Lake Buena Vista Chiropractic*

11444 S. Apopka Vineland Rd. #106A Orlando, FL. 32836
PH: 407-238-2306 FX: 407-238-2309
Doctor: David Young, D.C.

Name:_____ **Date of Birth**: ____/____/____**Social Security #**_____-_____-_____

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

Phone#_____**E-mail address**:_____

Marital status (circle): Married Single Divorced **Occupation**:_____

How were you referred to our office?_____

Have you been to a chiropractor before: YES / NO

AUTHORIZATION AND RELEASE: I authorize and payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand there is no guarantee that my insurance companies or prepaid health plan will cover or pay for all of my charges. Notwithstanding denial, reduction of benefits or failure to pay for any reason, I understand that I am responsible for all remaining charges.

HEALTH INFORMATION USAGE**: The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.**

INFORMED CONSENT: I hereby request and give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Physical therapy, exercises, and acupuncture may also be used (or on the patient named below, for whom I am legally responsible).

Although spinal manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:

Soreness: I am aware that like exercise it is common to experience muscle soreness in the first few treatments.
Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare.
Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disk, or other abnormality is detected, this office will proceed with extra caution.
Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in one million to once in ten million treatments. Once in a million is about the same chance as getting hit by lightening. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death.

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits

I realize that the practice of medicine, including chiropractic is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient's Signature X_____Date _____

*dba for Young Chiropractic llc

HISTORY OF PRESENT AND PAST ILLNESS

Enter date symptoms started: _____. Are your problems due to an injury?: Yes / No

List symptoms you are experiencing today: Choose the severity level associated with each symptom

_____ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

_____ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

_____ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

List any past **injuries**, **illnesses**, **auto accidents**, or **surgeries**? (include dates): _____

_____

What medications/drugs are you taking?_____

Days lost from work:_____ Work Restrictions_____:_____

Any Allergies?_____

Women: Are you pregnant?_____

Review of systems: **Mark all problems you currently have.**

Musculoskeletal		**Respiratory**		**Endocrine**	
Osteoporosis	_____	Asthma	_____	Thyroid Issues	_____
Arthritis	_____	Sleep Apnea	_____	Excessive Thirst	_____
Scoliosis	_____	Shortness of breath	_____	Excessive Urination	_____
Neck Pain	_____	Allergies / Hay Fever	_____	Frequent Infections	_____
Back Problems	_____	Sputum	_____	Hot/Cold Intolerance	_____
Hip Disorders	_____	Cough	_____	Low Energy	_____
Knee Injuries	_____	**GastroIntestinal**		**Genitourinary**	
Foot/Ankle Pain	_____	Anorexia/bulimia	_____	Kidney Stones	_____
Shoulder Problems	_____	Abdominal pain or blood	_____	Burning on urination	_____
Elbow/Wrist Pain	_____	Nausia / Vomiting	_____	Bedwetting	_____
TMJ issues	_____	Heartburn	_____	Prostate Issues	_____
Poor Posture	_____	Constipation	_____	Erectile Dysfunction	_____
Neurological		Diarrhea	_____	PMS symptoms	_____
Headache	_____	**HEENT**		**Constitutional**	
Dizziness	_____	Blurred Vision	_____	Fainting	_____
Numbness / Tingling	_____	Ringing in ears	_____	Low Libido	_____
Pins & Needles	_____	Hearing loss	_____	Fever	_____
Ataxia	_____	Runny Nose	_____	Chills	_____
Fainting	_____	Congestion	_____	Sudden Weight loss	_____
Cardiovascular		Sore Throat	_____	Fatigue / Weakness	_____
High blood pressure	_____	**Integumentary**		**Psychiatric**	
Chest Pain / Angina	_____	Skin Cancer	_____	Anxiety	_____
Poor Circulation	_____	Psoriasis	_____	Depression	_____
Palpitations	_____	Eczema	_____	**Lymphatics**	
Hematologic		Acne	_____	Enlarged lymph nodes	_____
Excessive Bruising	_____	Hair Loss	_____	Splenectomy	_____
Anemia	_____	Rash	_____		

Family History: (M=Mother, F=Father, S=Sibling

□Heart Disease ____ □Back Pain____ □Cancer____ □Blood Pressure____ □Diabetes____ □Other:_____

Social History

□Smoker (packs /day)____ □Alcohol Consumption (cups/day)____ □Coffee (cups/day)____ □Water (cups/day) ____

Exercise: □None □Moderate □Daily Type: _____

I certify the information provided is accurate to the best of my knowledge:

Patient's Signature X _____ Date _____

Lake Buena Vista Chiropractic (dba for Young Chiropractic llc)

