RIDGE CHIROPRACTIC

APPLICATION FOR CARE/ SOLICITUD DE CUIDADO

Name: _____ Home Phone: _____
Nombre Teléfono Residencial

Address: _____ Work phone: _____
Dirección Teléfono del trabajo

City,State,Zip: _____ Cell Phone: _____
Ciudad,Estado,Código postal Teléfono móvil

Email Address: _____
Correo Electrónico

Birth Date: _____ Age: ____ Marital Status: S M D W
Fecha de nacimiento Edad Estado Civil

Occupation: _____ # Of Children: _____
Ocupación # de ninos

Name& Number Of emergency Contact: _____
Nombre y número del contacto de emergencia

Relationship: _____ Do You have insurance? □ Yes □ No
Relación ¿Tiene usted seguro?

History of Complaint /Historia Medio

Please identify the condition(s) that brought you to this office (in order of severity), and circle your level of pain on a scale of 1 to 10 (Zero=no pain;10= Worst pain)/Identifique la(s) condición(es) que lo llevaron a esta oficina (en orden de gravedad) y encierre en un círculo su nivel de dolor en una escala del 1 al 10 (Cero=sin dolor; 10=Peor dolor).

1._____ Pain Level: 0 1 2 3 4 5 6 7 8 9 10
Nivel de dolor

2._____ Pain Level: 0 1 2 3 4 5 6 7 8 9 10
Nivel de dolor

3._____ Pain Level: 0 1 2 3 4 5 6 7 8 9 10
Nivel de dolor

When did the problem(S) begin? _____
¿Cuándo comenzaron los problemas?

When is the problema at its worst? Early AM mid-morning mid-day Early evening Late evening
¿Cuándo empeora el problema ? Temprano en la manana mediodia Temprano en la noche Tarde noche

How long does it last? Constant throughout day I experience it on and off during the day
¿Cuánto dura ? Constante durante toda el dia Lo experimento intermitentemente durante el dia
It comes and goes throughout the week
Va y viene durante la semana

How did the injury happen? _____
¿Cómo ocurrió la lesión?

Is your problem the result of ANY type of accident? □ **Yes** □ **NO**
¿Su problema es a causa de CUALQUIER tipo de accidente?

Has the condition(s) ever been treated by anyone in the past? □ **Yes** □ **NO**
¿Ha recibido atención médica por este problema anteriormente?

If yes, when: _____ and by who? _____
En este caso, ¿cuándo? ¿Y por quién?

How long were you under care: _____ What were the results: _____
¿Cuánto tiempo estuvo recibiendo tratamiento ? cuales fueron los resultados

Name of previous Chiropractor: _____
Nombre de el quiropráctico anterior

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PLEASE MARK the areas on the diagram with the following letters to describe your symptoms:
POR FAVOR MARQUE las áreas en el diagrama con las siguientes letras para describir sus síntomas:

R = Radiating
Irradiante

A = Aching
Doloroso

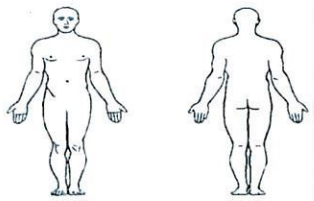
B = Burning
Quemazón

N = Numbness
Entumecimiento

D = Dull
Sordo

S = Sharp/Stabbing
Punzante

T = Tingling
Hormigueo



What relieves your symptoms? /¿Qué alivia tus síntomas?

What makes them feel worse? / ¿Qué las hace sentir peor?

Please list any restricted activities, your current activity level, and your usual activity level:
Enumere las actividades restringidas, su nivel de actividad actual y su nivel de actividad habitual:

RESTRICTED ACTIVITY / ACTIVIDAD RESTRINGIDA	CURRENT ACTIVITY LEVEL / NIVEL DE ACTIVIDAD ACTUAL	USUAL ACTIVITY LEVEL / NIVEL DE ACTIVIDAD HABITUAL
EX: Walking/ Caminar	ex: walk half mile 2x/week/caminar media milla 2 veces por semana	ex: walk one mile 4x/week/caminar una milla 4 veces por semana

Identify any other injuries to your spine, minor or major, that the doctor should know about:
Identifique cualquier otra lesión en la columna, menor o mayor, que el médico deba conocer:

Please list **all** prescription medications (and their purpose) and non-prescription medications/vitamins/supplements you are currently/Enumere **todos** los medicamentos recetados (y su objetivo) y los medicamentos/vitaminas/suplementos sin receta que esté tomando actualmente.

