Bartz Chiropractic
1316 SW 4th Terrace, Suite 102
Cape Coral, FL 33991

Auto Accident History

Date _____

Name_____
First Middle Last
Address_____
City_____State_____Zip_____
Soc Sec #_____Home Phone_____
Birthdate_____ Age_____Cell Phone_____
Marital Status: M S W D Gender: M F

AUTO ACCIDENT INFORMATION

Date of Accident: _____ Time of Accident: _____

In your own words, please describe how accident happened: _____
_____
_____
_____
_____

In your own words, please describe injury received and to what parts of body: _____
_____
_____
_____

What type of car were you in? _____

What type of car was other driver in? _____

Were you: ( ) Driver ( ) Passenger ( ) Front Seat ( ) Back Seat

Where you wearing your seatbelt? ( ) Yes ( ) No

Does your car have airbags? ( ) Yes ( ) No If yes, did they inflate? ( ) Yes ( ) No

Approximate speed of vehicle at time of accident: _____

Number of people in your vehicle? _____ Other Vehicle? _____

Were you struck from: ( ) Behind ( ) Front ( ) Left side ( ) Right side

What direction were you headed? ( ) North ( ) East ( ) South ( ) West
on (name of street) _____

What direction was the other vehicle headed? ( ) North ( ) East ( ) South ( ) West
on (name of street) _____

Were you knocked unconscious? ( ) Yes ( ) No. If yes, for how long?_____

Did any part of your body strike anything in vehicle? ( ) Yes ( ) No

If yes, please describe: _____

_____

Was there damage to your car? ( ) Minor ( ) Moderate ( ) Extensive ( ) Totaled

Was the accident? ( ) Complete Surprise ( ) Saw car coming (able to brace body for impact)

Position of body at impact: ( ) Straight Ahead ( ) Slouched ( ) Rotated Left ( ) Rotated Right

Were police notified? ( ) Yes ( ) No

Was a police report filed? ( ) Yes ( ) No

Was a traffic violation issued ( ) Yes ( ) No If so, to whom? _____

Please describe how you felt:

a. DURING the accident:_____

b. IMMEDIATELY AFTER the accident: _____

c. LATER THAT DAY_____

d. THE NEXT DAY: _____

Where were you taken after the accident? _____

How long after the accident did you go? _____

Have you ever been treated by a hospital or another doctor since the accident? ( ) Yes ( ) No.

If yes, please list doctor's name and address: _____

What type of treatment did you receive? _____

What recommendations were made? _____

Since this injury occurred, are your symptoms: ( ) Improving ( ) Getting Worse ( ) Same

Home care how you treat symptoms: _____

CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

☐ Headache	☐ Irritability	☐ Numbness in Toes	☐ Face Flushed	☐ Feet Cold	☐ Neck Pain
☐ Chest Pain	☐ Shortness of Breath	☐ Buzzing in Ears	☐ Hands Cold	☐ Neck Stiff	☐ Dizziness
☐ Fatigue	☐ Loss of Balance	☐ Stomach Upset	☐ Sleeping Problems	☐ Heavy Head Feeling	☐ Depression
☐ Fainting	☐ Constipation	☐ Back Pain	☐ Pins & Needles Arms	☐ Lights Bother Eyes	☐ Loss of Smell
☐ Cold Sweats	☐ Nervousness	☐ Pins & Needles in Legs	☐ Loss of Memory	☐ Loss of Taste	☐ Fever
☐ Tension	☐ Numbness in Fingers	☐ Ears Ring	☐ Diarrhea	☐ Other (add below)	

Symptoms Other Than Above: _____

_____

What are your PRESENT complaints and symptoms? _____

_____

_____

Do you have any previous illnesses which relate to this case? _____ ( ) Yes ( ) No

If yes, please describe: _____

_____

Did you have any physical complaints BEFORE THE ACCIDENT? ( )Yes ( ) No
If yes, please describe in detail: _____

_____

_____

Have you ever been involved in an accident before? ( ) Yes ( ) No.

If yes, please describe, including date(s) and type(s) of accidents, as well as injuries received. _____

_____
_____

Have you lost time from work as a result of this accident? ( ) Yes ( ) No (If yes, please complete below)
a. Last Day Worked: _____
b. Type of Employment: _____
c. Are you being compensated for time lost from work? ( ) Yes ( ) No. (If yes, please complete below)
Type of compensation you are receiving? _____
Do you notice any activity restrictions as a result of this injury?( ) Yes ( ) No (If yes, please complete below) _____
_____

Other pertinent information:_____
_____
_____
_____

Have you contacted an adjuster regarding this claim?
Company: _____
Address: _____ Phone # _____
Adjuster: _____ Claim#: _____

