OCEAN CHIROPRACTIC CENTER
OF AVENTURA

ACCIDENT HISTORY

FULL NAME_____
ADDRESS_____
_____
DATE OF BIRTH_____
SS#_____
MARITAL STATUS: M W Sep D Sin

DATE_____
PHONE NUMBER #_____
DATE OF ACCIDENT _____
TIME OF ACCIDENT_____
CLAIM NUMBER#_____
EMAIL ADDRESS_____

☐ AUTO ACCIDENT
☐ PERSONAL INJURY
☐ WORKER'S COMPENSATION
☐ OTHER_____

If worker's compensation please complete following:
EMPLOYER_____
OCCUPATION_____
TELEPHONE #_____
SUPERVISOR_____
LENGTH OF EMPLOYMENT_____
AUTHORIZATION ☐ YES ☐☐ NO

HISTORY

1. Were you a: ☐ Driver ☐ Passenger ☐ Other_____

2. Location of accident _____
STREET CITY

3. Traveling or stopped facing which direction: N S E W

4. History of accident:
☐ Stopped and rear ended ☐ Hit head on ☐ Lost control of car
☐ Other car ran a stop sign or red light ☐ Other _____

Accident Description _____
_____
_____
_____

5. Did you strike any objects inside the car? ☐ Yes ☐ No
If yes, what did you hit?
☐ Steering Column ☐ Rearview Mirror ☐Dash Board ☐Cannot Remember
☐ Seat Broke ☐Windshield ☐Headrest ☐Other _____
☐ Side Window ☐ Door Panel

6. What portion of your body did you hit?
☐ Head ☐Face ☐ Arms
☐ Chest ☐Knees ☐ Other_____

7. Were you ☐ Unconscious ☐ Cut ☐ Bleeding?
If cut or bleeding, on what part(s) of your body? _____

8. Do you have any bruises? ☐ Yes ☐No
If yes, on what part(s) of the body? _____

9. Did you feel immediate pain? ☐ Yes ☐ No
   If yes, where did you feel the pain?
   ☐ Head ☐ Mid Back ☐ Extremity _____
   ☐ Neck ☐ Low Back ☐ Other _____

   If not, when did your pain start? _____

10. Did you or do you feel: ☐ Loss of Memory ☐ Dizzy ☐ Loss of Sleep
    ☐ Head Feels Heavy ☐ Blurry Vision ☐ Ringing in the Ears

11. Were you wearing your seat belt? ☐ Yes ☐ No

12. After the accident, did you:
    ☐ Go Home ☐ Go About Your Business ☐ Got to Hospital

HOSPITAL

13. If taken to the hospital, how?
    ☐ By Ambulance ☐ Drove by Yourself ☐ Driven by Friend

    Name of Hospital _____
    Were you seen in the Emergency Room? ☐ Yes ☐ No
    Were you admitted to the hospital? ☐ Yes ☐ No
    If admitted, how long did you stay? _____
    Name of admitting or hospital physician _____
    In Emergency Room or Hospital – What was done?
    ☐ Examination ☐ Cervical collar ☐ Complete bed rest
    ☐ X-Rays ☐ Stitches ☐ Physiotherapy
    ☐ Prescription ☐ Other _____

14. After your release – What did you do?
    ☐ Return to Work ☐ Return Home To Bed ☐ Other _____

15. Did you consult another physician? ☐ Yes ☐ No
    Name of DR._____
    Date of visit_____
    What did he do for you? _____
    Are you still seeing him? ☐ Yes ☐ No

PAST HISTORY

16. Have you been in any previous accidents? _____

17. Have you ever been treated for neck or back problems before? _____

18. Have you enjoyed good health prior to the accident? _____

19. Have you had previous surgery or conditions that I should know about? _____
    _____

20. What are your present complaints? _____
    _____
    _____

21. Did you miss work as a result of the accident? ☐ Yes ☐ No
    If yes, what dates? _____

22. Do you have an attorney representing you? ☐ Yes ☐ No

If yes, please write your attorney's information below:

Name_____

Address_____

_____

Phone #_____

23. Since the accident, have you been Unable to:

☐ Return to Work ☐ Exercise ☐ Resume daily activities

☐ Drive ☐ Sleep ☐ Other _____

Since the accident are you:

☐ Bedridden

☐ Walking with a limp

☐ Having psychological side effects

☐ Having anxiety while driving

☐ In need of live-in help to care for yourself

☐ In need of assistance of a walker, wheelchair, cane or crutches

☐ Able to return to work

☐ Able to return to work on light duty

Restrictions:

☐ No Bending

☐ No Lifting

☐ No Twisting

24. Additional Comments_____

_____

_____

_____

_____

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 service or treatment 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.
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 of 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.
C. 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.
D.
E. The accompanying statement or bill is **properly completed** in all material provisions and all relevant information has been provided therein. This means that teach request for information has been responded to **truthfully, accurately,** and in a **substantially complete** manner.
F.
G. 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 on 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 Statute.

