North Florida Medical Center
Bringing the Care, Back to Healthcare
O: 904.500.NFMC
F: 904.264.2330
www.nfmcjax.com
frontdesk@nfmcjax.com

Personal Injury Questionnaire

Patient Full Name: _____ Phone Number: _____

Insurance Co.: _____ Policy #: _____ Agent's Name: _____

Attorney Name: _____ Phone Number: _____

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

Were there any witnesses? ( ) Yes ( ) No Name(s): _____

Date of Accident: ____/____/____ Time Of Accident: ___:___ AM/PM

Were You: ( ) Driver ( ) Passenger – Front Seat ( ) Passenger – Back Seat

Number Of People In Your Vehicle: ____ Were You Wearing The Seat Belt? ( ) Yes ( ) No

Location of Accident: _____

What Direction Was The Other Vehicle Headed? _____

Were You Struck From: ( ) Front ( ) Back ( ) Right Side ( ) Left Side

Approximate Speed of Your Car: _____mph Approximate Speed of Other Car: _____mph

Were You Knocked Unconscious? ( ) Yes ( ) No If So, For How Long? _____

Were Police Notified? ( ) Yes ( ) No If So, JSO or FHP? _____

In Your Own Words, Please Describe the Accident: _____

_____

_____

_____

Did You Have Physical Complaints Before This Accident? ( ) Yes ( ) No If Yes, Please Describe: _____

_____

_____

Do You Have Any Congenital (From Birth) Factors Which Relate To This Problem? ( ) Yes ( ) No If Yes, Please Describe: _____

_____

Do You Have Any Previous Illnesses Which Relate To This Case? ( ) Yes ( ) No If Yes, Please Describe: _____

_____

Where Were You Taken After The Accident? _____

Have You Been Treated By another Doctor since the Accident? ( ) Yes ( ) No If Yes, Please List Name and Address: _____

_____

What Type Of Treatment Did You Receive? _____

Have You Ever Been Involved In An Accident Before? ( ) Yes ( ) No If Yes, Please Describe With Date, Type of Accident, And Injuries: _____

_____

Do You Notice Any Activity Restriction Since This Accident? ( ) Yes ( ) No If Yes, Please Describe: _____

_____

Check Symptoms You Have Noticed Since the Accident:

☐ Headache	☐ Stiff Neck	☐ Loss of Balance
☐ Loss of Smell	☐ Loss of Taste	☐ Diarrhea
☐ Cold Sweats	☐ Fever	☐ Sleeping Problems
☐ Back Pain	☐ Nervousness	☐ Tension
☐ Irritability	☐ Chest Pain	☐ Dizziness
☐ Pins & Needles in Arm	☐ Pins & Needles in Leg	☐ Numbness in Fingers
☐ Numbness in Toes	☐ Fatigue	☐ Depression
☐ Loss of Memory	☐ Loss of Balance	☐ Fainting

Symptoms Other Than Above:

_____

Have You Lost Time From Work? ( ) Yes ( ) No If Yes, Last Day Worked? _____

Type of Employment? _____ Present Salary? _____

Are You Being Compensated For Time Lost From Work? ( ) Yes ( ) No

If Yes, Please State What Type of Compensation You Are Receiving: _____

Other Pertinent Information:

_____

_____

Patient Signature: _____ Date: ____/____/____

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Personal Information

Full Name: _____ Email: _____

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

Home Phone: _____ Cell Phone: _____ Occupation: _____

Sex: M__ F__ Marital Status: S __ M __ D __ W __ Age: _____ DOB: _____ SS#: _____

How Did You Hear About Our Clinic? _____

Name Of Person Responsible For Account: _____ Method Of Payment: _____

Emergency Contact Name: _____ Phone Number: _____

Present Complaint

Briefly Describe Symptoms: _____

_____

Other Doctors Seen For This Condition: _____ Treatment Rendered: _____

Are You Taking Any Medication: Y __ N __ What Kind: _____

Previous Surgeries: _____

List Physicians Seen Within Last Year: For What Condition(s):