ASSIGNMENT OF BENEFITS and MEDICAL RELEASE

ASSIGNMENT OF BENEFITS

I, _____ , hereinafter ASSIGNOR, hereby authorize
(Name of insured patient)
_____ to pay directly to **Bartz Chiropractic, LLC**
(Name of Insurance Carrier) (Name of Medical Provider)

hereinafter ASSIGNEE, the medical benefits other wise payable to me for their services, but not to exceed the charges of those services. I hereby ASSIGN to ASSIGNEE any benefits or causes of action under any policy of insurance, indemnity agreement, or any other collateral source as defined in Florida Statutes for any service and or charges provided by ASSIGNEE. This ASSIGNMENT OF BENEFITS is given in exchange for ASSIGNEE agreeing to send request for payment to the above named insurance carrier for all payments due and payable pursuant to the ASSIGNOR'S contract of insurance. This ASSIGNMENT OF BENEFITS is IRREVOCABLE unless subsequent revocation is in writing and agreed to by both parties.

MEDICAL RELEASE

This document shall be sufficient to authorize any person having records of medical treatment, services, or supplies pertaining to me, to release true copies of same to ASSIGNEE or any insurer providing coverage to me in connection with the processing of any claim for benefits made by the ASSIGNEE herein. A photocopy of this document shall be as binding as an original signature page.

IN WITNESS WHERE OF the undersigned ASSIGNOR and ASSIGNEE have hereunto set their hands, this _____day of_____ , 20___ .

_____ _____
Patient's Signature (ASSIGNOR) Authorized Representative of ASSIGNEE

_____
Patient's Name (Please Print Clearly)

Auto Accidents:

I authorize the release of PIP/Med. payment records to Bartz Chiropractic, LLC.
I authorize Bartz Chiropractic, LLC the right to obtain my Declaration Page of my Auto Policy.

_____ _____ _____
Patient Name (Please Print Clearly) Patient/Guardian Signature Date

APPLICATION FOR FLORIDA "NO FAULT" BENEFITS

Date:_____ **File Number:**_____

Insurance Company:_____

Policy Number:_____ **Date of Accident:**_____

TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE FLORIDA PERSONAL INJURY PROTECTION LAW, PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY. ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURANCE COMPANY MAKES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION, IS GUILTY OF A FELONY OF THE THIRD DEGREE.

Name:_____ **Address:**_____

Phone Number:_____ **City, State, Zip Code:**_____

Date of Birth:_____ **Social Security Number:**_____

How long have you been a resident of Florida?_____

Date of accident:_____ **Time of accident:**_____

Location of accident:_____

Description of accident:_____

_____

_____

_____

_____

Make and model of vehicle you were occupying during accident:_____

As a result of this accident, were you injured?_____**If yes, complete the form. If no, sign below and return to us.**

_____ _____

Signature Date

Description of Injury:_____

_____

Were you treated by a doctor?_____**If yes, name and address:**_____

Were you treated at a hospital?_____**If yes, name and address:**_____

Amount of medical expenses to date: $_____**Will you have more expenses?**_____

At the time of accident, were you employed?_____**If yes, did you lose any wages?**_____

If yes, amount lost? $_____**Your weekly salary or wage: $**_____

Date disability from work began:_____**Date you returned to work:**_____

Have you received benefits under Worker's Compensation?_____**If yes, amount and frequency: $**_____

Name and addresses of employer or previous employer along with occupation and dates of employment:

_____

As a result of this accident, have you had any other expenses?_____**If yes, explain below with expense amounts.**

_____

_____ _____

Signature Date

Form 1250F

http://www.claimspages.com

Bartz Chiropractic

"Serving your Mid-Cape Chiropractic Needs"

INSURANCE COMPANY:_____

For and in consideration of the above mentioned provider agreeing to pursue my insurance provider for payment of benefits due me and not requiring prepayment for services. I hereby irrevocably assign to the aforementioned medical provider (the "Provider") any Personal Injury Protection benefits I may have in accordance with Florida Statute 627.736(5). This includes any benefits from my insurance company or any other entity that may be responsible for expenses incurred, and I authorize the Provider to prosecute said action and collect legal expenses as they see fit. THIS DOCUMENT CONSTITUTES AN ASSIGNMENT OF BENEFITS. I hereby further give a lien to the Provider 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 the Provider. This is to act as an irrevocable assignment of my rights and benefits to the extent of the services provided. I agree to cooperate with the Provider and any attorney that the Provider chooses, and to do all things reasonable to effect payment of bills by the insurance company to the Provider including, but not limited to, disclosing patient's medical condition and treatment. This assignment concerns only the bills for the Provider and those costs (including, but not limited to attorney's fees, court costs and interest) necessary in procuring payment from the above-named insurance company, etc. This assignment is not intended 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 the PIP insurance coverage. I understand that this is a benefit and convenience to me in that the Provider will pursue collection against the insurance company on my behalf. I hereby instruct and direct my insurance company to pay my benefits by check, made payable to and mailed to the Provider at the address listed above. If my current policy prohibits direct payments to doctors, then I hereby instruct and direct my insurance company to make the check payable to me and mail it to the Provider at the address listed above. Furthermore, I hereby give the Provider limited power of attorney to endorse/sign my name on any and all checks for payment to the Provider. This assignment is intended to serve as assignment of the patients rights and benefits under his/her aforementioned insurance policy in favor of the Provider. If any language within this agreement has the effect of invalidating this assignment, that language shall be deemed void and the assignment shall remain in full force and effect. A photocopy of this assignment shall be considered as effective and valid as the original.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date