ACCIDENT/INJURY FORM

NAME_____ DATE_____

Date of Accident_____ Time: ___am ___pm Location of Accident_____

AUTO INJURY

Were You: ( ) Driver ( ) Front Passenger ( ) Rear Passenger ( ) Pedestrian

Were you struck from: ( ) Behind ( ) Right Side ( ) Left Side ( ) Front ( ) Parked

Were you wearing a seatbelt: ( ) Yes ( ) No

Did the seatbelt leave any marks or discolorations: ( ) Yes ( ) No

Did the airbags deploy: ( ) Yes ( ) No

Which direction were you looking: ( ) Forward ( ) Left ( ) Right ( ) Down

Where were your hands: ( ) steering wheel ( ) Other: _____

Did you see the impending collision: ( ) Yes ( ) No / Unexpected

What speed were you hit at: ( ) Slow ( ) Moderate ( ) High

What type of car were you in: _____

Other Vehicle's type of car: _____

After Impact: did your body move: ( ) Up ( ) Down ( ) Sideways

Did your head hit the: ( ) Steering wheel ( ) dashboard ( ) Windshield

Were you rendered unconscious: ( ) Yes ( ) No

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

Did you go to the hospital ( ) Yes ( ) No, If yes which hospital _____

If Yes, when & how: _____

What services were provided at the hospital: _____

Describe the circumstances of the accident (Be Specific)_____

_____

Have you lost any days of work? ( ) Yes ( ) No If Yes, _____ through _____

****

CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT

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

INSURANCE INFORMATION

Your Auto Insurance Company: _____

Policy #: _____ Claim #: _____

Adjustor's name:_____Phone #:_____

Health Insurance: _____: Policy #:_____

Attorney's name:_____Phone #:_____

Patient's Signature/Legal Guardian X_____ Date: _____

Patient's Name: _____ Date: ____/____/____

Circle or Answer all activities you are currently experiencing issues with since your accident.

Loss of Enjoyment

1. Work
   a. Loss of status within organization
   b. Loss of job security
   c. Loss of promotional prospects
   d. Difficulty in performing duties
   e. Reduced quality of work
   f. Other: _____
   _____
2. School
   a. Loss of attending class
   b. Loss of attending functions
   c. Loss of gym class
   d. Loss of studying
   e. Other: _____
   _____
3. Domestic
   a. Loss of interior cleaning
   b. Loss of interior maintaining
   c. Loss of interior preparing meals
   d. Loss of attending to spouse
   e. Loss of attending to children
   f. Loss of interior decorating
   g. Loss of entertaining
   h. Loss of pet care
   i. Other: _____
   _____
4. Household
   a. Loss of exterior cleaning
   b. Loss of exterior landscaping
   c. Loss of exterior maintenance
   d. Loss of exterior decorating
   e. Loss of pet care
   f. Other: _____
   _____
5. Hobbies/Sports
   a. Pre accident sports/hobbies:
      _____
      i. Played socially
      ii. Played competitive
      iii. Played regionally
   b. Post accident:
      i. Cannot play social
      ii. Cannot play competitive
      iii. Cannot play regionally
      iv. Cannot play original sport
      v. Cannot play any sport

Duties Under Duress

1. Work duties under duress due to:
   a. Difficulty with stability/mobility
   b. Postural difficulties
   c. Difficulty with dexterity
   d. Fatigue
   e. Anxiety
   f. Reduced concentration
   g. Pain interfering with work capacity
2. Studying difficulty due to:
   a. Difficulty with stability/mobility
   b. Postural difficulties
   c. Difficulty with dexterity
   d. Fatigue
   e. Anxiety
   f. Reduced concentration
   g. Pain interfering with studying capacity
3. Domestic duties difficult due to:
   a. Difficulty with stability/mobility
   b. Postural difficulties
   c. Difficulty with dexterity
   d. Fatigue
   e. Anxiety
   f. Reduced concentration
   g. Pain
4. Household duties difficult due to:
   a. Difficulty with stability/mobility
   b. Postural difficulties
   c. Difficulty with dexterity
   d. Fatigue
   e. Anxiety
   f. Reduced concentration
   g. Pain
5. Other activities that you cannot perform since accident (be specific, examples: sex, traveling, birthdays): _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____

I currently am experiencing these losses of enjoyment factors and duties under duress since the accident.

