Bode Chiropractic Accident & Wellness

13694 W. Hillsborough Ave. Tampa, FL 33635

Initial Patient Questionnaire

Date: _____ HT:_____ WT:_____ SSN:_____-_____-_____ Sex: M / F

Name: _____ DOB: ___/___/_____ Age:_____

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

Phone: Home:_____ Cell: _____ Work: _____

Marital Status: _____ Occupation: _____ Employer: _____

Emergency Contact: _____ Relation: _____ Phone: _____

Your Email: _____

Primary Care Physician: _____ Phone: _____

History of Condition

What problem(s) are you having that bring you to our office? Please list.

1.)_____ Date of Onset: _____

2.)_____ Date of Onset: _____

3.)_____ Date of Onset: _____

4.)_____ Date of Onset: _____

Current Medications: _____

_____

Current Allergies: _____

In general, what would you say your overall health is right now? (circle) Excellent Very Good Good Fair Poor

Please check any of the following that you have been diagnosed with or have experienced:

___ Diabetes	___ Asthma	___ Depression	___ Mumps	___ Arthritis/Osteoporosis
___ Heart Disease	___ Tuberculosis	___ Mental Disorder	___ Measles	___ Stroke
___ High Blood Pressure	___ Herpes	___ Liver Problems	___ Chicken Pox	___ Polio
___ Blood Clots	___ HIV/AIDS	___ Vascular Disease	___ Epilepsy/Seizures	___ Cancer
___ Alcohol/Drug abuse	___ Smoking	___ Bursitis	___ Head Concussion	___ Headaches/Migraines

___ Other (please explain): _____

List any surgeries you have had: _____

List any hospitalizations you have had: _____

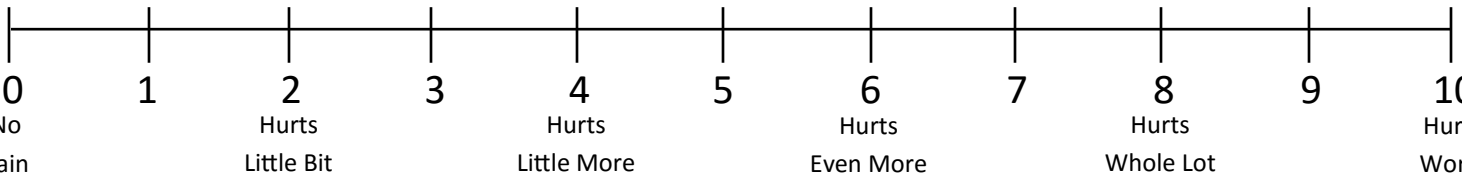
List any previous injuries/accidents you have had. Please list dates and treatment if any: _____

_____

Do you have a family history of chronic illness? If so, please describe: _____

_____

Please rate your pain as of today:



I certify to the best of my knowledge, the above information is complete and accurate. I agree to notify this practitioner immediately whenever I have changes in my health condition. I understand that my chiropractor may need to contact my physician if my condition needs to be co-managed. Therefore I give authorization to my chiropractor to contact my physician if necessary.

Patient Signature: _____ **Date:** _____

Bode Chiropractic Accident & Wellness

13694 W. Hillsborough Ave. Tampa, FL 33635

History of Accident

Patient Name: _____ DOB:_____

Date of Accident: _____ Time of Accident: _____ AM/PM

Where were you seated? _____

Make/Model of vehicle you were occupying: _____

Location were the accident occurred: _____

Approximately how fast were you traveling when the accident occurred? _____ MPH

Make/Model of other vehicle(s) involved: _____

In your own words, briefly describe the accident: _____

_____

_____

_____

_____

At the time of the accident, which direction were you facing? (Forward, turned, etc.) _____

Were you surprised by the accident? **Y / N** Were you wearing a seatbelt? **Y / N**

Did the airbags deploy? **Y / N** Were you rendered unconscious? **Y / N**

Were the police notified? **Y / N** Was a report filed? **Y / N** With whom? _____

How did you feel immediately following the accident? _____

Is the pain: ____ Getting better ____ No improvement ____ Getting worse

Did you go to the hospital? **Y / N** Where? _____ How? _____

Were X-rays/CT/MRI performed? **Y / N** Which? _____

Were you prescribed medication? **Y / N** What? _____

Have you seen another doctor for this injury? **Y / N** Who? _____

Have you been able to work since the accident? **Y / N** Why? _____

What could you do before the accident that you are now unable to do? _____

_____

Do you have an attorney? **Y / N** Who? _____

Patient Signature: _____ Today's Date:_____

SYMPTOM SURVEY

Please circle all that apply

General Symptoms:
Nervousness Irritability Fatigue
Depression Loss of Sleep Tension PMS