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.

OIR-B1-1571
12/03

OCEAN CHIROPRACTIC CENTER
OF AVENTURA

TO: ATTORNEY/INSURANCE CARRIER FROM:

RE: PATIENT RECORDS RELEASE AND DOCTOR'S LIEN

_____

_____

_____

Ref Patient Name: _____

Ref #: _____

RELEASE OF RECORDS: I do hereby authorize the above doctor to furnish you, my attorney/insurance carrier, with a full report of his or her case history, examination, diagnosis, treatment, and prognosis of myself in regard to my accident /illness which occurred/began on _____ (date of accident or injury).

LIEN ON SETTLEMENT: I hereby give a Lien to said doctor on any settlement, claim, judgment, or verdict as a result of said accident / illness, and authorize and direct you, my attorney/insurance carrier, to pay directly to said doctor such sums as may be due and owing my doctor for service rendered me, and to withhold such sums from such settlement, claim, judgment, or verdict as may be necessary to protect said doctor adequately.

ASSIGNMENT OF BENEFITS: I further assign my claim or right to compensation for treatment expenses incurred with the doctor/clinic named above arising from a tort or liability claim in connection with this accident or injury.

IRREVOCABLE LIEN: I understand that this Lien shall be irrevocable either by myself or any other agent that represents me; that in the event another attorney is substituted in this matter, the new attorney shall honor this lien as inherent to the settlement and enforceable upon the case as if it was executed by him.

RESPONSIBILITY FOR PAYMENT: I understand that I am directly and fully responsible to said doctor/clinic for chiropractic bills submitted by him or her for service rendered me, and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, claim, judgment, or verdict by which I may eventually recover said fee. A photocopy or facsimile of this executed instrument shall be considered as valid as the original.

Patient Signature: _____ Dated: _____

The undersigned, being attorney of record or authorized representative of insurance carrier for the above patient does hereby acknowledge receipt of the above lien, and does agree to honor the same to protect adequately the above named doctor/clinic. In additional consideration to the above, for executing this lien, the doctor/clinic will provide the attorney with billing summaries and availability to discuss the patient's care on a reasonable basis.

Auth. Signature: _____ Dated: _____

NOTICE: Please date, sign, and return the original to our office as soon as possible. (Reply envelope attached)

Ocean Chiropractic Center of Aventura
Dr.Craig Kaler
20772 West Dixie Highway
Aventura, FL, 33180

This form (or a suitable "Letter of Protection" from the attorney) must be executed by both the patient and the patient's attorney before this clinic will consider awaiting settlement for payment of services rendered in this case.

NOTICE OF PRIVACY PRACTICE

THIS NOTICE DESCRIBES HOW HEALTHY INFORMATION ABOUT YOU MAY BE USED
AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
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 04/04/03 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 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 this 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.

USES AND DISCLOSURES OF HEALTH INFORMATION

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

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

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

Healthcare operations: We may use or disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessments 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, payment of 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 disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use and 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 patients rights section of this notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help you 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 disclosure of your health information, we will provide you with an opportunity to object to uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a 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 our 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 a 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 and 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 authorize federal officials health information to correctional institutions or law enforcement official having lawful intelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials 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 contract information listed at the end of this notice. We will charge you a reasonable cost-based fee for expenses such as copes and staff time. You may also request access by sending us a letter to the address at the end of the Notice.

Disclosure Accounting: You have the right to receive a list of instances in which we use our business associated disclosed your health information for purposes, other than treatment, payment, healthcare operation and certain other activities, for the last 6 years,

but not before April 14, 2003. If you request this 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 of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by out agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health by alternative means or location or to alternative locations (You must make your request in writing.) Your request must specify the alternate means or location your 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.

Electronic Notice: If you receive this notice on our web-site or by electronic mail (e-mail), you are entitled to receive this notice in written form.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or alternative locations, you may complain to us using the contact information listed at the end of this notice. You may also summit a written complaint to the U.S. Department of Health and Human Services. We will mail you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Lazara Sanchez
Address: 20772 West Dixie Hwy
Aventura, FL 33180

Email: OCEANCHIROCTR@GMAIL.COM
Telephone: 305-932-3773

X_____
Patient Signature

X_____
Printed Name