Females: Is there any chance that you are pregnant?/Femeninas: ¿Existe alguna posibilidad de que esté embarazada? ☐ **Yes** ☐ **No**

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PAST HISTORY /Historial de la condicion

Have you suffered with any of this or a similar problem in the past? ☐ **Yes** ☐ **No**
¿Ha sufrido alguno de estos problemas o un problema similar en el pasado?

If yes, how many times? _____ When was the last episode? _____
En caso afirmativo, ¿cuántas veces? ¿Cuándo fue el último episodio?

How did the injury happen?/¿Cómo ocurrió la lesión?

Have you tried any other forms of treatment/ ¿Has intentado alguna otra forma de tratamiento? ☐ **Yes** ☐ **No**
If yes, please state what type of treatment:_____ , and who provided it:_____
En caso afirmativo, indique qué tipo de tratamiento: , y quién lo proporcionó:
How long ago?_____ What were the results: ☐ **favorable** ☐ **unfavorable** please explain:
¿Hace cuanto? ¿Cuáles fueron los resultados? ☐ **Favorables** ☐ **desfavorables** por favor explique:

Please identify any and all types of jobs, activities, or events you have experienced in the past that have imposed any physical stress on you or your body/Identifique todos y cada uno de los tipos de trabajos, actividades o eventos que haya experimentado en el pasado y que haya impuesto algún estrés físico a usted o a su cuerpo:

Please identify **ALL PAST** and any **CURRENT** conditions you feel may be contributing to your present problem/Identifique TODO EL PASADO y cualquier condición ACTUAL que crea que puede estar contribuyendo a su problema actual:

	Condition	How long ago	Type of care received	By whom
Injuries				
Surgeries				

Social History/ Historia social

	Todos los días	Los Fines de semana	Ocasionalmente	Nunca
1. Smoking: cigars cigarettes pipe Fumar : Cigarros Cigarrillos puros	☐ daily	☐ weekends	☐ occasionally	☐ never
2. Alcoholic beverage consumption: Consumo de bebidas alcohólicas:	☐ daily	☐ weekends	☐ occasionally	☐ never
3. Recreational drug use: Uso de drogas recreativas:	☐ daily	☐ weekends	☐ occasionally	☐ never

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4. Hobbies/recreational activities/exercise/sports/:Pasatiempos/actividades recreativas/ejercicio/deportes

Family History/ Historial familiar

1. Does anyone in your family suffer with the same condition(s)? □ **Yes** □ **No**
Alguien en su familia sufre la misma condición(es)?
If **yes** whom: grandmother grandfather mother father sibling(s) son(s) daughter(s)
Si es así, ¿quién? abuela abuelo madre padre hermano(s) hijo(s) hija(s)
Have they ever been treated for their condition? □ **Yes** □ **No** □ **I don't know**
¿Alguna vez han sido tratados por su condición? Si No No lo sé
2. Any other hereditary conditions the doctor should be aware of? □ **No** □ **Yes**
¿Alguna otra condición hereditaria que el médico deba tener en cuenta?

Please mark the listed items below as: **P** (Past) **C** (Currently) **N** (Never)

_ Headache
Dolor de cabeza
___ Neck pain
Dolor de cuello
___ Jaw Pain, TMJ
Dolor de mandíbula, ATM
___ Shoulder pain
Dolor de hombro
___ Upper back pain
Dolor de espalda superior
___ Mid back
Dolor de espalda media
___ Low back
Dolor de espalda baja
___ Hip pain
Dolor de cadera
___ Back Curvature\Scoliosis
Curvatura de espalda\escoliosis
___ Numb/Tingling arms
Brazos entumecidos/ Hormigueos
___ numb /tingling hands/ fingers
Dedos de las manos entumecidos/ Hormigueantes
___numb / Tingling legs
Piernas Entumecidas/ Hormigueantes
___ Numbs / tingling feet/toes
Dedos de los pies entumecidos / Hormigueantes
___ Knee problems
Problemas de rodilla
___ foot problems
Problemas en los pies

