Munday Chiropractic Clinic, P.A.

Appointment Date _____ Email _____

Name _____ DOB _____ Sex: ☐ M ☐ F Last 4 of SS# _____

Address _____ City _____ State _____ Zip _____

Cell Ph _____ Home Ph _____ Work Ph_____

Employer _____ Occupation _____ Spouse _____

Emergency Contact _____ Phone _____ Relationship _____

HEALTH INSURANCE: PRIMARY Insurance Co_____ Policyholder Name _____

DOB _____ Relation to Patient _____ Policyholder Employer_____

ACCIDENT INFORMATION: (SKIP this section if you were NOT involved in an accident): ☐ **AUTO** ☐ **WORK** ☐ **SLIP & FALL**

Date of Accident _____ Place of Injury _____ Insurance Co _____

Insured's Name/DOB_____ Has accident been reported to **your** insurance company or employer:

☐ Yes ☐ No Claim #_____ Provide dates & details of **ALL** prior accidents:_____

_____

1. **DESCRIBE COMPLAINT**: _____

Examples: Headaches, Neck Pain, Shoulder Pain, Lower Back Pain, Pain Going Down Hip/Leg, Etc.

2. Is the pain: ☐ Dull & Achy ☐ Tight & Stiff ☐ Sharp & Stabbing ☐ Numb & Tingly ☐ Shooting ☐ Burning ☐ Cramping

3. Is the pain: ☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe

4. How long have you had the pain: _____ ☐ Day(s) _____ ☐ Week(s) _____ ☐ Month(s) _____ ☐ Year(s)

5. Was there a certain event or activity that caused the pain: _____

6. Is the pain: ☐ Improving ☐ Worsening ☐ Staying the Same

7. **When** is pain WORSE: ☐ Morning Time ☐ Night Time ☐ After Day Wears On ☐ Fairly Steady ☐ Off & On With No Pattern

8. **What** WORSENS pain: ☐ Activity ☐ Moving Wrong ☐ Bending ☐ Lifting ☐ Walking ☐ Sports ☐ Getting Up From A Chair

☐ Using a Computer and/or Deskwork ☐ Housework ☐ Performing Your Work Duties Other_____

9. **What** IMPROVES it: ☐ Rest ☐ Activity ☐ Ice Packs ☐ Heating Pad ☐ Over-The-Counter Meds ☐ Prescription Meds

☐ Massages ☐ Past Chiropractic Care ☐ Physical Therapy ☐ Nothing Other_____

10. Is there any other complaint that is less severe today that you would like the doctor to address: _____

_____

Medicare Patients:** PLEASE CHECK ***ONLY ONE that you would like to be able to do without pain:

☐ Bend & Lift ☐ Get Up From Sitting ☐ Get A Good Night's Sleep ☐ Work At a Desk/Computer ☐ Play Sporting Activities

☐ Do Yardwork ☐ Do Housework ☐ Play With/Care For Child(ren)/Grandchild(ren) ☐ Perform Normal Work Duties

1. CURRENT HEALTH HISTORY: List all CURRENT illness or disease you are experiencing (such as cancers, tumors, infections, aneurysms, diabetes, liver/kidney disease, blood/lymph node disorders) etc: _____

_____

2. What Is Your Usual Blood Pressure _____/_____

3. List Blood Thinners: _____ ☐ NONE

4. List Medication Allergies: _____ ☐ NONE

5. Your Height _____feet _____inches

6. Your Weight _____ Any Recent Unexplained Weight Loss: ☐ YES ☐ NO If Yes, Explain: _____

7. Current Fever: ☐ YES ☐ NO

8. Any Recent Loss of Bowel or Bladder Control: ☐ YES ☐ NO If Yes, Explain:_____

9. Any Recent Seizures, Paralysis, Slurred Speech, Blurry/Double Vision: ☐ YES ☐ NO If Yes, Explain: _____

10. Do You Have **OSTEOPOROSIS**: ☐ YES ☐ NO

11. List Any Skin Disorders/Skin Allergies (ie: Menthol, Eucalyptus, Latex):_____

12. Do You Have a **PACEMAKER** or Other **ELECTRICAL DEVICE** You Wear/Or Have Implanted: ☐ YES ☐ NO IF **YES**, **ALERT US**

