

REGISTRATION

Date: _____

Phone: _____

Patient: _____
Last Name First Name Initial

Street Address: _____

City/State/Zip Code: _____

Sex: M F Age: _____ Birthdate: _____ Single Married Widowed Separated Divorced

Social Security #: _____ Email: _____

Insured's Name: _____
Last Name First Name Initial

Patient Agreement:

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with _____
Name of Insurance Company

and assign directly to Pain Relief Center of Homestead all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature of Insured/Guardian

Date

Present Complaints (Please circle the appropriate ones)

Headache
Mental dullness
Loss of memory
Dizzy
Ears ringing/buzzing
Upper back pain
Lower back pain
Midback pain
Pins and needles in hands
right/left

Feet/Hands Cold
Depression
Rib pain
Nervousness
Eye strain/pain
Shortness of breath
Fear
Confusion
Pins and needles in arms
right/left

Unbalanced
Fainting
Blurred vision
Irritability
Double vision
Loss of smell
Chest pain
Neck pain
Pins and needles in legs
right/left

Medical Implants: _____

Surgical Implants: _____

Medical alerts: _____

Pregnancy: yes ___ no ___

Pain Relief Center of Homestead
46 N. Homestead Blvd.
Homestead, FL 33030
Phone (305) 249-2250
Fax (305) 249-2266

Medications: (please list all medications and supplements that you currently take)

| | | |
|-------|-------|-------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Allergies: (please list all medications that cause allergic reaction)

| | | |
|-------|-------|-------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Smoking: ___ Yes ___ No If yes, _____ Packs per Day for _____ years

Alcohol ___ Yes ___ No If yes, Number of drinks per week _____

Surgical History: Please list ALL previous surgery and the date on which it was performed:

| | |
|----------------------|-------------------|
| Surgery _____ | Date _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Personal Medical History & Review of Systems:

Please indicate with an "X" any medical problems that you currently have or have had in the past.

NO MEDICAL PROBLEMS - no prior history of any significant medical problems

Lungs / Pulmonary - breathing disorders

- | | | |
|------------------------------------|---|---|
| <input type="checkbox"/> asthma | <input type="checkbox"/> pulmonary embolism | <input type="checkbox"/> respiratory arrest |
| <input type="checkbox"/> COPD | <input type="checkbox"/> pneumonia | <input type="checkbox"/> sleep apnea |
| <input type="checkbox"/> emphysema | <input type="checkbox"/> tuberculosis | <input type="checkbox"/> other: _____ |

Cardiac / Heart and peripheral vascular disease

- | | | |
|--|---|--|
| <input type="checkbox"/> chest pain / angina | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> irregular heartbeat, arrhythmia |
| <input type="checkbox"/> heart attack, myocardial infarction | <input type="checkbox"/> heart murmur, valve disorder | <input type="checkbox"/> peripheral vascular disease |
| <input type="checkbox"/> congestive heart failure | <input type="checkbox"/> mitral valve prolapse | <input type="checkbox"/> deep vein thrombosis |
| <input type="checkbox"/> other: _____ | <input type="checkbox"/> bleeding problems | |

Neurologic Disorders

- | | | |
|--|--------------------------------------|---|
| <input type="checkbox"/> stroke or TIA | <input type="checkbox"/> parkinson's | <input type="checkbox"/> cerebral palsy |
| <input type="checkbox"/> peripheral neuropathy | <input type="checkbox"/> MS | <input type="checkbox"/> polio |
| <input type="checkbox"/> other: _____ | | |

Bone & Joint Disorders

- | | | |
|---|--------------------------------|---|
| <input type="checkbox"/> osteoarthritis | <input type="checkbox"/> gout | <input type="checkbox"/> osteomyelitis |
| <input type="checkbox"/> rheumatoid arthritis | <input type="checkbox"/> lupus | <input type="checkbox"/> ankylosing spondylitis |
| <input type="checkbox"/> other: _____ | | |

Gastrointestinal Disorders

- | | | |
|--|---|---|
| <input type="checkbox"/> peptic ulcer or stomach ulcer | <input type="checkbox"/> diverticulitis | <input type="checkbox"/> hepatitis - Type _____ |
| <input type="checkbox"/> acid reflux, GERD | <input type="checkbox"/> irritable bowel | <input type="checkbox"/> liver disease |
| <input type="checkbox"/> GI bleed | <input type="checkbox"/> inflammatory bowel disease | |
| <input type="checkbox"/> other: _____ | | |

Genitourinary Disorders

- urinary tract infection
- kidney problems
- dialysis, kidney failure
- bladder problems
- kidney stones
- other: _____

Metabolic & Other Disorders

- Diabetes x _____ years
- skin disorder _____
- depression
- thyroid problems
- psoriasis
- anxiety
- sickle cell disease
- any skin ulcer
- alcohol or drug dependency
- high cholesterol or lipids
- tooth abscess, gingivitis
- other: _____

Cancer : any type -- please specify _____

Other medical problems NOT included above (explain) _____

Family History:

Please indicate with an "X" any significant family medical history or problems.

- asthma
- tuberculosis
- sleep apnea
- COPD or Emphysema
- other lung : _____
- heart attack, myocardial infarction
- congestive heart failure
- irregular heartbeat, arrhythmia
- bleeding problems
- other heart : _____
- Peripheral neuropathy
- MS or Parkinson's
- other neuro : _____
- osteoarthritis
- Lupus
- gout
- rheumatoid arthritis
- Other bone & joints: _____
- acid reflux, GERD
- inflammatory bowel disease
- hepatitis - Type _____
- liver disease
- other GI : _____
- kidney problems
- dialysis, kidney failure
- diabetes
- psoriasis
- high cholesterol or lipids
- thyroid problems
- sickle cell disease
- any skin ulcer
- Malignant hyperthermia

Cancer : any type -- please specify _____

Other medical problems NOT included above (explain) _____

PATIENT INSURANCE INFORMATION:

Please check any and all insurance coverage you or your spouse has applicable in this case.

- Medicare
- Blue Shield
- Auto Accident
- Medicaid
- Major Medical
- Union Plan
- Blue Cross
- Worker's Compensation
- Other

Insurance Identification Number: _____

Medicare/Medicaid Identification Number: _____

Major Medical or Auto Insurance:

Date of Accident: _____

Insurance Company Name: _____

Adjuster: _____

Address/Phone: _____

Claim #: _____ Policy #: _____ Effective Date: _____

**Primary Care Physician:
Name & Address:**

Phone #: _____

LEGAL INFORMATION:

Attorney Name & Address:

Attorney Phone #: _____

***Person to contact in an emergency (Name and Phone #):**

PAIN RELIEF CENTER OF HOMESTEAD

INSURANCE VERIFICATION FORM

Name: _____

The OWNER of the vehicle is _____

My relationship to the OWNER of the vehicle is _____

The DRIVER of the vehicle is _____

My relationship to the DRIVER of the vehicle is _____

Name of PASSENGER(s) in vehicle _____

My relationship to the PASSENGER(s) in the vehicle _____

Without exceptions, provide a complete list of all the people you lived with on the date of the accident/loss:

| Name | Driver's License (Y/N) | Relationship to you |
|-------|------------------------|---------------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Without exceptions, provide a complete list of all the vehicle/s, whether operable or not -- owned, leased, titled, or registered to you, or any one or more of the above listed persons with whom you lived on the date of the accident/loss.

| Year | Make/Model | Owner Name | Insurance Company | Policy # |
|-------|------------|------------|-------------------|----------|
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |

**AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION
FROM OTHER HEALTHCARE FACILITIES**

Patient Name: _____ SSN: _____
 Telephone #: _____ Date of Birth: ____/____/____
 Address: _____ City: _____ State: _____ Zip: _____

| | |
|--|-------------------------------------|
| Name of Healthcare Facility from which Records are Requested: | |
| (Please Print) | Ph: _____ Fax: _____ |
| Address: _____ | City: _____ State: _____ Zip: _____ |
| Dates of Treatment Requested: _____ | |
| Reason for Disclosure: _____ | |

MAIL INFORMATION TO: **PAIN RELIEF CENTER OF HOMESTEAD**
46 N. HOMESTEAD BLVD, HOMESTEAD, FL 33090
Or FAX TO: **305.248.2266**

I hereby authorize Pain Relief Center of Homestead, to obtain the health information indicated below that is contained in my patient records to the Recipient named above. I understand and acknowledge that this may include treatment for physical and mental illness, alcohol/drug abuse, and or HIV/AIDS test results or diagnoses. This authorization does not include permission to release outpatient Psychotherapy Notes. The release of Psychotherapy Notes requires a separate authorization. Psychotherapy Notes are defined as notes that document private, joint, group, or family counseling sessions that are separated from the rest of a patient's medical record.

| | | |
|--|---|-------------------|
| Check a Box <input checked="" type="checkbox"/> | History & Physical | EKGs |
| | Physical / Occupational Therapy Reports | Radiology Reports |
| | Laboratory Reports | Pathology Reports |
| | Other (Specify) | |

This consent is subject to revocation at any time except to the extent the action has been taken thereon. This authorization and consent will expire one year from the date of authorization written below.