_____ _____

_____ _____

Women Only: Are You Pregnant? Y __ N __ Date Of Last Menstrual Period: ___/___/___

Insurance Information

Relationship To Insured: Self __ Spouse __ Child __ Other__

Insured's Full Name:	Insured's DOB: ____/____/____
Address:	City: State: Zip:
Home Phone:	SS#:
Attorney Name:	Phone Number:
Insurance Company:	Phone Number:
Group #:	Insured's ID #:
Employed By:	Phone Number:
Address:	City: State: Zip:
Additional Insurance Company:	Phone Number:
Insured's SS#:	Policy #:

Patient Name: _____ Date: ___/___/___

Neck Pain and Disability Index (Vernon – Mior)

Section 1 Pain Intensity
- ☐ I have no pain at the moment
- ☐ The pain is very mild at the moment
- ☐ The pain is moderate at the moment
- ☐ The pain is fairly severe at the moment
- ☐ The is very severe at the moment
- ☐ The pain is the worst imaginable at the moment

Section 2 Personal Care (Washing, Dressing, Etc.)
- ☐ I can look after myself normally, without causing extra pain
- ☐ I can look after myself normally, but it causes pain
- ☐ It's painful to look after myself and I am slow and careful
- ☐ I need some help, but manage most of my personal care
- ☐ I need help every day in most aspects of self-care
- ☐ I do not get dressed, I wash with difficulty and stay in bed

Section 3 Lifting
- ☐ I can lift heavy weights without extra pain
- ☐ I can lift heavy weights but it gives me extra pain
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on the table
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
- ☐ I can lift very heavy weights
- ☐ I cannot lift or carry anything at all

Section 4 Reading
- ☐ I can read as much as I want to with no pain in my neck
- ☐ I can read as much as I want to with slight pain in my neck
- ☐ I can read as much as I want with moderate pain in my neck
- ☐ I cannot read as much as I want because of moderate pain in my neck
- ☐ I can hardly read at all because of severe pain in my neck
- ☐ I cannot read at all

Section 5 Headaches
- ☐ I have no headaches at all
- ☐ I have slight headaches which come infrequently
- ☐ I have moderate headaches which come infrequently
- ☐ I have moderate headaches which come frequently
- ☐ I have severe headaches which come frequently
- ☐ I have headaches almost all the time

Section 6 Concentration
- ☐ I can concentrate fully when I want to, with no difficulty
- ☐ I can concentrate fully when they want to, with slight difficulty
- ☐ I have a fair degree of difficulty in concentrating when I want to
- ☐ I have a lot of difficulty in concentrating when I want to
- ☐ I have a great deal of difficulty in concentrating when I want to
- ☐ I cannot concentrate at all

Section 7 Work
- ☐ I can do as much work as I want to
- ☐ I can only do my usual work, but no more
- ☐ I can do most of my usual work, but no more
- ☐ I cannot do my usual work
- ☐ I can hardly do any work at all
- ☐ I cannot do any work at all

Section 8 Driving
- ☐ I can drive my car without any neck pain
- ☐ I can drive my car as long as I want with slight pain in my neck
- ☐ I can drive my car as long as I want with moderate pain in my neck
- ☐ I cannot drive my car as long as I want because of moderate pain in my neck
- ☐ I can hardly drive at all because of severe pain in my neck
- ☐ I can't drive my car

Section 9 Sleeping
- ☐ I have no trouble sleeping
- ☐ My sleep is slightly disturbed (less than 1 hour sleepless)
- ☐ My sleep is mildly disturbed (1-2 hours sleepless)
- ☐ My sleep is moderately disturbed (2-3 hours sleepless)
- ☐ My sleep is greatly disturbed (3-5 hours sleepless)
- ☐ My sleep is completely disturbed (5-7 hours sleepless)

Section 10 Recreation
- ☐ I am able to engage in all my recreation activities with no neck pain at all
- ☐ I am able to engage in all my recreation activities, with some pain in my neck
- ☐ I am able to engage in most, but not all of my recreation activities because of pain in my neck
- ☐ I am able to engage in a few of my usual recreation activities because of pain in my neck
- ☐ I can hardly do any recreation activities because of pain in my neck
- ☐ I can't do any recreation activities at all

