Caring Concepts, Inc

Patient Intake

Today's Date:_____

PATIENT INFORMTION

Last Name: _____
First Name: _____
Address_____
City _____ **State**_____ **Zip**_____
Birthdate_____ **Age**_____
Sex: M F **Status:** Married Widowed Single
Patient Employer/School _____
Occupation_____

SPOUSE INFORMATION

Spouse's Name_____

IF MINOR , PARENT/GUARDIAN INFORMATION

Parent Name: _____
Relationship: _____
Parent Name: _____
Relationship: _____

CONTACT IN CASE OF EMERGENCY

Name_____**Relationship**_____
Phone _____

PHONE NUMBERS

Cell _____
Home _____
Work _____

HEALTH INSURANCE INFORMATION

Primary Insurance _____
ID# _____ **Group#**_____
Policy Holder's Name_____
Policy Holder's Date of Birth_____
Relationship to Patient: _____
2nd Insurance _____
ID# _____**Group#**_____

ACCIDENT INFROMATION

Is condition due to an accident? __ Yes __ No
Type of Accident __ Auto __ Work __ Other _____
Accident Date: _____
Insurance: _____
Claim #:_____
Attorney Name _____

WOULD YOU LIKE A TEXT OR EMAIL REMINDER?
How much notice would you like before your appointment: 1 day 2days 1 week 1 hour 2 hours 4 hours

___Text (phone carrier) Boost Mobile AT&T Cricket Sprint T-Mobile Verizon Virgin Mobile
___Email _____

What is your reason for coming today? _____
_____
_____

What treatment have you already received for your condition? Medications Surgery Physical Therapy
Chiropractic None Other: _____
Primary Doctor: _____ **Date of Last:** Physical Exam _____
When was the last X-ray: _____ **Body area:** _____ **Where:** _____
When was the last MRI: _____ **Body area:** _____ **Where:** _____
Women: Are you pregnant? __ Yes __ No **Due Date:** _____
Medical History: provide date & description (ex. Auto accident '96, High Blood Pressure, hip replacement 2014, cancer)

_____
_____
_____
_____

Medication: _____
_____

Authorizations:

A. I hereby authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the third party who accepts assignment.

B. I authorize payment of any medical benefits from third-parties for benefits summated for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum I now or hereafter owe this office by my attorney, out of proceeds of any settlement of any case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and services rendered.

C. I understand and agree that health and accident policies are an arrangement between an insurance carrier and me. Furthermore, I understand this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment my care and treatment, any fees for products or professional services rendered will be immediately due and payable.

D. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

My Financial Responsibility

Payment or Co-payment is expected when services are rendered. We will gladly process your insurance. The portion we collect is an estimate only. You are responsible for any amount not paid by your insurance.

I understand that I will be responsible for all co-pays, deductibles and/or portion of fees that my insurance does not cover. If my insurance does not respond to my submitted medical claims within 60 days, I understand that I am responsible for all charges. I also understand that I will be responsible for all costs incurred should legal or other means of recovery for these charges become necessary.

Note: There is a $20.00 fee for all appointments not canceled 24 hours prior to scheduled time.
There is a $35.00 service charge for any returned check.

I have read the above statements and understand that I am personally financially responsible for all services not covered by my insurance company. I am also responsible for applicable annual deductible and/or co-payment.

X_____ _____

Signature of patient or person acting on patients behalf Date

Caring Concepts, Inc
1215 W Baker St.
Plant City, FL 33563
813-754-2273

Consent to use PHI

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information
Your Protected Health Information will be used by Caring Concepts, Inc. or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices
You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office.

_____Patient Initials I have received a copy of the Notice of Patient Privacy Policy.

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Notice of Treatment in Open or Common Areas
Treatment itself will not occur in an open area; however, we may ask about your symptoms in an open are. There are private areas available upon request if you would prefer.

Disclosure Authorization:
I authorize the disclosure of health information about me as described below:
Persons who MAY RECEIVE INFORMATION (relatives, friends, doctors)

_____

_____

If you do not wish for us to contact you by telephone regarding appointments and or test results please indicate this to the front office.

Revocation of Consent
You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

_____ _____ _____

Patient or Legally Authorized Individual Signature | Date

Print Patient's Full Name | Time

Witness Signature | Date

CARING CONCEPTS, INC.

Todd Glenn, D.C.
William Garrison, D.C.
Vel Garrison, Clinic Adm.

1215 W. Baker St.
Plant City, FL 33563
Telephone: (813) 754 -2273
Fax: (813) 754 -5680

Informed Consent

Patient Name_____ Date_____

The primary treatment used by doctors of chiropractic is the spinal manipulation adjustment. I will use my hands or a mechanical device upon your body in such a way as move your joints. You may feel or sense movement. Your treatment may also include one or more of the following therapy modalities: ultrasound, interferential current, electrical muscle stimulation (SINE), hot or cold packs.

