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Rockledge, FL. 32955
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PATIENT NAME: _____TODAY'S DATE: __/__/____ DATE OF INJURY: __/__/____

PATIENT INTAKE – PERSONAL INJURY (NON-AUTO ACCIDENT)

PERSONAL INFORMATION

First Name:_____ M.I._____ Last Name:_____ Preferred Name: _____

Address:_____ City:_____ State: _____Zip:_____

Birthdate:_____/_____/_____ Age_____ Gender: ☐ Male ☐ Female ☐ Unspecified SSN:_____/_____/_____

Primary Phone: _____ Cell Phone: _____ Work Phone: _____

Home Email: _____ Work Email:_____

By providing my email address, I authorize my doctor to contact me via the email address(es) provided.

Which email would you like us to use to communicate with you? (check one) ☐ Home ☐Work

Contact Method: (check one) ☐ Primary Phone ☐ Cell Phone ☐ Work Phone ☐ Home Email ☐ Work Email

Occupation: _____ Employer: _____

Drivers License #: _____

Spouse/Parents Name: _____ Spouse/Parents Occupation: _____

Spouse/Parents Employer: _____ Spouse/Parents Social Security #: _____

Spouse/Parents Work #: _____ Spouse/Parents Cell #: _____

EMERGENCY CONTACT

Name: _____ Relation to You: _____

Home#: _____ Work #: _____ Cell #: _____

HOW DID YOU HEAR ABOUT US?

Please be as specific as possible so we can track how our patients FIRST heard about us!

☐BrevardChiro.com ☐BrevardDisc.com ☐Google ☐Drive-by ☐Email Blast ☐TV Commercial ☐Radio ☐Facebook
☐Yelp ☐Direct Mailer ☐YouTube ☐School ☐Work ☐Clinic Employee: _____
☐Magazine Ad:_____ ☐Newspaper:_____ ☐Referred by Friend:_____
☐Current Patient of Physician/NP ☐Other: _____

ATTORNEY INFORMATION

If you do not have an attorney, leave this section blank.

Attorney's Name: _____ Name of Law Firm: _____

Attorney's Address: _____ City: _____ State: _____Zip:_____

Attorney's Phone Number: _____ Email: _____

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INSURANCE OR PRIVATE PAY INFORMATION

Please provide insurance card(s) to receptionist.

Type of Insurance: ☐ Private Ins. ☐ Medicare ☐ Auto Ins. ☐ Worker's Comp ☐ Other________________________________

Primary Insurance Carrier: ____ Phone: ________________________________

Policy#_____________________________ Group #___________________________ Claim#_________________________________

Name of Policy Holder: ____ Relationship to Patient: _________________________

Policy Holder's Birthdate: ______/_____/______ Policy Holder's SSN: ______/____/______ Employer: _______________________

Is patient covered by another insurance? ☐ Yes ☐ No

Type of Insurance: ☐ Private Ins. ☐ Medicare ☐ Auto Ins. ☐ Worker's Comp ☐ Other________________________________

Secondary Insurance Carrier: ____ Phone: ________________________________

Policy#_____________________________ Group #___________________________ Claim#_________________________________

Name of Policy Holder: ____ Relationship to Patient: _________________________

Policy Holder's Birthdate: ______/_____/______ Policy Holder's SSN: ______/____/______ Employer: _______________________

_ _

Reason for today's visit: ____

Is this condition due to an accident? ☐ Yes ☐ No Date of Accident: ____

Type of Accident ☐ Auto ☐ Work ☐ Slip & Fall ☐ Other ____

To whom have you made a report of your accident? ☐ Auto Insurance ☐ Employer ☐ Worker Compensation ☐ Other

ASSIGNMENT/AUTHORIZATION/RELEASE:

I certify that I, and/or my dependents, have insurance with the above named insurance company(s) and assign directly to Brevard Chiropractic & Injury Center all benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. I understand that "co pays" are payable at the time of each visit and that I am financially responsible for all charges whether or not paid by insurance. The above named provider's office may use my health care information and may disclose such information to the above named insurance company(s) and their agents for the purpose of obtaining payment for services and determining benefits payable for related services.

☐ **Private Pay/Cash:** By checking this box, I acknowledge that I do not have insurance and understand that I am financially responsible for all services at the time they are rendered.

____ ____
Name of Person Responsible For This Account Relationship to Patient

X ____ ____
Responsible Party Signature Date

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ACCIDENT INFORMATION

DATE OF INCIDENT:	TIME OF INCIDENT:	LOCATION OF INCIDENT:

WHAT CAUSED THE INCIDENT/INJURY?

DURING THE INCIDENT, DID YOU FALL TO THE GROUND?	DID YOU HIT YOUR HEAD?	DID YOU LOSE CONSCIOUSNESS?
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

HOW DID YOU LAND (I.E. ON BACK, ON HANDS AND KNEES, ETC.)?