Head:
Headache 1) Mild 2) Moderate 3) Severe
Scale of 1-10: _____
How often? _____ times per _____
1) Constant 2) Intermittent 3) Throbbing
Located: 1) Back of Head 2) Memory loss 3) Temples
4) Right Side 5) Left Side 6) Behind the eyes
With: 1) Lightheadedness 2) Memory loss
3) Fainting 4) Blurred vision 5) Double vision
6) Sensitivity to light 7) Loss of balance
8) Hearing loss 9) Ringing in the ears

Neck:
Pain: 1) Left side 2) Right side 3) Both
Level: 1) Mild 2) Moderate 3) Severe
Scale of 1-10: _____

Shoulders:
Pain in joint 1) Left 2) Right 3) Both
Pain across shoulder 1) Left 2) Right 3) Both
Limited movement 1) Left 2) Right 3) Both
Tension 1) Left 2) Right 3) Both

Arms:
Pain above elbow 1) Left 2) Right 3) Both
Pain in elbow 1) Left 2) Right 3) Both
Pain in forearm 1) Left 2) Right 3) Both
Pins & Needles (Upper Arm) 1) Left 2) Right 3) Both
Pins & Needles (Forearm) 1) Left 2) Right 3) Both
Numbness in upper arm 1) Left 2) Right 3) Both
Numbness in forearm 1) Left 2) Right 3) Both

Hands:
Pain in wrist 1) Left 2) Right 3) Both
Pain in hand 1) Left 2) Right 3) Both
Pins & needles 1) Left 2) Right 3) Both
Numbness 1) Left 2) Right 3) Both

Mid Back:
Pain 1) Left 2) Right 3) Both
Level: (Scale of 1-10) _____
Type: Sharp/stabbing or dull ache
Muscle spasms 1) Left 2) Right 3) Both

Chest:
Deep chest pain 1) Left 2) Right 3) Both
Pain around ribs 1) Left 2) Right 3) Both
Shortness of breath
Irregular heartbeat

Abdomen:
Pain: 1)Mild 2)Moderate 3)Severe
Nervous stomach Nausea Gas
Constipation Diarrhea Heartburn
Indigestion Loss of appetite

Low Back:
Upper lumbar: 1) Left 2) Right 3) Both
Lower lumbar: 1) Left 2) Right 3) Both
Sacroilliac: 1) Left 2) Right 3) Both
Muscle Spasms: 1) Left 2) Right 3) Both
Pain: 1) Mild 2) Moderate 3) Severe
Level: (Scale of 1-10) _____

Hips and Legs:
Pain in buttocks 1) Left 2) Right 3) Both
Pain in hip joint 1) Left 2) Right 3) Both
Pain down leg 1) Left 2) Right 3) Both
Radiating to 1) Knee 2) Calf 3) Foot
Numbness in leg 1) Left 2) Right 3) Both
Pins and needles 1) Left 2) Right 3) Both
Knee pain 1) Left 2) Right 3) Both
Leg cramps 1) Left 2) Right 3) Both
Pain 1) Mild 2) Moderate 3) Severe
Level: (Scale of 1-10) _____

Feet:
Ankle pain: 1) Left 2) Right 3) Both
Swollen ankles: 1) Left 2) Right 3) Both
Foot pain: 1) Left 2) Right 3) Both
Numbness: 1) Left 2) Right 3) Both

Other symptoms that you have: _____
Are all of the symptoms directly caused by the accident: YES NO

_____
Patient Signature

Rode Chiropractic
Accident & Wellness Center

Review of Systems

Please check YES or NO to ALL below.

