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 Miami** 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	Feet/Hands Cold	Unbalanced
Mental dullness	Depression	Fainting
Loss of memory	Rib pain	Blurred vision
Dizzy	Nervousness	Irritability
Ears ringing/buzzing	Eye strain/pain	Double vision
Upper back pain	Shortness of breath	Loss of smell
Lower back pain	Fear	Chest pain
Midback pain	Confusion	Neck pain
Pins and needles in hands right/left	Pins and needles in arms right/left	Pins and needles in legs right/left

Medical Implants: _____ **Medical alerts:** _____
Surgical Implants: _____ **Pregnancy:** **yes** ____ **no** ____

Pain Relief Center of Miami
1717 N. Bayshore Dr Suite 204
Miami, FL 33132
Phone (305)373-5411
Fax (305) 248-2266

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

☐ asthma ☐ pulmonary embolism ☐ respiratory arrest
☐ COPD ☐ pneumonia ☐ sleep apnea
☐ emphysema ☐ tuberculosis ☐ other: _____

Cardiac / Heart and peripheral vascular disease

☐ chest pain / angina ☐ high blood pressure ☐ irregular heartbeat, arrhythmia
☐ heart attack, myocardial infarction ☐ heart murmur, valve disorder ☐ peripheral vascular disease
☐ congestive heart failure ☐ mitral valve prolapse ☐ deep vein thrombosis
☐ other: _____ ☐ bleeding problems

Neurologic Disorders

☐ stroke or TIA ☐ parkinson's ☐ cerebral palsy
☐ peripheral neuropathy ☐ MS ☐ polio
☐ other: _____

Bone & Joint Disorders

☐ osteoarthritis ☐ gout ☐ osteomyelitis
☐ rheumatoid arthritis ☐ lupus ☐ ankylosing spondylitis
☐ other: _____

Gastrointestinal Disorders

☐ peptic ulcer or stomach ulcer ☐ diverticulitis ☐ hepatitis - Type _____
☐ acid reflux, GERD ☐ irritable bowel ☐ liver disease
☐ GI bleed ☐ inflammatory bowel disease
☐ 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 & joint: _____
☐ 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/MIAMI

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 #

46 N. Homestead Blvd, Homestead, FL 33030 Telephone: (305)248-2250 Fax: (305)248-2266
1717 N. Bayshore Dr. Suite 204, Miami, FL 33132 Telephone: (305)373-5411

AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION FROM OTHER HEALTHCARE FACILITIES

Patient Name:_____ SS#:_____

Telephone #:_____ Date of Birth: _____/_____/_____

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

Name of Healthcare Facility from which Records are Requested:

_____ Ph: _____ Fax: _____
(Please Print)

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

Dates of Treatment Requested: _____

Reason for Disclosure: _____

MAIL INFORMATION TO: **PAIN RELIEF CENTER OF Miami**
1717 N. Bayshore Dr. Suite 204, Miami, FL 33132

Or FAX TO: **305.248.2266**

I hereby authorize **Pain Relief Center of Miami,** 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 outpatientPsychotherapy 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 ☑

	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.

_____ Date Signed: _____/_____/_____
Signature of Patient or Legal Representative

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: _____ SS#: _____
(Nombre Paciente)
Telephone #: _____ Date of Birth: _____/ _____/ _____
(Telefono #) (Nacimiento Fecha)
Address: _____
(Direccion)

I authorize **PAIN RELIEF CENTER OF MIAMI,** to release the health information indicated below to:
Yo autorizo a **PAIN RELIEF CENTER OF MIAMI,** a proporcionar la informacion 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 (Continuidad de la atencion) ____ Insurance (Seguro) _____ Legal (Legal) _____ Personal Use (Uso Personal) _____ Other Reason (Otros Propositos)

Check a Box ☑

	Complete Record (Record Completo)		Radiology Reports (Reportes Radiologia)
	Therapy Physical/ Occupational (Terapia Fisica/ Ocupacional)		Pathology Reports (Reporte Patologia)
	Lab Reports (Informes de Laboratorio)		EKGs
	Other (Specify) Otros (Especifique)		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 específica autorización dada 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 (Informacion de Pruebas Geneticas)

☐☐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.)