Your health care (or payment for care) will not be affected by whether or not you sign this authorization. Once your health care information is released, redisclosure of your health care information by the Recipient may no longer be protected by law.

 Signature of Patient or Legal Representative

Date Signed: ____/____/____

Printed Name: _____ Relationship if not Patient: _____

****If other than the patient's signature, a copy of legal paperwork verifying the patient's personal representative MUST accompany the request (i.e. court appointed guardian, durable power of attorney for health care). For a deceased patient: A death certificate coupled with executor or administrator of estate paperwork must accompany authorization. Exception: parent signing for patient under the age of 18.**

****For a deceased patient, a court entry or order appointing a fiduciary, executor, or administrator or letters of appointment received from Probate Court must accompany an authorization signed by the named individual. If the estate has not been probated, a death certificate is required coupled with the documents naming the administrator or executor of the estate.**

AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION

Patient Name: _____ SSN: _____
 (Nombre Paciente)
 Telephone #: _____ Date of Birth: ____/____/____
 (Telefono #) (Nacimiento Fecha)
 Address: _____
 (Direccion)

I authorize PAIN RELIEF CENTER OF HOMESTEAD, to release the health information indicated below to:
 Yo autorizo a PAIN RELIEF CENTER OF HOMESTEAD, a proporcionar la información de salud como se indica a:

Person/ Organization: _____ (Persona/
 Organizacion)
 Address: _____
 (Direccion)
 Phone: _____ Dates of Medical Record Requested: _____
 (Telefono) (Record Medico Fechas Requeridas)

Reason for Disclosure (Proposito de Entrega):
 Continuing Care Insurance Legal Personal Use Other Reason
 (Continuidad de la atencion) (Seguro) (Legal) (Uso Personal) (Otros Propositos)

Check a Box

| | |
|---|--|
| <input type="checkbox"/> Complete Record (Record Completo) | <input type="checkbox"/> Radiology Reports (Reportes Radiologia) |
| <input type="checkbox"/> Therapy Physical/ Occupational (Terapia Fisica/ Ocupacional) | <input type="checkbox"/> Pathology Reports (Reportes Patologia) |
| <input type="checkbox"/> Lab Reports (Informes de Laboratorio) | <input type="checkbox"/> EKGs |
| <input type="checkbox"/> Other (Specify) Otros (Especifique) | <input type="checkbox"/> Operative Report (Reporte Operativo) |

SPECIFIC AUTHORIZATIONS

The Following information will not be released unless you specifically authorize it by marking the relevant box(es) below:
 (La siguiente información no puede ser revelada sin la especifica autorización cada marcando la caja(s) siguientes)

- Drug/ Alcohol Abuse or Treatment (Abuso o Tratamiento de Droga/ Alcohol)
 HIV/ AIDS Test Results or diagnoses (Resultado o Diagnostico VIH/ CIDA)
 Genetic Testing Information (Información de Pruebas Genéticas)
- Psychotherapy Notes (The release of Psychotherapy Notes required a separate authorization)
 (Notas de Psicoterapia) (Revelar Notas de Psicoterapia requiere una autorización por separado)

This consent is subject to revocation at any time except to the extent the action has been taken thereon. This authorization and consent will expire one year from the date of authorization written below.
 (Este consentimiento puede ser revocado en cualquier momento excepto cuando la acción ya ha sido tomada. Esta autorización y consentimiento vencerá a un año de la firma del presente formulario.)

Your health care (or payment for care) will not be affected by whether or not you sign this authorization. Once your health care information is released, redisclosure of your health care information by the Recipient may no longer be protected by law.
 (Su cuidado de salud (o pagos por el mismo) no podrán ser afectados firme o no esta autorización. Una vez que su información sea entregada , la misma ya no estará resguardada por las leyes.)

 Signature of Patient Or Legal Representative
 (Firma del Paciente o Representante Legal)

Date Signed: ____/____/____

 Printed Name (Nombre en Letras de Molde)

Relationship if Not Patient: _____
 (Relación si No es el Paciente)

*If other than the patient's signature, a copy of legal paperwork verifying the patient's personal representative MUST accompany the request (i.e. court appointed guardian, durable power of attorney for health care).
 (Si no es la firma del paciente, una copia del documento legal verificando que es el representante del paciente TIENE que ser acompañada con este formulario)

Pain Relief Center Of Homestead
46 N. Homestead Blvd.
Homestead, Fl 33030
(P) 305-248-2250 (F) 305-248-2266

MOTOR VEHICLE COLLISION QUESTIONNAIRE

Please answer all questions completely:

1. Your name and address:

2. Phone Number: _____

3. Please describe the collision in your own words:

4. Where did the collision occur? City/Town: _____ **State:** _____

5. Date of collision: _____ **Time:** _____ **AM PM**

6. Were you the: driver passenger pedestrian

7. If passenger, were you in the front seat right rear seat left rear seat

8. What type of vehicle were you in? _____

9. What type was the other vehicle? _____

10. Did your vehicle strike the other vehicle? yes no

11. Was your car struck by the other vehicle? yes no

12. What direction was your vehicle going? _____

13. What direction was the other vehicle going? _____

14. Was the impact from: the front the rear the left side the right side

15. What was the approximate speed at the time of the impact?

Your vehicle _____ mph Other vehicle _____ mph

16. What was the weather at the time of the collision? dry wet icy

17. Was your vehicle in: park neutral in gear moving stopped

18. Were your brakes being applied? yes no

19. Was your vehicle shoved: forward backward sideways

20. Were you shoved: forward whipped backward

21. Did your seat have a head restraint (headrest?) yes no

22. If yes, what was the position low mid-position high

23. Did your head ride over the headrest? yes no

24. Did your hat/glasses end up in the back seat or rear window? yes no

25. Did any other part of your body hit the interior of the vehicle? yes no

26. If yes, please specify: seatbelt restraints steering wheel dashboard

windshield side door side window other _____

27. Which part of your body? chest head chin face R L knee

R L shoulder R L hand other _____

28. Were you holding on to the steering wheel? yes no

29. Did you brace your arms against the dash? yes no

30. Did you brace your legs against the floorboard? yes no

31. Was your ankle turned? yes no

32. Did the vehicle go into a spin or roll as a result of the impact? yes no

Pain Relief Center Of Homestead
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33. If yes, explain: _____
34. How much damage was there to the outside of the vehicle? none some a lot
35. How much damage was there to the inside of the vehicle? none some a lot
36. At the point of impact, where did you experience pain? Be specific:

37. Immediately after the accident were you: conscious dazed unconscious
38. If you lost consciousness, how long? _____
39. Were you wearing a seat belt? yes no
40. Did the belt have a shoulder harness? yes no
41. If yes, did it contribute to the pain you are experiencing? yes no
42. At the time of impact were you: looking straight ahead looking to the right
 looking to the left looking down looking up
43. Did the seat break as a result of the impact? yes no
44. Were you braced for the impact? yes no
45. Were you surprised by the impact? yes no
46. Did you go to the hospital? yes no
47. If yes, when? right after the accident next day other _____
48. If yes, how did you get there? ambulance other: _____
49. If by ambulance, did the ambulance attendants place you in a: neck brace
 back brace other _____
50. Any medication or medical supplies given? _____
51. Did you have x-rays taken at the hospital? yes no
- If you went to the hospital, please answer the following:
Name of hospital _____
Treatment Received _____
52. Have you had any similar problems before? yes no
53. If yes, explain: _____
54. Are you diabetic? yes no
55. Do you have high blood pressure? yes no
56. Do you have low blood pressure? yes no
57. Do you have arthritis or degenerative joint disease? yes no
58. What type of work do you do? _____
59. What are your job requirements? _____
60. Have you lost any days of work from this injury? yes no
61. If yes, give dates: _____
- Patient Signature _____ Date _____
- Print Name _____

Pain Relief Center of Homestead
46 N. Homestead Blvd.
Homestead, Fl 33030
(305)248-2250

LIEN ASSIGNMENT

I _____ (patient name) residing at _____ (address) hereby enter into the following agreement with **Pain Relief Center of Homestead** (medical provider), hereinafter known as "the provider" in order to guarantee payment for services rendered by "the provider" to me. I understand that I am directly and fully responsible to "the provider" for all medical bills for services rendered to me. I understand that I am directly and fully responsible to "the provider" for any remaining balance on all medical bills for services rendered to me that were submitted on my behalf to the responsible insurance carrier. This document further serves to acknowledge my responsibility to repay all remaining balances subsequent to all applicable insurance payments. I agree to make myself available to appear or correspond with "the provider" as often as may be necessary for any collections effort that is undertaken.