13. PAST HEALTH HISTORY: Please list PAST surgeries and/or medical procedures you have had:

Date:_____ Procedure:_____ Date:_____ Procedure:_____

Date:_____ Procedure:_____ Date:_____ Procedure:_____

14. PAST ILLNESSES: Please list all PAST illnesses, such as cancers, bone tumors, infections, aneurysms, injuries:

Date:_____ Condition:_____ Date:_____ Condition:_____

Date:_____ Condition:_____ Date:_____ Condition:_____

15. MARK ONE: ☐ I Never Smoked ☐ Former Smoker ☐ Current Smoker, How Much:_____ Pack(s)/Day or _____ Pack(s)/Week

16. MARK ONE: ☐ I Don't Drink Any Alcohol ☐ Rarely Drink ☐ Social/Moderate Drinker ☐ Heavy Drinker: _____oz per day

17. Name of your primary care physician: _____

18. Approximate Date or Year of Last Eye Exam: _____

19. Have you ever had Chiropractic care? ☐ YES ☐ NO If YES, Last treatment date:_____ Result _____

INFORMED CONSENT TO CHIROPRACTIC TREATMENT: I, the undersigned, hereby request and consent to the performance of chiropractic treatment, including but not limited to, physical examination, x-rays, spinal manipulation, manual/massage therapies, physical modalities, i.e., heat, cold, ultrasound, electrical stimulation and/or any other procedures performed on myself or the patient for whom I am legally responsible by the licensed chiropractic physicians, licensed massage therapists and/or employees of Munday Chiropractic Clinic, P.A., as authorized by the chiropractic physicians. I understand that I have the opportunity to discuss the nature and purpose of chiropractic manipulations and other procedures with the chiropractic physicians of Munday Chiropractic Clinic, P.A. I understand that Munday Chiropractic Clinic, P.A. cannot guarantee that I will respond to treatment; no physician can guarantee a cure for any disease or condition. I understand that in the practice of chiropractic medicine, there are some risks to treatment, including but not limited to: fractures, disc injuries, dislocations, sprains, strokes, temporary bruising, soreness, increased pain or discomfort and/or aggravation of symptoms. I do not expect the chiropractic physician to be able to anticipate and explain all risks and complications and I wish to rely on the physician and/or massage therapist to exercise professional judgment during the course of treatment felt to be necessary at the time and based upon the facts known as provided by me, that is in my best interest. I have read, or have had read to me, the above consent and by signing below I hereby give my consent to be treated by Munday Chiropractic Clinic, P.A., as deemed appropriate through the use of the above-named treatments.

Women Only: I hereby declare that to the best of my knowledge, ☐ I AM or ☐ I AM NOT pregnant. If there is a chance that I may be pregnant, I will inform the Staff and/or Doctor prior to my examination.

Patient's Signature _____ **Printed Name**_____
(Parent/Guardian signature if patient is under 18 years of age)

MUNDAY CHIROPRACTIC CLINIC, P.A.'s OFFICE POLICY

TO BE READ & INITIALED BY **ALL** PATIENTS:

1. You agree to inform our office of any name, address, telephone number, email, and/or insurance changes.
2. All monies owed will be collected at the time of service payable by cash, check, or credit card. For your convenience, we can store your credit card on file in an encrypted fashion.
3. If you are unable to keep a **MASSAGE** appointment, please notify us **24 HOURS** before your appointment. If you do not, we will try to fill your missed **MASSAGE**, but in the event that we cannot, you are responsible for paying the missed massage fee as follows: **$20 fee for missing 15 min, $30 for missing 30 min, $40 for missing 45 min, $50 for missing 60 min, $60 for missing 75 min, $70 for missing 90 min, and $90 for missing 120 min without 24 hours notice.** If your first massage is missed without proper notification, all future massage appointments **must be secured** with a credit card on file. In the event you continue to miss massages without proper notice, you hereby consent for us to charge the missed massage fee to any credit card on file without prior notification. **Read item #3 above and confirm your agreement by *INITIALING HERE*: _____**
4. Returned checks will result in a $25.00 service fee. You will only be sent a statement if your balance exceeds $10.00.
5. There is a **minimum** $25.00 charge for the completion of paperwork such as **Disability Forms** and **FMLA Forms.**

TO BE READ & INITIALED **ONLY** BY PATIENTS USING HEALTH INSURANCE:

1. We will verify your insurance for Chiropractic benefits. Coverage is obtained from your insurance company using information provided by you. **We must emphasize that as medical providers, our relationship is with you, not your insurance company.** The information provided by your insurance company is not a guarantee of payment. It is an estimate of what might or might not be covered under your policy at the time of inquiry. You will be responsible for any non-covered/unpaid amounts.
2. It is your responsibility to inform us of any changes to your insurance policy so that your coverage can be re-verified.
3. It is your responsibility to be aware of the services being provided to you and if it is a covered benefit under your insurance.
4. We will send all required claim forms and documentation in hopes your claims are processed in a timely manner.
5. Final determination of benefits available is determined when the claim is sent to your insurance company and we receive an explanation of benefits from them. After all co-pays, contracted plan reductions and insurance payment credits are applied to your account, any remaining portion will be your responsibility. We will attempt to contact you to collect any unpaid amounts, but if we are unsuccessful or have had no response to mailings, telephone calls or, texts, you hereby consent for us to charge any credit card on file for any unpaid amounts. **Read item #5 above and confirm your agreement by *INITIALING HERE*: _____**
6. If you have a **Health Reimbursement Account** that pays for services when the claim is submitted, you must secure your account with a credit card on file. In the event your fund is depleted when we submit our claim, we will attempt to contact you to collect any unpaid amounts. If we are unsuccessful or have had no response to mailing, telephone calls or, texts, you hereby consent for us to charge any credit card on file for any unpaid amounts.
   Read item #6 above and confirm your agreement by *INITIALING HERE*: _____
7. If you believe that your **Insurance Deductible** has been met, even after we verify with your health insurance company that it is not yet met, you will be required to pay for your services at the time of your visit. In the event that our claim is paid, you will have a credit on your account. **Read item #7 above and confirm your agreement by *INITIALING HERE*: _____**
8. If you are a **MEDICARE PATIENT**, please be advised that Medicare **ONLY COVERS SPINAL ADJUSTMENTS** in a Chiropractor's office. All services other than the **Spinal Adjustment** will be your financial responsibility.

TO BE SIGNED BY **ALL** PATIENTS:

By signing below, you have read and understand the above Office Policy and agree to meet all financial obligations.

_____ _____ _____

Printed Name | Signature of Patient/Parent/Legal Guardian | Date

CONSENT TO TREAT A MINOR: I hereby authorize and give consent for the Chiropractic Physicians at Munday Chiropractic Clinic to examine, and if needed, treat my minor child _____

Print Minor's Name Here

_____ _____ _____

Printed Name of Parent/Legal Guardian | Signature of Parent/Legal Guardian | Date

MUNDAY CHIROPRACTIC CLINIC, P.A.

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Munday Chiropractic Clinic, P.A. to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). The Notice of Privacy Practices provided by Munday Chiropractic Clinic, P.A. describes such uses and disclosures more completely and may be obtained from the front desk.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Munday Chiropractic Clinic, P.A. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to: Munday Chiropractic Clinic, P.A. at 6645 N. Socrum Loop Rd, Lakeland, Florida 33809.

With this consent, Munday Chiropractic Clinic, P.A. may communicate in any of the following methods that assist the practice in carrying out TPO, including but not limited to, appointment reminders, billing, insurance, clinical care, diagnostic test results, patient statements, portal login and/or medical records. I understand that communicating via email and text is not a secure method of communication and I also understand there are potential security risks associated with faxing, secure emailing or mailing information. I hereby authorize the use of any of these methods of communication.

- **Call** and/or **text** my home phone, work phone, mobile phone or, other alternative numbers, and leave a message on voicemail or in person to others
- **Mail** to any addresses that are on file
- **Email** to any email addresses that are on file
- **Fax, secure email or mail** to my **retained personal injury or worker's compensation attorney(s)**

I have the right to request that Munday Chiropractic Clinic, P.A. restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to allow Munday Chiropractic Clinic, P.A. to use and disclose my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Munday Chiropractic Clinic, P.A. may decline to provide treatment to me.

_____	_____	_____
Signature of Patient/Parent/Legal Guardian	Print Patient Name	Date

REQUEST TO RESTRICT RELEASE OF INFORMATION: HIPAA requires Munday Chiropractic Clinic, P. A., to protect the privacy of your PHI. However, if you do not object, our office, based on professional judgment and if it is felt to be in your best interest, may share current, relevant PHI with family members and/or friends involved in your health care or payment for your health care in certain circumstances. For example, if your family member or friend presents to our office requesting a copy of your MRI report, we may release such report. If there is a specific person that you **DO NOT WISH** to have your PHI, please name the person(s) below.

_____

Non-Authorized Person(s) - Please Print

APPLICATION FOR BENEFITS—PERSONAL INJURY PROTECTION

DATE	POLICY HOLDER	DATE OF ACCIDENT	CLAIM NUMBER

YOUR NAME AND ADDRESS	EMAIL ADDRESS

PHONE: (H) (W)	DATE OF BIRTH	SSN

DATE, TIME AND PLACE OF ACCIDENT:

DESCRIPTION OF ACCIDENT AND VEHICLES INVOLVED:

AT THE TIME OF THE ACCIDENT:		
	WERE YOU THE DRIVER OF THE POLICYHOLDER'S CAR?	□ YES □ NO
	WERE YOU A PASSENGER IN THE POLICYHOLDER'S CAR?	□ YES □ NO
	WERE YOU A PEDESTRIAN?	□ YES □ NO
	WERE YOU THE DRIVER OF A CAR OTHER THAN THE POLICYHOLDER'S?	□ YES □ NO

ARE YOU A MEMBER OF THE POLICYHOLDER'S HOUSEHOLD? □ YES □ NO IF YES, WHAT IS YOUR RELATIONSHIP?