___allergies
Alergias
___ Convulsion/Epilepsy
convulsiones/epilepsia
___Dizziness
Mareos
___Fainting
Desmayo
___Blurred vision
Visión Borrosa
___ Double Vision
Visión Doble
___ Loss of balance
Pérdida del equilibrio
___ Tremors
Temblores
___ Sinus/ Drainage problems
Problemas De drenaje/sinusitis
___Ringing in ears
Zumbido en los oídos
___ Hearing loss
Pérdida de la audición
___ Asthma
Asma
___ Difficulty Breathing
Respiración dificultosa
___ Lung problems
Problemas Pulmonares
___ Heart problems
Problemas del corazón
___ Depression
Depresión

___ ___frequent colds/Flu
resfriados frequentes /Gripe
___High blood pressure
Hipertensión
___ Low blood pressure
Presión arterial baja
___ Ulcers
Úlceras
___Digestive problems
Problemas digestivos
___Colon Trouble
Problemas de colon
___ Diarrhea/Constipation
Diarrea/Estreñimiento
___ Kidney trouble
problemas renales
___Gallbladder trouble
Problemas de vesícula biliar
___ Liver trouble
Problemas hepáticos
___ Prostate problems
Problemas de próstata
___Impotence
Impotencia
___ Menstrual Problems
Problemas menstruales
___Irritable
Irritable
___Chestpain
Dolor en el pecho

___ swollen/painful joints/Articulaciones hinchadas/Dolorosas

Please mark the listed items below as: **P** (Past) **C** (Currently) **N** (Never)

___ broken bone
Hueso roto

___ disability
Discapacidades

___ cancer
Cáncer

___ rheumatoid arthritis
artritis reumatoide

___ tumors
Tumores

___ heart attack
Infarto de miocardio

___ cerebrovascular
Cerebrovascular

___ osteoarthritis
osteoartritis

__ diabetes
Diabetes

___ dislocations
Dislocación

___ thyroid disorder
Trastornos de la tiroides

___ swollen/painful joints/Articulaciones hinchadas/Dolorosas

Por la presente autorizo que el pago se realice directamente a Champion Wellness center of Haines city por todos los beneficios que puedan pagarse según un plan de atención médica o de cualquier otra fuente colateral. Autorizo el uso de esta solicitud o copias de la misma con el fin de procesar reclamos y afectar los pagos, y además reconozco que esta asignación de beneficios no me exime de ninguna manera de la responsabilidad de pago y que seguiré siendo financieramente responsable ante Champion Wellness center of Haines city por cualquier y todos los servicios que recibo en esta oficina que no están cubiertos por un plan de atención médica.

Signature of Patient or Authorized Person/Firma del paciente o persona autorizada Date/Fecha

Signature of Doctor Date

Notes/ Notas

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ACTIVITIES OF DAILY LIVING/ ACTIVIDADES DE LA VIDA DIARIA

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life./ identifique cómo su(s) condición(es) actual(es) están afectando su capacidad para realizar actividades que habitualmente forman parte de su vida.