I agree to comply with all Insurance Company regulations including, but not limited to examinations under oath and independent medical examinations. I understand that any failure on my part to comply with any condition precedent to insurance coverage, may, at the election of the medical provider, serve to revoke any assignment of benefits.

The Provider agrees to seek compensation from the appropriate insurance carrier prior to invoking the terms of this lien based on the accuracy of the information the patient has provided. The patient shall provide all necessary insurance information, police reports, and any additional documentation or information deemed necessary by the provider for the submission of the aforementioned insurance claim as applicable. Failure to provide accurate insurance information leading to a viable source of coverage may serve to invalidate any executed assignment of benefits.

I hereby give and grant this lien on my case to "the provider" against any and all proceeds of any settlement, judgment, verdict, or other disposition of any litigation filed or contemplated on my behalf that may be paid to me OR MY ATTORNEY as a result of the injuries for which I have been treated. I grant "the provider" the aforesaid lien against such sums of the aforesaid settlement, judgment, verdict, or other disposition of any litigation filed or contemplated on my behalf as may be necessary to adequately reimburse "the provider" for services rendered to me and towards all outstanding balances. I hereby agree to provide accurate contact information for the attorney pursuing any litigation on my behalf.

I hereby direct and authorize direct payment to "the provider", such sums as may be due and owing for medical services rendered to me. I further direct my ATTORNEY to honor the aforesaid lien and to withhold such sums from any settlement, judgment, verdict, or other disposition of any litigation filed or contemplated on my behalf as may be necessary to adequately reimburse "the provider" for services rendered to me towards all outstanding balances.

I understand that this document may not be rescinded and that my ATTORNEY shall not honor any such rescission. I hereby instruct that in the event another ATTORNEY is substituted in my case, the new ATTORNEY honor this lien as inherent to the settlement, judgment, verdict, or other disposition of any litigation filed or contemplated on my behalf and enforceable upon the case as if it were executed by him/her. I hereby direct my attorney, on demand, to provide the status of such litigation to "the provider" or his attorney engaged in any collection efforts. Furthermore, I direct my attorney to contact "the provider" prior to disbursement of any funds to ascertain any outstanding balances due and owing to **Pain Relief Center of Homestead** (medical provider).

Patient: _____ Signature: _____ Date: _____

Attorney: _____ Signature: _____ Date: _____

Provider: Pain Relief Center of Homestead Signature: _____ Date: _____

**Pain Relief Center Of Homestead
46 N. Homestead Blvd.
Homestead, Fl 33030
(P) 305-248-2250 (F) 305-248-2268**

OFFICE POLICY & PROCEDURE

- 1. I am aware that my insurance coverage may not fully cover all treatment that is recommended.**
- 2. Co-pay Policy - Co-pays are due PRIOR to being seen by our doctors. If your co-pay is not paid at the time of your visit and/or your account has a co-pay balance you will be required to pay your balance in full prior to seeing the doctor(s). Should you maintain a balance, you will be required to reschedule your office visit.**
- 3. Imaging Study Policy - The office requires 5 business days' notice to pick up films/reports; this includes CDs of imaging studies and any associated treatment notes and/or reports.**
- 4. Fax Policy - be advised that due to circumstances out of our control our office will no longer fax working restrictions or disability notices to insurance carriers, attorneys or other third parties for our patients. They will be provided to you.**
- 5. Forms Policy - Insurance forms, disability notices and working restriction forms and/or reports will be available 5 business days after they are received by our office. Please be advised that these items will only be provided to patients under Active Care. Active care is defined as an appointment within the last 5 business days.**
- 6. Scheduling Policy - our office reserves the right to discharge you from care due to non-compliance after 3 missed scheduled appointments.**

(Print) Patient name

Patient signature

Date

**Pain Relief Center of Homestead
46 N. Homestead Blvd.
Homestead, FL 33030
(P) 305-248-2250 (F) 305-248-2266**

Informed Consent for Examination and Treatment

I (we) hereby consent to the performance of examination and treatment on me or on _____, by the licensed doctors of chiropractic, medical doctors, and/or licensed physical therapists that may be employed by or engaged in practice in this clinic.

I have had an opportunity to discuss with the doctor(s) or other clinic personnel the nature and purpose of the different physical therapy procedures and chiropractic treatment (manipulation/adjustment). I understand that neither chiropractic nor medical treatment is an exact science and that my care may involve judgments to attempt to anticipate or explain risks and complications and an undesirable result does not necessarily indicate an error in judgment. No guarantee for results can be made or expected but rather I wish to rely on the doctor to choose and recommend a best course of treatment based upon facts known that is in my best interest.

I further understand that there are certain degrees of risk associated with chiropractic health care and physical therapy, which includes rarely, but not limited to fractures, disc injuries, strokes, and strain/sprains and am therefore willing to accept and consent to the risk associated with the care I am about to receive.

I have read, or the above information has been explained regarding consent. I have had an opportunity to ask questions about my examination and treatment. By signing below, I agree and intend this consent form to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment.

Female Patients: By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time. Date of last menstrual period _____

Patient's Name (Print)

Patient's Signature

Date

State relationship to patient if signing for patient

PAIN RELIEF CENTER OF HOMESTEAD

IME & EUO NOTICE AND PATIENT'S FINANCIAL RESPONSIBILITY

Please be advised that your insurance company reserves the right by law, to schedule an Independent Medical Examination (IME) and/or Examination Under Oath (EUO). A letter will be mailed to your attention, as well as to your attorney, It is your responsibility to attend the appointment (s).

Failure to be present on the required date would make you responsible for any unpaid balance of medical bills left outstanding. Your P.I.P carrier will not make payment without your cooperation regarding this matter.

I, the patient also agree to be financially responsible for all charges incurred at this facility including my insurance deductible, co-payment and any services rejected by my insurance company.

Su compañía de seguro tiene el derecho de citarlo/a para una examinacion medica independiente y una examinacion bajo juramento. Usted sera notificado por correo y su abogado recibira una copia. Es su responsabilidad de asistir a esas citas.

Si usted no se presenta a esta cita en la fecha requerida, sera responsable por las cuentas medicas que esten pendientes. Su compañía de seguro no hara ningun pago sin su cooperacion al respecto.

Yo, el paciente, estoy de acuerdo de ser responsable economicamente por todos los cargos incurridos en esta oficina, incluyendo, mi deducible, co-pago, ó cualquier otros cargos, no cubiertos ó no pagos por mi compañía de seguro.

**I fully understand the context of this letter:
Entiendo el contenido de esta carta en su totalidad:**

X _____

Date/Fecha _____

PAIN RELIEF CENTER OF HOMESTEAD

ASSIGNMENT OF BENEFITS FORM AUTHORIZATION TO PROVIDE COPY OF UPDATED PIP PAYOUT SHEET AND RESERVE THE RIGHT TO RESERVE MONIES IN ESCROW FOR BILLS DISPUTED

PATIENT: _____

S

I, the undersigned patient hereby assign the rights and benefits of insurance to the applicable personal injury protection, medical payments, and other insurance to PAIN RELIEF CENTER OF HOMESTEAD ("Provider"), for services and supplies rendered for treatment of personal injuries sustained in any accident/incident, including but not limited to the accident/incident of _____ (Date of accident/incident) to the undersigned patient and covered by Personal Injury Protection (PIP) Coverage or other insurance. I agree to pay any applicable deductible or co-payment not covered by the PIP or other insurance coverage. I authorize the Provider to release medical information as required.

This assignment includes but is not limited to all rights to collect benefits directly from the insurance company for services that I have received and all rights to proceed against the insurance company obligated to provide benefits in any action including legal suits for any reason the company fails to make payment to which I am due. As part of this assignment I authorize Provider to sign my name as an endorsement on any check made payable to myself and Provider for services or supplies rendered. This assignment also includes the right to collect payment for the reasonable costs for copying and mailing records. This assignment also includes any right to recover attorney's fees and costs for such action brought by the Provider as patient's assignee. I understand and agree that the attorney selected may be different than the attorney handling my personal injury/bodily injury claim or case.

