MONSALVE INTEGRATIVE HEALTH

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PERSONAL INJURY / ACCIDENT MEDICAL HISTORY INTAKE FORM

(Mark a ✓ on each that applies)

Referred by: _____ Account No.: _____Date: _____

Full Name: _____

Gender: ☐M ☐F Marital Status: □ Single □ Married □ Widowed □ Separated □ Divorced Age: _____

Birth Date: ___/____/____ Height _____ Weight _____

Address: _____

City: _____State: _____ Zip:_____

Social Security No.: _____-_____-_____ Driver's License No.:_____

Home Phone: (____) _____ Cellular Phone.: _____

Who Referred you: _____

Employer: _____ Work Phone: (_____) _____

Email: _____

****

INSURANCE / ATTORNEY INFORMATION:

Insured's Name: _____
(Last) (First) (Init)

Relation to patient: _____ D.O.B.: _____ Soc. Sec. #: _____

Insurance Company: _____

ID#: _____ Group #: _____

Do you have MedPay? ☐Yes ☐No Were you at fault? ☐ Yes ☐ No

****

Have you retained an attorney? Yes / No

Your Attorney's Name: _____

Your Attorney's Phone: (_____) _____ Fax (_____) _____

Your Attorney's Address: _____

City: _____ State: _____ Zip: _____

ACCIDENT INFORMATION:

Date of Accident: _____/_____/_____ Time of Accident: _____ a.m. / p.m.

Your Vehicle: Year _____ Make _____ Model_____

Other Vehicle: Year _____ Make _____ Model_____

Seat Belt: ☐ Yes ☐ No Accident Type: ☐Rear ended ☐Head-on ☐Broad-sided

Damage to Your Vehicle: $ _____ Other Vehicle Damage: $ _____

Describe Accident: _____

_____

ACCIDENT SPECIFICS: (Mark a ✓ on each that applies to the accident)

Was this injury accident related? ☐ Yes ☐ No ☐ Auto ☐ Work ☐ Other

Was this a Job or Work related injury: ☐ Yes ☐ No Were you the: ☐ Driver ☐ Passenger

If passenger, where were you sitting: ☐ Front Seat ☐ Back Seat

Were you wearing your seatbelt: ☐ Yes ☐ No Did the airbag deploy: ☐ Yes ☐ No

Impending Collision, were you: ☐ Aware ☐ Unaware ☐ Braced ☐ Not braced

Did your head: ☐ Strike Object ☐ Not strike Object ☐ Break Glass ☐ Other

Did you experience: ☐ Shock ☐ Loss of Consciousness ☐ Whiplash ☐ Other

The Weather Conditions were they: ☐ Sunny ☐ Raining ☐ Snowing ☐ Foggy

The Road was: ☐ Dry ☐ Wet ☐ Icy Time of Day: ☐ Dawn ☐ Day ☐ Dusk ☐ Night

State your emotions and physical state immediately following the accident: _____

_____

State your emotions & physical state after the first few days: _____

_____

IMMEDIATELY FOLLOWING THE ACCIDENT: (Mark a ✓ on each that applies to the accident)

☐ Ambulance / Paramedics were called
☐ I was transported to Hospital by Ambulance
☐ I was diagnosed at the Hospital
☐ Medication was prescribed
☐ I was treated at the scene
☐ I went to Hospital in my own
☐ I was treated at the Hospital
☐ Follow-up was recommended

OTHER DOCTORS SEEN:

☐ Orthopedist ☐ Neurologist ☐ Psychiatrist ☐ Physiatrist ☐ Chiropractor
☐ Acupuncturist ☐ General Practitioner ☐ Physical Therapist ☐ Massage Therapist
☐ Other

SYMPTOMATOLOGY: (Pain characteristics for major area of complaint)

The pain started: _____

_____

The pain is made **better** by: _____

_____

and **worse** by_____

_____

There is / There isn't **radiation** into: _____

_____

There is / There isn't **parentheses (tingling/numbness)** into: _____

_____

The pain is **located:** _____

_____

The pain is (as far as timing is concerned: i.e. comes & goes, constant, etc.):_____

