Welcome to Pitts Family Chiropractic

PLEASE PRINT

Today's Date ____ / _____ / _____

Mr.___ Mrs.___ Ms.___ Miss.___ Dr.___ Prof.___ Rev.___

First Name: _____ Middle: _____

Last Name: _____

What do you prefer to be called:_____

Gender: Male ___ Female ___ Date of Birth:____ / _____ / _____ Height:____/____ Weight:_____

Address:_____

City: _____ State: _____Zip Code: _____

SSN: _____ Email: __

Primary Phone: _____ Cell Phone: _____

Employer's Name & number: _____

In case of emergency whom would you like us to contact? _____

Relation: _____ Phone: _____

Who is your medical doctor? _____

Employment Status: Employed __ Student __ Self Employed __ Retired __ Other __
Marital Status: Single __ Married __ Other __
Race: (check one) White __ Black/African American __ Hispanic __ American Indian __ Other __
I choose not to specify __
Multi-Racial: (check one) Yes __ No __ Unknown __
Ethnicity: (check one) Hispanic or Latino __ Not Hispanic or Latino __ I choose not to specify __
Preferred Language: (check one) English __ Spanish __ Other I choose not to specify __
Are you a smoker? Yes __ No __
If yes, how often do you smoke? Current everyday smoker _ Current sometime smoker __
Are you a former smoker? Yes __ No __

How often do you exercise? _____

Social Habits? (alcohol, caffeine, recreational drugs, etc) _____

Briefly list your main health problems: _____

Do you have a family history with any of the following (**circle all that apply**)

Diabetes Rheumatoid Arthritis Back problems Cancer Tuberculosis

Heart attacks Hypertension Other:_____ Relation:_____

Do you have a pacemaker or electric implants? Yes___ No___
For Women: Are you pregnant? Yes __ No __ If so, due date: ___ / ____ / ____

Medications:_____

Allergies:_____

Auto Accident Questionnaire

Date of Auto Accident: ____ / ____ / ____

Claim number: _____

Attorney name & number: _____
OR
Auto insurance company & ID: _____

Adjuster name & number:_____

Make/Model of your vehicle: _____
You were: Driver ___ Passenger ___
You were: Front seat ___ Back seat ___
Using seat belts: Yes ___ No ___
You were heading: North ___ South ___ East ___West ___
Street/Road/Highway:
_____

Your speed:_____ Speed of other vehicle: _____
Did the impact to your vehicle come from the: Front ___ Rear ___ Right ___Left ___
During the impact, were you facing: Left ___ Right ___ Forward ___ Backward ___
Were you: Aware of oncoming hit ___ **OR** Surprised by the accident ___
Please describe in detail how your accident happened:

_____

_____

Were you knocked unconscious? Yes ___ No____ If so, how long _____

Where did you feel the pain immediately after the accident: _____

Where were you taken after the accident? _____

What treatment was given, if any: _____

Was any other Doctor consulted after your accident? ___ Yes ___ No

If so, what was the Doctor's name? _____

What type of Doctor was it: D.C. ___ M.D. ___ D.O. ___ D.D.S ___ Not sure ___

What was the diagnosis? _____

Have you ever had any complaints in the involved area before?: Yes ___ No ___
If so, what are the complaints:
_____

Before the injury were you capable of working equally with others your age?: Yes ___ No ____

Are your work activities restricted as a result of this accident?: Yes ___ No ___
If so, what activities:
_____

Since the injury, are your symptoms: Improving ___ Getting worse ___ Same ___

Have you had previous chiropractic care? Yes ___ No ___

Main complaint: _____

_____

Does your pain radiate to other areas? __ Yes __ No If yes, where? _____

_____

What terms describe your discomfort best? (aching, burning, tingling, etc.) _____

_____

How often do you feel this discomfort throughout the day? _____

What aggravates this condition? _____

On a pain scale of 1 to 10, with 10 being the most severe, how would you rate your current level of discomfort?

Neck:	0	1	2	3	4	5	6	7	8	9	10
Mid back:	0	1	2	3	4	5	6	7	8	9	10
Low back:	0	1	2	3	4	5	6	7	8	9	10

801 Northeast 25th Avenue
Ocala, Fl. 34470

Phone: (352) 732-0200
Fax: (352) 732-2623

Pitts Family Chiropractic

Dr. Sonja J. Lonadier

Dr. Travis R. Wilemon

Dr. Jeanna L. Taylor

Dr. William M. Stankosky

Today's Date: ___ / ___ / ___

Attorney/Law firm: _____

Patient Name: _____

Date of accident: ___ / ___ / ___

To Whom It May Concern:

Our office has agreed to provide services for the above named patient, related to the above noted date of accident/injury. “Services” is defined to include supplies. In exchange for not requiring full payment at the time of service, the patient has agreed to execute this letter of protection and we have agreed to accept this letter of protection.