I hereby instruct the insurance carrier that in the event the subject benefits are disputed for any reason that the amount of benefits claimed is to be set aside and not disbursed until the dispute is resolved. As part of this assignment of benefits, I further instruct the insurance carrier to notify the Provider immediately after any dispute as to the payment so that it may preserve and exercise its legal rights. Also, in addition to notifying me and my legal representative, I instruct the insurance carrier to immediately notify the Provider of any scheduled examinations under oath or independent medical examinations and/or depositions. I authorize and instruct the insurance carrier to provide to Provider upon request any and all documents in my file, including but not limited to an up-to-date and unredacted and complete payout register and all medical records. I understand that any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement containing any false, incomplete, or misleading information is guilty of a felony of the third degree. I have read the information herein and it is true to the best of my knowledge and belief.

x _____
Patient Signature

Date

x _____
Dr. Neil Bressler

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:

| | | |
|-------------------------------|-----------|------|
| | | |
| Name (<i>PRINT or TYPE</i>) | 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 (15) and (16), 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*):

| | | |
|-------------------------------|-----------|------|
| Neil Bressler, D. C. | | |
| Name (<i>PRINT or TYPE</i>) | 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.

**Pain Relief Center of Homestead
46 N. Homestead Blvd.
Homestead, Fl 33030
(305)248-2250**

We may use and disclose your PHI (private health information) in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We may also disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute.

We may use or disclose your PHI for workers compensation and similar programs.

We may use a sign-in sheet at the front desk and we may call you in to see the doctor by name.

We may contact you by mail or phone, at your residence, to remind you of appointments or to provide information about treatment alternatives. Unless you instruct us otherwise, we may mail you a postcard reminding you to make an appointment and we may leave a message for you on any answering device or with any person who answers the phone at your residence.

You can make a reasonable request for us to use alternative methods of communicating with you in a confidential manner. These requests must be submitted in writing in a clear and concise fashion. We are not required to agree with your request. However, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when information is necessary to treat you.

Rights that you have:

You have the right to request restrictions on some of the uses or disclosures described above. Except as stated, we are not required to agree to such restrictions.

You have the right to inspect and obtain copies of your medical information. (A fee for the costs of copying, mailing, labor and supplies associated with your request will be charged.)

You have the right to request amendments to your medical information. Such requests must be in writing, and must state the reason for the requested amendment. We will notify you as to whether we agree or disagree with the requested amendment. If we disagree with any requested amendment, we will further notify you of your rights.

You have the right to request an accounting of any disclosure we make of your medical information except for disclosures we make to you, to carry out treatment, payment or healthcare operations, as requested by your written authorization, as permitted or required under 45 CFR 164.502, for emergency or notification purposes, for national security or intelligence purposes as permitted by law, or to correctional facilities or law enforcement officials as permitted by law.

You have the right to receive a paper copy of this notice. To obtain a paper copy of this notice, please contact our office manager.

You have the right to file a complaint if you believe your privacy rights have been violated. You may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing and addressed to this office at the above address. You will not be penalized for filing a complaint.

This privacy policy is subject to change as circumstances dictate. Any changes will be effective upon the release of a revised policy as stated in this notice.

Signature of Patient or Legal Guardian: _____

Date: _____

Print Name of Patient or Legal Guardian: _____

Date: _____

APPLICATION OF "NO FAULT" BENEFITS

| | | | |
|------|--------------------|--------------|--------------|
| DATE | YOUR POLICY HOLDER | DATE OF LOSS | CLAIM NUMBER |
|------|--------------------|--------------|--------------|

DETERMINATION OF BENEFITS DUE UNDER "NO FAULT" AUTO INSURANCE LAW, REQUIRES THE ATTENDING PHYSICIAN TO COMPLETE THIS REPORT IT PROMPTLY

TO: _____
CLAIM DEPARTMENT
(Name of Insurance Company)

(Pursuant to Florida Statute 617.234, any person who knowingly and with intent to injure, defraud or deceive any insurance company by filing a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree.)

TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE PERSONAL INJURY PROTECTION LAW, PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY.

| | | | |
|---|--|---|---|
| YOUR NAME | | PHONE NUMBER: HOME | BUSINESS |
| YOUR ADDRESS (NO. STREET, CITY OR TOWN, STATE AND ZIP CODE) PERMANENT ADDRESS, IF DIFFERENT, HOW LONG HAVE YOU LIVED IN FLORIDA? | | DATE OF BIRTH | SOCIAL SECURITY NO. |
| DATE AND TIME OF ACCIDENT A.M. P.M. | PLACE OF ACCIDENT (STREET, CITY, OR TOWN AND STATE) | | |
| BRIEF DESCRIPTION OF ACCIDENT SEE POLICE REPORT | | | |
| DESCRIBE MOTOR VEHICLES YOU OWN: OTHER VEHICLES IN YOUR FAMILY: | 1. _____ 2. _____ 3. _____ | VEHICLE OWNER | 1. _____ 2. _____ 3. _____ INSURER |
| AS A RESULT OF THIS ACCIDENT WERE YOU INJURED? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YOUR ANSWER IS YES, COMPLETE THE REST OF THIS FORM, IF NO, SEND HERE AND RETURN THIS FORM TO US. | | | |
| SIGNATURE: _____ | | DATE: _____ | |
| DESCRIBE YOUR INJURY FULL EXTENT OF INJURY NOT KNOWN AT THE PRESENT TIME | | | |
| WERE YOU TREATED BY A DOCTOR? YES <input type="checkbox"/> NO <input type="checkbox"/> | DOCTOR'S NAME AND ADDRESS Neil Bresler, D.C. 46 N. Homestead Blvd. Homestead, FL 33030 | | |
| IF YOU WERE TREATED IN A HOSPITAL WERE YOU AN IN-PATIENT? <input type="checkbox"/> OUT-PATIENT? <input type="checkbox"/> | HOSPITAL'S NAME AND ADDRESS | | |
| AMOUNT OF MEDICAL BILLS TO DATE \$ | WILL YOU HAVE MORE MEDICAL EXPENSE? YES <input type="checkbox"/> NO <input type="checkbox"/> | AT THE TIME OF ACCIDENT WERE YOU IN THE COURSE OF YOUR EMPLOYMENT? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| DID YOU LOSE WAGES OR SALARY AS A RESULT OF YOUR INJURY? YES <input type="checkbox"/> NO <input type="checkbox"/> | IF YES, AMOUNT LOST TO DATE \$ | WHAT IS YOUR AVERAGE WEEKLY WAGE OR SALARY? \$ | |
| IF YOU LOST WAGES: DATE DISABILITY FROM WORK BEGAN | DATE YOU RETURNED TO WORK | | |
| HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR PAYMENTS UNDER ANY WORKERS' COMPENSATION OR UNEMPLOYMENT LAW? IF YES: \$ _____ per week Name of W/C insurer: _____ \$ _____ per month _____ | Have you received or are you eligible for benefits from the following sources: Medicaid NO <input type="checkbox"/> YES <input type="checkbox"/> \$ _____ Health insurer, if any, (name): _____ Medicare NO <input type="checkbox"/> YES <input type="checkbox"/> \$ _____ Military Benefits NO <input type="checkbox"/> YES <input type="checkbox"/> \$ _____ \$ _____ | | |
| LIST NAMES AND ADDRESSES OF YOUR PRESENT EMPLOYER(S) AND GIVE YOUR OCCUPATION AND DATES OF EMPLOYMENT FOR EACH | | | |
| EMPLOYMENT AND ADDRESS | | OCCUPATION | FROM TO |
| EMPLOYMENT AND ADDRESS | | OCCUPATION | FROM TO |
| AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES? YES <input type="checkbox"/> NO <input type="checkbox"/> IF YES, EXPLAIN ON REVERSE SIDE. | | | |
| I hereby authorize release of medical information including, but not limited to, medical bills and reports, to such parties as the company may deem necessary to protect its rights of recovery under the No-Fault Act. | | | |
| SIGNATURE: _____ | | DATE: _____ | |

ATTENDING PHYSICIAN'S REPORT

| | | | |
|------|--------------------|--------------|--------------|
| DATE | YOUR POLICY HOLDER | DATE OF LOSS | CLAIM NUMBER |
|------|--------------------|--------------|--------------|

DEFERMENT OF BENEFITS DOES UNDER "NO FAULT" AUTO INSURANCE LAW, REQUIRE, THE ATTENDING PHYSICIAN TO COMPLETE THIS REPORT IF DIRECTLY