_____

DAILY ACTIVITIES:

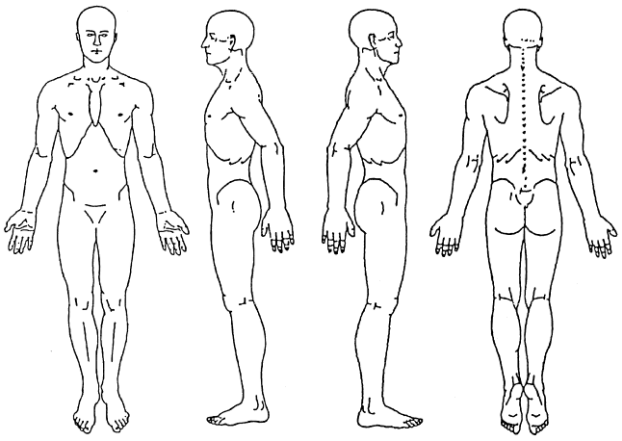
How many days out of an average week do you have pain? ☐ >1 ☐ 2-5 ☐ 5-7
How much time out of an average day are you in pain? ☐ Always ☐ Sometimes ☐ Never
What are the worst times of day for the pain? ☐ Morning ☐ Noon ☐ Evening ☐ Other
When do you feel the best? ☐ Morning ☐ Noon ☐ Evening ☐ Other

PAIN RATING:

On a scale of 0 – 10, rate your pain: (Please O the number that best describes your pain)

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

Please use the legend symbols below to accurately mark the areas in which you feel these sensations:
Stabbing/Cutting-//// Tingling-**** Burning-XXXX Cramping- ^^^^
Numbness-NNNN Dull-####



Describe the overall severity of the pain:
☐ Mild Nuisance ☐ Mild to moderate, but can live with it
☐ Moderate, having trouble coping with it ☐ Severe, it is ruining my quality of life

How do the following activities affect your pain?

	No Change	Relieves	Increased	Duration
Sitting	☐	☐	☐	_____
Walking	☐	☐	☐	_____
Standing	☐	☐	☐	_____
Lying Down	☐	☐	☐	_____
Looking up	☐	☐	☐	_____
Looking Down	☐	☐	☐	_____
Lifting	☐	☐	☐	_____

PROGRESSION:

How is your pain compared to when the pain episode first started?

☐ Much Improved ☐ Somewhat Improved ☐ Much Worse ☐ Somewhat Worse ☐ No Change

What do you do to relieve the pain?

_____

_____

Please mark a ✓ on each that applies to your daily activities:

☐ Have difficulty climbing stairs.
☐ Have to use handrails to get up stairs, etc.
☐ Have to hold onto something to sit or stand from a chair.
☐ Stay at home most of the time.
☐ Do not do jobs around the house.
☐ Walk slower than usual.
☐ Can only walk short distances.
☐ Have to sit most of the day.
☐ Can only stand for short periods of time.
☐ Stays in bed most of the day.
☐ Change position frequently to try and get comfortable.
☐ Have difficulty turning over in bed.
☐ Have to lie down and rest frequently.
☐ Have difficulty sleeping.
☐ Have to get other people to do things for me.
☐ Have difficulty getting dressed.
☐ Have to get dressed with someone's help.
☐ Have difficulty bending or kneeling.
☐ Have a loss of appetite.
☐ Have more irritable stages.

What are some recreational activities that you participated in before this current problem and which ones cannot be performed now to the same extent as before?

