Wolstein Chiropractic & Sports Injury Center
Dr. Sheryl M Haynes, D.O.
32976 US Hwy 19 N. Plam Harbor, FL. 34684
P: 727-787-6677 F: 727-787-1177

INITIAL INJURY EVALUATION HISTORY AND PHYSICAL

Date of Injury: _____

A. Patient Information

Name: _____ D.O.B: _____
Today's Date: _____ Home/Cell Phone: _____
Address: _____
City: _____ State: _____ Zip Code: _____
E-mail: _____
Sex: Male☐ Female☐ SS#: _____ ☐ Married☐ Widowed☐ Single☐ Divorced
Emergency Contact: _____ Phone: _____
Primary Care Physician: _____ Phone: _____

B. Chief Complaints:

_____
_____
_____

C. History of Present Symptoms:

_____
_____
_____

Sleep Pattern: _____
_____

Prior Injuries: _____
_____

Smoking: Y: ____ N: ____ **Alcohol:** Y: ____ N: ____ **Illicit Drugs:** Y: ____ N:____

Allergies: _____
Family History: _____
_____

D. Past Medical History:

_____
_____
_____
_____
_____
_____

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E. Pain Survey

Please check any of the following that pertain to your pain(s)

1. Neck Pain ___
Ache ___ Burning ___ Sharp ___ Tightness ___ Other _____
Does pain travel to left arm? ___ right arm? ___
Do you have pins & needles in your left arm? ___ right arm? ___
Do you have numbness in your left arm? ___ right arm? ___
Do you have previous injuries to your left neck? ___ right neck? ___

2. Upper Back
Ache ___ Burning ___ Sharp ___ Tightness ___ Other _____

3. Mid Back Pain
Ache ___ Burning ___ Sharp ___ Tightness ___ Other _____

4. Low Back Pain
Ache ___ Burning ___ Sharp ___ Tightness ___ Other _____
Does the pain travel to either buttock or leg? left leg / buttock ___ right leg / buttock ___
Do you have pins & needles in your buttock or leg? left leg / buttock ___ right leg / buttock ___
Do you have numbness in you buttock or leg? left leg / buttock ___ right leg / buttock ___
Do you have any previous injuries to your low back? right side ___ left side ___

5. Headaches
Front of head _____ Back of head _____ Sides of head _____ All of head _____

6. Do you have any of the following:
Dizziness _____ Changes in vision _____ Passing out _____ Nausean & Vomiting _____
Additional comments: _____
_____

7. Additional Pain Areas: _____
_____
_____

Does anything lessen your pain? If yes, explain _____
_____
_____

Does anything worsen your pain? If yes, explain _____
_____
_____

Patient/Guardian Name(print): _____
Patient/Guardian Name(sign): _____
Date: _____

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Current Medications & Frequency:

Name: _____ Doseage: _____ Frequency: _____
Name: _____ Doseage: _____ Frequency: _____
Name: _____ Doseage: _____ Frequency: _____
Name: _____ Doseage: _____ Frequency: _____
Name: _____ Doseage: _____ Frequency: _____
Name: _____ Doseage: _____ Frequency: _____
Name: _____ Doseage: _____ Frequency: _____
Name: _____ Doseage: _____ Frequency: _____
Name: _____ Doseage: _____ Frequency: _____
Name: _____ Doseage: _____ Frequency: _____

PRESCRIPTION REFILL POLICY:

Please do not wait until you run out of medicine to call for a refill. In fact, call at least TWO DAYS ahead, in order for us to process the request. Your doctor must review you medical file(s) before renewing a presccription. Therefore, please do not call for medication refills after hours or on the weekends. This is a time when records are unavailable. The file(s) are reviewed and prescriptions are called in at the end of office hours, after all patients have been seen. By law, doctors cannot order certain narcotics, over the phone. A written prescription will be prepaired in these situations.

IT CAN TAKE UP TO 48 HOURS, AFTER YOU CALL, BEFORE YOUR DOCTOR CAN REVIEW YOUR FILE AND CALL IN OR WRITE A PRESCRIPTION.

I have read, understand, and agree with the above.

Patient/Guardian Name(print): _____
Patient/Guardian Name(sign): _____
Date: _____

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AUTHORIZATION TO RELEASE RECORDS:

ATTENTION MEDICAL RECORDS DEPARTMENT

Physician: _____

Medical Facility: _____

Phone: _____

Fax: _____

Please release all records, radiology/diagnostic reports and any results pertaining to any and all treatment rendered to the following patient.