DID YOU SUSTAIN ANY CUTS/SCRAPES/ABRASIONS/BRUISES FROM THE INCIDENT?
☐ Yes ☐ No If "Yes", what part of your body? _____

DID ANYONE WITNESS THE INCIDENT?	WAS A REPORT FILED?	IF YES, WHAT IS THE REPORT NUMBER?
☐ Yes ☐ No	☐ Yes ☐ No	_____

EXPLAIN IN DETAIL HOW IT HAPPENED: _____
_____
_____
_____.

DID YOU HAVE PAIN THAT STARTED THE DAY AFTER THE INCIDENT OR LATER? ☐ YES ☐ NO
If "Yes", please describe: _____

TREATMENT

WERE YOU TREATED ON THE SCENE BY PARAMEDICS?
☐ Yes ☐ No

DID YOU GO TO THE EMERGENCY ROOM, HOSPITAL, OR URGENT CARE?
☐ Yes ☐ No

IF "YES", WHEN DID YOU GO?
☐ Day of the Accident ☐ Other Date: ____/____/____

IF THE DAY OF, HOW DID YOU GET THERE?
☐ Ambulance ☐ Self ☐ Other: _____

WHAT HOSPITAL?
_____

DO YOU HAVE ANY FRACTURES?
☐ Yes ☐ No If "Yes", where? _____

WHAT TREATMENT WAS PROVIDED?
_____

WHICH OF THE FOLLOWING DIAGNOSTIC TESTS HAVE YOU HAD FOR THIS INCIDENT?

	LOCATION	DATE	KNOWN RESULTS
☐ X-Ray	_____	____/____/____	_____
☐ CT Scan	_____	____/____/____	_____
☐ MRI	_____	____/____/____	_____
☐ Ultrasound	_____	____/____/____	_____

HAVE YOU SEEN ANY OTHER DOCTORS FOR THIS INCIDENT?
☐ Yes ☐ No If "Yes", please provide the name of the doctor(s) and date(s) seen:

1. _____ Date(s): _____
2. _____ Date(s): _____
3. _____ Date(s): _____

HAVE YOUE RECEIVED ANY OF THE FOLLOWING TREATMENTS FOR THIS INCIDENT? (CHECK ALL THAT APPLY)
☐ Medications (List Type): _____
☐ Injections (Type/Area): _____
☐ Surgeries (Type/Area): _____
☐ Orthotics/Braces/Splints: _____
☐ Heat ☐ Ice ☐ Acupuncture ☐ Pool Therapy ☐ Massage

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HAVE YOU HAD ANY PHYSICAL THERAPY FOR THIS INCIDENT? ☐ Yes ☐ No
IF SO, WHERE? _____ **FOR HOW LONG?** _____

HAVE YOU HAD ANY CHIROPRACTIC TREATMENT FOR THIS INCIDENT? ☐ Yes ☐ No
IF SO, WHERE? _____ **FOR HOW LONG?** _____

DID YOU HAVE A DELAY IN CARE AFTER THIS INCIDENT (I.E. NOT SEEN FOR INJURIES WITHIN A FEW DAYS AFTER THIS INCIDENT)? ☐ Yes ☐ No

DID YOU HAVE A GAP/BREAK IN CARE FOR THIS INCIDENT (I.E. DID NOT SEE A HEALTH CARE PROVIDER OR HAD CARE AGAIN FOR 2 WEEKS OR MORE)? ☐ Yes ☐ No

IF "YES" TO ANY OF THE ABOVE, PLEASE CHECK THE REASON(S) FROM THE FOLLOWING LIST:

- ☐ I thought I would get better with time or assumed I could treat myself at home.
- ☐ I have no health insurance and did not know where to go.
- ☐ I ran out of health insurance benefits.
- ☐ I could not afford to pay out-of-pocket expenses for needed care.
- ☐ I was out of town and unable to find a provider in that area.
- ☐ I was refused treatment at my regular doctor's office as it was auto insurance.
- ☐ I was afraid I would lose my job.
- ☐ Insurance Company problems over treatment and/or payment.

CURRENT COMPLAINTS

What are your main problems or difficulties NOW? (Check all that apply)

1. *For each area of complaint, please provide a **pain rating** from 0-10 using the following scale:*

0 None **1-2** Mild **3-4** Uncomfortable
5-6 Distressing (Fairly Severe) **7-8** Very Severe (Horrible) **9-10** Unbearable (Worst Possible)

2. *For each area of complaint, please describe the **type of pain** using the following descriptors:*

Achy, Dull, Stabbing, Sharp, Burning, Throbbing, Shooting, Pins & Needles, Tightness