Constitutional

YES	NO	
☐	☐	Excessive daytime sleepiness
☐	☐	Fatigue
☐	☐	Fevers
☐	☐	Low Energy
☐	☐	Trouble getting to sleep
☐	☐	Trouble staying asleep
☐	☐	Weight gain
☐	☐	Weight loss

Eyes

YES	NO	
☐	☐	Blurred vision
☐	☐	Double vision
☐	☐	Loss of vision

Ears, Nose, Mouth and Throat

YES	NO	
☐	☐	Loss of sense of smell
☐	☐	Hearing loss
☐	☐	Ringing in your ears

Cardiovascular and Respiratory

YES	NO	
☐	☐	Chest Pain
☐	☐	Palpitations
☐	☐	Shortness of breath

Gastrointestinal

YES	NO	
☐	☐	Constipation
☐	☐	Diarrhea
☐	☐	Heartburn
☐	☐	Nausea
☐	☐	Vomiting

Bladder & Sexual Function (Genitourinary)

YES	NO	
☐	☐	Discomfort or burning
☐	☐	Loss of bladder control
☐	☐	Loss or desire for sex
☐	☐	Menopause (women)
☐	☐	Trouble with erection (men)
☐	☐	Urgency to urinate

Skin

YES	NO	
☐	☐	Change in hair or nails
☐	☐	Change in skin color
☐	☐	Itching
☐	☐	Rash

Neurological

YES	NO	
☐	☐	Confusion
☐	☐	Falling down
☐	☐	Headaches
☐	☐	Incoordination
☐	☐	Involuntary movements or jerking
☐	☐	Lightheaded or dizzy
☐	☐	Loss of consciousness/fainting/passing out
☐	☐	Numbness
☐	☐	Seizure or convulsion
☐	☐	Spinning or vertigo
☐	☐	Tingling
☐	☐	Tremor
☐	☐	Trouble speaking
☐	☐	Trouble walking
☐	☐	Weakness
☐	☐	Trouble swallowing

Musculosketal

YES	NO	
☐	☐	Back pain
☐	☐	Double vision
☐	☐	Loss of vision

Memory, Thinking, Mood, Psychiatric

YES	NO	
☐	☐	Anxiety
☐	☐	Depressed mood
☐	☐	Hallucinations (seeing or hearing things)
☐	☐	Memory loss

Hematologic (blood) and lymphatic

YES	NO	
☐	☐	Anemia
☐	☐	Easy bruising or bleeding
☐	☐	Slow to heal after cuts

Allergic and Immune

YES	NO	
☐	☐	Allergic reaction to medicine or x-ray dye

Smoking, Alcohol and Drugs

YES	NO	
☐	☐	Do you use tobacco products? How much? _____ per _____
☐	☐	Do you drink alcohol? How much? _____ per _____
☐	☐	Do you use any drugs for recreation? How much? _____ per _____

_____ _____

Signature of patient **Date**

Signature of person completing form **Date**
(if not patient)

ASSIGNMENT OF BENEFITS,
LIENS AND DIRECT PAYMENT AUTHORIZATION

MEDICAL PROVIDER: Garrett S. Bode, DC, PA

13694 W. Hillsborough Ave.

Tampa, FL 33635

Ph: 813-891-1600

INSURANCE COMPANY: _____

For and in consideration of the above-mentioned provider agreeing to pursue my insurance provider for payment of benefits due me and not requiring prepayment for services, I hereby irrevocably assign to the aforementioned medical provider (the "Provider") any Personal Injury Protection benefits I may have in accordance with Florida Statute 621.736(3). This includes any benefits from my insurance company or any other entity that may be responsible fro expenses incurred, and I authorize the 'Provider' to prosecute said action and collect legal expenses as they see fit. THIS DOCUMENT CONSTITUTES AN ASSIGNEMNT OF BENEFITS. I hereby further give a lien to the 'Provider' against any and all insurance benefits named herein, and any and all proceeds of any settlement, judgement or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by the 'Provider'. This is to act as an irrevocable assignment of my rights and benefits to the extent of the services provided. I agree to cooperate with the 'Provider' and any attorney that the 'Provider' chooses, and to do all things reasonable to effect payment of the bills by the insurance company to the 'Provider' including, but not limited to, disclosing patient's medical condition and treatment. This assignment is not intended to assign any other causes of action that may belong to the undersigned patient. I agree to pay any applicable deductible or co-payment not covered by the PIP insurance coverage. I understand that this is a benefit and convenience to me in that the provider will pursue collection against the insurance company in my behalf. I hereby instruct and direct my insurance company to pay my benefits by check made payable to and mailed to the 'Provider' at the address listed above. If my current policy prohibits direct payments to doctors, then I hereby instruct and direct my insurance company to make the check payable to me and mail it to the 'Provider' at the address listed above. If this 'Provider' is providing medical care related to an auto accident, 'Provider' is charging a reasonable fee for necessary care related to the accident and these bills should be paid to the full extent of the benefits available under my policy of insurance. If any portion of any charge for these services is either reduced or denied in whole or in part, both the provider and the insured request that my insurance company hold the escrowed funds for 'Provider', until such time as all escrowed hinds are paid to 'Provider', or 'Provider' instructs my insurance company that 'Provider' is no longer making any claim to the escrowed funds. Furthermore, I hereby give the 'Provider' limited power of attorney to endorse/sign my name on any and all checks for payment to the 'Provider'. This agreement is intended to serve as an assignment of the patient's rights and benefits under his/her aforementioned insurance policy in favor of the 'Provider. If any language within this agreement has the effect of invalidating this assignment, that language shall be deemed void and the assignment shall remain in full force and effect. A photocopy of this assignment shall be considered as effective and valid as the original.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date