Pain Scale:

Rate The Severity Of Your Pain By Checking One Box On The Following Scale:

No Pain	1	2	3	4	5	6	7	8	9	10	Excruciating Pain

Patient Name: _____ Date: ___/___/___

Low Back Pain and Disability Questionnaire

Section 1 Pain Intensity
- ☐ The pain comes and goes and is very mild
- ☐ The pain is very mild and does not vary much
- ☐ The pain comes and goes and is moderate
- ☐ The pain is moderate and does not vary much
- ☐ The pain comes and goes and is very severe
- ☐ The pain is severe and does not vary much

Section 2 Personal Care (Washing, Dressing, Etc.)
- ☐ I would not have to change my way of washing or dressing in order to avoid pain
- ☐ I do not normally change my way of washing or dressing even though it causes some pain
- ☐ Washing and dressing increase the pain but I managed not to change my way of doing it
- ☐ Washing and dressing increase the pain and I find it necessary to change my way of doing it
- ☐ Because of the pain I am unable to do some washing and dressing without help
- ☐ Because of the pain I am unable to do any washing and dressing without help

Section 3 Lifting
- ☐ I can lift heavy weights without extra pain
- ☐ I can lift heavy weights but it gives me extra pain
- ☐ Pain prevents me from lifting heavy weights off the floor
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on the table
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
- ☐ I can only lift very light weights at the most

Section 4 Walking
- ☐ I have no pain while walking
- ☐ I have some pain while walking but it does not increase with distance
- ☐ I cannot walk more than 1 mile without increasing pain
- ☐ I cannot walk more than ½ mile without increasing pain
- ☐ I cannot walk more than ¼ mile without increasing pain
- ☐ I cannot walk at all without increasing pain

Section 5 Sitting
- ☐ I can sit in any chair as long as I like
- ☐ I can only sit in my favorite chair as long as I like
- ☐ Pain prevents me from sitting more than 1 hour
- ☐ Pain prevents me from sitting more than 30 minutes
- ☐ Pain prevents me form sitting more than 10 minutes
- ☐ I avoid sitting because it increases pain immediately

Section 6 Standing
- ☐ I can stand as long as I want without pain
- ☐ I have some pain while standing but does not increase with time
- ☐ I cannot stand for longer than 1 hour without increasing pain
- ☐ I cannot stand for longer than 30 minutes without increasing pain
- ☐ I cannot stand for longer than 10 minutes without increasing pain
- ☐ I avoid standing because it increases the pain immediately

Section 7 Sleeping
- ☐ I get no pain in bed
- ☐ I get pain in bed but it does not prevent me from sleeping well
- ☐ Because of my pain, my normal night's sleep is reduced by less than 1/4
- ☐ Because of my pain, my normal night's sleep is reduced by less than 1/2
- ☐ Because of my pain my normal night's sleep is reduced by less than 3/4
- ☐ Pain prevents me from sleeping at all

Section 8 Social Life
- ☐ My social life is normal and gives me no pain
- ☐ My social life is normal but increases the degree of pain
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interest, example dancing
- ☐ Pain has restricted my social life and I do not go out very often
- ☐ Pain has restricted my social life to my home
- ☐ I have hardly any social life because of the pain

Section 9 Traveling
- ☐ I get no pain while traveling
- ☐ I get some pain while traveling, but none of my usual forms of travel make it any worse
- ☐ I get extra pain while traveling but it does not compel me to seek alternative forms of travel
- ☐ I get extra pain while traveling which compels me to seek alternative forms of travel
- ☐ Pain restricts all forms of travel
- ☐ Pain prevents all forms of travel except that done lying down

Section 10 Changing Degree Of Pain
- ☐ My pain is rapidly getting better
- ☐ My pain fluctuates but overall is definitely getting worse
- ☐ My pain seems to be getting better but improvement is slow at present
- ☐ My pain is neither getting better nor worse
- ☐ My pain is gradually worsening
- ☐ My pain is rapidly worsening