TO: _____

CLAIM DEPARTMENT
(Name of Insurance Company)

| | | | |
|--|--|---|----------------|
| 1. PATIENT'S NAME AND ADDRESS | | | |
| 2. AGE | 3. SEX | 4. OCCUPATION (IF KNOWN) | |
| 5. HISTORY OF OCCURRENCE AS DESCRIBED BY THE PATIENT <i>PATIENT WAS INVOLVED IN A COLLISION ON</i> | | | |
| 6. DIAGNOSES AND CONCURRENT OR CONTRIBUTING CONDITIONS * | | | |
| 7. WHEN DID SYMPTOMS FIRST APPEAR? DATE: _____ | | 8. WHEN DID THE PATIENT FIRST CONSULT YOU FOR THIS CONDITION? DATE: _____ | |
| 9. HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION? YES <input type="checkbox"/> NO <input type="checkbox"/> If "Yes" state when and describe: | | | |
| 10. IS THE CONDITION SOLELY AS A RESULT OF THIS ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> If "No" explain: | | | |
| 11. IS THIS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 12. WILL INJURY RESULT IN PERMANENT DISFIGUREMENT OR PERMANENT DISABILITY? YES <input type="checkbox"/> NO <input type="checkbox"/> If "Yes" describe: <i>CANNOT BE DETERMINED AT THIS TIME</i> | | | |
| 13. PATIENT WAS DISABLED (Unable to work) FROM: _____ TO: _____ | | 14. IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK | |
| 15. REPORT OF SERVICES * <i>WILL BE MAILED WITHIN THIRTY FIVE DAYS</i> | | | |
| DATE OF SERVICE | PLACE OF SERVICE | DESCRIPTION OF SURGICAL SERVICE OR MEDICAL SERVICE RENDERED | CHARGES |
| | <i>Pain Relief Center of Homestead</i> | | \$ |
| | | | \$ |
| TOTAL CHARGE TO DATE \$ | | | |
| 16. IS THE PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? YES <input type="checkbox"/> NO <input type="checkbox"/> | | ESTIMATED FUTURE CHARGES \$ <i>NOT KNOWN</i> | |

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DECEIVE, REFRAID OR DECEIVE ANY INSURANCE COMPANY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THIRD DEGREE. PURSUANT TO FLORIDA STATUTE 627.405(3) "UNDER PENALTY OF PERJURY I DECLARE THAT I HAVE READ THE FOREGOING AND THE FACTS ALLEGED ARE TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF."

Dr. Neil Bressler

47-3832491

| | | | |
|---------------------------------|------------------------------|--------------------------------------|-----------------|
| PHYSICIAN'S NAME (PRINT) | PHYSICIAN'S SIGNATURE | CRS/TIN IDENTIFICATION NUMBER | |
| 46 N. Homestead Blvd. | Homestead | FL | 33039 |
| NO. STREET | CITY OR TOWN | STATE | ZIP CODE |

SV Motif - Exam Re-exam Form

Patient Name: _____

Date: _____

HT: _____ WT: _____ Pulse: _____ bpm - BP: _____ / _____ mmHg - Resp _____ DOB _____ / _____ / _____

Date of Injury _____ / _____ / _____

Subjective
 Description
 Improvement
 Unchanged
 DME Use Helping
 Chiropractic and Pain

PCP - _____ Medical Specialist - _____

Prior Injury - _____ L/R Handed - _____ Working - Yes No _____

Disability Note been filed: Yes No Temp: _____ Age: _____ SpO₂: _____

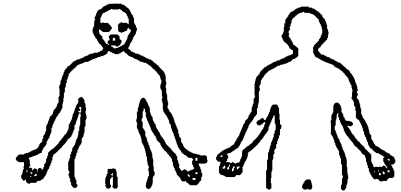
Headache

Severity: Mild Moderate Moderate/Severe Severe Frequency: Constant Occasional Intermittent Frequent
 Status: Routine Initial Unchanged Improved Worse Recovered New Motion: Stiffness Instability Restricted Movement
 Pain: Throbbing Burning Stabbing Sharp Achy Dull Pounding Pulsating Excruciating Stinging Numb achy
 Location: Localized in... Shooting into... Migrating to... Radiating to... **L R B VAS: 10**

Neck

L R B Mid VAS: ___/10

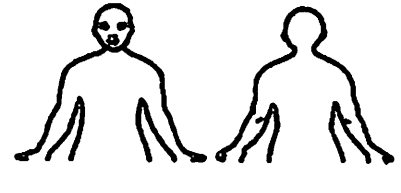
Severity: Mild Moderate Moderate/Severe Severe Frequency: Constant Occasional Intermittent Frequent
 Status: Routine Initial Unchanged Improved Worse Recovered New Motion: Stiffness Instability Restricted Movement
 Pain: Throbbing Burning Stabbing Sharp Achy Dull Pounding Pulsating Excruciating Stinging Numb achy
 Sensory: Crawling Pins & needles Prickly Tingling Numb Location: Localized in... Shooting into... Migrating to...
 Radiating to _____



Mid/Upper Back

L R B Mid VAS: ___/10

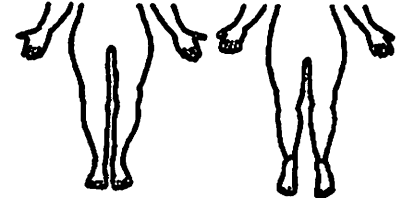
Severity: Mild Moderate Moderate/Severe Severe Frequency: Constant Occasional Intermittent Frequent
 Status: Routine Initial Unchanged Improved Worse Recovered New Motion: Stiffness Instability Restricted Movement
 Pain: Throbbing Burning Stabbing Pulsating Sharp Achy Dull Numb achy Excruciating Pounding Stinging
 Sensory: Crawling Pins & needles Prickly Tingling Numb
 Location: Localized in... Shooting into... Migrating to... Radiating to _____



Low-Back

L R B Mid VAS: ___/10

Severity: Mild Moderate Moderate/Severe Severe Frequency: Constant Occasional Intermittent Frequent
 Status: Routine Initial Unchanged Improved Worse Recovered New Motion: Stiffness Instability Restricted Movement
 Pain: Throbbing Burning Stabbing Pounding Sharp Achy Dull Pulsating Excruciating Stinging Numb achy
 Sensory: Crawling Pins & needles Prickly Tingling Numb
 Location: Localized in... Shooting into... Migrating to... Radiating to _____



TR/MTBI/PTSD

- Nausea (O)cc (S)ometimes (P)ersistent
- Vomiting (O) (S) (P)
- Disoriented (O) (S) (P)
- Amnesia (O) (S) (P)
- Irritability (O) (S) (P)
- Lethargy (O) (S) (P)
- Cognitive Changes (O) (S) (P)
- Vision Blurred (O) (S) (P)
- Altered Breathing (O) (S) (P)
- Loss of Consciousness (O) (S) (P)
- Headache (O) (S) (P)
- Migraine (O) (S) (P)
- Personality Changes (O) (S) (P)
- Ataxic/Walking Difficulty (O) (S) (P)
- Deviated Gaze / Eye Movement (O) (S) (P)
- Ringing in Ears (O) (S) (P)
- Light Sensitivity (O) (S) (P)
- Balance (O) (S) (P)

TBI = Traumatic Brain Injury MTBI = Mild Traumatic Brain Injury PTSD = Post Traumatic Stress Disorder

SEXUAL RELATIONS

- No Change Painful/Limited Unable due to pain

Neck/Trunk

| Range of Motion | Pain Level |
|--------------------------------|-------------------------------|
| Flexion _____/60 | 1 2 3 |
| Extension _____/60 | 1 2 3 |
| Right Lateral Flexion _____/45 | 1 2 3 |
| Left Lateral Flexion _____/45 | 1 2 3 |
| Right Rotation _____/60 | 1 2 3 |
| Left Rotation _____/60 | 1 2 3 |
| Orthopedic Findings: | Left Right Bilaterally |
| Jackson | +- +- +- |
| Valzava | +- +- +- |
| Scot-Hall | +- +- +- |
| Distraction | +- +- +- |
| Shoulder Depression | +- +- +- |
| Cervical Compression | +- +- +- |
| Upper Limb Tension Test | +- +- +- |
| O'Donoghue's | +- +- +- |

