Cocoa Accident & Injury Center, Inc.
PH: (321) 735-9050 Fax: (321) 735-9429

Titusville Chiropractic & Injury Center, Inc.
PH: 321-567-4984 Fax: (321)567-7626

Melbourne Accident & Injury Center, Inc.
PH: (321) 622-6610 Fax (321) 622-6716

PATIENT INITIAL FORM

Patient Name:_____ DOB:_____ Age:_____

Phone:_____ Social Security #:_____

Address:_____ City:_____ Zip Code:_____

Date of Accident: _____ Occupation:_____

Marital Status: S M WI DI Gender: M / F

Emergency Contact Name: _____ Emergency Contact PH:_____

Insurance Carrier: _____ Member ID_____

Please Describe how the problem began_____

Please complete the following regarding how you feel.

Pain is result of: Auto Accident Slip & Fall Work Accident Everyday Pain

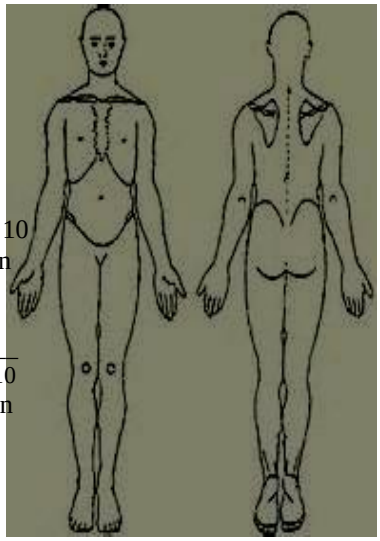
If pain was from any accident, Date of Accident? _____

How often are you symptoms present? Constantly Frequently Occasionally Intermittently

Describe your current symptoms: Stabbing Sharp Tingling Throbbing Burning
Dull Numbness Soreness Aches Weakness Other:_____

Can you preform daily activities like Cleaning, Hygiene, Ect.? Yes Not at all Only with help

Please Put an X on the areas that you feel pain > > >



What is your pain now?

Current Complaint

_____

0 1 2 3 4 5 6 7 8 9 10
No Pain Unbearable Pain

Range of pain level over the last week:

_____

0 1 2 3 4 5 6 7 8 9 10
No Pain Unbearable Pain

PERSONAL HEALTH HISTORY

Patient Name:_____ DOB:_____ Date:_____

All information will be kept strictly confidential. Your responses will help determine if chiropractic treatment will benefit you. Please check all the conditions that you currently have or have had in the past.

GENERAL
[ ] Allergy
[ ] Chills
[ ] Convulsions
[ ] Fainting
[ ] Fatigue
[ ] Fever
[ ] Loss of sleep
[ ] Loss of weight
[ ] Nervousness, depression
[ ] Neuralgia
[ ] Sweats
[ ] Tremors

CARDIOVASCULAR
[ ] Hardening of arteries
[ ] High blood pressure
[ ] Low Blood pressure
[ ] Pain over heart
[ ] Poor blood circulation
[ ] Rapid heartbeat
[ ] Slow heartbeat
[ ] Swelling of ankles

GENITOURINARY
[ ] Bed wetting
[ ] Blood in urine
[ ] Frequent urination
[ ] Lack of bladder control
[ ] Kidney infection
[ ] Prostrate problems
[ ] Pus in urine

RESPITRATORY
[ ] Chest pain
[ ] Chronic pain

[ ] Difficult breathing
[ ] Spitting up blood
[ ] Spitting up phlegm
[ ] Wheezing

EYE, EAR, NOSE & THROAT
[ ] Asthma
[ ] Cold / flu
[ ] Tonalities
[ ] Deafness
[ ] Dental decay
[ ] Earache
[ ] Ear discharge
[ ] Enlarged glands
[ ] Enlarged thyroid
[ ] Eye pain
[ ] Failing vision
[ ] Far sightedness
[ ] Gum trouble
[ ] Hay fever
[ ] Sore Throat
[ ] Nasal obstruction
[ ] Near sightedness
[ ] Nose bleeds
[ ] Sinus infection