Reading/Concentrating Leer/ Concentrarse	N/A	No Effect	Painful (can do) Doloroso (puede hacer)	Painful (limits) Doloroso (límites)	Unable to Perform No se pudo realizar
Extended Computer Use Uso extendido de la computadora	N/A	No Effect	Painful (can do) Doloroso (puede hacer)	Painful (limits) Doloroso (límites)	Unable to Perform No se pudo realizar
Washing/Bathing Lavar/Bañarse	N/A	No Effect	Painful (can do) Doloroso (puede hacer)	Painful (limits) Doloroso (límites)	Unable to Perform No se pudo realizar
Dressing Vestir	N/A	No Effect	Painful (can do) Doloroso (puede hacer)	Painful (limits) Doloroso (límites)	Unable to Perform No se pudo realizar
Shaving Afeitarse	N/A	No Effect	Painful (can do) Doloroso (puede hacer)	Painful (limits) Doloroso (límites)	Unable to Perform No se pudo realizar
Taking Out Garbage Sacar la basura	N/A	No Effect	Painful (can do) Doloroso (puede hacer)	Painful (limits) Doloroso (límites)	Unable to Perform No se pudo realizar
Sleeping Dormir	N/A	No Effect	Painful (can do) Doloroso (puede hacer)	Painful (limits) Doloroso (límites)	Unable to Perform No se pudo realizar
Rolling Over voltearse	N/A	No Effect	Painful (can do) Doloroso (puede hacer)	Painful (limits) Doloroso (límites)	Unable to Perform No se pudo realizar
Carring (Groceries, Children) Cargar(Compros.Niño)	N/A	No Effect	Painful (can do) Doloroso (puede hacer)	Painful (limits) Doloroso (límites)	Unable to Perform No se pudo realizar
Lifting (Groceries,Children) Levantar (compras,niños)	N/A	No Effect	Painful (can do) Doloroso (puede hacer)	Painful (limits) Doloroso (límites)	Unable to Perform No se pudo realizar
Yard work Trabajo en el patio	N/A	No Effect	Painful (can do) Doloroso (puede hacer)	Painful (limits) Doloroso (límites)	Unable to Perform No se pudo realizar
Pet Care Cuidado de mascotas	N/A	No Effect	Painful (can do) Doloroso (puede hacer)	Painful (limits) Doloroso (límites)	Unable to Perform No se pudo realizar

Driving Conducir	N/A	No Effect	Painful (can do) Doloroso (puede hacer)	Painful (limits) Doloroso (límites)	Unable to Perform No se pudo realizar
Walking Caminar	N/A	No Effect	Painful (can do) Doloroso (puede hacer)	Painful (limits) Doloroso (límites)	Unable to Perform No se pudo realizar
Bending Doblarse	N/A	No Effect	Painful (can do) Doloroso (puede hacer)	Painful (limits) Doloroso (límites)	Unable to Perform No se pudo realizar
Sitting Sentarse	N/A	No Effect	Painful (can do) Doloroso (puede hacer)	Painful (limits) Doloroso (límites)	Unable to Perform No se pudo realizar
Standing Parrarse	N/A	No Effect	Painful (can do) Doloroso (puede hacer)	Painful (limits) Doloroso (límites)	Unable to Perform No se pudo realizar
Sit to stand position Acción de sentarse	N/A	No Effect	Painful (can do) Doloroso (puede hacer)	Painful (limits) Doloroso (límites)	Unable to Perform No se pudo realizar
Stand to Sit Position Acción de levantarse	N/A	No Effect	Painful (can do) Doloroso (puede hacer)	Painful (limits) Doloroso (límites)	Unable to Perform No se pudo realizar
Climbing Stairs Subir Escalada	N/A	No Effect	Painful (can do) Doloroso (puede hacer)	Painful (limits) Doloroso (límites)	Unable to Perform No se pudo realizar
Household Chores Tareas del hogar	N/A	No Effect	Painful (can do) Doloroso (puede hacer)	Painful (limits) Doloroso (límites)	Unable to Perform No se pudo realizar
Sweeping/ Vacuuming Uso de aspiradora	N/A	No Effect	Painful (can do) Doloroso (puede hacer)	Painful (limits) Doloroso (límites)	Unable to Perform No se pudo realizar
Dishes Fregar	N/A	No Effect	Painful (can do) Doloroso (puede hacer)	Painful (limits) Doloroso (límites)	Unable to Perform No se pudo realizar
Laundry Lavandero	N/A	No Effect	Painful (can do) Doloroso (puede hacer)	Painful (limits) Doloroso (límites)	Unable to Perform No se pudo realizar

Escala Analógica Visual Cuadruple

Nombre:_____ **Fecha:**_____

Favor leer cuidadosamente:
Instrucciones: Favor de circular el número que mejor describa la contestación de la pregunta.

Nota: Si tiene más de un problema, favor de contestar cada pregunta individualmente para cada problema e indique la puntuación de cada uno. Favor de indicar su dolor hoy, en su estado regular y en su peor estado.

Ejemplo:

Dolor de cabeza Cuello Espalda baja

Sin dolor_____El peor dolor

0 1 2 3 4 5 6 7 8 9 10

1- ¿Cómo está su dolor ahora mismo?