Pain Scale:

Rate The Severity Of Your Pain By Checking One Box On The Following Scale:

No Pain	1	2	3	4	5	6	7	8	9	10	Excruciating Pain

Assignment of Benefits

Financial Responsibility

I understand that insurance billing is service provided as a courtesy and that I am at all times financially responsible to Back & Neck Institute and/or North Florida Medical Center and/or its affiliate entities for any charges not covered by health care benefits. It is my responsibility to notify Back & Neck Institute and/or North Florida Medical Center of any changes in my health care coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by Back & Neck Institute and/or North Florida Medical Center and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form that I am accepting financial responsibility as explained above for all payment for medical services and/or supplies received

Assignment of Benefits

I authorize direct remittance of payment of all insurance benefits, including Medicare, if I am a Medicare beneficiary, to Back & Neck Institute and/or North Florida Medical Center for all covered medical services and supplies provided to me during courses of treatment and care provided by Back & Neck Institute and/or North Florida Medical Center and/or its affiliated entities or otherwise at its direction. I understand and agree this Assignment of Benefits will have continuing effect for so long as I am being treated or cared for by Back & Neck Institute and/or North Florida Medical Center, and will constitute a continuing authorization, maintained on file with Back & Neck Institute and/or North Florida Medical Center, which will authorize and allow for direct payment to Back & Neck Institute and/or North Florida Medical Center of all applicable and eligible insurance benefits for all subsequent and continuing treatment, services, supplies and/or care provided to me by Back & Neck Institute and/or North Florida Medical Center.

Authorization to Release Information

I authorize the release of any medical or any other information to the Health Care Financing Administration, my insurance carrier(s), or other entity necessary to determine insurance benefits or the benefits payable for related medical services and/or supplies provided to me by Back & Neck Institute and/or North Florida Medical Center. A copy of this authorization will be sent to the Health Care Financing Administration, my insurance carrier(s), or other medical entity, if requested. The original authorization will be kept on file by Back & Neck Institute and/or North Florida Medical Center.

Patient/Insured Name (print): _____

Date of Birth: ____/____/____

SS#: ____-___-____

Patient Signature: _____ Date: ____/____/____

Witness Signature: _____ Date: ____/____/____

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Informed Consent to Chiropractic Adjustments and Care

Doctor Initials	Patient Initials	
☐	☐	I have been informed that it is not uncommon that patients have some increased discomfort after an adjustment. If that happens I will apply ice to the area and rest it. If I am concerned about this discomfort or develop any new symptoms, I can call the number listed above during office hours for emergency attention. If I am out of town or unable to contact the doctor, I can present myself to an emergency room. If any tests were performed outside of this office (laboratory or diagnostic procedures), I understand that the doctor will notify me of the results at my next scheduled appointment.
Doctor Initials	Patient Initials	
☐	☐	I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, and, if necessary, diagnostic x-ray, on me by the doctor of chiropractic named above and/or in this clinic authorized by the doctor of chiropractic listed above. I have had an opportunity to discuss with the doctor of chiropractic named above and/or with other office or clinic personnel, the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed. I further understand am informed that, as in all healthcare, in the practice of chiropractic there are some very slight risks to treatment, including, but not limited to, muscle strains and sprains, disc injuries, physical therapy burns, rib injury, and strokes. Strokes are the most serious complication of chiropractic treatment. The most recent studies (Journal of the CAA, Vol. 37 No. 2, June 1993) estimate that the incidence of this type of stroke is 1 in every 3 million upper cervical adjustments. I do not expect the doctor to be able 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 the facts then known, as in my best interests.
Doctor Initials	Patient Initials	
☐	☐	I have read the above consent, with the doctor, as indicated by our initials. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Print Patient Name: _____ Date: ____/____/____

Patient Signature: _____

Doctor Signature: _____

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Notice of Doctor's Lien

I do authorize Back & Neck Institute and/or North Florida Medical Center to furnish you, my attorney, with a full report of the examination, diagnosis, treatment, and prognosis, etc. of myself in regards to the accident in which I was recently involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such as may be due and owing them for medical services rendered to me, both by reason of any other bills that are due to the office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor. Further, I hereby give lien on my case to said doctor against any and all proceeds of my settlement, judgment, 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 connected therewith.