Lumbar/Lower Trunk

| Range of Motion | Pain Level |
|--------------------------------|-------------------------------|
| Flexion _____/60 | 1 2 3 |
| Extension _____/25 | 1 2 3 |
| Right Lateral Flexion _____/25 | 1 2 3 |
| Left Lateral Flexion _____/25 | 1 2 3 |
| Orthopedic Findings: | Left Right Bilaterally |
| Beit | +- +- +- _____ |
| Wac compression | +- +- +- _____ |
| Straight Leg Raise | +- +- +- _____ |
| Minor's sign | +- +- +- _____ |
| Yeoman's test | +- +- +- _____ |
| Babinski sign | +- +- +- _____ |
| Bragard's sign | +- +- +- _____ |
| Keop's test | +- +- +- _____ |
| Milgrams | +- +- +- _____ |
| Hibb's | +- +- +- _____ |
| Patrick Patro | +- +- +- _____ |
| Valzava's | +- +- +- _____ |

Therapist/Injury Trunk

| | | | | |
|-----------------------------|-------------|-------------------|--------------------|---|
| Ranges of Motion | | Pain Level | | |
| Flexion | ___/30 | 1 | 2 | 3 |
| Right Rotation | ___/30 | 1 | 2 | 3 |
| Left Rotation | ___/30 | 1 | 2 | 3 |
| Orthopedic Findings: | Left | Right | Bilaterally | |
| Schepersmann's | +- | +- | +- | |
| Kemp's | +- | +- | +- | |
| Forester's | +- | +- | +- | |

Objective

| | |
|-------------------------------------|----------------|
| ___ UE and LE neuro normal | Deficits _____ |
| ___ Leg Length R L leg ___ cm | _____ |
| ___ LE neuro normal | _____ |
| ___ Trigger Points | _____ |
| ___ ROM | _____ |
| ___ Improvement | _____ |
| ___ Muscle Spasm | _____ |
| ___ Physical Examination | _____ |
| ___ TBA/Concussion Symptoms present | _____ |

Assessment

| | |
|--------------------------------|--|
| ___ Acute / Subacute / Chronic | ___ Permanency |
| ___ Multiple Injuries | ___ Diagnosis Update |
| ___ Imaging/Alt Prognosis | ___ Physical Examination Clinical Corr |
| ___ No Pre-existing | ___ Informed Consent |
| ___ Exacerbation | ___ MRI Correlation |
| ___ Improvement | ___ |
| ___ Practice Focus | ___ |
| ___ Decreased Care Frequency | ___ |
| ___ Pregnancy and Imaging | ___ |
| ___ Imaging Necessary | ___ |

Prognosis

| |
|---|
| ___ Good |
| ___ Fair |
| ___ Guarded |
| ___ Prognosis Changed (must be included with Dx change) |

Objective - Palpation

| | | | |
|--------|-------------|----------|--------------|
| | Left | / | Right |
| C | _____ | _____ | _____ |
| T | _____ | _____ | _____ |
| L | _____ | _____ | _____ |
| Pubic | _____ | _____ | _____ |
| Sacrum | _____ | _____ | _____ |

Shoulder

L R B VAS: ___/10

Severity: Mild Moderate Moderate/Severe Severe Frequency: Constant Occasional Intermittent Frequent
 Status: Routine Initial Unchanged Improved Worse Recovered Motion- Stiffness Inflexibility Restricted Movement
 Pain- Throbbing Burning Stabbing Sharp Achy Dull Pounding Pulsating Excruciating Stinging Numb achy
 Sensory- Crawling Pins & needles Prickly Tingling Numb Location- Localized In...Shooting into...Migrating to...
 Radiating to _____

| | | | |
|---------------------|-------------|--------------|------------------|
| | Left | Right | Bilateral |
| Applies Scratch | +- | +- | +- |
| Apprehension | +- | +- | +- |
| Yergason's | +- | +- | +- |
| Codman's/Supra-pres | +- | +- | +- |
| Daubarn's | +- | +- | +- |
| Ant/Post Drawer | +- | +- | +- |
| McMurray's | +- | +- | +- |
| Val / Var Stress | +- | +- | +- |
| Patella Comp | +- | +- | +- |
| Distraction | +- | +- | +- |

Knee

L R B VAS: ___/10

Severity: Mild Moderate Moderate/Severe Severe Frequency: Constant Occasional Intermittent Frequent
 Status: Routine Initial Unchanged Improved Worse Recovered Motion- Stiffness Inflexibility Restricted Movement
 Pain- Throbbing Burning Stabbing Sharp Achy Dull Pounding Pulsating Excruciating Stinging Numb achy

Ankle

L R B VAS: ___/10

Severity: Mild Moderate Moderate/Severe Severe Frequency: Constant Occasional Intermittent Frequent
 Status: Routine Initial Unchanged Improved Worse Recovered Motion- Stiffness Inflexibility Restricted Movement
 Pain- Throbbing Burning Stabbing Sharp Achy Dull Pounding Pulsating Excruciating Stinging Numb achy
 Sensory- Crawling Pins & needles Prickly Tingling Numb Location- Localized In...Shooting into...Migrating to...
 Radiating to _____

| | | | |
|-----------------------|----|----|----|
| Anterior Drawer | +- | +- | +- |
| Val / Var Stress test | +- | +- | +- |
| Homan's sign | +- | +- | +- |
| Thompson sign | +- | +- | +- |
| Val / Var Stress test | +- | +- | +- |
| Tinel's sign | +- | +- | +- |

Elbow

L R B VAS: ___/10

Severity: Mild Moderate Moderate/Severe Severe Frequency: Constant Occasional Intermittent Frequent
 Status: Routine Initial Unchanged Improved Worse Recovered Motion- Stiffness Inflexibility Restricted Movement
 Pain- Throbbing Burning Stabbing Sharp Achy Dull Pounding Pulsating Excruciating Stinging Numb achy

Causal Relationship

___ Bodily injury and consistent 100% **Comments: (to be added at end of macro)**

Diagnosis Changes - Codes only Listed *Diagnosis update MUST BE checked

| | | | |
|-------|-------|-------|-------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Diagnosis Updated (found in Diagnosis Patient Education)
 728.4 Ligamentous Laxity Present

Research References - INSERT INTO BOTTOM OF ASSESSMENT

- Lumber Support
- Chiropractic and Headache Treatment
- Chiropractic and Cost Effective
- Chiropractic and Pain Management
- Intervertebral Disc and Chiropractic Management
- Lower Back Pain
- Chiropractic and Autonomics
- Trigger Point Therapy
- Multiple Injuries
- Tinnitus
- Diabetes Increases Care
- Airbag Injury
- Carpal Tunnel and MVA
- Acute Schmorl's Nodes
- Prior Cervical Fusion and Bodily Injury
- Neck Injury Increased with Head Turned
- Disc Herniation Causes Headaches
- Discogenic Pain Causes Extremity Symptoms
- Sprains are Permanent
- Facet Syndrome
- Nerve Injury Permanent

- Degenerative Disc and Inversion
- Disc Injury and Whiplash Stals
- Whiplash and Persistent Pain
- Intervertebral Disc Pain Generator
- Ligament Injuries are Permanent
- Pre-existing Increases Bodily Injury
- Spinal Range of Motion Normal Reference

X-RAYS ORDERED:

C/S: A/P LATERAL DAVIS VIEWS: 4 / 7

T/S: A/P LATERAL

L/S: A/P LATERAL

PELVIS:

KNEE: L/R AP/Lat

SHLDR:

L/R AP/Lat

ANKLE: L/R AP/Lat

WRIST:

L/R AP/Lat

HAND:

ELBOW: L/R AP/Lat

RIBS:

CHEST:

OTHER:

Treatment Plan

Visit Status - per week for weeks CONTINUE WITH SAME TREATMENT PLAN

Modality -

Adjustment -

Suboccipital Cervical Thoracic Lumbar Sacrum Left Sacroiliac Right Sacroiliac

Shoulder L/R Knee L/R Ankle L/R Wrist L/R

Hot/Cold Pack -

Suboccipital Cervical Thoracic Lumbar Sacrum Left Sacroiliac Right Sacroiliac Shoulder Knee

E-Stim

Suboccipital Cervical Thoracic Lumbar Sacrum Left Sacroiliac Right Sacroiliac Shoulder Knee

Cryotherapy

Suboccipital Cervical Thoracic Lumbar Sacrum Left Sacroiliac Right Sacroiliac Shoulder Knee

Ultrasound

Suboccipital Cervical Thoracic Lumbar Sacrum Left Sacroiliac Right Sacroiliac Shoulder Knee

Therapeutic Exercises

Suboccipital Cervical Thoracic Lumbar Sacrum Left Sacroiliac Right Sacroiliac (Bands / Bike / WBV / Stability step)