Sin dolor_____**El peor dolor**

0 1 2 3 4 5 6 7 8 9 10

2- ¿Cómo es su dolor en promedio?

Sin dolor_____**El peor dolor**

0 1 2 3 4 5 6 7 8 9 10

3- ¿Cómo es su dolor en su mejor momento (cuán cerca del 0)?

Sin dolor_____**El peor dolor**

0 1 2 3 4 5 6 7 8 9 10

4- ¿Cómo es su dolor en su peor momento (cuán cerca del 10)?

Sin dolor_____**El peor dolor**

0 1 2 3 4 5 6 7 8 9 10

Otros comentarios:

_____

_____

_____

Accident Questions

Preguntas de Accidente

Name:_____ Date:_____

Nombre Fecha:

Date and type of accident:_____ Auto Other:_____

Fecha y tipo de accidente Auto Otro

Make&model of the vehicle you were in : _____

Marca y modelo del vehículo en el que viajaba:

Were you a pedestrian: _____ Name of your own Auto Insurance Co:_____

¿Eres peatón? Nombre de su compañía de seguros para automóvil:

Make & model of the other vehicle : _____ Speed of the other vehicle: _____

Marca y modelo del otro vehículo Velocidad del otro vehículo

City & State the accident occurred:_____

Ciudad y Estado en la que ocurrió el accidente

Which police Dept. responded to the scene:_____ Was report filed:_____

¿Qué Departamento de Policía respondió a la escena? Se completó un informe:

Were you punched in (on the clock) for work at the time of the accident? ☐Yes ☐ No

¿Le habían registrado su entrada al trabajo en el reloj al tiempo del accidente?

Were you in a company vehicle? ☐ Yes ☐ No Was this accident in a parking lot? ☐ Yes ☐ No

¿Estabas en un vehículo de la empresa? Sí No ¿Fue este accidente en un estacionamiento? Sí No

Were you the :☐ Driver, ☐ Front passenger, ☐ Rear passenger, ☐ Pedestrian

¿Fuiste el : Conductor, Pasajero delantero, Pasajero trasero, Peatón

How many people were in the vehicle at the time of the accident?_____

¿Cuántas personas estaban en el vehículo en el momento del accidente?

Were you wearing a seat belt? ☐ Yes ☐ No

¿Llevabas puesto el cinturón de seguridad?

Did the airbag Deploy? ☐ Yes ☐ No Are there any injuries from the airbag?_____

¿Se desplegó la bolsa de aire? ¿Hay alguna lesión causada por la bolsa de aire ?

Was your vehicle: ☐**Stopped** ☐**Moving** At the time of impact? Speed you were traveling? ___

¿Su vehículo estaba detenido o moviéndose al momento del impacto? ¿A qué velocidad viajabas?

Were you : ☐Surprised by impact ☐ Braced for impact

Estabas : Sorprendido por el impacto Preparado para el impacto

At the time of impact were you /En el momento del impacto, usted:

☐Looking straight ahead ☐ Looking to the left ☐Looking to the right ☐ Looking down

Accident Questions

Preguntas de Accidente

☐ Looking up

Mirando al frente Mirando a la izquierda Mirando a la derecha Mirando hacia abajo

Mirando hacia arriba

Was impact from: ☐Front☐ Rear ☐Left ☐ Right Other :_____

Fue impactado de: Delantero ☐Trasero Izquierdo Derecha Otro

Did your car impact another vehicle? ☐YES ☐NO Did your car impact a structure?☐ YES ☐No

¿Su automóvil impactó contra otro vehículo? ¿Su auto impactó contra una estructura?

Please describe the accident in your own words:

Describa el accidente con sus propias palabras:

_____

_____

Did any part of your baby strike anything in the vehicle? ☐YES ☐ NO

¿Alguna parte de su bebé golpeó algo en el vehículo?

If yes,explain/En caso afirmativo, explique:

_____

_____

Patient Condition & Treatment/Condición y tratamiento del paciente

Did you lose consciousness ☐Yes ☐No If yes for how long:_____

¿Perdió el conocimiento? En caso afirmativo, ¿por cuánto tiempo?