I agree to never rescind this document and that a recession will not be honored by my attorney. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney will honor this lien as inherit to the settlement and enforceable upon the case as if it were executed by him.

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

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but may declare the entire balance due and payable.

Patient Signature: _____ Date: ____/____/____

The undersigned being attorney of the record for the above patient does hereby agree to observe all of the terms above and agree to withhold such from any settlement, judgment, or verdict as any be necessary to adequately protect said doctor's name above. The attorney further agrees that in the event this lien is litigated, the preventing party will be awarded attorney's fees and costs.

Attorney Signature: _____ Date: ____/____/____

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Notice of Privacy Practices

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review carefully.

At Back & Neck Institute, we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective April 14, 2003, and applies to all protected health information as defined by federal regulations.

Each time you visit Back & Neck Institute, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- A tool in educating health professionals,
- A source of data for medical research,
- A source of information for public health officials charged with improving the health of this state and the nation,
- A source of data for our planning and marketing,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

*Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of Back & Neck Institute, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request,
- Inspect and copy your health record as provided for in 45 CFR 164.524,
- Amend your health record as provided in 45 CFR 164.528,
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528,
- Request communications of your health information by alternative means or at alternative locations,
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522, and
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

- Maintain the privacy of your health information,
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this notice,
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us, or if you agree, we will email the revised notice to you.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information as we have received a written revocation of the authorization according to the procedures included in the authorization.

For More Information or To Report a Problem

If you have questions and would like additional information, you may contact the practice's Privacy Officer, Tanya Alcantara, at (904) 269-3664.

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer or with your regional Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights.

Examples of Disclosures for Treatment, Payment and Health Operations

For Example: Information obtained by a nurse, physician, or other member of your health care team, will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.

We will also provide your physician or a subsequent health care provider with copies of various reports that should assist him or her in treating you once you're discharged from this hospital.

We will use your health information for payment.

For Example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health operations.

For Example: We will share your relevant health information with other providers involved in your care, to assist in the coordination of your care. This may include specialists, hospitals, clinics, and other individuals or organizations prior to or after us who have provided you with health care.

Business Associates: there are some services provided in our organization through contacts with business associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Directory: Unless you notify us that you object, we will use your name, location in the hospital, general condition, and religious affiliation for directory purposes. This information may be provided to members of the clergy and, except for religious affiliation, to other people who ask for you by name.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with Family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and establish protocols to ensure the privacy of your health information.

Funeral Director: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Organ Procurement Organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Marketing: We may contact your to provide appointment reminders or information about treatment alternative or other health-related benefits and services that may be of interest to you.

Fund-Raising: We may contact you as part of a fund-raising effort.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Law Enforcement: We may disclose health information for enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision for your health information be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in food faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

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Acknowledgment Form

Acknowledgment of Receipt of Privacy Notice

I have been presented with a copy of Back & Neck Institute and North Florida Medical Center's Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information:

_____

_____

_____

_____

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulation pertaining to medical assignment of benefits apply.

Patient Signature: _____ Date: ____/____/____

If not signed by patient, please indicate relationship to patient (e.g., spouse)

Relationship: _____ Date: ____/____/____

If the patient refuses to sign, indicate your attempt to obtain a signature below:

( ) Patient refused to sign this Acknowledgment.

Date: ____/____/____

Time: ___:___ AM/PM

Employee Name: _____

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To: _____

_____

Phone: _____ Fax: _____

I, _____, give full authorization to release my _____ to the physicians of Back & Neck Institute and/or North Florida Medical Center for purposes of diagnosing my condition. If you have any questions, please feel free to contact me at the number listed below.

Thank you,

_____ _____
Patient Signature Date

_____ _____
Phone Number Date of Birth

_____
Contact Person

This consent is valid for sixty days from the date of signature.