Patient Name: _____

DOB: _____ /_____ /_____

Social Security Number: _____ - _____ - _____

Thank You,

Patient/Guardian Name(print): _____

Patient/Guardian Name(sign): _____

Date: _____

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:

Patient Name (print):	Patient Name (sign):	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)*:

Physician Name (print):	Physician Name (Sign):	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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ASSIGNMENT OF INSURANCE BENEFITS, LIEN, RELEASE & DEMAND

Insurer and Patient please read the following in its entirety carefully!

I, the undersigned patient/insured, knowingly, voluntarily and intentially irerevocably assign the rights and benefits of my automobile Insurance, known as Personal Injury Protection (herein after PIP), Unisured Motorist, and Medical Payments policy of insurance to the above health care provider. I understand it is the intention of the provider to accept this assignment of benefits in lieu of demanding payment at the time of service. I understand this document will allow the provider to file suit against an insurer for payment of the insurance benefits or an explanation of benefits and to seek 627.428 damages from the insurer. This assignment of benifits includes transportation, medications, supplies, overdue interest and any potential claim for common law or statutory bad faith/unfair claims handling. If the insurer disputes the validity of this assignment of benefits then the insurer is instructed to notify the provider in writing within five days of receipt of this document. Failure to inform the provider shall result in a waiver by the insurer to contest the validity of this document. The undersigned directs the insurer to pay the health care provider the maximum amount directly without any reduction and without including the patient's name on the check. To the extent the PIP insurer contends there is a material misrepresentation on the application for insurance resulting in the policy of insurance is declared voided, rescinded, or canceled, I as the named insured under said policy of insurance, hereby assign the right to receive the premiums paid for my PIP insurance to this provider and to file suit for recovery of the premiums. The insurer is directed to issure such a refund check payable to this provider only. Should the medical bills not exceed the premium refund, then the provider is directied to mail the patient/named insured a check whcih represents the difference between te medical bills and the premums paid.

LEIN: I, the undersigned patient guarantee full payment to Wolstein Chiropractic & Sports Injury Center, LLC. and agree that I will remain personally responsible for unpaid charges as a result of any deductible, co-payment, and treatment after benefits are exhausted and/or for any other treatment/ service that remain unpaid. Furthermore, I grant Wolstein Chiropractic & Sports Injury LLC. a lien against any recovery, which I may have against any tortfeasor, responsibe party, or any responsible insurance carrier. I direct my attorney to withhold any funds I receive from any settlement to pay for any outstanding balance to Wolstein Chiropractic & Sports Injury Center LLC. I agree to and instruct my attorney to promptly advise Wolstein Chiropractic & Sports Injury Center LLC., of any settlement as a result of the injuries sustained in the _____ (DATE) motor vehicle accident, slip-n-fall, or motorcycle accident. Additionally I agree and instruct my attorney that I will not accept any settlement check until the remaining balcance is resolved with Wolstein Chiropractic & Sports Injury Center LLC..

DIPUTES: The insurer is drected by the provider and the undersigned to not issue any checks or drafts in partial setlement of a claim that contain or are accompanied by language releasing the insurer or it's insured patient from liability unless there has been a prior written settlement agreed to by the health provider (specifically the office manager) and the insurer as to the amount payable under the insurance policy. The insured and provider hereby contest and objects to any reductions or partial payments. Any partial or reduced payment, regardless or the accompanying language, isssued 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. The insurer is hereby placed on notice that this provider reserves the right to seek the full amount of the bill submitted. If the PIP insurer states it can pay claims at 200% of the Medicare Fee Schedule or any other fee schedule contained within Fla. Stat. 627.736 (2018), the the insurer is instructed & directed to provide this provider with a copy of the policy of insurance within 10 days. Any effort by the insurer to pay a disputed debt as full satisfaction must be mailed to the above, after speaking with the office/billing manager and mailed to the attention of the office/billing manager. See Fla. Stat. 673.3111.