AS A RESULT OF THIS ACCIDENT, WERE YOU INJURED? □ YES □ NO IF YES, COMPLETE THE REST OF THIS FORM. IF NO, SIGN AND RETURN THIS FORM TO US.

SIGNATURE: _____ DATE: _____

DESCRIBE YOUR INJURY:

DID A DOCTOR TREAT YOU? □ YES □ NO	DOCTOR'S NAME AND ADDRESS:
IF YOU WERE TREATED IN A HOSPITAL, WERE YOU AN ☐ IN-PATIENT ☐ OUT-PATIENT	HOSPITAL'S NAME AND ADDRESS:

HAVE YOU EVER HAD THE SAME OR A SIMILAR CONDITION? ☐ YES ☐ NO IF YES, STATE WHEN AND DESCRIBE:

IS CONDITION SOLEY A RESULT OF THIS ACCIDENT? ☐ YES ☐ NO IF NO, EXPLAIN:

AMOUNT OF MEDICAL BILLS TO DATE:	WILL YOU HAVE MORE MEDICAL EXPENSES? ☐ YES ☐ NO	WERE YOU IN THE COURSE OF YOUR EMPLOYMENT? ☐ YES ☐ NO
DID YOU LOSE WAGES AS A RESULT OF YOUR INJURY? ☐ YES ☐ NO	IF YES, AMOUNT LOST TO DATE:	WHAT IS YOUR AVERAGE WEEKLY WAGE OR SALARY?

DATE DISABILITY FROM WORK BEGAN: DATE YOU RETURNED TO WORK:

HAVE YOU EVER RECEIVED, OR ARE ELIGIBLE FOR, BENEFITS UNDER:

ANY WORKER'S COMPENSATION LAW?	□ YES	□ NO	IF YES, AMOUNT (CHOOSE ONE):
EMPLOYMENT BY US GOVERNMENT?	□ YES	□ NO	PER WEEK _____
MILITARY SERVICE?	□ YES	□ NO	PER MONTH _____

NAME AND ADDRESS OF YOUR PRESENT EMPLOYER, YOUR OCCUPATION & DATES OF EMPLOYMENT:

AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES? □ YES □ NO IF YES, PLEASE EXPLAIN:

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.

MUNDAY CHIROPRACTIC CLINIC, P.A.

Patient/Insured: _____ Date of Loss: _____

Insurer: _____ Claim #: _____

Authorization to Release Auto Insurance Information and/or Obtain PIP Benefit Payout Information

I hereby grant my authorization for Munday Chiropractic Clinic, P.A. to request and obtain my PIP insurance policy benefits for the accident noted above. I also hereby authorize and direct my insurer to send to Munday Chiropractic Clinic, P.A. an accounting ledger showing all PIP benefit payouts for the above noted accident.

_____ _____

Patient/Insured Signature Date Signed

Assignment of PIP Benefits

I hereby assign my PIP automobile insurance policy benefits relating to the above captioned accident to Munday Chiropractic Clinic, P.A. for professional services rendered and covered under my PIP and/or Medical payments policy. All payments for such services shall be forwarded directly to Munday Chiropractic Clinic, P.A. All payments will be overdue if not paid within the allowed 30 day period after the insurer is furnished with properly completed claim form and medical records. Overdue payments will bear 10% interest per annum. In the event an insurer fails to pay Munday Chiropractic Clinic, P.A. the full amount of the treatment allowed by current fee schedules, I authorize and direct the insurer to set aside/escrow an amount equal to the full amount of any such reduction until Munday Chiropractic Clinic, P.A. has exercised its rights under this assignment and the dispute is resolved. This assignment will remain in effect until 48 hours after Munday Chiropractic Clinic, P.A. receives written notice that it is being revoked. It is specifically agreed that any such revocation of this assignment will not apply to any treatment or associated expenses incurred on or before the date of notice of revocation is received by Munday Chiropractic Clinic, P.A. The undersigned agrees to pay any applicable deductible and/or co-payments not covered under the available PIP and/or Medical Payments policy. Furthermore, the undersigned agrees to pay all outstanding balances in excess of the available insurance coverage limits.

_____ _____

Patient/Insured Signature Date Signed