The patient hereby agrees to pay the billing for our services from any recovery obtained by the patient due to the above noted accident. This letter of protection is intended to be a legally enforceable agreement requiring the attorney(s) and/or law firm representing the patient to pay the billing for for our services from any recovery obtained for the patient. Accordingly, this letter of protection includes

At the time of any recovery on behalf of the patient for the above noted accident, the attorney(s) agree to request in writing the balance due from our office and we agree to respond in writing stating the balance owed for services related to the above noted accident.

The attorney(s) for the patient agree that any outstanding bill for services owed to us by the patient due to the above noted accident shall be paid directly to us from the amount recovered and collected, if such amount is adequate to cover the bill. The “amount recovered” for the patient shall be defined as the gross sum received, less payment of our attorney's fee and client costs, and also less statutory liens that take priority over this letter of protection.

If the patient objects to the amount of the bill, the attorney(s) agree to hold in their trust account an amount sufficient to pay the entire bill or that portion of the amount recovered that is available to pay the bill, whichever is less. The only exception would be upon an Order of a Court of competent jurisdiction directing the payment of such funds. If, after a reasonable period, there appears to be no agreement between us and the patient, the attorney(s) will notify both the patient and is that the entire amount held to pay the bill will be deposited with the Clerk of Court in the County in which the funds are being held in trust and shall be made the subject of the inter pleaded action.

It is intended the patient's signature on this agreement is an irrevocable letter of protection directing payment of our bill by any subsequent attorney(s) of the patient for the above noted accident. If the patient obtains a recovery and has no attorney at the time such recovery, it is intended this agreement by the patient is a direction to any party paying such recovery to honor this letter of protection. This letter of protection does not eliminate or compromise the obligation of the patient to pay the billing for our services if there is no recovery obtained by the patient.

I have reviewed, understand, and agree to the terms of this letter of protection.

Patient Name: _____ Date: ___ / ___ / ___
Signature

Doctor Name: _____ Date: ___ / ___ / ___
Signature

Attorney Name: _____ Date: ___ / ___ / ___
Signature

Assignment of Benefits

(Authorization to settle claim and direction to pay medical provider directly)

By my signature below, for good and valuable consideration (including but not limited to the extension of credit to me), I hereby assign, transfer and convey to _____

(provider information, leave blank)

(hereinafter “the Provider”) all of my rights, title and interest in and to medical expense reimbursement in whatever form, including but not limited to any automobile liability medical expense payments or other health benefits indemnification and/or agreement otherwise payable to me. This payment shall not exceed my indebtedness owed by me to the assignee that is not otherwise satisfied by the above mentioned assigned proceeds. I also acknowledge that any medical expense not covered under my insurance policy will be my responsibility.

I further authorize the provider to negotiate, collect and settle any claim with any insurance carrier or other third party payer with regard to these services, which authorization shall include authority to: (1) request and receive from any insurer or any other party and all documentation and records that I am empowered to request regarding this claim, including , without limitation, a statement of coverage, policy declarations page and insurance policy pursuant to Section 627.4137. In addition, the provider has the authority to request and receive any Independent Medical Examination Reports, notices sent to me regarding appointments for Independent Medical Examinations and Examinations under oath (including proof of mail), Records Review Reports, coverage denial letters, Explanations of Benefits, and Benefit Payment Sheets or Logs (P.I.P. Payout Sheets), without regard as to whether such documentation has already been provided to me and, (2) to endorse in my name any check issued for payment where benefits were assigned. By way of this assignment and notice, I further instruct you, the insurer to furnish to Provider copies of all future notices of requested medical examinations or statements.

The Provider hereby objects to any reductions or partial payments. Any partial or reduced payment, regardless of accompanying language, issued by the insurer and deposited by the provider shall be done so under protest, at the risk of the insurer, and the deposit shall not be deemed a waiver, accord, satisfaction, discharge, settlement or agreement by the provider to accept a reduced amount as payment in full.

I further direct my insurer to direct all payments for services rendered by the Provider directly to Provider at the billing address contained on Provider's medical bills.

This is a direct and irrevocable assignment of my rights and benefits under my policy of insurance.

A photocopy of this form shall be considered as effective and valid as the original.