Shoulder Knee

Bracing

Suboccipital Cervical Thoracic Lumbar Sacrum Left Sacroiliac Right Sacroiliac

Home Exercises

Suboccipital Cervical Thoracic Lumbar Sacrum Left Sacroiliac Right Sacroiliac Shoulder Knee

Range of Motion Exercises

Suboccipital Cervical Thoracic Lumbar Sacrum Left Sacroiliac Right Sacroiliac Shoulder Knee

Vibratory Massage - Manual/Mechanical

Suboccipital Cervical Thoracic Lumbar Sacrum Left Sacroiliac Right Sacroiliac

Traction - Mechanical

Suboccipital Cervical Thoracic Lumbar Sacrum Left Sacroiliac Right Sacroiliac

Trigger Point Therapy

Suboccipital Cervical Thoracic Lumbar Sacrum Left Sacroiliac Right Sacroiliac

Intersegmental Traction

Suboccipital Cervical Thoracic Lumbar Sacrum Left Sacroiliac Right Sacroiliac

Report To:

- Same as last report (oo all)
- PCP Neurologist Lawyer
- Carrier Pain Management Other _____
- Orthopedic The Patient

Disability Status

- Working light duty
- Working Full time full duty
- Not Working

**DIAGNOSIS LIST
ICD-10**

| | | | | |
|---------|---|--|---------|--|
| R51 | Headache | | M25.511 | Pain in right shoulder |
| G44.801 | Post-traumatic headache, unspecified, intractable | | M25.512 | Pain in left shoulder |
| G44.809 | Post-traumatic headache, unspecified, not intractable | | M79.601 | Pain in right arm |
| G44.811 | Acute post-traumatic headache, intractable | | M79.602 | Pain in left arm |
| G44.819 | Acute post-traumatic headache, not intractable | | M79.621 | Pain in right upper arm |
| G44.821 | Chronic post-traumatic headache, intractable | | M79.622 | Pain in left upper arm |
| G44.829 | Chronic post-traumatic headache, not intractable | | M23.521 | Pain in right elbow |
| | | | M23.522 | Pain in left elbow |
| M54.2 | Cervicalgia | | M79.631 | Pain in right forearm |
| M54.11 | Radiculopathy, occipito-atlanto-axial region | | M79.632 | Pain in left forearm |
| M54.12 | Radiculopathy, cervical region | | M25.531 | Pain in right wrist |
| M54.13 | Radiculopathy, cervicothoracic region | | M25.532 | Pain in left wrist |
| M50.91 | Other cervical disc degen, C2-C3, C3-C4 | | M79.641 | Pain in right hand |
| M50.92 | Other cervical disc degen, C4-C5, C5-C6, C6-C7 | | M79.642 | Pain in left hand |
| M50.99 | Other cervical disc degen, C7-T1 | | M79.644 | Pain in right finger(s) |
| M46.02 | Enthesopathy, cervical region | | M79.645 | Pain in left finger(s) |
| M49.01 | Spinal stenosis, occipito-atlanto-axial region | | | |
| M49.02 | Spinal stenosis, cervical region | | M25.551 | Pain in right hip |
| | | | M25.552 | Pain in left hip |
| M54.6 | Pain in thoracic spine | | M79.654 | Pain in right leg |
| M54.14 | Radiculopathy, thoracic region | | M79.655 | Pain in left leg |
| M54.15 | Radiculopathy, thoracolumbar region | | M79.651 | Pain in right thigh |
| M51.24 | Other interv disc displac, thoracic | | M79.652 | Pain in left thigh |
| M51.25 | Other interv disc displac, thoracic-lumbar | | M25.561 | Pain in right knee |
| M51.34 | Other interv disc degen, thoracic | | M25.562 | Pain in left knee |
| M49.04 | Spinal stenosis, thoracic region | | M79.661 | Pain in right lower leg |
| | | | M79.662 | Pain in left lower leg |
| M54.5 | Low back pain | | M79.671 | Pain in right foot |
| M54.40 | Lumbago with sciatica, unspecified | | M79.672 | Pain in left foot |
| M54.41 | Lumbago with sciatica, right side | | M25.571 | Pain in right ankle and joints of right foot |
| M54.42 | Lumbago with sciatica, left side | | M25.572 | Pain in left ankle and joints of right foot |
| M54.16 | Radiculopathy, lumbar region | | M79.674 | Pain in right toe(s) |
| M54.17 | Radiculopathy, lumbosacral region | | M79.675 | Pain in left toe(s) |
| M54.18 | Radiculopathy, sacral and sacrococcygeal region | | | |
| M54.91 | Sciatica, right side | | M89.11 | Cervical Subluxation M89.01 Segmental dysfunction |
| M54.92 | Sciatica, left side | | M89.12 | Thoracic Subluxation M89.02 Segmental dysfunction |
| M51.26 | Other intervertebral disc displac, lumbar region | | M89.13 | Lumbar Subluxation M89.03 Segmental dysfunction |
| M51.27 | Other intervertebral disc displac, lumbosacral region | | M89.14 | Sacral Subluxation M89.04 Segmental dysfunction |
| M51.35 | Other intervertebral disc degen, lumbar region | | M89.15 | Pelvic Subluxation M89.05 Segmental dysfunction |
| M51.37 | Other intervertebral disc degen, lumbosacral region | | | |
| M49.05 | Spinal stenosis, lumbar region | | M41.22 | Other idiopathic scoliosis, cervical region |
| | | | M41.23 | Other idiopathic scoliosis, cervicothoracic region |
| R11.0 | Nausea | | M41.24 | Other idiopathic scoliosis, thoracic region |
| R59.1 | Weakness | | M41.25 | Other idiopathic scoliosis, thoracolumbar region |
| R59.01 | Other Nausea | | M41.26 | Other idiopathic scoliosis, lumbar region |
| R42 | Dizziness | | M41.27 | Other idiopathic scoliosis, lumbosacral region |

**DIAGNOSIS LIST
ICD-10**

| | | | | |
|----------|--|--|----------|--|
| M79.1 | Myalgia | | M43.11 | Spondylolisthesis, occipito-atlanto-axial region |
| M62.890 | Muscle spasm of back | | M43.12 | Spondylolisthesis, cervical region |
| M62.891 | Muscle spasm of calf | | M43.19 | Spondylolisthesis, cervicothoracic region |
| | | | M43.14 | Spondylolisthesis, thoracic region |
| R07.1 | Chest pain on breathing | | M43.15 | Spondylolisthesis, thoracolumbar region |
| R07.0 | Pain in throat | | M43.16 | Spondylolisthesis, lumbar region |
| R07.82 | Intercostal pain | | M43.17 | Spondylolisthesis, lumbosacral region |
| R07.89 | Other chest pain | | M43.18 | Spondylolisthesis, sacral and sacrococcygeal region |
| R10.0 | Acute abdomen | | M43.19 | Spondylolisthesis, multiple sites in spine |
| R10.84 | Generalized abdominal pain | | | |
| R10.10 | Upper abdominal pain, unspecified | | R64.84 | Jaw Pain |
| R10.11 | Right upper quadrant pain | | M26.6 | TMJ Articular Disorder |
| R10.12 | Left upper quadrant pain | | M26.62 | TMJ Arthritis |
| R10.31 | Right lower quadrant pain | | M26.63 | Articular Disc Disorder of TMJ |
| R10.32 | Left lower quadrant pain | | S03.404 | TMJ Sprain |
| R10.817 | Generalized abdominal tenderness | | G50.0 | Trigeminal Neuralgia |
| | | | | |
| M43.21 | Fusion of spine, occipito-atlanto-axial region | | M50.1 | Cervical disc disorder with radiculopathy |
| M43.22 | Fusion of spine, cervical region | | M51.14 | Thoracic disc disorder with radiculopathy |
| M43.23 | Fusion of spine, cervicothoracic region | | M51.16 | Lumbar disc disorder with radiculopathy |
| M43.24 | Fusion of spine, thoracic region | | | |
| M43.25 | Fusion of spine, thoracolumbar region | | M59.20 | Other cervical disc displacement, unspecified |
| M43.26 | Fusion of spine, lumbar region | | M51.26 | Other lumbar disc displacement, unspecified |
| M43.27 | Fusion of spine, lumbosacral region | | M51.9 | Unspecified thoracic, thoracolumbar and lumbosacral intervertebral disc disorder |
| M43.28 | Fusion of spine, sacral and sacrococcygeal region | | | |
| | | | V49.89C* | Car occupant (driver) |
| | | | V49.89C* | Passenger injured in collision with other car, in traffic |
| M35.7 | Hypomobility of Segment | | | |
| M24.20 | Loosy of Ligament | | S16.100A | Strain of Muscles/fascia/tendons of neck - Initial Enc |
| M21.769 | Unequal leg length (acquired) | | S16.100D | Strain of Muscles/fascia/tendons of neck - Sub Enc |
| S69.4 | Chronic Pain syndrome (fibromyalgia) | | S39.012A | Strain of Muscles/fascia/tendons of lumbar Initial Enc |
| | | | S39.012D | Strain of Muscles/fascia/tendon of lumbar Sub Enc |
| S19.400A | Sprain of Ligaments - Cervical - Initial Enc. | | S39.013A | Strain of Muscles/fascia/tendon of Pelvis Initial Enc |
| S19.400D | Sprain of Ligaments - Cervical - Subsequent Enc. | | S39.013D | Strain of Muscles/fascia/tendon of Pelvis Sub. Enc |
| S29.300A | Sprain of Ligaments - Thoracic - Initial Enc | | S46.812A | Strain of Muscles/fascia/tendon of left sh - Initial Enc |
| S29.300D | Sprain of Ligaments - Thoracic - Subsequent Enc | | S46.812D | Strain of Muscles, fascia/tendon of left sh - Sub Enc |
| S39.500A | Sprain of Ligaments - Lumbar - Initial Enc | | S46.811A | Strain of Muscles, fascia/tendon of right sh - Initial Enc |
| S39.500D | Sprain of Ligaments - Lumbar - Subsequent Enc | | S46.811D | Strain of Muscles, fascia/tendon of right sh - Sub Enc |
| S33.600A | Sprain of sacroiliac joint, Initial Enc | | | |
| S33.600D | Sprain of sacroiliac joint, Subsequent Enc | | M59.06 | Segmental and somatic dysfunction of lower extremity. |
| | | | S76.011A | Strain of muscle, fascia and tendon of right hip, left |
| M59.07 | Segmental and somatic dysfunction of upper extremity. | | S76.012A | Strain of muscle, fascia and tendon of left hip, left |
| S43.512A | Sprain of right acromioclavicular joint, Initial encounter | | | |
| S43.522A | Sprain of left acromioclavicular joint, Initial encounter | | | |
| S43.411A | sprain of right coracoclavicular (Ligament), Initial encounter | | | |
| S43.412A | sprain of left coracoclavicular (Ligament), Initial encounter | | | |