_____

_____

How often do you have to stop activities and sit or lie down to control your symptoms?
☐ Several Times ☐ Occasionally ☐ Approximately _____ per day ☐ Never ☐ All Day

List your hobbies & exercise activities _____

_____

SOCIAL HISTORY:

☐ Smoker ☐ Non-Smoker ☐ Do not drink alcohol ☐ Drink alcohol
How much? _____ How often? _____
☐ Do not take drugs ☐ Take Drugs How much? _____ How often? _____
Number of Children: _____

MEDICAL HISTORY:

List any medical professionals you have seen for this problem: _____

List any medications you are currently taking: _____

_____

List the treatments you have had for your problem:
☐ Chiropractic ☐ Osteopathy ☐ Trigger Point Injections ☐ Epidural Injections
☐ Acupuncture ☐ Hot packs ☐ Ultrasound ☐ Massage
☐ Electrical Stimulation ☐ Strengthening Exercises ☐ Aerobics
☐ Bed Rest ☐ Back Brace ☐ Other: _____

List the types of Diagnostic Testing that has been performed for this problem:
☐ X-Rays ☐ C.T. Scan ☐ M.R.I. Scan ☐ Discogram ☐ Bone Scan
☐ E.M.G.

List Past Surgeries: ☐ None

_____

_____

List Past Hospitalizations: ☐ None

_____

_____

List previous back, neck and musculoskeletal problems:

_____

_____

MEDICAL HISTORY:

Do you have or have you ever had diseases or conditions of (please check Yes or No)

Respiratory:

Bronchitis	Yes □ No □
Emphysema	□ No □
Asthma	Yes □ No □
Chronic Cough	Yes □ No □
Morning Cough	Yes □ No □
Shortness of Breath	Yes □ No □
Wheezing	Yes □ No □

Cardiovascular:

High Blood Pressure	Yes □ No □
Chest Pain	Yes □ No □
Heart Attack	Yes □ No □
Heart Murmur	Yes □ No □
Arrhythmia	Yes □ No □
Phlebitis	Yes □ No □
Hardening of the Arteries	Yes □ No □
Artificial Valve	Yes □ No □
Pacemaker	Yes □ No □

Other Systemic:

Hepatitis	Yes □ No □
Diabetes	Yes □ No □
Thyroid Problems	Yes □ No □
Kidney Disease	Yes □ No □
Dialysis	Yes □ No □
Bladder Problems	Yes □ No □

Gastrointestinal

Stomach absorptive disorder	Yes □ No □
Nausea, vomiting, diarrhea when taking antibiotics	Yes □ No □
Yeast infection when taking antibiotics	Yes □ No □
Arthritis/joint Deformity	Yes □ No □
Artificial Joint	Yes □ No □
Convulsions	Yes □ No □
Epilepsy, Seizures	Yes □ No □
Fainting	Yes □ No □

Do you have any current problems with:

☐ Anxiety ☐ Depression ☐ Irritability ☐ Other: _____

Do you have a home exercise program that you follow on a regular basis?

☐ Yes ☐ No

NOTES:

_____

_____

_____

_____

_____ _____

Signature Date

ASSIGNMENT, LIEN, AUTHORIZATION OF INSURANCE BENEFITS AND POWER OF ATTORNEY

Name of Patient: _____ **Date of Accident: _____**

I hereby authorize and direct any insurance company and/or my attorney to pay directly Monsalve Integrative Chiropractic such sums as may be due and owing the office for services rendered to me, both by reason of accident or illness, and by reason of any other bills that are due this office, and to withhold such sums from any disability benefits, or any other insurance benefits obligated to reimburse me or from any settlement, judgment or verdict on my behalf as may be necessary to adequately protect said Office

I hereby further give a lien to said Office against any and all insurance benefits that I may be entitled to and any and all proceeds for any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by said Office. This is to act as an assignment of my rights and benefits to the extent of the Office's services provided.

I hereby assign all of my interest and rights to PIP benefits, which shall include, but not be limited to the right to file a PIP suit or seek arbitration for PIP benefits relative to treatment by said Office. I hereby assign and transfer to this Office any and all causes of action that I might have or that might exist in my favor against any insurance carrier that may be liable for payment of PIP benefits, and authorize this Office to prosecute said cause of action either in my name or in the Office's name and further I authorize this Office to compromise, settle or otherwise resolve said claim or cause of action as thy see fit. Further, in the event that the within assignment is not consented to by an insurer or in any other manner is held invalid by any party, arbitrator or any other person, I hereby give this Office the power of attorney to bring any arbitration proceeding or suit in my name on my behalf as if I had filed such action myself. I further agree to fully cooperate with regard to prosecuting such action or proceeding.