Complaints NOW	Pain Rating (1-10)	Type of Pain	Did You Have This Complaint BEFORE the Accident?
☐ Headaches			☐ Yes ☐ No
☐ Facial Pain			☐ Yes ☐ No
☐ Neck Pain			☐ Yes ☐ No
☐ Upper Back Pain			☐ Yes ☐ No
☐ Mid-Back Pain			☐ Yes ☐ No
☐ Lower Back Pain			☐ Yes ☐ No
☐ Buttock Pain			☐ Yes ☐ No
☐ Hip Pain (Left)			☐ Yes ☐ No
☐ Hip Pain (Right)			☐ Yes ☐ No
☐ Knee Pain (Left)			☐ Yes ☐ No
☐ Knee Pain (Right)			☐ Yes ☐ No
☐ Ankle Pain (Left)			☐ Yes ☐ No
☐ Ankle Pain (Right)			☐ Yes ☐ No
☐ Shoulder Pain (Left)			☐ Yes ☐ No
☐ Shoulder Pain (Right)			☐ Yes ☐ No
☐ Elbow Pain (Left)			☐ Yes ☐ No
☐ Elbow Pain (Right)			☐ Yes ☐ No
☐ Wrist / Hand Pain (Left)			☐ Yes ☐ No
☐ Wrist / Hand Pain (Right)			☐ Yes ☐ No
☐ Bowel / Bladder Dysfunction			☐ Yes ☐ No
☐ Dizziness			☐ Yes ☐ No
☐ Ringing / Buzzing in the Ears			☐ Yes ☐ No
☐ Other:			☐ Yes ☐ No

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DO YOU HAVE ANY NUMBNESS, TINGLING, OR RADIATING PAIN?
☐ Yes ☐ No If So, Where?
_____

IN GENERAL, ARE YOUR SYMPTOMS:
☐ Getting Better ☐ Getting Worse ☐ No Change

WHAT MAKES YOUR PAIN BETTER? (CHECK ALL THAT APPLY)
☐Rest ☐Medications ☐Heat ☐Ice ☐Stretching ☐Exercise ☐Physical Therapy
☐Chiropractic ☐Massage ☐Sitting ☐Standing ☐Lying Down ☐Other: _____

WHAT MAKES YOUR PAIN WORSE (CHECK ALL THAT APPLY)
☐Sitting ☐Standing ☐Bending ☐Lifting ☐Walking ☐Work ☐Lying Down ☐Grasping
☐Reaching ☐Stress or Tension ☐Coughing or Sneezing ☐Weather Changes ☐Other: _____

DO YOU HAVE ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY)

☐ Depression / Sadness	☐ Nervous / Worried	☐ Nightmares About Accident
☐ Crying Episodes	☐ Problems Thinking	☐ Memory Loss / Forgetful
☐ Discouraged / Frustrated	☐ Lack of Concentration	☐ Changed Behavior
☐ Imitable / Angry	☐ Appetite Changes (Loss / Gain)	☐ Other: _____

ACTIVITIES OF DAILY LIVING / FUNCTIONAL STATUS

(These questions are about how your symptoms/injuries affect your activities now. Check **ALL** the activities that have been limited in the last 4 weeks due to your injuries/accident.)

BASIC SELF-CARE / ACTIVITIES OF DAILY LIVING:
☐Bathing / Showering ☐Dressing ☐Eating ☐Urinating ☐Defecating / Toilet Hygiene
☐Brushing Teeth ☐Combing Hair ☐Sexual Activity

COMPLEX SELF-CARE AND HOUSEHOLD DUTIES:
☐Meal Preparation ☐Cleaning ☐Vacuuming ☐Sweeping / Mopping ☐Yard Work
☐Managing Medications ☐Financial Management

BASIC MOBILITY:
☐Walking ☐Sit-to-Stand ☐Running ☐Driving/Riding ☐Bending ☐Kneeling ☐Grasping
☐Lifting from Floor ☐Pulling ☐Climbing Stairs ☐Moving Neck ☐Pushing ☐Reaching
☐Getting Up from Lying Down ☐Lifting above Shoulder ☐Squatting / Stooping

BASIC OMMUNICATION:
☐Seeing ☐Hearing ☐Speaking ☐Writing ☐Typing ☐Texting ☐Computer Use

CHILDCARE ACTIVITIES: (☐ N/A, I Do Not Have Small Children)
☐Lifting/Holding ☐Dressing Child ☐Helping w/Homework ☐Changing Diapers ☐Bathing Child
☐Car Seat Management ☐ Other: _____
Number of Children: ____ Age(s) of Children: _____

DO YOU HAVE PROBLEMS SLEEPING DUE TO YOUR PAIN?
☐ Yes ☐ No

HOW MANY HOURS OF RESTFUL SLEEP TO YOU GET PER NIGHT?
☐ Yes ☐ No

DO YOU SLEEP TOO MUCH?
☐ Yes ☐ No

ARE THERE ANY HOBBIES OR RECREATIONAL ACTIVITIES YOU COULD DO PREVIOUSLY THAT YOU CANNOT DO NOW?
☐ Yes ☐ No If "Yes", what activities: _____

MEDICAL HISTORY

IN GENERAL, HOW WOULD YOU RATE YOUR OVERALL HEALTH?
☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Bad

List all current medical illnesses:

_____ _____
_____ _____
_____ _____

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MEDICAL HISTORY (CONTINUED)

HAVE YOU EVER HAD ANY SURGERIES/HOSPITALIZATIONS?
☐ Yes ☐ No If "Yes", please list:

TYPE OF SURGERY / WHY HOSPITALIZED	YEAR	FULLY RECOVERED?
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

EVER BEEN IN AN AUTO ACCIDENT BEFORE? ☐Yes ☐No **IF "YES", HOW MANY?** _____ **WHEN?** _____ **DID YOU COMPLETELY RECOVER?** ☐ Yes ☐ No

IF YOU DID NOT COMPLETELY RECOVER, WHAT ARE THE RESIDUAL COMPLAINTS? (☐ N/A)
_____

HAVE YOU EVER HAD TRAUMA (I.E. BROKEN BONES, SPRAINS, STRAINS, ETC.)?
☐Yes ☐No If "Yes", please explain: _____

ARE YOU ALLERGIC TO ANY MEDICATIONS?
☐Yes ☐No If "Yes", explain: _____

ARE YOU ALLERGIC TO LATEX? ☐ Yes ☐ No **ARE YOU ALLERGIC TO MEDICAL TAPES?** ☐ Yes ☐ No

DO YOU USE THE FOLLOWING?
☐Cane ☐Walker ☐Crutches ☐Wheelchair

IF SO, HOW LONG?
_____

MEDICATIONS

Please list **ALL PRESCRIPTION** medications that you are **CURRENTLY** taking:

MEDICATION	DOSE	HOW OFTEN	WHEN STARTED?	WHY?

Please list **ALL OVER-THE-COUNTER** medications that you are **CURRENTLY** taking:

MEDICATION	DOSE	HOW OFTEN	WHEN STARTED?	WHY?

FAMILY MEDICAL HISTORY (Examples: Diabetes, High Blood Pressure, Cancer, etc.)

Mother: _____
Father: _____
Siblings / Other Relatives: _____

HAVE YOU HAD PROBLEMS IN THE PAST WITH ANY OF THESE BODY PARTS OR SYMPTOMS? (CHECK ALL THE APPLY)

☐ Head ☐ Nerves ☐ Bones/Joints ☐ Eyes/Ears ☐ Face/Throat
☐ Circulation/Heart ☐ Lungs ☐ Kidneys/Liver ☐ Blood/Anemia ☐ Male Parts
☐ Female Parts ☐ Brain ☐ Cancer ☐ Stomach/Bowels ☐ AIDS/HIV
☐ Other: _____

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Directions: *This questionnaire has been designed to give the doctor information as to how your pain has affected your ability to manage in everyday life. Please check one item in each section that most closely applies to you.*

INJURY HISTORY

Section 1. Pain Intensity

□ I can tolerate the pain I have without using painkillers.
□ The pain is bad but I manage without taking painkiller
□ Painkillers give no relief from pain and I do not use them.
□ Painkillers give complete relief from pain.
□ Painkillers give moderate relief from pain.
□ Painkillers give very little relief from pain.

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 extra pain.
□ It is 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, 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 causes extra pain, but I can manage if they are conveniently positioned (on a 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.
□ I cannot lift or carry anything at all.

Section 4. Walking

□ Pain does not prevent me from walking any distance.
□ Pain prevents me from walking more than one mile.
□ Pain prevents me from walking more than ½ mile.
□ Pain prevents me from walking more than ¼ mile.
□ I can only walk using a cane or crutches.
□ I am in bed most of the time and have to crawl to the toilet.

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 for more than one hour.
□ Pain prevents me from sitting for more than 30 minutes.
□ Pain prevents me from sitting for more than 10 minutes.
□ Pain prevents me from sitting at all.

Section 6. Standing

□ I can stand as long as I like without extra pain.
□ I can stand as long as I want but it causes extra pain.
□ Pain prevents me from standing for more than one hour.
□ Pain prevents me from standing for more than 30 minutes.
□ Pain prevents me from standing for more than 10 minutes.
□ Pain prevents me from standing at all.

Section 7. Sleeping

□ Pain does not prevent me from sleeping well.
□ I can sleep well only by using tablets.
□ Even when I take tablets I have less than 6 hours sleep.
□ Even when I take tablets I have less than 4 hours sleep.
□ Even when I take tablets I have less than 2 hours sleep.
□ Pain prevents me from sleeping at all.

Section 8. Sex Life

□ My sex life is normal and causes no extra pain.
□ My sex life is normal and causes some extra pain.
□ My sex life is nearly normal but is very painful.
□ My sex life is severely restricted by pain.
□ My sex life is nearly absent because of pain.
□ Pain prevents any sex life at all.

Section 9. Social Life

□ My social life is normal and gives me no extra pain.
□ My social life is normal but increase the degree of pain.
□ Pain has no significant effect on my social life apart from limiting my more energetic interests.
□ Pain has restricted my social life and I do not go out as often.
□ Pain has restricted my social life to my home.
□ I have no social life because of pain.

Section 10. Traveling

□ I can travel anywhere without extra pain.
□ I can travel anywhere but it gives me extra pain.
□ Pain is bad but I manage journeys over 2 hours.
□ Pain restricts me to journeys of less than one hour.
□ Pain restricts me to short necessary trips under a half hour.
□ Pain restricts me from traveling except to the doctor or hospital.