GASTROINTESTINAL
[ ] Excessive Gas
[ ] Colitis
[ ] Colon trouble
[ ] Constipation
[ ] Diarrhea
[ ] Difficult digestion
[ ] Bloated abdominal
[ ] Excessive hunger
[ ] Gallbladder trouble
[ ] Hemorrhoids
[ ] Vomiting blood

[ ] Jaundice
[ ] Liver trouble
[ ] Nausea
[ ] Pain stomach
[ ] Poor appetite
[ ] Vomiting

SKIN
[ ] Boils
[ ] Bruise easily
[ ] Dryness
[ ] Hives / rash
[ ] Itching
[ ] Skin rash
[ ] Veracious veins

WOMEN ONLY
[] *Congested breasts*
[] *Cramps or backache*
[] *Excess menstrual flow*
[] *Hot flashes*
[] *Irregular cycle*
[] *Lumps in breast*
[] *Menopause*
[] *Painful menstruation*
[] *Vaginal discharge*

Are you pregnant?
[ ]Yes [ ] No
If so, how many months?
_____

How many children have you had?_____

Check all that apply
[ ] Alcoholism
[ ] Anemia
[ ] Appendicitis
[ ] Arteriosclerosis
[ ] Cancer
[ ] Chicken pox
[ ] Cholera
[ ] Cold Sores
[ ] Diabetes
[ ] Diphtheria
[ ] Eczema
[ ] Edema
[ ] Emphysema
[ ] Epilepsy
[ ] Fever blisters
[ ] Goiter
[ ] Gout
[ ] Heart disease
[ ] Herpes
[ ] Influenza
[ ] Lumbago
[ ] Malaria
[ ] Measles
[ ] Hepatitis
[ ] Multiple sclerosis
[ ] Mumps
[ ] Pacemaker
[ ] Pleurisy
[ ] Pneumonia
[ ] Polio
[ ] Rheumatic fever
[ ] Scarlet fever
[ ] Stroke
[ ] Tuberculosis
[ ] Typhoid fever

[ ] Ulcers
[ ] Venereal disease
[ ] Whooping cough
[ ] HIV/AIDS

[ ] OTHERS_____

MEDICAL RECORDS / X-RAY RELEASE FORM

STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

[ ] Cocoa Accident & Injury Center, Inc.
PH: (321) 735-9050 Fax: (321) 735-9429

[ ] Titusville Chiropractic & Injury Center, Inc.
PH: 321-567-4984 Fax: (321)567-7626

[ ] Melbourne Accident & Injury Center, Inc.
PH: (321) 622-6610 Fax (321) 622-6716

Date:_____ Patient Name:_____

PERSONS AUTHORIZED TO USE OR DISCLOSE INFORMATION
Information listed above will be used or disclosed by: _____

PERSONS TO WHOM INFORMATION MAY BE DISCLOSED
Information described below may be disclosed to the above listed offices at the Injury Centers of Brevard

Name:_____ Social Security #:_____

DOB:_____

I hereby request and authorize that the following medical documents/ records to be released and that they be promptly transferred to the above listed offices at the Injury Centers of Brevard.

_____ X- RAY Films
___X_ Complete Medical file
___X___ Medical Records
___X____ Daily Notes
___X___ Other: DOL_____
___X_____ Including HIV/AIDs

Expiration Date of Authorization
This authorization is effective through ____/____/____ unless revoked or terminated by the patient or the patients personal representative.

Right to Terminated or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to the above listed offices at the Injury Centers of Brevard . You should contact the Compliance office to terminate the authorization.

Potential for Re-Disclosure
Information that is disclosed under this Authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under federal privacy regulations.

_____ _____
Patient Signature Date

_____ _____
Representative Signature / Print Name Date

INJURY CENTERS OF BREVARD
Titusville Chiropractic & Injury Center, Inc. Cocoa Accident & Injury Center, Inc.
Melbourne Accident & Injury Center, Inc.

Informed Consent

I have been informed it is not uncommon for patients to have some increased discomfort after an adjustment. If that happens, I will apply ice to the area and rest. If I am concerned about this discomfort or develop any new symptoms, I can call the office for attention. If I am out of town or unable to contact the aforementioned number, I can present, myself to the emergency room.