I understand that I remain personally responsible for the total amounts due the Office for services, subject to Florida Law. I further understand and agree that this Assignment, Lien, and Authorization does not constitute any consideration for the Office to await payments and they may demand payments from me immediately upon rendering services at their option. I further understand and agree should I receive any payments made on my behalf from any insurance company I will endorse the check over to Monsalve Integrative Chiropractic within 30 days of my receipt of same and fully understand that failure to do so will result in collections procedures against me.

I authorize this Office to release any information pertinent to my case to any insurance company, adjuster, or attorney to facilitate collection under this Assignment, Lien, and Authorization, so long as the request is submitted in writing. I agree tat the above mentioned Office is hereby given Power of Attorney to endorse/sign my name on any and all checks for payment of my doctor's bill. I further authorize any insurance company and any other physicians who have treated me for this accident to provide this Office with any documentation needed, with regard to the payment of my bills.

Date: _____ **Patient Signature: _____**

PATIENT NAME: _____

INSURANCE INFORMATION:

Date of Accident: _____

Ins. Company: _____

Policy #:_____

Claim #:_____

Adjuster's name: _____

Phone #:_____

Fax #:_____

Benefits available: Policy Limit $_____PT BEN_____

LAWYER INFORMATION:

Lawyer:_____

Address:_____

_____

Phone: _____

Fax: _____

Contact Person:_____

Spoke With:_____ Date:_____Time_____

To: _____
_____
_____

Re: Medical Reports and Doctor's Lien

I authorized the above doctor and/or their authorized representatives to furnish my attorney, any attorney or attorneys who subsequentialy are either associated with the said attorney or substituted in their place, with a full report of my examination, diagnosis, treatment, prognosis, itemized bill of charges incurred, etc. in regard to the accident in which I was involved on _____, and hold the above doctor free and harmless from any liability in such transfer of information.

Out of the proceeds of the settlement and/or judgment in my claim for personal injuries, I hereby assign, set over and transfer to the above doctor such monies due and owing to him or the group for medical, chiropractic, x-rays, physical therapy, supplies and/or laboratory fees rendered to me, either by reason of the above accident or otherwise. I further give to the above doctor a lien on any and all funds received by me or in my behave in association with the settlement or satisfaction of judgment arising from claims presented on my behalf.

I fully understand that I am directly responsible to said doctors/group for all medical bills submitted by them for services rendered to me. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually receive said fee. In the event legal action shall be brought in order to enforce this lien, then the prevailing party shall be entitled to reasonable costs and attorney fees in addition to any judgment rendered. It is acknowledged by the undersigned that this assignment and lien is further consideration for the services rendered by the above doctor in addition to the obligation to pay for the medical services.

Patient's personal injury claim medical payments are hereby assigned and will be paid directly from the insurance company to Monsalve Intregrative Chiropractic.

Attorney agrees to notify the doctors immediately of the name and contacting information of any attorney substituted in his or her place.

_____ _____

PRINT PATIENT NAME DATE

_____ _____

SIGNATURE OF PATIENT SIGNATURE OF PARENT/GUARDIAN

ACKNOWLEDGEMENT OF ASSIGNMENT AND LIEN BY ATTORNEY

The undersigned being the attorney of record on his own behalf and on behalf of any other attorney or attorneys who are associated with the undersigned or who are substituted in his stead for the above patient, does hereby acknowledge receipt of a copy of the assignment and lien, and said attorney acknowledges that he/she obligates themselves to the terms of the assignment and lien in consideration for the rendering of medical services to their client by the above doctor and rendering of a report and bill to said attorney. In the event legal action shall be brought in order to enforce this lien, then the prevailing party shall be entitled to reasonable costs and attorney fees in addition to any judgment rendered. A photographic reproduction of this authorization may be used in place of the original. No charges or alterations of the monies billed herein will be accepted unless confirmed in writing by the doctor. Please date, sign and return on copy as soon as possible to the above referenced medical provider of service in order that treatment can continue on the herein contained lien basis.