What were your symptoms following the accident?_____

¿Cuáles fueron sus síntomas después del accidente?

Did you go to the hospital? ☐ Yes☐ No If yes, name of the hospital:_____

¿Fuiste al hospital? En caso afirmativo, nombre del hospital:

When did you go ?☐ Immediately after accident ☐ Later that Day ☐ Next day ☐ Other:

¿Cuándo fuiste? Inmediatamente después del accidente Más tarde ese día Al día siguiente

Transport by ambulance? ☐YES ☐ NO Do you have any of the following: ☐Cuts ☐Scrapes ☐ Bruises

¿Transporte en ambulancia? ¿Tiene alguno de los siguientes síntomas: Cortes Rasguños Moretones

Were X-rays prescribed?☐YES☐ NO If yes, which body part?

¿Se recetaron radiografías? En caso afirmativo, ¿qué parte del cuerpo?

Were any other tests performed?☐ Yes ☐NO if yes what test?

Accident Questions
Preguntas de Accidente

¿Se realizaron otras pruebas? En caso afirmativo, ¿qué prueba?

Was medication prescribed ☐YES ☐ NO

¿Se le recetó medicación?

Are you Pregnant? ☐Yes☐ No If yes, due date:_____

¿Estás embarazada? En caso afirmativo, fecha de vencimiento

Do you smoke? ☐Yes ☐No If yes, How much: _____

¿Usted fuma? En caso afirmativo, cuánto:

Drink alcohol? ☐Yes☐ No If yes, How much:

¿Beber alcohol? En caso afirmativo, cuánto:

SYMPTOMS/INJURIES/SÍNTOMAS/LESIONES:

Have you been able to work sincethis injury? ☐ Yes ☐ No How many work days have you missed?

¿Ha podido trabajar desde esta lesión? ¿Cuántos días de trabajo ha perdido?

Please circle your symptoms since your injury
Por favor, marque con un círculo sus síntomas desde su lesión:

Headaches Dolores de cabeza	Neck pain Dolor de cuello	Neck stiffness Rigidez en el cuello	Jaw problems Problemas en la mandíbula
Lt/RT Arm Pain LT/Rt Dolor en el brazo	Lt/RT shoulder pain Lt/rt Dolor de Hombro	LT/RT Hands Finger pain Numbness Lt/Rt Dolor y adormecimineto en las manos y los dedos	Mid Back-pain Dolor en la parte media de la espalda
Back stiffness Rigidez en la espalda	Chest pain Dolor en el pecho	Low Back pain Dolor lumbar	LT/RT foot/toe pain/numbness
Lt/Rt hip pain Dolor de cadera	LT/RT Leg pain LT/RT Dolor en la pierna	LT/RT Knee/ankle pain LT/RT Dolor de rodilla/tobillo	Dizziness Mareos
Nasuase Náuseas	Fatigue Fatiga	Sleep difficulty Dificultad para dormir	Abdominal pain Dolor abdominal
Hearing loss Pérdida de audición	Vision blurred Visión borrosa	Difficulty Turning Head to the RT/LT Dificultad para girar la cabeza hacia el RT/LT	

Does Coughing/sneezing increase your pain? ☐ Yes ☐ No

¿Toser/estornudar aumenta el dolor?

Accident Questions
Preguntas de Accidente

Are your symptoms getting worse? ☐ Yes ☐ No Is it constant or does it come and go?_____

¿Tus síntomas están empeorando? ¿Es constante o va y viene?

Rate the severity of your pain on a scale from 1(lease pain) to 10 (severe pain)

Califique la gravedad de su dolor en una escala de 1 (dolor de arrendamiento) a 10 (dolor intenso)

Type of pain: ☐Sharp ☐ Cramping ☐ Dull ☐ Throbbing ☐ Burning ☐ Stabbing ☐ Grading

Tipo de dolor: ☐Calambres ☐ agudos ☐ Golpe ☐ punzante ☐ Ardor ☐ Punzante ☐ Gradación

Insurance/Attorney Information/Información de Seguros/Abogados:

What is the name/Policy# of your auto Insurance?/¿Cuál es el nombre/# de póliza de su seguro de automóvil?

What is the Name of other parties' auto insurances?/¿Cuál es el nombre de los seguros de auto de terceros?