RELEASE OF INFORMATION: I hereby authorize this provider to: furnish an insurer, an insurer's intermediary, the pateint's other medical providers, and the patients attorney via mail, fax, or email, with any and all informaton that may me containeed in the medical records; and for my insurance carrier to send insurance coverage information (declaration sheet & policy of insurance) in writing and telephonically to the above-named provider; request from any insurer all explanation of benefits (EOBs) for all provier and non-redacted PIP payout sheets; obtain any wrtten and verbal statements the patient or anyone else provided to the insurer; obtain copies of the entire claim file and all medical records, including but not limited to, documents, reports, scans notes bills, opinions, X-rays, IMEs, and MRIs, from any other medical provider or any insurer. The provider is permitted to produce my medical records to its attorney in connection with any pending lawsuits. The insurer is directed to keep the patien't medical record from this provider private and condidential. The insurer is not authorized to provide these medical records to anyone without the patient's and the provider's prior express written permission. **PLEASE NOTE: The insurer is not authoried to release protected health information (PHI) to third party vendors that schedule independent medical eaminations or independent medical examination physicians.**

DEMAND: Demand is hereby made for the insurer to pay all bills within 30 days without reduction and to mail the latest non-reducted PIP payout sheet ad the insurance coverage declaration sheet, and the insurance policy to the above provider within 15 days, as well as notify the provider pursuant to F.S. 627.736 (6-F) when benefits have been exhausted. The insurer is directied to pay the bill in the order they are received. However, if a bill from this provider and a claim from anyone else is received by the insurer on the same day, the insurer is directied to not apply this provider's bill to the deductible. If a bill from this provider and a claim from anyone else is received by the insurer, on the same day, the insurer is directed to pay this provider first before the policy is exhausted. The insurer is instructied to inform, in writing, the provider of any dispute.

CAUTION: **Please read before signing. If you do not completely understand this document, please ask us to explain it to you. If you sign below we will assume you understand and agree to the above. I certify that I have read and agree to all of the above and was not soliited or promised anything in exchange for receiving health care. I agree that the prices for the medical care is reasonable.**

Patient/Guardian Name(print): _____

Patient/Guardian Name(sign): _____

Date: _____

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INITIAL VISIT

Patient Name: _____ DOB: _____ Gender: M ___ F ___

Date: _____ Date of Injury: _____

Blood Pressure: ____/____ Pulse: _____ Height: ____'____" Weight: _____

SESSION NOTES:

Continue Chiropractic Care: Y ____ N ____

Trigger Injection Point(s)
Location:
20550 ___ 20551 ___ 20553 ___ 20600 ___ 20605 ___ 20610 ___ 20612 ___

1% Lidocaine _____
Dexamethasone _____
Kenalog _____

Physician Signature: _____ Date: _____

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OFFICE POLICIES

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The following is an explanation of our clinic policies. We believe that a clear definition will allow us both to concentrate on the most important issues: REGAINING AND MAINTING YOUR HEALTH.

Appointments & Scheduling:

In order to better serve our patients we ask that you call if you are unable to make your appointment or if you will be late. Your appointment time is reserved for you. If you fail to notify our office, it leaves a time slot open that could be used to help another patient. If you are scheduled for a massage and are more than 5 minutes late, you may ot be able to get your massage. This will depend on the scheduling of other patients. Please try to arrive earlier than your scheduled time. To schedule, cancel, or change appointments, you must call the office at: 727-787-6677.

If you are unable to keep you appointment, please call. Late arrival may necessitate rescheduling your appointment or missing out on therapies. If a patient fails to keep an appointment and does not call within 24 hours to cancel, a $50 fee will be applied to their bill.

Cell Phone Policy:

We ask that while in the office you refrain from using your cell phone. If a call is important and you "must" take it, please understand that the doctor will bypass you for the next ready patient, so that we don't delay others. You will then be the next patient to be seen by the doctor. We also ask that you wait to place your scheduled appointment in your phone until you are away from the reception desk. This will allow others to check out and this will comply with HIPPA standards.

Health Insurance Policy:

Today most insurance policies do cover chiropractic care but may not cover all treatments offered in our office. We will be happy to file your primary insurance claim and do everything we can to ensure that you receive proper reimbursement. We cannot take responsibility for what your health insurance will or will not cover. If your policy has a deductible, then we suggest you pay this amount at the onset of your care. Payments for services are neither implied nor agreed to by our office. *Our office takes no responsibility for non-payment by insurance companies for services rendered.*

I agree that my account with Wolstein Chiropractic & Sports Injury Center is my responsibility. I agree to standby any balance that has gone unpaid over 60 days. If I default on my account, I agree to pay all costs of collections, including collection agency fees and /or reasonable attorney's fees. Furthermore, I understand that these prodedures and fees are subject to change without prior notice. I understand and agree to the conditions of this policy.

Patient/Guardian Name(print): _____

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