_____ _____

ATTORNEY'S 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.

PALMER Chiropractic Clinics

1000 Brady Street
Davenport, IA 52803
Business (563) 884-5805
Fax (563) 884-5581

Imaging Consultation Services

Patient's Name: _____ Age: _____ Sex: M / F

Referring Doctor: _____ NPI: _____

Chief Complaint, Area of Concern: _____

Previous Diagnosis, Surgery, Trauma, Cancer, _____ ☐ Include Previous Imaging Reports

Date of Examination: _____ Verbal Report ( )_____ FAX Report ( ) _____

☐ Payment Enclosed (Master Card, Visa, Discover, American Express or Check) **20% POS Discount**.

☐ INSURANCE billing-assumes DC billed TC ☐ Bill Doctor

Card Type: _____ Card #: _____ Expiration Date: _____ V-Code: _____

Submit Copy of Insurance Card / Documentation OR Complete the Following:

Patient's Address: _____ City: _____ State: _____ Zip: _____

Home Phone: ( )_____ Date of Birth: _____ / _____ / _____ SS #:_____

Patient's Employer: _____ Work Phone ( ) _____

Primary Insurance Company: _____ Adjustor: _____

Address: _____ City: _____ State: _____ Zip: _____Phone: ( )_____

Policy #: _____ Claim #: _____ Group/Plan: _____

First Insured's Name: _____ SS #: _____

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

Date of Birth: _____ / _____ / _____ Relationship: ☐ Spouse ☐ Child ☐ Other _____

Insured's Employer:_____

Related to Employment: ☐ Accident? ☐ Date: _____ / _____ / _____ State:_____

Attorney: _____

Address: _____ City: _____ State: _____ Zip: _____Phone: ( )_____

Patient Consent:
I understand that this office will have my radiographs interpreted by Ian McLean, D.C., D.A.C.B.R., a radiologist certified by the American Chiropractic Board of Radiology. I am aware that I will be responsible for this service and accordingly I hereby authorize Palmer Chiropractic Clinics assignment of benefits for services rendered directly from my insurance carrier or attorney. Accordingly I authorize Palmer Chiropractic Clinics to obtain information necessary to secure payment of benefits and authorize the use of this signature on associated benefit submissions. I also, authorize the release of any medical information necessary to process this claim. Any amounts owed but not collected will be my responsibility.

<u>This service is not covered by Medicare</u>:

Patients/Guardian Signature: _____ **Date:** _____

PALMER IMAGING CONSULTATION SERVICES

√	CPT	DESCRIPTION	FEE	√	CPT	DESCRIPTION	FEE	√	CPT	DESCRIPTION	FEE
	72040-26	Cervical 2-3v	$24.00		73030-26	Shoulder 2v	$24.00		73600-26	Ankle 2v	$24.00
	72050-26	Cervical 4v	$30.00		73080-26	Elbow 2-4v	$24.00		71010-26	Chest 1v	$24.00
	72052-26	Cervical 6v	$30.00		73100-26	Wrist 3v	$24.00		71020-26	Chest 2v	$24.00
	72070-26	Thoracic 2v	$24.00		73120-26	Hand 3v	$24.00		72010-26	Spine, entire	$70.00
	72100-26	Lumbar 2v	$24.00		73510-26	Hip Uni 2v	$24.00		72148-26	MRI – Over read	$70.00
	72110-26	Lumbar 4-5v	$30.00		73560-26	Knee 2v	$24.00				
	71101-26	Ribs 3v	$24.00		73630-26	Foot 3v	$24.00				

Diagnosis Codes: 1._____ 2. _____ 3._____ 4._____

idm 9/13