# Vero Walk-In Chiropractic & Wellness Patient Information

Please Print:

Name: _____ Birthdate: _____

Address: _____

City : _____ State: _____ Zip: _____

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

Please circle: Male Female Married Single Widowed Divorced Separated

Home Phone: _____ Cell Phone : _____ Work Phone: _____

Email Address: _____

Employer: _____ Occupation: _____ # of years: _____

Spouse or Parent Name: _____ Birthdate: _____ Phone #: _____

Emergency Contact: _____ Phone #: _____ Relationship: _____

Name of Local Primary Physician: _____ May we contact them? _____

Who may we thank for referring you to us? _____

Did you see our: Website Facebook Business Sign Word of Mouth

**Symptoms**

Main complaint: _____

When did it start? _____ How did it start? _____

What activity bothers it the most? _____ Getting Better/Worse? _____

When is the pain at its worst? (Circle) AM PM Mid Day Sleep Sitting Moving Resting Working

Rate the pain (0 Pain Free – 10 Unbearable Pain) 0 1 2 3 4 5 6 7 8 9 10

Secondary complaint: _____

Other chiropractors? _____ Positive experience? _____ Last visit? _____

Other type of physician or therapist? _____ Positive experience? _____

**Health History-**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| AIDS/HIV | Allergy Shots | Anemia | Anorexia | Appendicitis | Arthritis | Asthmas | Bleeding | Stroke |
| Breast Lump | Bronchitis | Bulimia | Cancer | Cataracts | Chicken Pox | Depression | Diabetes | Thyroid |
| Emphysema | Epilepsy | Fractures | Glaucoma | Goiter | Gonorrhea | Gout | Heart Dx | Implants |
| Hepatitis | Hernia | Herniated Disc | Herpes | HI Cholesterol | Kidney Dx | Liver Dx | Measles | Prostate |
| Migraines | Miscarriage | Mono | M.S. | Mumps | Osteoporosis | Pacemaker | Parkinson's | Polio |
| Pneumonia | Prosthesis | Rheumatoid | Chronic Fatigue | HI Blood Pressure | Fibromyalgia | Other: _____ | | |

Women- How many children? _____ Are you currently pregnant? _____ Nursing? _____

Taking birth control pills? _____ Date of last menstrual cycle? _____

Previous surgeries and dates: _____

List all medications you are currently taking: _____

What kind of exercise do you do? _____

What supplements do you take? _____

How much do you smoke per day? _____ Drink per week? _____

*All above questions have been answered accurately and I understand that giving incorrect information can be dangerous and can hinder treatment. I authorize this office to release any information pertaining to my treatment to third party payers or other health care providers. I authorize and request my insurance company to pay directly to this office any payable benefits. I further understand that payment may be less that the actual cost of services and will be responsible for any outstanding money amount owed to this office.

Patient Signature: _____ Date: _____

# Acknowledgement of Receipt of Notice of Privacy Practices

Please check one of the following:

_____ I acknowledge that I have declined the opportunity to receive a paper copy of the Notice of Privacy Practices but I understand it is available to read at any time upon request.

-OR-

_____ I acknowledge that I wanted and was provided a paper copy of the Notice of Privacy Practices and that I have read and understand the Notice of Privacy Practices.

I understand this form will be placed in my patient chart and maintained for 6 years.

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Patient Name Printed

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Signature of Patient/Parent/Legal Guardian

*Optional
All medical records on file with Vero Walk-In Chiropractic & Wellness are kept private and confidential. However, I authorize Vero Walk-In Chiropractic & Wellness to discuss my medical history/treatment with the following individuals: _____ (initials)

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*This information will remain on file for 6 years unless informed otherwise by the above named patient.

# Informed Consent to Chiropractic Treatment

The Nature of Chiropractic treatment: The Doctor of Chiropractic may perform an examination of the area of complaint and if medically necessary, s/he may take radiographs in order to correctly diagnose the condition. The doctor uses their hands or a mechanical device to move your joints. You may hear a "click" or a "pop" similar to your knuckles cracking and you may feel the joint moving. Additional therapies such as myofascial release, ice, electric muscle stimulation or cold laser may also be used. The doctor will make a very reasonable effort during the examination to screen for contraindications to care: however if you have a condition that would otherwise not come to the doctor's attention, it is your responsibility to inform the doctor.

Possible Risks: As with any healthcare procedure, complications are possible following a chiropractic manipulation. These complications could include but not limited to: fractures of bone, muscular strain, ligamentous strain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. Some patients may feel stiff and sore after the first few days of treatment.

Probability of Risks Occurring: The risks of complications due to chiropractic treatment have been described as rare. The risk of cerebrovascular injury or stroke has been estimated at one in one million to one in twenty million.

Other Treatments which could be considered outside this office may include: over the counter analgesics and rest, medical care including medically prescribed anti-inflammatories, tranquilizers, analgesics, medical pain management including injections, hospitalization or surgery.