LETTER OF PROTECTION

AUTHORIZATION AND MEDICAL ASSIGNMENT

I_____, do hereby authorize and direct my attorneys,_____, to pay **Bode Spinal Center, 13694 W. Hillsborough Ave. Tampa, FL. 33635** from the share of my proceeds of any recovery as a result of the settlement or litigation of the accident on _____ the unpaid balance for the reasonable and customary charges as determined by the insurance company, for professional services rendered by said hospital, physician, or other medical care provider, shall serve as my authority for my said physician, hospital , or medical care provider to proceed against my insurance carrier in the method and manner as provided in Florida Stature. Said professional services to include those for the medically necessary and reasonable diagnosis treatment and care heretofore and hereafter rendered to me as well as those medical reports, consultations, with my attorney and court appearances on my behalf. Payment of these balances as herein stated shall be the same as if paid by me.

I understand that this assignment in no way relieves me of my personal responsibility and obligation to pay my physician, hospital, or medical care provider for such charges as herein stated for such services rendered and that such physicians, hospitals, or other medical care providers fee for such services rendered is not contingent upon the outcome of this litigation.

I further authorize the before said physician, hospital, or medical care provider to furnish my attorney with a full report of the physicians, hospitals, or medical care providers treatment, evaluation of me in regard to the said incident.

In exchange for this letter of protection, it is our understanding that all such related bills will be directed to this office and not to the client/patient and that client/patients account will not be turned over to any type of collection agency or credit bureau, nor will any adverse credit information be reported against this client's credit during the pendency of this case and if this account is turned over to a collection agency or credit bureau, or if any adverse information is reported against this clients credit by you, directly or indirectly, this Letter of Protection is null and void and this law has no further obligation to you whatsoever.

_____

Signature (Client/Patient) **Date** **Firm Representative** **Date**

Bode Chiropractic
13694 W Hillsborough Ave
Tampa, Florida 33635
813-891-1600

BODE CHIROPRACTIC
Accident & Wellness Center
13694 W. HILLSBOROUGH AVE.
TAMPA, FL 33635
PH: (813) 891-1600
FAX: (813) 891-1660

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED. REVIEW IT CAREFULLY.

At Bode Chiropractic we have always kept your health information secure and confidential. The Health Insurance Portability and Accountability Act that requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice. The law permits us to use or disclose your health information to those involved in your treatment. For example, reviews of your file by a specialist doctor whom we may involve in your care. We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer. We may use your information to contact you. For example, we may send newsletters or other information. We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the phone. In an emergency, we may disclose your health information to a family member or another person responsible for your care. We may release some or all of your health information when required by law. If this practice is sold, your information will become the property of the new owner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization. You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.

You have the right to transfer copies of your health information to another practice. We will mail your files for you. You have a right to receive a copy of your health information, with a few exceptions. Please provide us with a written request regarding the information you want to have copied, however, we may charge you a reasonable fee for the copies.

You have the right to request and amend your health information. Please provide us with your request to make changes in writing. If you wish to include a statement in your file, please provide it to us in writing. We may or may not make the changes that you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will neither move nor alter earlier documents, but will add new information.

Y0U HAVE THE RIGHT TO RECEIVE A COPY OF THIS NOTICE AT ANYTIME UPON REQUEST

If we change any details of this notice we will notify you in writing.

You may file a complaint with the Department of Health and Human Services, 200 Independence Ave SW, Room 509F, Washington, DC 20201. Before filing a complaint however, please contact our Privacy Officer at 813-891-1600. This notice went into effect on October 1, 2007.

ACKNOWLEGEMENT: I have read, understand, and agree with the above Notice of Privacy Prac.