_____ Date Signed: _____/ _____/ _____
Signature of Patient Or Legal Representative
(Firma del Paciente o Representante Legal)

_____ Relationship if Not Patient: _____
Printed Name (Nombre en Letra de Molde) (Relacion 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 Miami
1717 N. Bayshore Dr Suite 204.
Miami, Fl 33132
(P) 305-373-5411 (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

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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 Miami
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Miami, Fl 33132
(P) 305-373-5411 (F) 305-248-2266

LIEN ASSIGNMENT

I_____(patient name) residing at_____(address) hereby enter into the following agreement with **Pain Relief Center of Miami**_(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 Miami** (medical provider).

Patient: _____ Signature: _____ Date: _____

Attorney: _____ Signature: _____ Date: _____

Provider: Pain Relief Center of Miami Signature: _____Date: _____

Pain Relief Center of Miami
1717 N. Bayshore Dr Suite 204.
Miami, Fl 33132
(P) 305-373-5411 (F) 305-248-2266

OFFICE POLICY & PROCEDURE

1. I am aware that my insurance coverage may not fully cover all treatment that is recommended.

2. **Copay 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 I** – 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

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(P) 305-373-5411 (F) 305-248-2266

Informed Consent for Examination and Treatment

I (we) herby 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 MIAMI

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 compañia 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 pendientas. Su compañia 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 compañia de seguro.

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

X _____

Date/Fecha _____

1717 N. Bayshore Dr. Suite 204, Miami, FL 33132 Phone (305) 373-5411 Fax (305) 248-2266

PAIN RELIEF CENTER OF MIAMI

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 MIAMI ("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

1717 N. Bayshore Dr. Suite 204 Miami, FL 33132 Phone (305) 373-5411 Fax (305) 248-2266

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 *(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 (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 *(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.

Pain Relief Center of Miami
1717 N. Bayshore Dr Suite 204.
Miami, Fl 33132
(P) 305-373-5411 (F) 305-248-2266

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 DIRECTLY

TO: _____
CLAIM DEPARTMENT
(Name of Insurance Company)

(Pursuant to Florida Statute 817.234, 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:	1. _____		1. _____		1. _____
OTHER VEHICLES: VEHICLE:	2. _____	OWNER	2. _____	INSURER	2. _____
IN YOUR FAMILY:	3. _____		3. _____		3. _____

AS A RESULT OF THIS ACCIDENT WERE YOU INJURED? ☐ YES ☐ NO IF YOUR ANSWER IS YES, COMPLETE THE REST OF THIS FORM, IF NO, SIGN 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 ☐ NO ☐	DOCTOR'S NAME AND ADDRESS Neil Bressler, D.C. 1717 N. Bayshore Dr. Suite 204 Miami, FL 33132
IF YOU WERE TREATED IN A HOSPITAL WERE YOU AN IN-PATIENT? ☐ OUT-PATIENT? ☐	HOSPITAL'S NAME AND ADDRESS

AMOUNT OF MEDICAL BILLS TO DATE $	WILL YOU HAVE MORE MEDICAL EXPENSE? YES ☐ NO ☐	AT THE TIME OF ACCIDENT WERE YOU IN THE COURSE OF YOUR EMPLOYMENT? YES ☐ NO ☐
DID YOU LOSE WAGES OR SALARY AS A RESULT OF YOUR INJURY? YES ☐ NO ☐	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:	Have you received or are you eligible for benefits from the following sources:
$ _____ per week Name of W/C insurer:	Medicaid NO ☐ YES ☐ $ _____ Health Insurer, is any, (name):
$ _____ per month _____	Medicare NO ☐ YES ☐ $ _____ _____
	Military Benefits NO ☐ YES ☐ $ _____ $ _____

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 ☐ NO ☐ 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 prefect its rights of recovery under the No-Fault Act.

SIGNATURE: _____ DATE: _____

ATTENDING PHYSICIAN'S REPORT

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 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
PATIENT WAS INVOLVED IN A COLLISION ON

6. DIAGNOSIS AND CONCURRENT OF CONTRIBUTING CONDITIONS *

7. WHEN DID SYMPTOMS FIRST APPEAR?	8. WHEN DID THE PATIENT FIRST CONSULT YOU FOR THIS CONDITION?
DATE:	DATE:

9. HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION?
YES ☐ NO ☐ If "Yes" state when and describe*

10. IS THE CONDITION SOLELY AS A RESULT OF THIS ACCIDENT?
YES ☐ NO ☐ If "No" explain*

11. IS THIS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT?
YES ☐ NO ☐

12. WILL INJURY RESULT IN PERMANENT DISFIGUREMENT OR PERMANENT DISABILITY?
YES ☐ NO ☐ If "Yes" describe* ***CANNOT BE DETERMINED AT THIS TIME***