PATIENT: _____

DATE OF SERVICE: _____

SUBJECTIVE:

Complaint: Headache () Neck () Radiates R/L UB () MB () LB () Radiates R/L Sacral () Pelvic () T.M.J R/L Ribs Ant. R/L Ribs Post R/L
 Upper Ext: Shoulder R/L Arm R/L Elbow R/L Forearm R/L Wrist R/L Hand R/L Fingers R/L
 Lower Ext: Hip R/L Thigh R/L Hamstring R/L Knee R/L Shin R/L Calve R/L Ankle R/L Foot R/L Leg R/L Toes R/L
 Numb/Ting. Arm R/L Hand R/L Leg R/L Foot R/L Chest: Pain / Sore / Tight

ADL's Limited ()

OBJECTIVE: T=Tenderness, S=Spasm, TP=Trigger Point

The patient continues to exhibit the above OBJECTIVE in: Cervical _____ Thoracic: _____ Lumbar: _____ Other: _____

Range of Motion:

Cervical ROM was painful in FLEX EXT R/L L/R restricted in: FLEX EXT R/L L/R

Thoracic ROM was painful in FLEX EXT R/L L/R restricted in: FLEX EXT R/L L/R

Lumbar ROM was painful in FLEX EXT R/L L/R restricted in: FLEX EXT R/L L/R

TREATMENT

| Initials | Units | SERVICE(S) | REGION(S) / AREA(S) / DESCRIPTION(S) |
|----------|-------|---------------------------------------|--|
| | | Office Visit, CAT | I/II/III/IV/V NP EP |
| | | C.M.T. (98940) (98941) | C/T/L/S/P TECHNIQUE: ACTIVATOR DROP DIVERSIFIED |
| | | C.M.T Extra Spinal (98943) | Shldr: R/L Wrist: R/L Ankle: R/L Knee R/L TMJ: R/L Other: |
| | | Massage Mech (97039) | C/T/L/S/P (Jensen) Mechanical Massage (Jensen Rub) is a vibratory massage. The benefits of massage therapy may include increasing blood circulation, reducing swelling, relaxing muscles, relieving muscle pain and spasms, and aid in recovery and range of motion |
| | | Trigger Point (97140) | C/T/L/S/P Upper Ext: L/R Lower Ext: R/L TRAPS: R/L Other: _____ R/L (Acufreec tool is used) . With trigger point therapy, a chiropractor gently applies pressure to the affected area to release adhesions and increase range of motion over them. It is also used to decrease muscle spasms in muscles that have been damaged. () 8 to 23 min () 24 - 38 min () 30 - 52 minutes |
| | | Therapeutic Exercises (97110) (97150) | C/T/L/S Shldr R/L Arm R/L Elbow R/L Wrist R/L Hand R/L Thigh R/L Hip R/L Knee R/L Leg R/L Ankle R/L Foot R/L Hand: R/L () 8 to 23 minutes () 24 - 38 minutes () 30 - 52 minutes Type: Vibration Bicycle Neckays Theraband exercises Therabul Medicine ball Other: _____ This patient has now progressed to a point in their therapy where it is now indicated that we assist the patient in developing strength, endurance and flexibility. |
| | | Hot () Cold () Packs (97010) | C/T/L/S/P Upp. Ext: R/L Low. Ext: R/L Other: Cold/heat is used as a local, superficial, hypo/hyperthermal effect on the body. Pain and swelling reduction is the desired effect. |
| | | E.M.S (90283) | C/T/L/S Shldr: R/L Arm: R/L Elbow R/L Wrist: R/L Hand R/L Thigh: R/L Hip: R/L Knee: R/L Leg: R/L Ankle: R/L Foot: R/L TMJ: R/L Wrist: R/L Hand: R/L () This modality is used to reduce adhesions, edema and muscle spasms. |
| | | Ultrasound (97035) | C/T/L/S/P Shldr: R/L Arm: R/L Elbow R/L Wrist: R/L Hand R/L Thigh: R/L Hip: R/L Knee: R/L Leg: R/L Ankle: R/L Foot: R/L TMJ: R/L Wrist: R/L Hand: R/L () 8 to 23 min () 24 - 38 min () 30 - 52 minutes This modality is used to provide a deep penetrating heat effect which breaks down scar tissue and reduces edema. |
| | | Mech. Traction (97012) | C/T/L/S Mechanical traction is being applied to separate and stretch the spinal segments which reduces edema and promotes joint hydration. |
| | | Paraffin (97018) | Shouder R/L Elbow R/L Wrist R/L Hand R/L Knee R/L Ankle R/L Foot R/L Paraffin bath has the therapeutic effects of decreasing pain and increasing soft-tissue extensibility. |
| | | X-Rays (# of Views) | C/S: T/S: L/S: PELVIS: OTHER: X-Ray Tech: _____ DAVIS VIEWS: 4/7 KNEE: SHLDR: ANKLE: WRIST: HAND: ELBOW: |
| | | Supplies | LUMBAR BRIT/ KNEE / ANKLE / ELBOW / WRIST / CERVICAL PUMP |
| | | R.O.F | X-RAYS / MRI / CT SCAN / NCV / Functional MEDICAL RECORDS: CLINIC / HOSPITAL / ORTHOPEDIC Other: |

PLANTREATMENT GOALS:

- Reduce symptoms, Increase Functional Capacity & Return to Normal ADL
- Therapeutic Phase 1: Acute Inflammatory, Reduce Inflammation, Muscle Spasm and Pain
- Therapeutic Phase 2: Repair & Remobilization: Functional Scar formed & Increase Pain Free ROM
- Therapeutic Phase 3: Remodeling/Rehabilitation: Increase coordination, Strength Endurance & Work Capacity

ASSESSMENT:

- No Change
- Improving
- Slight Improvement
- As Expected
- Slower than Expected
- Exacerbated

Notes: _____

Assistant: _____

Patient: _____

Doctor: _____

Therapist: _____

Neil Dressler DC
 C111044

All treatment being rendered is based on subjective complaints and examination findings and is medical necessary
 C/S: Cervical Spine T/S: Thoracic Spine L/S: Lumbar Spine S: Sacroiliac S: Spasm TP: Trigger Point R: Right L: Left