Signature_____

Date_____

PATIENT INFORMED CONSENT

State law requires offices to obtain your informed consent prior to examination and treatment. The purpose of this form is to inform you. What your being asked to sign is simply a confirmation that you have been informed of the following.

EXAMINATIONS

X-RAYS: This office uses highly sensitive x-ray film, intensifying screens and filters that provide high quality x-rays with the lowest possible x-ray exposure. The only noteworthy risk with taking x-rays deals with pregnancy. **If there is any possibility that you are pregnant, inform us prior to any x-ray procedure.** If there is no possibility of this condition, the risks are so rare we have no available statistics to quantify their probability.

TREATMENT

Chiropractic adjustment/manipulation: The doctor will use his hands or a mechanical device upon your body in such a way as to move your joints in various directions. This procedure may cause an audible "pop" or "click" to be heard coming from your joints, this is not a cause for alarm. There are some material risks involved in doing these procedures they are as follows:

Pain: Chiropractic treatments may result in a temporary increase in soreness in the area receiving treatment.

Rib Fractures: Fractures caused by chiropractic treatments are rare. They occur most frequently in patients with osteoporosis or weakened bones. Evidence of osteoporosis can be noted on your x-rays, and if detected, the most appropriate and gentle treatments are used, minimizing the possibility of fractures to the ribs.

Disc Injury: Chiropractic treatment is appropriate for the treatment of many kinds of back problems, including some disc problems.[1] Occasionally, chiropractic may aggravate or cause a problem if the disc is in a severely weakened state. However, this occurs so rarely that statistics to quantify the probability are unavailable, but estimates place risk of serious injury at about 1 serous complication per 100 million low back manipulations.[2]

Stroke: The overall incidence of stroke in the general population is about 2 per 1000 people.[3] Although chiropractic adjustment/manipulation has been implicated as a possible cause of stroke, this possibility is extremely rare. The best available data suggests that stroke secondary to chiropractic adjustment/manipulation may occur in 1 per 100,000 patients[4] – a rate well below the overall average risk in the general population. In comparison, the overall average risk of death from taking non-steriodal anti-inflammatory drugs (aspirin, Ibuprofen, Naxproxen sodium etc.) is 4 per 100,000 patients.[5] The risk of serious complication or death from spine surgeries of the neck is 11.25 per 1000 patients.[5] As you can see, the risk of stroke from chiropractic treatments is much lower than other common medical treatments. Even though the risk is small, we have implemented procedures and test that will likely reduce the potential for stroke even more.

Chiropractic is a system of health care delivery. As with any health delivery system we cannot promise a cure for any symptom, disease, or condition as a result of treatment in this office. We will always give you our best care, and if your results are not acceptable, we will refer you to another health care provider who we feel will assist your situation.

If you have any questions on the above information, please ask the doctor. When you have a clear understanding, please sign and date below.

I HAVE READ OR HAVE HAD READ TO ME THIS CONSENT FORM AND I HAVE BEEN INFORMED OF THE MOST LIKELY COMPLICATIONS, OF THE POSSIBLE UNDESIRED RESULTS OF CHIROPRACTIC EXAMINATION AND TREATMENT IN THS OFFICE AND I UNDERSTAND THEM. I HEREBY AUTHORIZE AND DIRECT DR. GARRETT BODE, D.C. OR ASSISTANTS TO PROVIDE SUCH ADDITIONAL SERVICES AS THEY MAY DEEM REASONABLE AND NECESSARY.

Patient's Signature_____ Date_____

Patient's Printed Name _____ Date_____

Parent's/Guardian's Signature_____ Date_____
If patient is less than 18 years of age.

Parent's/Guardian's Printed Name _____ Date_____

References

1. Troyanovich SJ, Harrison DE. Low Back pain and the lumbar intervertebral disc: Clinical considerations for the doctor of chiropractic. *J Manipulative Physiol Ther* 1999; 22 (2): 96-104.
2. Shekelle PG, Spine update: Spinal Manipulation, *Spine* 1994; 19; 858-86
3. Clayman CB. *The American Medical Association Home Encyclopedia*. New York: Random House: 947-948
4. Dabbs V, Lauretti WJ. Risk Assesment of Cervical Manipulation vs. NSAIDS for the treatment of neck pain. *J Manipulative Physiol Ther* 1995; 18:530-536.
5. Harwitz El, Aker PD, Adams AH, Meeker WC, Shekelle PG. Manipulation and mobilization of the cervical *Spine*: A systematic review of the literature, *Spine* 1996; 21: 1746-1760.