Risks:
As with any health care procedure, there are certain complications which may arise during a chiropractic adjustment, those complications may include: disc injuries, dislocations, muscle strain, or fractures. Some types of manipulations of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke. There is very little risk of harm associated with of the therapy modalities used in this office.

The probability of the above risk occurring is rare.
Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of the history and examination and/or x-ray. Stroke has been the subject of tremendous disagreement within and without the profession with a study suggesting that there is at most a one-in-a-million chance of such an outcome. Since even that risk should be avoided if possible we employ tests in our examination which are designed to identify if you may be susceptible to that kind of injury.

Other treatment options may include: self-administered analgesics and rest, medical care with prescription drugs, hospitalization, and surgery.

Do not sign until you have read and understand the above.

I have read the above explanation of the chiropractic treatment. By signing below I state that I have weighed the risk involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risk I hereby give my consent to that treatment.

Signature_____ Date_____

Witness_____

ASSIGNMENT OF BENEFITS, LIENS, DIRECT PAYMENT AUTHORIZATION, AUTHORIZATION TO RELEASE INSURANCE INFORMATION, AND AUTHORIZATION TO ESCROW UNPAID MEDICAL & PIP BENEFITS

CARING CONCEPTS, INC.

INSURANCE CARRIER: _____ POLICY NUMBER: _____DATE OF LOSS: _____

For and in consideration of CARING CONCEPTS, INC. agreeing to pursue the responsible automobile insurance carrier for payment of benefits due and not requiring prepayment for services, I hereby irrevocably assign all rights and benefits to CARING CONCEPTS, INC. for Personal Injury Protection, extended Personal Injury Protection, Medical Payment Coverage, and other benefits which I may have in accordance with Florida Statute §627.736. This includes any benefits from my insurance company and any other entity which may be responsible for medical expenses incurred. I further authorize CARING CONCEPTS, INC. to collect payments & prosecute any necessary actions to collect payment for services as they see fit and allowable by law and contract. THIS DOCUMENT CONSTITUTES AN ASSIGNMENT OF RIGHTS AND BENEFITS.

I hereby further give a lien to CARING CONCEPTS, INC. against any and all insurance benefits named herein, and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by CARING CONCEPTS, INC. as a result of the above stated loss date. This document acts as an irrevocable absolute assignment of my rights and benefits to the extent of the charges for services provided. I agree to cooperate with CARING CONCEPTS, INC. and their attorney's (at their choosing), and to do all things reasonable to effect payment of the bills by the insurance company or other entity to CARING CONCEPTS, INC. including, but not limited to, disclosing my medical condition, being available for factual discovery or other cooperation.

This assignment concerns only the bills for CARING CONCEPTS, INC. and those costs including, but not limited to, attorney's fees, other costs, and interest necessary in procuring payment from the above-named insurance company and/or other entities. This assignment is not intended to assign any other causes of action that may belong to the undersigned patient. I agree to pay any applicable deductible or co-payment not covered by any policy of insurance cited above. I understand that as a benefit and convenience to me, CARING CONCEPTS, INC. will bill and pursue collection against the insurance company or other responsible entity on my behalf. I hereby instruct and direct my insurance company to pay my benefits directly to CARING CONCEPTS, INC. at the address provided on the bill. If my current policy prohibits direct payment to doctors, then I hereby instruct and direct my insurance company or other responsible entity to make the check payable to me and mail it to CARING CONCEPTS, INC. at the address on the bill. CARING CONCEPTS, INC.'s medical care is being provided for a reasonable fee for treatment causally related to the above loss date and is medically necessary. I instruct my insurance carrier or other responsible entity to pay these bills to the full extent of my available benefits under the insurance policy and Florida law. If any portion of the charge for these services is either reduced or denied in whole or in part, my insurance company or other entity is to place funds equal to the amount of the reduced or denied charges into escrow and hold the escrowed funds until agreement or resolution of legal action by CARING CONCEPTS, INC. . I further instruct my insurance company to make payment for charges submitted by CARING CONCEPTS, INC. in priority to any other requests to escrow benefits, including a request by myself to reserve benefits for pending disability claims. I hereby give CARING CONCEPTS, INC. limited power of attorney to endorse and sign my name on any draft for payment to either CARING CONCEPTS, INC. or myself if said draft represents payment for charges related to services rendered by CARING CONCEPTS, INC. .