Police/ Policía:

Did the police come to the accident site: Yes NO

¿Acudió la policía al lugar del accidente?

Were there any witnesses? Yes No If yes,please give the front desk a copy

¿Hubo testigos? En caso afirmativo, entregue una copia a la recepción

Was a traffic violation issued? Yes No If yes,To whom?_____

¿Se emitió una infracción de tránsito? En caso afirmativo, ¿A quién?

To the best of my knowledge, the above information is complete and correct. I understand it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.A mi leal saber y entender, la información anterior es completa y correcta. Entiendo que es mi responsabilidad informar a mi médico si yo, o mi hijo menor de edad, alguna vez tenemos un cambio en la salud.

Signature of patient ,parent,Guardian or Personal representative Date

Firma del paciente, padre, tutor o representante personal Fecha

---

Please print name of patient ,parents,guardian or personal representative Date

Por favor, escriba el nombre del paciente, los padres, el tutor o el representante personal Fecha

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**):*

Name *(PRINT or TYPE)*	Signature	Date
Brett Summers, D.C.		

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.

OIR-B1-1571
Pub. 1/2004

Notice of Initiation of Treatment

Patient Name: _____ **DOB:** _____

PHYSICIAN: Dr. Brett Summers, D.C.

INSURED: _____

DATE OF LOSS: _____

INSURANCE COMPANY: _____

CLAIM NUMBER: _____

To Whom It May Concern:

Please be advised that I have been consulted by and have been rendering medical treatment to the above referenced patient, with the patients first date of treatment occurring on _____.

Enclosed, please find a direction to pay, which the patient has directed you to send all payments for services rendered to the undersigned. The patient has also granted us a lien on the benefits.

In accordance with F.S. 627.736 (5) (b), I will be timely submitting the bills.

Thank you,

_____ _____

Dr. Brett Summers, D.C. Date

Ridge Chiropractic Center
863-421-9700

Assignment of Benefits, Lien, Cause of Action, and Authorization

Patient Name: _____ DOB: _____ Claim # _____

I hereby authorize and direct you, my insurance company and/or attorney, to pay directly to Ridge Chiropractic/Champion Wellness Center of Haines City, LLC (Assignee) such sums as may be due and owing Assignee for services and treatment rendered to me both by reason of accident or illness, and by reason of any other bills that are due Assignee, and to withhold such sums from any disability and benefits, personal injury protection, medical payment benefits, no fault benefits, or any other insurance benefits obligated to reimburse me or from any settlement, judgment, or verdict which may be paid to me as a result of injuries or illness for which I have been treated by Assignee. This is to act as an assignment of my rights and benefits to the extent of the Assignee's service provided.

In the event my insurance company is obligated to make payments to me upon the charges made by Assignee for its services denies or reduces payment, I direct my insurer to escrow any personal injury protection and/or medical payments benefits it might have or that might have or that might exist in my favor against such company. I further authorize Assignee to file suit for such benefits assigned herein and to compromise, settle, or otherwise resolve said claim or cause as they see fit.

In the event of litigation or arbitration, I agree to cooperate with Assignee and any attorney retained by them in any manner reasonably required. I understand that this cooperation may include giving sworn testimony at deposition, arbitration, or trial of the case, and execution of releases, settlement papers, and settlement checks. I further agree not to compromise or extinguish the value of this assignment by taking a position inconsistent with Assignee's pursuit of payment.

I understand that I remain personally responsible for the total amounts due Assignee for its services which are not otherwise required by the law to be paid by my insurance company and in accord with the policy of insurance issued to me. I further understand and agree that this Assignment of Benefits, Lien, Cause of Action, and Authorization does not constitute any consideration for Assignee to await such payments which I may otherwise owe, and they may demand such payments from me immediately upon rendering services at their option.

I authorize Assignee to release information pertinent to my case to any insurance company, adjuster, or attorney to facilitate collection under Assignment of Benefits, Lien, Cause of Action, and Authorization. I authorize, grant, and designate that the above mentioned Assignee be given special Power of Attorney to endorse/sign my name on any and all checks and claim forms for payment for all services rendered by Assignee directly to Ridge Chiropractic/Champion Wellness Center of Haines City, LLC.

