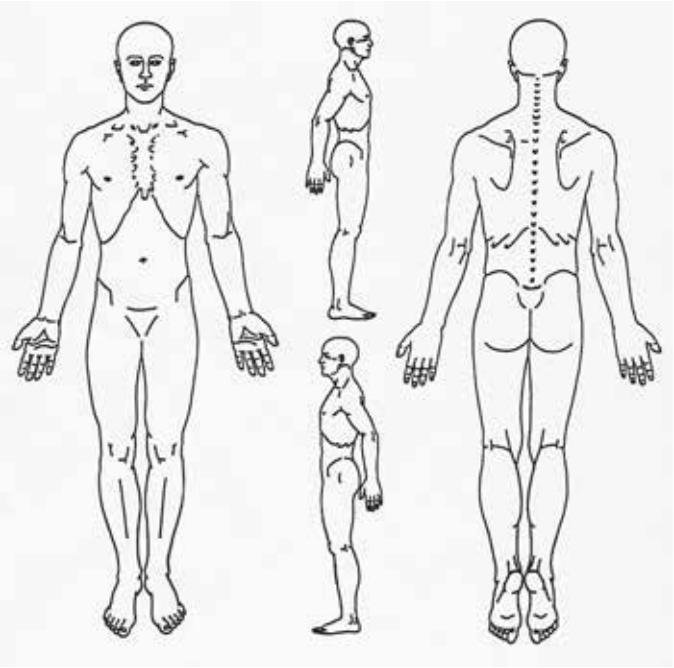
**Name:** _____ **Date:** _____

Auto Accident Details:

1. Were you the □ driver □ front seat passenger □ rear seat passenger □ motorcycle rider
2. The make of the vehicle that you were in during the accident was a _____
3. The make of the other vehicle involved in the accident was a _____
4. Your estimated speed at the time of the accident was _____
5. The time of day of the accident was □ daytime □ dawn □ dusk □ dark
6. Road conditions at the time of the accident were □ dry □ wet □ snow □ ice
7. Were you wearing a seatbelt at the time of the accident? □ yes □ no Did an airbag deploy? □ yes □ no
8. Was your head turned at the time of the accident? □ yes □ no
9. If you were the driver, was your foot applied on the brake at the time of the accident? □ yes □ no
10. Did you strike any part of the interior of the vehicle during the accident? □ yes □ no
11. Did you lose consciousness as a result of the accident? □ yes □ no If yes, how long? _____
12. Was a police report made at the accident scene? □ yes □ no Who was found to be "at fault"? _____
13. Estimated property damage to your vehicle _____
14. After the crash did you go □ home □ emergency room. Mode of transportation? _____
15. What were your primary symptoms after the accident? _____
16. Have you seen any other physicians or received treatment for your injuries anywhere else? □ yes □ no
    If yes, where? _____
17. Please describe and diagram your accident below:

Please mark the figures below with the letters that best describe the sensation or pain you are feeling. Please mark areas where pain radiates or spreads with a ↑, ↓, or ←, → arrow to indicate the direction of radiating pain. (Include all affected areas)

| | | | | | |
|---|---|---|---|---|---|
| >>> | **Ache** | XXX | **Burning** | - - - - | **Throbbing** |
| === | **Numbness** | /////// | **Stabbing** | oooo | **Pins & Needles** |



**Severity of Pain**

List region of pain and circle severity (1=least, 10=greatest)

1.

2.

3.

4.

Name_____ Date _____

## Instrumental Activities of Daily Living Scale (I.A.D.L.)

Choose the option below that best describes your ability:

| | |
|---|---|
| **1. Ability to use the telephone:**<br>a. Operates telephone on own initiative. Able to look up and dial numbers, etc.<br>b. Dials a few well-known numbers.<br>c. Answers telephone, but does not dial.<br>d. Does not use telephone at all. | **2. Laundry:**<br>a. Does personal laundry completely.<br>b. Launders small items.<br>c. All laundry must be done by others. |
| **3. Shopping:**<br>a. Takes care of all shopping needs independently.<br>b. Shops independently for small purchases.<br>c. Needs to be accompanied on any shopping trip.<br>d. Completely unable to shop. | **4. Mode of transportation:**<br>a. Travels independently on public transportation or drives own car.<br>b. Arranges own travel via taxi, but does not otherwise use public transportation.<br>c. Travels on public transportation when accompanied by another.<br>d. Travel limited to taxi or automobile with assistance of another.<br>e. Does not travel at all. |
| **5. Food Preparation:**<br>a. Plans, prepares and serves adequate meals independently.<br>b. Prepares adequate meals if supplied with the ingredients.<br>c. Heats, serves and prepares meals or is able to prepare meals, but does not maintain adequate diet.<br>d. Needs to have meals prepared and served. | **6. Responsibility for own medications:**<br>a. Is responsible for taking medication in correct dosages at correct time.<br>b. Takes responsibility if medication is prepared in advance in separate dosage.<br>c. Is not capable of dispensing own medication. |
| **7. Housekeeping:**<br>a. Maintains house alone or with occasional assistance.<br>b. Performs light daily tasks such as dish washing, bed making, etc.<br>c. Performs light daily tasks unsuccessfully.<br>d. Needs help with all home maintenance tasks.<br>e. Does not participate in any housekeeping tasks. | **8. Ability to handle finances:**<br>a. Manages financial matters independently (budgets, check writing, etc.<br>b. Manages day-to-day purchases, but needs help with major purchasing, etc.<br>c. Incapable of handling money. |

## Katz Basic Activities of Daily Living (ADL) Scale

Check "yes" if you are able to do the task independently or "no" if you are unable.

| | YES | NO |
|---|---|---|
| 1. Bathing – Able to bath without assistance. | | |
| 2. Dressing – Able to dress without assistance. | | |
| 3. Toileting – Able to use toilet or urinal without assistance. | | |
| 4. Transferring – Moves in and out of bed or chair alone. | | |
| 5. Continence – Controls bowel and bladder completely by self | | |
| 6. Feeding – Feeds self without assistance. | | |

# AUTO ACCIDENT INFORMATION

Patient's Name: _____

**INSURANCE**

Patient's Insurance Company Name: _____

Claim Adjuster's Name: _____

Claim Adjuster's Phone Number and Ext: _____

Date of Injury: _____

Insurance's Medical Claim Number: _____

Insurance Policy Number: _____

Insurance Deductible: _____

Policy Type: 80/20 or 100%

**ATTORNEY**

Attorney Name: _____

Attorney Phone Number: _____

Legal Assistant/Case Manager Name: _____

Legal Assistant/Case Manager Phone Number: _____

**Pursuant to FL Statute Chapter 627.736 – Required personal injury protection benefits: exclusions: priority: claims –

a) Medical Benefits – Eighty percent of all reasonable expenses for necessary medical, surgical, X-ray, dental and rehabilitative services, including prosthetic devices and medically necessary ambulance, hospital, and nursing services if the individual receives initial services and care pursuant to subparagraph 1 – within 14 days after the motor vehicle accident.

The remaining twenty percent (20%) of all reasonable expenses will be the responsibility of the patient receiving care unless an attorney is representing the patient for injuries and remaining fee is paid out of a final settlement. If an attorney is not representing the patient or a settlement is not reached, then the patient is fully responsible for all outstanding charges regardless of accident liability or insurance status.

Patient Signature: _____ Date: _____