I further direct my insurance carrier or responsible other entity to provide information to CARING CONCEPTS, INC. which is otherwise available to me including but not limited to a copy of any applicable insurance policy, declaration page, all applicable endorsements, transcripts and/or copies of any recorded statements, examinations under oath and requests for same, independent medical evaluations and requests for same, peer review reports, and a listing of all PIP benefits paid to date which shall include when claims were made, when the claims were received, the payment or denial of each claim, the amount of the deductible and the claims applied thereto, and whether benefits have been exhausted and the amount of PIP benefits available, commonly known as a "PIP log". This request includes the name of other medical providers to whom payments have been under my policy of insurance. This agreement is intended to serve as an assignment of rights and benefits under my policy of insurance in favor of CARING CONCEPTS, INC. . If any language within this agreement has the effect of invalidating this agreement, that

language shall be deemed void and the remainder of the assignment shall maintain full force and effect. A photocopy of this assignment shall be considered as effective and valid as the original.

_____ _____ _____

Patient Signature Date Patient Name

If patient is incapacitated or under the age of 18, please indicate the patient name, guardian name and relation to patient, and obtain guardian signature.

Caring Concepts Chiropractic

Auto Accident Intake Form

Patients Name: _____ Todays Date: _____ Date of Accident: _____

Employment:

At time of Crash Occupation:_____ or Unemployed

Currently: Occupation:_____ or Unemployed

Was Unemployment due to auto accident: ___yes ___no

Type of Work: __Office __Light Labor __Moderate Labor __Heavy Labor

Past Medical History:

Surgeries (dates and residuals): _____

Fractures (dates and residuals): _____

Serious Illness (dates and residuals): _____

Workers Comp Injuries (dates and residuals): _____

Personal Injuries (dates and residuals): _____

Sports or other injuries to head, neck or back: _____

Any prior history of Current complaint: _____

Prior treatment by DC for these: _____

Current Medical History:

Current health problems: __None _____

Current Medications: __ None _____

Injury History:

Was the crash on the Job __Yes __No Seat Belt: ___Lap belt and Shoulder ___Lap only ___None ___Unsure

Your Vehicle (Year, Make, Model) _____

You were: __Driver __Front passenger __Rear Passenger __ Motorcycle operator __Motorcycle Passenger

Other: _____ Vehicle Driven By _____

Estimated Speed at moment of Crash: _____ ___Stopped ___Slowing ___Accelerating

Other Vehicle (Year, Make, Model): _____

Time Of Day: __daylight __Dawn __Dusk __Dark

Road Conditions: __ Dry __Damp __Wet __Snow __Ice Other_____

Head restraints: __ None __Integral Type __ Adjustable (__UP ___DOWN) ____Don't Know

If Adjustable, was the position altered by the crash? __Yes __No

Was the seat back adjustment altered by the crash? __ Yes __No Was the seat Broken? __Yes __No

Did the Airbag Deploy? __ Yes __No If yes, were you struck by the airbag? __ Yes __No

Body Position: __Good __Forward lean __Other_____

Head Position: __Forward __left (___degrees) __ right(___degrees) __Up(___degrees) __Down(___degrees)

Hand Position: __ one on wheel __two on wheel __ None on wheel __N/A
Brakes Applied: __Yes __No Were you aware of the impending crash? __Yes __No
Please describe what happened: _____
_____
_____
_____
_____
_____

During The Crash:
Did you strike any part of the vehicle: __Yes __No If yes, describe: _____
Did vehicle strike any objects after impact? __Yes __No If yes, describe: _____
Were you wearing hat or glasses? __Yes __No If yes, did the come off: ___hat ___glasses
Did you lose consciousness? __Yes __No If yes, how long? _____
Estimated property damage to your vehicle: _____
Estimated damage to other vehicle: __None __Minimal __Moderate __Major
Were the police called to the scene? __Yes __No Was a report made? __Yes __No

After the Crash:
Symptoms (circle all that apply and tell when the symptoms starts (example, Headache 2hrs. , neck pain Immediately):
Headache _____ Dizziness _____ Nausea_____ mid back pain _____
Confusion/Disorientation_____ Neck Pain_____ low back Pain _____
Paresthesia(s) _____ If yes, where? _____
Extremity Pain _____ If yes, Where? _____
Where did you go after the Crash? __Home __Work __Hospital/Doctor (Name _____)
Mode Of Transportation : _____

Emergency Department:
Radiographs: __Yes __No Body Parts imaged: _____
Results: _____
Lab Work: __Yes __No Cervical Collar: __Yes __No
Medications: _____
Other: _____
Follow Up Instructions: _____

Treatment History:
Dr: _____ Specialty: _____
Date seen: _____ Referred by: _____
Treatment Type _____
Currently treating: __Yes __No Any Disability __Yes __No describe: _____
Special Test: _____
Referred To: _____ Did Treatment Help? __Yes __No
Notes: _____

Dr: _____ Specialty: _____
Date seen: _____ Referred by: _____

Treatment Type _____

Currently treating: __Yes __No Any Disability __Yes __No describe: _____

Special Test: _____

Referred To: _____ Did Treatment Help? __Yes __No

Notes: _____

I certify that I'm the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

Patient/ Guardian Signature: _____ Date: _____