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

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various methods of physical therapy and cold laser therapy (Note: Patients who receive cold laser therapy must wear protective eye wear or may run the risk of eye damage. Pregnant patients are not to receive cold laser therapy.) And, if necessary, diagnostic x-rays on me by the doctor of chiropractic in this office or anyone working in this clinic authorized by the doctor of chiropractic.

I further understand and I am informed that, as in all health and chiropractic medicine there are some very slight risks to treatment including, but not limited to, muscle strains and sprains, disc injuries, and strokes. I do not expect the doctor to be able to anticipate and explain all the risks and complications. I wish to rely on the doctor to exercise judgment during the course of procedure which the doctor feels at the time based upon facts then known, is in my best interest.

OUR OFFICE POLICY

We believe that a clear definition of our office polices will allow you, our patient and our office, to concentrate on the big issue- **REGAINING AND MAINTANING YOUR HEALTH.**

Multiple appointments have been given to you for your convenience, to minimized waiting, and help incorporate these appointments into your daily routine. If you are unable to keep an appointment for any reason, it is required that you call immediately to re-schedule your visit. If you miss an appointment, it must be rescheduled within the week it is missed. This permits you to stay on the treatment schedule that the doctor prescribed for best results. Staff is not authorized to change or alter your prescription, only the doctor.

Upon final or discharge of care medical record request(s) will only be provided to another doctor or attorney with a signed medical release form. Medical records will not be released directly to the patient.

PAYMENT OF BILL

We will require that you honor financial agreements you make with our office. If you find that you cannot fulfill the agreement you have with us, please advise our financial department immediately so that new arrangements can be made. Our policy is that if a patient does not have cash a personal balance of $100,000. Insurance balances may exceed this. Any insurance checks sent to your home should be brought or sent to our office within three days, along with the stub or statement to indicate which services were paid.

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

I have read the above consent, and by signing below, I agree to the above name procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition for which I seek treatment.

RECEIPT OF NOTICE PRIVACY PRACTICE
I have received a copy of the Notice of Privacy from the Injury Centers of Brevard and have reviewed it carefully.

_____ DOB:_____ Date: _____

Patient/ Guardian Signature

_____

Witness **Date**

LETTER OF PROTECTION

INJURY CENTERS OF BREVARD

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Melbourne Accident & Injury Center, Inc.
PH: (321) 622-6610 Fax (321) 622-6716

Patient Name:_____ Date of Birth:_____

Date of Accident:_____

I do hereby authorize **Injury Centers of Brevard** to furnish my attorney with a full report of this examination, diagnosis, treatment, prognosis, etc. Regarding myself for medical conditions related to the accident dated above.

I hereby authorize and direct you, my attorney, to pay directly to the doctor such sums may be due and owing him for reasonable and necessary medical services rendered to me for the evaluation or treatment for the conditions related to this accident. I hereby further give a lien on my case to the doctor against any and all proceeds of my settlement, judgment or the verdict which may be paid to you by my attorney or myself as a result of the injuries of which I have been treated or injuries in connection therewith.

I fully understand that I am responsible to the doctor for all reasonable medical bills submitted by him for necessary services rendered to me and the payments for such bills will be paid solely out of my settlement, judgment or verdict. I further understand that his agreement is made for the doctor's protection in consideration of his awaiting payment. I understand and agree that my directions to you, as my attorney, are irrevocable until either the satisfaction of my financial account with Injury Centers of Brevard occurs or Injury Centers of Brevard releases such Letter of Protection.

I agree to promptly notify the doctor of any change or addition of attorney(s) used by me in connection of the accident and instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted or added attorney.

Please acknowledge this letter by signing below and return it to the doctor's office.

Patients Signature:_____ Date:_____

I, being the attorney of record for the above patient, do hereby agree to observe all the terms of the above and agree to withhold such sums for any settlement, judgment, or verdict as may be necessary to adequately protect and fully compensate the doctor named above in payment of his fees.