_____

Print Patient Name

_____ _____

Patient/Guardian Signature Date

Ridge Chiropractic
FINANCIAL AGREEMENT

Dear Patient:

We have attempted to provide you with the necessary information to determine the type of care you require and also the financial information you may need to determine how you wish to handle your financial obligation to Ridge Chiropractic.

We wish to make it very clear that your health is the sole responsibility of you, the patient, or your guardian.

These policies apply only to the services actually performed and in no way obligates the patient to continue the course of treatment recommended. If care is discontinued, the balance due for care received up to that date is due in full within 30 days of discontinuance of care.

I have elected to use the following payment plan to finance my care at Ridge Chiropractic:

✓ PERSONAL INJURY - Although my insurance or lawsuit may eventually pay Ridge Chiropractic in full for services rendered, I agree to take full responsibility for my account balance, whether active or inactive as a patient.

_____
Print Patient Name

_____ _____
Patient/Guardian Signature Date

Ridge Chiropractic
82 Maxcy Plaza Circle Haines City, Florida 33844
(863) 421-9700 · (863) 421-1953 (Fax)

Date: _____

Authorization for Release of Records

To: _____

Phone: _____ Fax: _____

Patient Name: _____ Date of Birth: _____

Patient Phone Number: _____

Please release the following medical information: _____

_____

To be released to: **Ridge Chiropractic**
82 Maxcy Plaza Circle
Haines City, FL 33844
Phone: (863) 421-9700
Fax: (863) 421-1953
rchiropractic1@gmail.com

Patient/Guardian Signature: _____ Date: _____

Champion Wellness of Haines City
82 Maxcy Plaza Circle
Haines City, Florida 33844
(863) 421-9700
(863 421-1953 Fax

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE

RE:

Patient: _____

Policy/Claim: _____ DOA: _____

S.S#/ID#: _____

I hereby instruct and direct that _____ to pay by check made out and directly to:

Champion Wellness of Haines City
82 Maxcy Plaza Circle
Haines City, Florida 33844
(863) 421-9700
Or

If may current policy prohibits direct payment to doctor, the I hereby also instruct and direct you to make out the check to me and mail it to follows:

Champion Wellness of Haines City
82 Maxcy Plaza Circle
Haines City, Florida 33844
(863) 421-9700

The Professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional service rendered. **THIS IS DIRECT ASSIGMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.** This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

Dated at Champion Wellness of Haines City _____ 20_____

_____ _____
Signature of Policyholder Witness

_____
Signature of Claimant, if other the Policyholder

Ridge Chiropr. .ic Care NOTICE OF PRIVAC. PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your Personal Health Information. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as **dictated by our office policy,** we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk staff. Keep this page for your records.

PERMITTED DISCLOSURES:

1. Treatment purposes - discussion with other health care providers involved in your care.
2. Inadvertent disclosures - open treating area means open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room. Often, private conversations require a specific appointment time outside of our normal adjusting hours. Please see a front desk staff member, and we will be happy to schedule this for you.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes - to process a claim or aid in investigation.
5. Emergency - in the event of a medical emergency we may notify a family member.
6. For public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To government agencies or law enforcement – to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons – discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders - **we may call your home and leave messages** regarding a missed appointment or notify you of changes in practice hours or upcoming events.
11. Change of ownership - in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive (detailed) privacy notice.
3. To request mailings to an address different than residence.
4. To request restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance.
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain one copy of your records at no charge, when timely notice is provided (72 hours).

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call us at 813-409-3304. If were unavailable, you may make an appointment with our receptionist within 72 hours, or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS - Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201

Please initial here: _____ if you wish to retain your copy of Page 1 of this notice.

Ridge Chiropractic Care's NOTICE REGARDING YOUR RIGHT TO PRIVACY continued....

I have received a copy of Ridge Chiropractic Care's Patient Privacy Notice. I understand my rights as well as the practice's duty to protect my health information and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this Notice of Privacy Practice at any time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this notice is available to me. At this time, I do not have any questions regarding my rights or any of the information I have received.

PRINT Patient's Name	Date of Birth	Chart#

Signature of Patient or Guardian	Date

Witness	Date