I have read the foregoing and understand and agree to each of the above provisions:

_____ ___ / ___ / ___

Patient's Signature Date

801 Northeast 25th Avenue
Ocala, Fl. 34470

Phone: (352) 732-0200
Fax: (352) 732-2623

Pitts Family Chiropractic

Dr. Sonja J. Lonadier

Dr. Travis R. Wilemon

Dr. Jeanna L. Taylor

Dr. William M. Stankosky

Authorization to release Healthcare Information

Patient's Name: _____ Date of Birth: ___ / ___ / ___
Previous Name: _____ Social Security # _____

___ I am requesting a copy of my records

OR

I request and authorize _____ to release healthcare information of the patient name above to:

Pitts Family Chiropractic
801 NE 25th Avenue
Ocala, Fl. 34470

This request and authorization applies to:

___ Healthcare information relating to the following treatment, condition or dates:
_____

___ All healthcare information

___ Other: _____

_____ ____ / ____ / ____
Patients Signature Date

Florida PIP Assignment of Benefits

I, _____ assign all of the rights and benefits of any applicable personal
Patient Name
injury protection, medical payments, or other coverage provided by any insurance policy issued pursuant to Florida Statues 627.730 – 627.7405, to _____
Provider Name
for services and supplies provided to me related to personal injuries I suffered in an automobile accident which occurred on ____ / ____ / _____.
Date of Accident
I agree to pay any co-payment or deductible not covered by the applicable personal injury protection, medical payments, or other insurance coverage. This assignment includes, but is not limited to:

- all rights to collect benefits directly from any insurance carrier obligated to provide benefits for services and supplies I have received:
- all rights to take legal or other action against any insurance carrier obligated to provide benefits if for any reason the insurance carrier fails to pay any benefits due: and
- all rights to recover attorney fees, legal assistant fees, costs, and any interest on fees and costs, for any legal or other action taken by _____ as my assignee.
Provider Name

This is an assignment of rights only, and is not a delegation of any of my duties under the subject insurance policy.
I agree that _____ may retain any attorney it chooses to bring legal
Provider Name
action against any insurance carrier obligated to provide benefits for services and supplies I have received , and that the attorney chosen may be different than any attorney I may have handling any claim I may have for personal injuries.
I have been given a copy of this assignment to retain for my records: I have read this assignment and I am executing this assignment and do so freely and voluntarily.

_____ ___ / ___ / ___
Patient Signature Date

_____ ___ / ____ / ___
Provider Signature Date

Patient is to initial each therapy performed and sign the log at the end of each section. Patients signature on this document attests to the fact that the services set forth herein were actually rendered. The person rendering the medical services for which a claim will be submitted has explained the services to me in detail.

___ Office visit	___ Manual Therapy	___ Spinal Manipulation
___ Therapeutic Ultrasound	___ Electrical Stimulation	___ Therapeutic Exercises
___ Cervical/Lumbar Traction	___ Massage Therapy	___ X-rays
___ Hot/Cold Pack	___ Extremity Manipulation	___ _____

_____ ____ / ____ / ____
Patient Signature Date of Service

- Our Policy requires payment in full for all services rendered at the time of the visit, unless other

arrangements have been made with the provider. If account balance has not been paid within 90 days of the date of service and no financial arrangements have been made, you will solely be financially responsible for any expenses incurred in collecting your account. We may send your account to our collections company, MJ Altman if after 5 months of no payment or arrangements have been broken with our financial department.

- I hereby state that all information that I have given to Pitts Family Chiropractic is complete and truthful. I will not misrepresent the severity or cause of my health concern. I further state that I have disclosed my full health history. I present myself for health reasons only and it is not my intent to mislead, defraud or coerce this office or any third party or misrepresent myself in any manner. I hereby request and consent to the performance of chiropractic adjustment and other chiropractic procedures including various modes of physical therapy and diagnostic x-rays on me by licensed doctors of chiropractic who may now or in the future treat me while employed at Pitts Family Chiropractic. I acknowledge that results are not guaranteed or assured. I understand that I will have an opportunity to discuss with my doctor the nature and purpose of chiropractic adjustments and other procedures. I understand and am informed that as in the practice of medicine, the practice of chiropractic has some risks to treatment including but not limited to: muscle strains and sprains, disc injuries, fractures, strokes, and dislocations. I do not expect the doctor to anticipate and explain all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time based upon all factors then known is in my best interests.

- I authorize Pitts Family Chiropractic to release any information required to process insurance claims. (If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA Notice that is available to you are at the front desk).

- 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.

Who may we thank for referring you to our office_____

Patient:_____
Print Name

_____ _____ / _____ / _____
Signature Date

If the patient is a minor (under 18 years old) Parent or Guardian must print and sign below

_____
Print Name

_____ __ __ / __ __ / __ __
Signature Date