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OCCUPATION / WORK HISTORY

(The purpose of this section is to understand how your injuries have affected your work.)

CURRENT EMPLOYER:	JOB TITLE / OCCUPATION:
JOB DUTIES AND RESPONSIBILITIES:	

WHAT ARE THE PHYSICAL REQUIREMENTS OF YOUR JOB? (CHECK ALL THAT APPLY)
☐Sitting ☐Standing ☐Typing ☐Bending ☐Squatting ☐Kneeling ☐Climbing (Ladders, etc.)
☐Lifting (_____ lbs.)

WERE YOU ABLE TO RETURN TO THE JOB AFTER THE ACCDENT?
☐ Yes ☐ No

IF NO, WHAT WAS THE LAST DATE YOU WORKED?
____/____/_____

IF YOU ARE UNABLE TO WORK SINCE THE ACCIDENT, WHY? (CHECK ALL THAT APPLY)
☐Too Much Pain ☐Restricted by Doctor ☐Too Tired ☐Unable to Concentrate ☐Laid Off
☐Fired ☐Employer Will Not All Return with Restriction or Pain

WERE YOU ABLE TO RETURN TO THE JOB AFTER THE ACCDENT?
☐ Yes ☐ No

IF "YES", EXPLAIN:
_____

SOCIAL HISTORY

DO YOU SMOKE / USE TOBACCO?
☐ Yes ☐ No

IF "YES", HOW OFTEN?
_____ / ☐ Day ☐ Week

DO YOU DRINK ALCOHOL?
☐ Yes ☐ No

IF "YES", HOW OFTEN?
_____ / ☐ Day ☐ Week

DO YOU USE RECREATIONAL DRUGS?
☐ Yes ☐ No

WHAT IS YOUR HEIGHT?
____'____"

WHAT IS YOUR WEIGHT?
_____ lbs.

PATIENT AFFIRMATION

By signing below, you confirm that the information you provided is accurate to the best of your knowledge.

_____ _____/_____/_____
Patient's Signature Date

_____ _____/_____/_____
Parent / Guardian Signature *(If patient is a minor)* Date

If filled out by a person other than the patient, please provide name and signature below.