APPLICATION FOR FLORIDA "NO FAULT" BENEFITS

Date:_____ **File Number:**_____

Insurance Company:_____

Policy Number:_____ **Date of Accident:**_____

TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE FLORIDA PERSONAL INJURY PROTECTION LAW, PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY. ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURANCE COMPANY MAKES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION, IS GUILTY OF A FELONY OF THE THIRD DEGREE.

Name:_____ **Address:**_____

Phone Number:_____ **City, State, Zip Code:**_____

Date of Birth:_____ **Social Security Number:**_____

How long have you been a resident of Florida?_____

Date of accident:_____ **Time of accident:**_____

Location of accident:_____

Description of accident:_____

_____

_____

_____

_____

Make and model of vehicle you were occupying during accident:_____

As a result of this accident, were you injured?_____**If yes, complete the form. If no, sign below and return to us.**

_____ _____

Signature Date

Description of Injury:_____

_____

Were you treated by a doctor?_____**If yes, name and address:**_____

Were you treated at a hospital?_____**If yes, name and address:**_____

Amount of medical expenses to date: $_____**Will you have more expenses?**_____

At the time of accident, were you employed?_____**If yes, did you lose any wages?**_____

If yes, amount lost? $_____**Your weekly salary or wage: $**_____

Date disability from work began:_____**Date you returned to work:**_____

Have you received benefits under Worker's Compensation?_____**If yes, amount and frequency: $**_____

Name and addresses of employer or previous employer along with occupation and dates of employment:

_____

As a result of this accident, have you had any other expenses?_____**If yes, explain below with expense amounts.**

_____

_____ _____

Signature Date

Form 1250F

http://www.claimspages.com

AUTHORIZATION FOR MEDICAL INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY HEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY CONDITION WHILE UNDER YOUR OBSERVATION OR TREATMENT, INCLUDING THE HISTORY OBTAINED, PHYSICAL AND X-RAY FINDINGS, DIAGNOSIS AND PROGNOSIS. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE FLORIDA "NO FAULT" AUTO INSURANCE LAW.

_____ _____

Signature Date

AUTHORIZATION FOR WAGE AND SALARY INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY HEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY WAGES OR SALARY WHILE EMPLOYED BY YOU. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE FLORIDA "NO FAULT" AUTO INSURANCE LAW.

_____ _____

Signature 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 *(PRINT or TYPE)*	Signature	Date

The undersigned licensed medical professional or medical director, if applicable, affirms the statement numbered 1 above and also:

A. I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.

B. The treatment or services rendered were explained to the insured person, or his or her guardian, **sufficiently** for that person to sign this form with informed consent.

C. The accompanying statement or bill is **properly completed** in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to **truthfully, accurately**, and in a **substantially complete** manner.

D. The coding of procedures on the accompanying statement or bill is proper. This means that **no service has been upcoded, unbundled**, or constitutes an invalid **or not medically necessary diagnostic test** as defined by Section 627.732(14) and (15), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Licensed Medical Professional Rendering Treatment/Services or Medical Director, if applicable *(Signature by his/ her **own hand**)*:

_____	_____	_____
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.

BODE CHIROPRACTIC
Accident & Wellness Center
13694 W. HILLSBOROUGH AVE.
TAMPA, FL 33635
PH: (813) 891-1600
FAX: (813) 891-1660

RECORDS REQUEST

PATIENT'S NAME:_____
DOB:_____
SS:_____
DATE OF RECORDS AND/OR MRI, CT'S ETC_____

I HEREBY REQUEST THAT YOU RELEASE MY MEDICAL RECORDS, MRI'S, CT'S TO THE ABOVE MENTIONED DR.

PATIENT'S SIGNATURE_____

BODE CHIROPRACTIC

Accident & Wellness Center

13694 W. HILLSBOROUGH AVE.
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PH: (813) 891-1600
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HOW DID YOU HEAR ABOUT OUR CLINIC:

PPO-HMO Provider book:_____

Sign/Location:_____

Friend/Relative/Co-worker:_____

Yellow Pages:_____

Attorney:_____

Another Doctor/or Clinic:_____

THANK YOU FOR CHOOSING ***BODE SPINAL CENTER*** FOR YOUR HEALTH CARE NEEDS.