1316 SW 4th Terrace ▪ Suite #102 ▪ Cape Coral, Fl 33991 ▪ Phone: 239.772.5582 ▪ Fax: 239.772.5215
www.bartzchiropractic.com

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.

Bartz Chiropractic 1316 SW 4th Terrace, #102 Cape Coral, FL 33991

Activities of Daily Living Assessment

Rate your current difficulties by placing the appropriate number in the box. If an activity does not cause pain or if pain does not affect an activity, leave box blank.

[1] This activity causes some pain, but it is only a minor annoyance.
[2] This activity causes a significant amount of pain, but I can do it.
[3] I cannot perform this activity due to pain and disability.

Self Care and Personal Hygiene

[ ] bathing/showering	[ ] brushing teeth	[ ] putting on shoes	[ ] eating	[ ] doing laundry
[ ] gooming hair	[ ] making the bed	[ ] putting on pants	[ ] dishes	[ ] going to toilet
[ ] washing face	[ ] putting on shirt	[ ] cooking	[ ] taking out trash	

Physical Activities

[ ] standing	[ ] walking	[ ] reaching	[ ] bending right	[ ] twisting right
[ ] sitting	[ ] squatting	[ ] bending forward	[ ] bending left	[ ] twisting left
[ ] reclining	[ ] kneeling	[ ] bending back	[ ] looking left	[ ] looking right

Functional Activities

[ ] carrying small objects	[ ] lifting weights off table	[ ] pushing/pulling while standing
[ ] carrying large objects	[ ] climbing stairs/incline	[ ] exercising upper body
[ ] carrying briefcase/purse	[ ] pushing/pulling while seated	[ ] exercising lower body
[ ] lifting object off floor		

Social and Recreational Activities

[ ] bowling	[ ] jogging	[ ] swimming	[ ] golfing	[ ] dancing
[ ] biking	[ ] hunting/fishing	[ ] competitive sports	[ ] gardening	
[ ] walking	[ ] horse riding	[ ] other:_____		

Difficulties with Traveling

[ ] driving in car	[ ] driving for long periods of time
[ ] riding as passenger	[ ] riding as passenger for long periods of time

Other activities

Use this scale for the following activities:
[1] This activity is slightly affected by my condition
[2] This activity is moderately affected by my condition
[3] This activity is severely affected by my condition
[4] I cannot perform this activity due to my condition

[ ] concentrating	[ ] listening	[ ] reading	[ ] studying	[ ] writing	[ ] using computer
[ ] sleeping	[ ] sexual relations				

Patient Signature:_____ Date: _____

Bartz Chiropractic, LLC

PATIENT CONSENT
FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I hereby state that by signing this Consent, I acknowledge and agree as follows:

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.

2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

3. I understand that, and consent to, the following appointment reminders that will be used by the Practice: a) a postcard mailed to me at the address provided by me; and b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone, or by e-mail.

4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.

5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.

6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for *all future* transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.

7. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.

8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

_____	_____
Name of Patient/Individual (Please print)	Signature of Patient/Individual
_____	_____
Signature of Legal Representative (e.g., Attorney-In-Fact, Guardian, Parent if a minor)	Relationship to Patient
_____	_____
Date Signed	Witness

Bartz Chiropractic

"Serving your Mid-Cape Chiropractic Needs"

Informed Consent to Chiropractic Care

Chiropractic care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to a stroke.

Prior to receiving chiropractic care at Bartz Chiropractic, a health history and physical examination will be completed. These procedures are performed by members of our faculty and are performed to assess your specific condition, your overall health and, in particular, your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan.

I understand and accept that there are risks associated with chiropractic care and give my consent to the examinations deemed necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment. I understand that all Doctors and Chiropractic Assistants at Bartz Chiropractic could be involved in my care. I also understand that my condition and treatment could be used for training and/or educational purposes with my consent. My name and other personal identifying information will be kept confidential.

_____ _____

Patient Name (printed) Relationship to patient

_____ _____

Patient or legal Guardian Signature Date

_____ _____

Witness Signature Date

1316 SW 4th Terrace ▪ Suite #102 ▪ Cape Coral, Fl 33991 ▪ Phone: 239.772.5582 ▪ Fax: 239.772.5215
www.bartzchiropractic.com