13. PATIENT WAS DISABLED (Unable to work)	14. IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK
FROM: TO:	

15. REPORT OF SERVICES * ***WILL BE MAILED WITHIN THIRTY FIVE DAYS***

DATE OF SERVICE	PLACE OF SERVICE	DESCRIPTION OF SURGICAL SERVICE OR MEDICAL SERVICE RENDERED	CHARGES
	Pain Relief Center of Miami		$
			$
		TOTAL CHARGE TO DATE $	

16. IS THE PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? YES ☐ NO ☐	**ESTIMATED FUTURE CHARGES $** ***NOT KNOWN***

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURANCE COMPANY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IF GUILTY OF A FELONY OF THIRD DEGREE.
PURSUANT TO FLORIDA STATUTE 627.736 (6) "UNDER PENALTY OF PERJURY I DECLARE THAT I HAVE READ THE FORGOING AND THE FACTS ALLEGED ARE TRUE, TO THE BEST OF MY KNOWLEDGE AND BELIEF."

Dr. Neil Bressler		**47-3032491**
PHYSICIAN'S NAME (PRINT)	PHYSICIAN'S SIGNATURE	IRS/TIN IDENTIFICATION NUMBER

1717 N Bayshore Drive	**Miami**	**FL**	**33132**
NO. STREET	CITY OR TOWN	STATE	ZIP CODE

SW Motif – Exam Re-exam Form

Patient Name:_____ **Date:**_____

HT: _____ **WT:** _____ Pulse: _____bpm - BP: _____/_____mmHg - Resp_____ DOB____/____/____ | **Date of Injury** ___/___/___

Subjective
___ Exacerbation
___ Improvement
___ Unchanged
___ DME Use Helping
___ Chiropractic and Pain

PCP - _____ **Medical Specialist -** _____

Prior Injury - _____ **Prior MRI -** _____ **Working -** Yes No _____

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

Headache

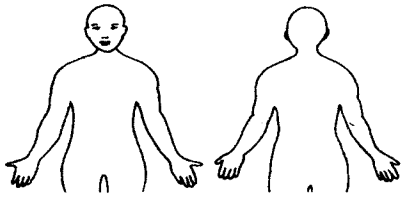
L R B **VAS:** ____10

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

Neck

L R B Mid VAS: ____/10

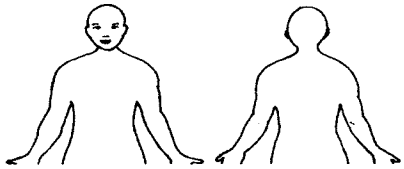
Severity: Mild Moderate Moderate/Severe Severe **Frequency:** Constant Occasional Intermittent Frequent
Status: Routine Initial Unchanged Improved Worse Recovered **Motion-** Stiffness Inflexibility Restricted Movement
Pain- Throbbing Burning Stabbing Sharp Achy Dull Pounding Pulsating Excruciating Stinging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



Mid/Upper Back

L R B Mid VAS: _____/10

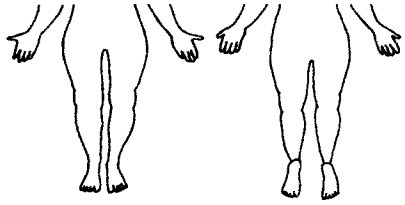
Severity: Mild Moderate Moderate/Severe Severe **Frequency:** Constant Occasional Intermittent Frequent
Status: Routine Initial Unchanged Improved Worse Recovered New **Motion:** Stiffness Inflexibility Restricted Movement
Pain: Throbbing Burning Stabbing Pulsating Sharp Achy Dull Numb achy Excruciating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



TBI/MTBI /PTSD

☐ Nausea ☐ (O)occ ☐(S)sometimes ☐ (P)persistent

☐ 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)
☐ Ataxia/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/Traps

Ranges of Motion		***Pain Level***
Flexion	___/50	1 2 3
Extension	___/60	1 2 3
Right Lateral Flexion	__/45	1 2 3
Left Lateral Flexion	___/45	1 2 3
Right Rotation	___/80	1 2 3
Left Rotation	___/80	1 2 3