X _____ ____/____/____

Patient's Signature/Legal Guardian **Date**

Assignment of Benefits & Rights and Direction to Pay Benefits Owed

I, the undersigned insured or beneficiary of an insurance policy, irrevocably assign to **Young Chiropractic llc (dba Lake Buena Vista Chiropractic),hereafter "Provider"** whatever rights I have under any policy of insurance and under Florida law, including, without limitation, any and all claims for attorney's fees, costs, interest and/or damages pursuant to Florida Statute 624.155. This Assignment of Benefits (AOB) includes an assignment of any potential claim for common law or statutory bad faith. If the Insurer disputes the validity of this AOB, then the insurer is instructed to notify the provider in writing within 10 days of receipt of this document. Failure to do so shall result in the provider relying on this AOB for direct payment and could constitute a waiver by the insurer to contest the validity of this document. I do hereby confirm that this AOB is irrevocable and instruct any insurance company or other collateral source for which I am entitled to benefits to pay for monies owed as a result of medical services rendered by (**Provider**) to promptly make payment in the name of and directly to (**Provider**) or its chosen billing service.

Pursuant to this AOB, (**Provider**) is authorized to file suit on my behalf against any insurance company that reduces or denies benefits for medical services rendered to me and to collect any damages awarded or settlement monies for services rendered, plus interest, costs, reasonable attorney's fees and a contingency fee multiplier. I understand that in any such lawsuit, my name or other identifying information will need to be included in and/or portions of my medical file attached to pleadings and/or formal discovery. I waive any confidentiality of my records and/or information but only to the extent necessary to prosecute a claim for unpaid or owed medical expenses against the insurance company or any other responsible party.

I acknowledge that (**Provider**) objects to any reductions or partial payments by the Insurer. Any partial or reduced payment, regardless of the accompanying language, issued by the Insurer and deposited by (**Provider**) shall be done 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. (**Provider**) reserves the right to seek the full amount of the bill submitted from the insurance company(ies) or me. Accordingly, the insurer is hereby instructed to set aside (escrow) any and all reduced or denied benefit payments for medical services rendered by this provider and not pay the disputed amount to anyone until the dispute is resolved.

I further instruct my insurance company to cooperate with the above-captioned (**Provider**) in resolving all medical billing disputes. Cooperation includes, but is not limited to, providing any and all declaration pages, PIP logs, payout ledgers, explanations of benefits, copies of checks, and any and all other documents or information to (**Provider**) or its attorneys, employees or other representatives acting on behalf of (**Provider**). If the insurer schedules a defense examination, examination under oath (EUO) or Independent Medical Examination (IME) of the patient, the insurer is hereby instructed to send a copy of said notification to this provider and the provider's attorneys. The provider and/or the provider's attorneys are authorized to appear at any patient EUO or IME set by the insurer. **THIS ASSIGNMENT OF BENEFITS DOES NOT ASSIGN ANY RIGHTS OR OBLIGATIONS UNDER THE POLICY OF INSURANCE, TO SUBMIT TO AN EUO OR RECORDED STATEMENT**. I further direct and authorize you to speak to an attorney, employee or any other representative of (**Provider**) or anyone acting on their behalf over the phone and provide them with any and all information you may have or documentation not previously listed above that they may request.

I, as the patient, agree to remain personally liable for the amounts billed by (**Provider**) regardless of the amount paid by the insurance company, unless ordered by a court of law. I fully understand that said health care services were provided to me in consideration for an unconditional promise to pay and for me providing these instructions to my insurance company. I, as the patient, further agree to be liable for reasonable attorney's fees and costs incurred in collecting any delinquent accounts or unpaid balances. By executing this document, I am placing my insurance company(ies) on notice that the claims for medical treatment rendered by (**Provider**) are related to my accident (or my covered conditions) and should be paid directly to (**Provider**) pursuant to this assignment of benefits and Florida law. Any delay in paying benefits owed under the insurance policy could adversely affect me.

BY EXECUTING THIS DOCUMENT, I AM PLACING MY INSURANCE COMPANY ON NOTICE THAT THIS IS A DIRECT ASSIGNMENT OF BENEFITS & RIGHTS PURSUANT TO FLORIDA LAW. AS THE INSURED OR BENEFICIARY OF SAID INSURANCE POLICY, I AM IRREVOCABLY ASSIGNING WHATEVER RIGHTS I HAVE UNDER MY POLICY OF INSURANCE (LESS THE DUTY TO ATTEND AN EUO) AND UNDER FLORIDA LAW TO THIS HEALTH CARE PROVIDER. A photocopy of this assignment shall be considered as effective and valid as the original.

X _____ ____/____/____ X _____ ____/____/____

Patient's Name | Date of Birth | Signature of Policyholder/Claimant | Date

_____ _____ ____/____/____

Name of Policy holder or Claimant | Acceptance of (**Provider**) | 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:

X _____ X _____ _____

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):*

David Young DC _____ _____

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.