MEDICAL HISTORY

(PLEASE CHECK ALL THAT APPLY)

Cardiovascular	Respiratory	Gastrointestinal	Endocrine	Hematologic
☐ Chest Pain	☐ Asthma	☐ Acid Reflux/GERD	☐ Obesity	☐ Bleeding Disorder
☐ Heart Attack	☐ Emphysema	☐ Ulcers	☐ Hypothyroid	☐ Anomia
☐ Heart Disease	☐ Chronic Bronchitis	☐ Polyps	☐ Hyperthyroid	☐ Easy Bruising
☐ Heart Rhythm Disturbances	☐ Frequent Pneumonia	☐ Hepatitis A, B, C	☐ Diabetes	☐ Anticoagulation
☐ Arterial Insufficiency	☐ Frequent Colds/Sore Throat	☐ Pancreatitis	☐ Insulin	(blood thinners)
☐ Venous Insufficiency	☐ Positive TB Test	☐ Bowel Problems	☐ Other	☐ Blood Clots
☐ High Blood Pressure	☐ Abnormal Chest x-ray	☐ Colitis		
☐ Low Blood Pressure	☐ Other	☐ Hiatal Hernia		
☐ Embolism		☐ Gallbladder Problems		
☐ Other		☐ Irritable Bowel Syndrome		
		☐ Crohn's Disease		
		☐ Special Diet		
		☐ Liver Disease		

Neurological	Psychological	Genitourinary	Musculoskeletal
☐ Memory Problems	☐ Nervous Breakdown	☐ Sexual Dysfunction	☐ Fibromyalgia
☐ Seizures	☐ Depression	☐ Sexually Transmitted Disease	☐ Rheumatoid Arthritis
☐ Stroke	☐ Anxiety	☐ Prostate Disease	☐ Osteoporosis
☐ Movement Disorders	☐ Panic Disorder	☐ Kidney Problems	☐ Back Problems
☐ Muscular Dystrophy	☐ Psychosis	☐ Chronic Infection	☐ Neck Problems
☐ Neuropathy	☐ Alcohol or Drug Abuse	☐ Bladder Problems	
☐ Migraine	☐ Other		
☐ Epilepsy			
☐ Headaches			

Cancer	Miscellaneous	General	Allergic/Immunological
☐ Site	☐ Glaucoma	☐ Medical Equipment	☐ Autoimmune Disorder
☐ Diagnosis Date	☐ Cataracts	☐ Cane	☐ Lupus, Sjogren's
☐ Chemotherapy	☐ Visual Problems	☐ Walker	☐ Raynaud's Syndrome
☐ Radiation	☐ Hearing Loss	☐ Wheelchair	☐ Immune Deficiency
☐ Other	☐ Chronic Skin Disorder	☐ Hospital Bed	☐ HIV
	☐ Pregnancy	☐ Oxygen at ___ liters	
	☐ Date of Last Period		

SURGICAL HISTORY

(Please list all surgeries)

Patient Name:	DOB:	MR:

MEDICATIONS

List all medications that you are taking NOW. (Include over the counter, herbal, vitamins, & other supplemental medications)

Medications	Dose (mg)	How often? (# of time/day)	What is this medication for?	Date started	Prescribing Doctor

Do you take any blood thinning medication? What? _____

(This is not an all-inclusive list but ex. of some anticoagulants are: Coumadim, Plavix, Ticlid, Aggranox, Pradaxa)

List all other pain medications that you have tried in the past & why you stopped;

_____

_____

ALLERGIES

Please list any known drug, food, or environmental allergies and indicate what the adverse effect/reaction is:

_____

_____

Topical Allergies: ☐ **Latex** ☐ **Iodine** ☐ **Tape** ☐ **IV Contrast** ☐ **Shellfish**

Patient Name:	DOB:	MR:

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(1)(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.

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Pub. 1/2004

OFFICE OF INSURANCE REGULATION
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Standard Disclosure and Acknowledgement Form
Personal Injury Protection - Initial Treatment or Service Provided

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