Orthopedic Findings:	*Left*	*Right*	*Bilaterally*
Jackson	+ -	+ -	+ -
Valsava	+ -	+ -	+ -
Soto-Hall	+ -	+ -	+ -
Distraction	+ -	+ -	+ -
Shoulder Depression	+ -	+ -	+ -
Cervical Compression	+ -	+ -	+ -
Upper Limb Tension Test	+ -	+ -	+ -
O'Donogue's	+ -	+ -	+ -

Lumbar/Lower Trunk

Ranges 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***
Belt	+ -	+ -	+ - _____
Iliac compression	+ -	+ -	+ - _____
Straight Leg Raise	+ -	+ -	+ - _____
Minor's sign	+ -	+ -	+ - _____
Yeoman's test	+ -	+ -	+ - _____
Babinski sign	+ -	+ -	+ - _____
Bragard's sign	+ -	+ -	+ - _____
Kemp's test	+ -	+ -	+ - _____
Milgrams	+ -	+ -	+ - _____
Hibb's	+ -	+ -	+ - _____
Patrick Fabre	+ -	+ -	+ - _____
Valsalva's	+ -	+ -	+ - _____

Thoracic/Upper Trunk

Ranges of Motion		*Pain Level*
Flexion	___/60	1 2 3
Right Rotation	___/30	1 2 3
Left Rotation	___/30	1 2 3

Orthopedic Findings:	*Left*	*Right*	*Bilaterally*
Schepelmann'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
___ TBAI/Concussion Symptoms present

Assessment

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

Prognosis

__ Good
__ Fair
__ Guarded
__ Prognosis Changed [must be included with Dx change]

Objective – Palpation

	Left	/	Right
C	_____	_____	_____
T	_____	_____	_____
L	_____	_____	_____
Pelvic		_____	_____
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 **R**estricted 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 _____

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 **R**estricted Movement
Pain- Throbbing Burning Stabbing Sharp Achy Dull Pounding Pulsating Excruciating Stinging Numb achy

	Left	Right	Bilateral
Apleys Scratch	+ -	+ -	+ - ____
Apprehension	+ -	+ -	+ - ____
Yergason's	+ -	+ -	+ - ____
Codmans/Supra-pres	+ -	+ -	+ - ____
Dawbarn's	+ -	+ -	+ - ____
Ant/Post Drawer	+ -	+ -	+ - ____
McMurray's	+ -	+ -	+ - ____
Val / Var Stress	+ -	+ -	+ - ____
Patella Comp	+ -	+ -	+ - ____
Distraction	+ -	+ -	+ - ____

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 **R**estricted 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 _____

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 **R**estricted Movement
Pain- Throbbing Burning Stabbing Sharp Achy Dull Pounding Pulsating Excruciating Stinging Numb achy

Anterior Drawer	+ -	+ -	+ - ____
Val / Var Stress test	+ -	+ -	+ - ____
Homan's sign	+ -	+ -	+ - ____
Thompson sign	+ -	+ -	+ - ____
Val / Var Stress test	+ -	+ -	+ - ____
Tinels sign	+ -	+ -	+ - ____

Causal Relationship

___Bodily injury and consistent Comments: (to be added at end of macro)_____
___100% _____

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

___Lumbar 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 Innervation
___Disc Injury and Whiplash Stats
___Whiplash and Persistent Pain
___Intervertebral Disc Pain Generator
___Ligament Injuries are Permanent
___Pre-existing Increases Bodily Injury
___ Spinal Range of Motion Normal Reference