Risks of Remaining Untreated: Delay of treatment may allow the formation of adhesions, scar tissue, and other degenerative changes which can further decrease skeletal mobility and induce chronic pain cycles. Over time, this process may complicate the condition and make future rehabilitation more difficult.

I, _____, have read the above explanation of chiropractic treatment and will present any questions that I may have to the doctor. By signing below I state that I have weighed the risks involved in undergoing treatment. I have freely decided to undergo the recommended treatment and I give my full consent to treatment.

_____

Date

_____ _____

Patient's Signature Doctor's Name

_____ _____

Signature of Parent/Guardian if Minor Doctor's Signature

# DOCTOR'S LIEN

To: Attorney

_____

_____

_____

D

Thomas Harmody, D.C.
3375 20th Street #110
Vero Beach, FL 32960
(772) 360-1245

Patient/Client: _____

RE: Reports and Doctor's Lien

I do hereby authorize the above doctor to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him for medical service rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgement or verdict as may be necessary to adequately protect said doctor. And I hereby further give a lien on my case to said doctor against any and all proceeds of any settlement, judgement or verdict which may be paid to you, my attorney, or myself as the results of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

Dated _____ Patient's signature _____

The undersigned, being attorney of record for the above patient, does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor named above.

Dated _____ Attorney's signature _____

Attorney: Please date, sign and return one copy to doctor's office at once. Keep one copy for your records.

# PERSONAL INJURY QUESTIONNAIRE

Name: _____ Date of Accident: _____ Time of Accident: _____

Describe the accident: _____

_____

_____

Please type your response to the questions below

At the time of accident were you the: Driver Front Passenger Left Rear Passenger Right Rear Passenger

Did your vehicle strike other vehicle? If yes where? _____

Was your car struck by another vehicle? If yes where? _____

At the time of Impact were you: Looking straight ahead Looking Right Looking Left No Recall

Were both hands on the steering wheel?

Was your foot on the brake?

Were you braced for impact?

Where in the car were you after the accident? _____

Were you wearing a seat belt?

Did you strike anything in vehicle at impact? If Yes what body part _____

Did your airbags deployed?

Immediately following the accident how did you feel? _____

Were you unconscious?

Were you in a daze?

Did you go to the hospital? If yes when: at the time of the accident or the next day?

How did you get to the hospital? By ambulance by private transportation? Not applicable

Did the ambulance attendants place you in a Neck collar? A splint? Brace? Not applicable

Name of Hospital_____

Were you admitted to the hospital? If admitted, how long did you stay? _____

Did you have x-rays taken?

What treatment or meds prescribed? _____

What was your diagnosis? _____

Have you seen any other doctor as a result of this accident? If yes who? _____

Do you have pain in your: neck upper back mid back low back knee foot shoulder arm hand headache

Is the pain: Constant Comes and Goes Sharp Dull Mild Moderate Severe

Do you have any numbness or tingling into your arms/hands or into your legs/feet?

Your most comfortable position: Sitting Standing On your side On your back Other _____

Your pain is helped by using: Ice pack Heating Pad Hot shower/bath Muscle rub Resting Moving

Have you lost any time from work because of this accident? I

If yes, give dates of time lost: From _____ to _____

Any additional information: _____

_____

_____

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.**

_____

_____

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(14) and (15), 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(11)(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.

# ASSIGNMENT OF BENEFITS

I, _____ Hereby authorize _____
(Name of Insured) (Name of Insurance Carrier)

Payable Directly to:
Payable to and mailed directly to:

Vero Walk-In Chiropractic, LLC.
3375 20th Street Suite #110
Vero Beach, FL 32960

The medical benefits otherwise payable to me for their services but not to exceed the charges of those services. I hereby IRREVOCABLY ASSIGN to VERO WALK-IN CHIROPRACTIC, LLC. Any benefits under any policy of insurance, indemnity agreement, or any other collateral source as defined in Florida Statues for any service and or charges provided by VERO WALK-IN CHIROPRACTIC, LLC.

In the event that my insurance company does not pay VERO WALK-IN CHIROPRACTIC, LLC. bills in full and pursuant to the terms of my policy of insurance, I hereby instruct the insurance carrier to set aside all funds in an amount that would be sufficient to pay such bills in full in accordance with the charges submitted. As part of this assignment of benefits, I further instruct the insurance carrier to notify the provider immediately after any disputes as to the payment so it may preserve and exercise its legal rights. Also, in addition to notifying me and my legal representative, I instruct the insurance carrier to immediately notify the provider of any scheduled examinations under oath or independent medical examinations. I authorize and instruct the insurance carrier to provide the Provider upon request any and all documents in my file, including but not limited to an up to date and unredacted and complete payout register and medical record. I understand that any person who knowingly and with intent to injure, defraud or deceive any insurance company, files a statement containing any false, incomplete or misleading information is guilty of a felony of the third degree. I have read the information herein and it is true to the best of my knowledge and belief.

IN WITNESS WHEREOF the undersigned have hereunto set their hands,

This _____ day of _____.

_____ _____
Patient's Signature Patient's Name (Please Print)