Attorney's Name:_____

Attorney's Signature:_____ Date:_____

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

OUR OBLIGATIONS

We are required by law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal obligation, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect on May 26, 2015, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practice, we will change this Notice and make the new Notice available to you upon request.

You may request a copy of our Notice at any time. For more information about privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH

We use and disclose health information about you for our treatment, payment and health care operations. For example:

Treatment: We may use or disclose your health information to a physician or other health care provider providing treatment to you.

Payment: We may use or disclose your information to your health insurer to obtain payment for services we provide to you.

Health Care Operations: We may use or disclose your health information in connection with our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation and certification, licensing or credentialing activities. For example, we may use or disclose your health information in order to conduct an internal assessment of the quality care we provide.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification (including identifying or locating) a family member, your personal representative or another person responsible for your care, to the extent necessary to help with your health care or with payment of your health care, if you agree that we may do so. We may also advise these persons of your locations, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information this is directly relevant to the person's involvement in your health care. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Disclosure Permitted or Required by Law: We are permitted and in some cases required, by law to make certain other disclosures of health information without your consent. We may disclose your health information, as appropriate, to the following entities under the following circumstances:

1. to public health agencies to satisfy certain reporting requirements, such as births and deaths, certain communicable diseases, child abuse and other public health issues;
2. to health oversight agencies such as governmental auditors, the Florida Agency for Health Care Administration, the Florida Department of Health and other agencies when required;
3. to any individual when Injury Centers of Brevard. is ordered by court or other legal process to do so;
4. to law enforcement officials when necessary for law enforcement purposes and required by law;
5. to a coroner or medical examiner when necessary to enable them to perform their duties;
6. to organ procurement organizations, to enable them to make suitability determination;
7. in case of an emergency; or

8. to researchers if their research has been approved by an institutional review board and they take certain steps to protect your privacy.

Appointment Reminder: We may use or disclose your health information to provide you with appointment reminders (such as a voicemail message, postcards, or letters of information about treatment alternatives of other health-related benefits and services that may be of interest to you.
Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.
Your Authorization: Other uses and disclosures of your health information will be made if you give us written authorization to do so. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

PATIENT RIGHTS

You have certain rights regarding your health information. These rights include:

1. the right to obtain a paper copy of this Notice;
2. the right to inspect and copy your health information (copies are available for a reasonable fee);
3. the right to request amendments to your health information you believe to be inaccurate;
4. the right to obtain an accounting of Injury Centers of Brevard uses and disclosures of your health information, subject to certain expectations;
5. the right to request restrictions on our permitted uses and disclosures of your information (although we are not legally obligated to honor this request); and
6. the right to request that communications regarding your health information be sent by alternative means or at alternative locations.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights or wish to exercise any of your rights described herein, please contact us using the contact information listed at the end of this Notice. You also may submit a written complaint to the US Department of Health and Human Services. We will provide you with the address to file your complaint with the US Department of Health and Human Services upon request. We support your right to the Privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the US Department of Health and Human Services.

ABUSE INFORMATION

INJURY CENTERS OF BREVARD

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408.810 On or before the first day of services and provided to client, a licensee must inform the client and his or her immediate family or representative, if appropriate, of the right to report:

- Complaints. The statewide toll-free number to report a complaint regarding the services you receive 1-888-419-3456
- To report abuse, neglect, or exploitation, please call toll free 1-800-96-ABUSE

PATIENTS COPY TO KEEP

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Injury Centers of Brevard

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You may refuse to sign this acknowledgment.

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

_____ *For Office Use Only*_____

We attempted to obtain a written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

( ) Individual refused to sign
( ) Communication barriers prohibited obtaining the acknowledgment
( ) An emergency situation prevented us from obtaining acknowledgment
*( ) Other (Please specify)*_____
_____

INJURY CENTERS OF BREVARD

ACKNOWLEDGEMENT OF RECEIPT OF ABUSE INFORMATION

I, _____, have read and received the phone numbers needed to report abuse and complaints on this _____ day of _____, 20____.

_____
Please Print Name

_____
Signature

_____
Date

_____ _____
Witness Date