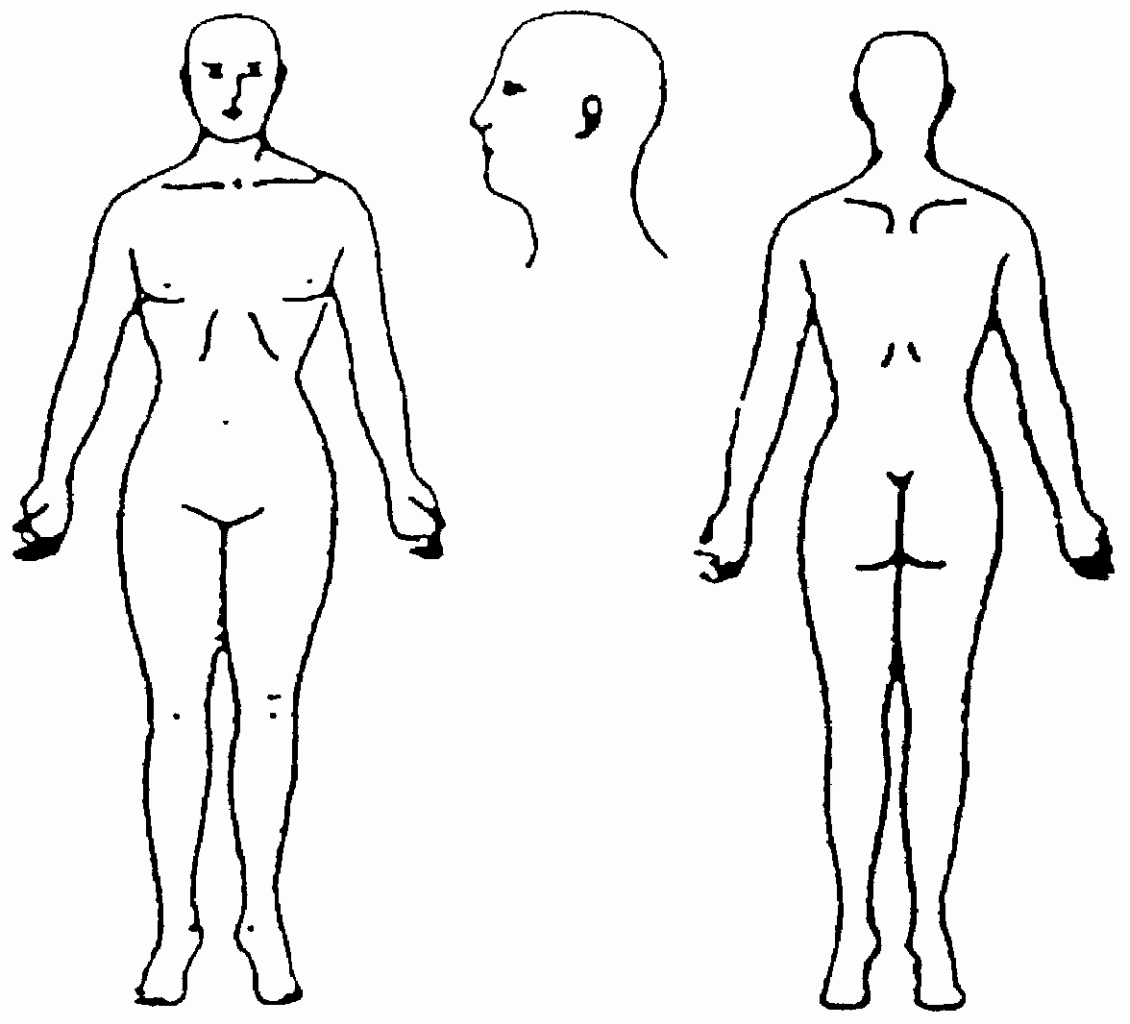
_____ _____
Printed Name Signature

SYMPTOM DIAGRAM

Name _____ Number _____ Date _____

Please be sure to fill this form out extremely accurately. Mark the area(s) on your body where you feel the described sensation(s). Use the appropriate symbol(s). Mark areas of radiating pain, and include all affected areas. You may draw on the face as well.

Aches ΛΛΛΛ Numbness oooo Pins/Needles ●●●● Burning xxxx Stabbing ////



Reference: Randsford. Spine, Vol. 1, No 2, June 1976

HIPAA NOTICE OF PRIVACY PRACTICES - FINANCIAL POLICY – MINOR CONSENT
Brevard Chiropractic & Injury Center

Patient Name: _____ Date: _____

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), commonly known as "HIPAA" is a Federal program that requires all medical records and other individually identifiable health information used or disclosed by us, in any form, whether electrically, on paper or orally, is kept properly confidential. The act gives you, the patient, significant rights and control over your health information. This notice describe certain obligations we have regarding ways in which we may use and disclose health information about you, it also outlines your rights to the health information we keep about you.

We understand that information about you and your health is personal and are committed to your privacy. We create a record of the care and services you receive. We need this record to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of the records of your care generated by this office, whether made by your personal doctor, others working in the office, or associates processing billing and your insurance claims.

We are required by law to:

- Make sure that health information that identifies you is kept private.
- Give you this Notice of our legal duties and privacy practices with respect to health information about you.
- Follow the terms of the Notice that is currently in effect.

A partial list of how we may use and disclose Health Information about you:

- For Treatment, payment, health care and business operations of this office.
- As required by Law, Law enforcement, lawsuits and disputes; protect public safety or assist apprehending criminals.
- Military or Veteran's and Workers Compensation.
- Public Health Risks; Coroners, health examiners and funeral directors.
- To government authorities to prevent child abuse or domestic violence; to avert a serious threat to health and safety
- National security and intelligence activities.
- Security Officials for Inmates:
- To government agencies for audits, investigations and other oversight activities.
- For certain limited research purposes.
- The practice maintains patient sign-in sheets that are visible and accessible to patients, staff and others who may enter this office.

As our patient, your rights regarding Health Information about you:

- Right to Inspect and copy.
- Right to Amend.
- Right to Request Restrictions.
- Right to Request Confidential Communication.
- Right to Accounting Disclosures.
- Right to a Paper copy of this Notice (full Notice is available upon request)

Changes to this Notice: We reserve the right to change this Notice. We will post a copy of a current notice in our facility with the current effective date on the first page.

Complaints: If you believe that your privacy rights have been violates, you may file a complaint with us. All complaints must be in writing. Please contact the administrator at the location where you were treated to file a complaint.

Acknowledgement of Receipt of HIPPA Notice of Privacy Practices:
I acknowledge that I was provided a copy of the Notice of Privacy Practices and have read (or had the opportunity to read if I chose) and understood the Notice. This notice is considered effective dates signed, and shall remain effective for a minimum of 6 years, unless otherwise revoked, in writing, by patient.

Unless you request otherwise, we may use or disclose health information to a family member or other personal representative to the extent necessary to help you with your healthcare or payment for your health care. In addition, we may use your confidential information to remind you of appointments, phone, email, postal service or other method requested by you.

Additional Disclosure Authority: In addition to the allowable disclosures described in the State of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to persons indicated as follows:

Name	Relationship
Name	Relationship

HIPAA NOTICE OF PRIVACY PRACTICES - FINANCIAL POLICY – MINOR CONSENT
Brevard Chiropractic & Injury Center

Patient Name: _____ Date: _____

Financial Policy:

Full payment is expected at the time of service. Payments accepted are cash, check or credit card.

IF you have insurance, we will make a copy of your card and collect any co-pay or co-insurance that is due. As a courtesy, our office will contact your insurance company to obtain a benefit quote. If there is a balance after your insurance processes the claim, we will forward you a statement. Insurance coverage varies greatly, if you have questions, feel free to contact our office and we will do our best to assist you. Please be aware that some insurance plans require pre-certification for care. Care will commence once approval has been obtained.