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 (cc 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
	G44.301	Post-traumatic headache, unspecified, intractable		M25.512	Pain in left shoulder
	G44.309	Post-traumatic headache, unspecified, not intractable		M79.601	Pain in right arm
	G44.311	Acute post-traumatic headache, intractable		M79.602	Pain in left arm
	G44.319	Acute post-traumatic headache, not intractable		M79.621	Pain in right upper arm
	G44.321	Chronic post-traumatic headache, intractable		M79.622	Pain in left upper arm
	G44.329	Chronic post-traumatic headache, not intractable		M25.521	Pain in right elbow
				M25.522	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
	M50.31	Other cervical disc degen, C2-C3, C3-C4		M79.641	Pain in right hand
	M50.32	Other cervical disc degen, C4-C5, C5-C6, C6-C7		M79.642	Pain in left hand
	M50.33	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)
	M48.01	Spinal stenosis, occipito-atlanto-axial region			
	M48.02	Spinal stenosis, cervical region		M25.551	Pain in right hip
				M25.552	Pain in left hip
	M54.6	Pain in thoracic spine		M79.604	Pain in right leg
	M54.14	Radiculopathy, thoracic region		M79.605	Pain in left leg
	M54.15	Radiculopathy, thoracolumbar region		M79.651	Pain in right thigh
	M51.24	Other interv disc displace, thoracic		M79.652	Pain in left thigh
	M51.25	Other interv disc displace, thoracic-columbar		M25.561	Pain in right knee
	M51.34	Other interv disc degen, thoracic		M25.562	Pain in left knee
	M48.04	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			
	M54.31	Sciatica, right side		M99.11	Cervical Subluxation M99.01 Segmental dysfunc
	M54.32	Sciatica, left side		M99.12	Thoracic Subluxation M99.02 Segmental dysfunc
	M51.26	Other intervertebral disc displace, lumbar region		M99.13	Lumbar Subluxation M99.03 Segmental dysfunc
	M51.27	Other intervertebral disc displace, lumbosacral region		M99.14	Sacral Subluxation M99.04 Segmental dysfunc
	M51.36	Other intervertebral disc degen, lumbar region		M99.15	Pelvic Subluxation M99.05 Segmental dysfunc
	M51.37	Other intervertebral disc degen, lumbosacral region			
	M48.06	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
	R53.1	Weakness		M41.25	Other idiopathic scoliosis, thoracolumbar region
	R53.81	Other Malaise		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
	M62.830	Muscle spasm of back		M43.12	Spondylolisthesis, cervical region
	M62.831	Muscle spasm of calf		M43.13	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, uspecified		R64.84	Jaw Pain
	R10.11	Right upper quadrant pain		M26.6	TMJ Articular Disorder
	R10.12	Left upper quadrant pain		M26.62	TMJ Arthralgia
	R10.31	Right lower quadrant pain		M26.63	Articular Disc Disorder of TMJ
	R10.32	Left lower quadrant pain		S03.4xxA	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		M50.20	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			
				V49.88X*	Car occupant (driver)
				V49.59X*	Passenger injured in collision with other mv, In traffic
	M35.7	Hypermobility of Segment			
	M24.20	Laxity of Ligament		S16.1XXA	Strain of Muscles/fascia/tendons of neck - Intial Enc
	M21.769	Unequal leg length (aquired)		S16.1XXD	Strain of Muscles/fascia/tendons of neck - Sub Enc
	G89.4	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
	S13.4XXA	Sprain of Ligments - Cervical - Initial Enc.		S39.013A	Strain of Muscles/fascia/tendon of Pelvis Initial Enc
	S13.4XXD	Sprain of Ligments - Cervical -Subsequent Enc.		S39.013D	Strain of Muscles/fascia/tendon of Pelvis Sub. Enc
	S23.3XXA	Sprain of Ligaments - Thoracic - Initial Enc		S46.812A	Strain of Muscles/fascia/tendon of left sh - Initial Enc
	S23.3XXD	Sprain of Ligaments - Thoracic - Sebsequent Enc		S46.812D	Strain of Muscles, fascia/tendon of left sh - Sub Enc
	S33.5XXA	Sprain of Ligaments - Lumbar - Initial Enc		S46.811A	Strain of Muscles, fascia/tendon of right sh - Initial Enc
	S33.5XXD	Sprain of Ligaments - Lumbar - Sebsequent Enc		S46.811D	Strain of Muscles, fascia/tendon of right sh - Sub Enc
	S33.6XXA	Sprain of sacroiliac joint, initial Enc			
	S33.6XXD	Sprain of sacroiliac joint, Subsequent Enc		M99.06	Segmental and somatic dysfunction of lower extremity.
				S76.011A	Strain of muscle, fascia and tendon of right hip, init
	M99.07	Segmental and somatic dysfunction of upper extremity.		S76.012A	Strain of muscle, fascia and tendon of left hip, init
	S43.51XA	Sprain of right acromioclavicular joint, initial encounter			
	S43.52XA	Sprain of left acromioclavicular joint, initial encounter			
	S43.411A	sprain of right coracohumeral (ligament), initial encounter			
	S43.412A	sprain of left coracohumeral (ligament), initial encounter			