As a courtesy to our patients we will provide a copy of your medical records at a cost according to Florida Statutes and per written request. Additionally, should you or your insurance company require forms or information, this office reserves the right to charge for time spent in preparation of those forms or requested medical information. It is your responsibility to make sure your insurance company is paying this office. Although this office may bill your insurance carrier for services rendered, all charges for services rendered are the patients' responsibility.

We will notify you as soon as we know of any difficulties we are having collecting monies from your insurance carrier. Should difficulties arise, you may need to contact your insurance company. If our office determines that your insurance carrier will reimburse you directly and not pay our office, you will be required to pay in full for all services at the time they are rendered. Our office makes every attempt to correspond with insurance carriers to assist them in correctly paying your claims.

All patients who have insurance, no matter the type it is, are required to pay co-payments, deductibles and/or percentages required each visit. If our office is a non-participating provider with the insurance company you have, we will gladly file those claims for you but you will be responsible for payment at the time service is rendered. If you are a Medicaid enrollee, your eligibility status must be verified each month. If your eligibility is terminated, you become responsible for services rendered. If you have been injured on the job, you must have authorization for care from the Worker's Compensation Insurance Company before an appointment or treatment can be rendered by our office. Your employer will assist you in securing that information.

Brevard Chiropractic & Injury Center also accepts Personal Injury Protection claims resulting from motor vehicle accidents and Workers Compensation claims to treat injured workers. Prior approval must be obtained with these cases before care can commence. You will also be required to complete an "Accident Form" in addition to the regular "Intake Forms" Brevard Chiropractic & Injury is also a provider for Medicare. You will be required to read and sign the separate Medicare policy documentation.

By signing below, I agree to the following: "I have read and understand "HIPPA Notice of Privacy Practices" &"Financial Policy" I understand that health and accident insurance policies are an agreement between and insurance carrier and me. I authorize payment from my insurance carrier directly to this office and with the understanding that all monies be credited to my account upon receipt. I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. We will require you to honor the financial agreements you make with our office. If you find that you cannot fulfill the agreement you have made with us, please advise our financial department immediately so new arrangements can be made. Any insurance checks sent to your home should be brought or sent to our office within three (3) days with Explanation of Benefits (stub/statement) to indicate which services were paid.

**Our office will submit your insurance claims for you as a courtesy. However, your insurance is an agreement between you and your carrier, not between your insurance company and this office.

Patients without insurance are expected to pay in full at the time services are rendered, unless other arrangements have been made with our financial department

Patient Signature: _____ Date: _____

Consent to Treatment of Minors:

By my signature below, I consent to any x-ray, examination, and chiropractic or rehabilitative diagnosis or treatment, which is deemed advisable by a licensed chiropractor, be rendered under the general of special supervision of any licensed chiropractor or trained professionals at Brevard Chiropractic & Injury Center.

Patient/Guardian Signature: _____ Date: _____

Patient/Guardian Printed Name: _____

Relation to Minor: _____

Informed Consent to Chiropractic Adjustments and Care

I have been informed that it is not uncommon for patients to 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 the discomfort or develop any new symptoms, I can call the office and speak to the staff. If I am out of town or unable to contact the doctor, I can present myself to the emergency room.

If any test were performed outside of this office (laboratory or other diagnostic procedures) I understand the doctor will notify me of the results at my next scheduled appointment or when the reports are available.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various methods of physical therapy and if necessary, diagnostic x-rays, on me by the doctor of chiropractic in this office and or anyone working in this clinic authorized by the doctor of chiropractic.

I further understand and have been informed that, as in all health care, in the practice of chiropractic there are some very slight risks to treatment, including, but not limited to muscle strains and sprains. I do not expect the doctor to be able to anticipate and explain all the 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, is in my best interests.

I have read the above consent, 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 condition for which I seek treatment.

_____ _____

Patient Date

_____ _____

Parent or Guardian Date

_____ _____

Witness Date

X-RAY/MEDICAL RELEASE/INSURANCE INFORMATION:

I hereby authorize that all medical records, x-rays and any other pertinent medical information be released to Brevard Chiropractic & Injury Center. Also to disclose all insurance coverage for treatment provided herein.

_____ _____

Patient Signature Social Security #

Brevard Chiropractic & Injury Center
Timothy Bortz, D.C.
3260 Murrell Road, Suite 101
Rockledge, FL. 32955
(321) 631-1100

Dr. Timothy Bortz, DC
3260 Murrell Rd., Suite 101
Rockledge, FL. 32955
321-631-1100
www.BrevardChiro.com

IRREVOCABLE DOCTORS LIEN

To: Attorney or Insurance Carrier _____

My Patient/Your Client: _____

Date of Accident: _____

I hereby authorize Brevard Chiropractic & Injury Center to furnish you, my attorney/insurance carrier, with a full report of their examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was involved.

I hereby authorize and direct you, my attorney/insurance carrier to pay directly to said doctor such sums as may be due and owing him/her office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor. I hereby further give a lien on my case to said doctor against any and all proceeds of any settlement, judgment or verdict which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated or injuries in connection therewith. In the event that a dispute may arise out of the terms of agreement and requires BCIC to hire an attorney, the patient shall be responsible for payment of all attorneys' fees and all costs that are incurred in enforcing the agreement.

I fully understand that I am directly responsible to said doctor for all professional bills submitted by him/her for services rendered to me and that this agreement is made solely for said doctor's additional protection and in consideration of him/her awaiting payment.

Patient Signature_____ Date _____

ASSIGNMENT OF NO-FAULT INSURANCE BENEFITS

I hereby authorize, direct and demand that my personal injury protection insurance pay directly to my assignee **Brevard Chiropractic & Injury Center 3260 Murrell Road, Suite 101 Rockledge, FL. 32955** such sums as my be due and owing in this office for services rendered to me, both by reason of accident or illness and by reason of any other bills that are due this office, and to withhold such sums from any disability benefits, medical payment benefits, no-fault benefits, health and accident benefits, worker's compensation benefits, or any other insurance benefits obligated to reimburse me or from any settlement, judgment or verdict on my behalf as may be necessary to adequately protect said office. I hereby further give a lien to said office 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 said office. This is to act as an assignment of all my rights, benefiting and privileges under my insurance policy to my assignees for any and all amounts owed.

I hereby assign and transfer to this my assignee/health care provider any and all causes of action that I may have or that might exist in my favor against my insurance company and authorize this office to prosecute said cause of action either in my name or in the office's name, and further I authorize this office to compromise, settle or otherwise resolve said claim or cause of action as they see fit.

I authorize the office to release pursuant to Privacy Rule, 45C.F.R. parts 160 and 164 promulgated pursuant to the HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 ("HIPAA"), Pub. L. No. 104-191, 110 Stat. 1936 (1996), any information including, but not limited to, medical records, insurance information or documents otherwise pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under this assignment.

Patient Signature_____ Date _____

AGREEMENT WITH MEDICAL SERVICE PROVIDER

I, _____, HEREBY, authorize my attorney to pay the proceeds of any net recovery all outstanding amounts owed to BREVARD CHIROPRACTIC & INJURY CENTER, for medical care or services. I agree that I am responsible to the above-named health care provider for the payment of all services rendered to me, regardless of the outcome of my case. My attorney is authorized to protect medical bills and expenses accrued. My attorney in no way accepts any direct or personal liability for any medical bills, expenses, or the payment of amounts owed to any health care provider. Any request by my attorney for any information or services are made on my behalf and are owed by me and in no way are the obligation of my attorney other than the withholding of suns from my recovery.

_____ _____
Patient Signature Date

_____
Patient Printed Name

_____
Treating Physician Signature

_____
Treating Physician Printed Name

The undersigned attorney for the above patient agrees with the assignment and authorization. Any outstanding amounts, at the time of recovery, will be protected to the extent of the remaining recovery funds. No additional or excess amounts shall be protected or paid unless a separate written agreement is entered into. This protection agreement is valid only so long as the treating healthcare provider strictly complies with the terms above and withholds any collection efforts and does not report any adverse credit information on the above patient.

_____ _____
Attorney Signature Date

_____
Attorney Printed Name

Brevard Chiropractic & Injury Center
Timothy Bortz, D.C.
3260 Murrell Road, Suite 101
Rockledge, Florida 32955
(321) 631-1100

CONSENT TO PARTICIPATE IN TELEMEDICINE CONSULTATION

Consultant: Andrew Akerman, M.D. Florida License: ME 93824

Patient's Name:_____ Medical Record No: _____

1. I understand that my healthcare provider, ***Timothy Bortz, D.C.,*** wishes me to engage in a telemedicine consultation with Andrew Akerman, M.D.

2. My health care provider has explained to me how the video conferencing technology will be used to affect such a consultation. I understand that this consultation will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.

3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my health care provider(s) or myself can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.

4. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my health care provider and consulting health care provider in order to operate the video equipment. The above mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine examination room; and/or (3) terminate the consultation at any time.

5. I have had the alternatives to a telemedicine consultation explained to me, and in choosing to participate in a telemedicine consultation I understand that some parts of the exam involving physical tests may be conducted by individuals at my location at the direction of the consulting health care provider.

6. In an emergency consultation, I understand that the responsibility of the telemedicine consulting specialist is to advise my local practitioner, and that the specialist's responsibility will conclude upon termination of the video conference connection.

7. I understand that billing will occur from both my practitioner and as a facility fee from the site from which I am presented.

8. I have read this document carefully, and understand the risks and benefits of the teleconferencing consultation and have had my questions regarding the procedure explained and I hereby consent to participate in a telemedicine visit under the terms described herein.

9. I understand that there will be no videotaping or recording of any materials, unless additional written consent is given. Recording of the medical examination is typically not required, and no recording will be done for the express purpose of maintaining confidentiality and patient privacy.

_____ _____

Patient/Parent/Guardian Signature Date and Time

_____ _____

Witness Signature Date and Time