Chiropractic Case History/Patient Information

Date: _____

Name:_____ Social Security #_____ Home Ph:_____

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

Email Address:_____ Cell Ph:_____

Age:_____ DOB:_____ Race:_____ Marital: M S W D

Occupation:_____ Employer:_____

Employer's Address:_____ Office Ph:_____

Spouse:_____ Occupation:_____ Employer:_____

How Many Children?_____ Names /Ages of children:_____

_____

Name of nearest relative:_____ Address:_____

Phone:_____

How were you referred to our office? _____

Family Medical Doctor: _____

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? _____

HISTORY OF PRESENT ILLNESS:

Chief Complaint\Purpose of this appointment: _____

Date symptoms appeared or accident happened: _____

Is this due to: AUTO____ WORK____ OTHER _____

Have you ever had the same or similar condition? YES____ NO ____ if yes, when and describe:

_____

Days lost from work: _____ Date of last physical examination: _____

PAST MEDICAL HISTORY:

Have you ever been diagnosed as having or have suffered from? (Place a check mark by conditions that may apply to you)

____Broken/Fractured Bones	____Osteoarthritis	____Eating Disorder
____Circulatory Problems	____Epilepsy	____Alcoholism
____Rheumatoid Arthritis	____Pace Maker	____Drug Addiction
____Seizures/Convulsions	____Strokes	____HIV Positive
____A Congenital Disease	____Cancer	____Gall Bladder
____Excessive Bleeding	____Ruptures	____Depression
____High/Low Blood Pressure	____Coughing Blood	____Ulcers

Do you have a history of stroke/hypertension? _____

Have you had any major illnesses, injury, falls, auto accidents or surgeries? Women, please include information about childbirth (include dates): _____

_____

Have you been treated for any health condition by a physician in the last year? YES___ NO___

If yes, describe: _____

What medications or drugs are you taking? _____

_____

Do you have any allergies to any medications? YES___ NO___ if yes, describe: _____

_____

Do you have any allergies of any kind? YES___ NO___ if yes, describe: _____

_____

Please list any other health problems you have, no matter how insignificant they may be:

_____

SOCIAL HISTORY:

Do you drink alcoholic beverages? ___ If so, how much per week? _____
Do you use any tobacco products? ___ Do you smoke? ____ If so, packs per day:_____
Do you take vitamin supplements? ____ If so, please list:_____
Do you consume caffeine? ___ If so, how much per day:_____
Do you exercise? ____ If yes, what is the frequency and type of exercise? _____
What are your hobbies? _____
What percentage of time during the day (at home or at your job away from home) do you spend: Lifting____ sitting_____ bending_____ working at a computer_____

FAMILY HISTORY:

Parents:
Father: Living____ deceased____ current age if still living:____ Cause of death and age at death if deceased:_____(check one)

Mother: Living____ deceased____ current age if still living:____ Cause of death and age at death if deceased:_____(check one)

Check if applicable to you:_____ As an adopted child, little is known of birth parents or family.
Do you have any family members who suffer from the same condition you do? If so, please list:_____

FAMILY DISEASES (Check if applicable and indicate whether family member is Father, Mother, Sister, Brother):

Tuberculosis ___	Cancer___	Mental Illness____
Diabetes____	Asthma___	Heart Disease____
Stroke___	Kidney Disease____	Lung Disease____
Arthritis____	Liver Disease____	

Other_____

Please check any and all insurance coverage that may be applicable in this case:
*Major Medical *Worker's Compensation *Medicaid * Medicare * Auto Accident
*Medical Savings Account & Flex Plan * Other

Name of Primary Insurance Company: _____
Name of Secondary Insurance Company (if any):_____
AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their patient health information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your patient health information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your patient health information we encourage you to read the HIPPA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's Signature:_____ Date:_____
Guardian's Signature Authorized Care:_____Date:_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

_____ _____

Patient Name (Please print) Date

_____

Parent, Guardian or Patient's legal representative

_____

Signature

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.

FINANCIAL ARRANGEMENTS AND MEDICAL INSURANCE

We are committed to providing you with the best possible chiropractic care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

Payment for all services rendered in our office will be due at the time the services are provided unless payment arrangements have been made and approved by the staff or the doctor. This is to aid in reducing billing costs. We accept cash, checks, Visa, MasterCard, American Express, and Discover.

We will be happy to file a claim with your insurance company for your reimbursement. To aid us in doing this, please furnish us with a copy of your insurance card, an address to your insurance company and a telephone number that we may use to contact your insurance company. We will also assist you by calling you insurance carrier for pre-certification and information regarding your benefits.

You must realize, however, that:

1. **Your insurance is a contract between you and your insurance company. We are not a party to that contract.**
2. **Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.**

We must emphasize that as a physician, our relationship is with you, NOT your insurance company. While filing of insurance claims is a courtesy we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payments on your account. If such problems do arise we encourage you to contact us promptly for assistance in the management of your account. If you have any questions regarding the above information or any uncertainty regarding insurance coverage, PLEASE do not hesitate to ask us.

I HAVE READ AND FULLY UNDERSTAND THAT I AM SOLELY RESPONSIBLE FOR ANY BALANCE ON MY ACCOUNT.

Signature: _____ Date: _____

3430 Cleveland Avenue, Fort Myers, FL 33901
Phone: (239) 936-2889 Fax (239) 689-1765

Dr. Marshall Webb, D.C.
3430 Cleveland Avenue
Fort Myers, FL 33901
(239) 936-2889 FAX (239) 689-1765

I authorize my insurance company to pay Marshall Webb, D.C. directly. I also authorize the release of information regarding my records to my insurance company and my attorney.

SIGNED _____

DATE _____

Dr. Marshall Webb, D.C.
3430 Cleveland Avenue
Fort Myers, FL 33901
(239) 936-2889 FAX (239) 689-1765

NOTICE OF DOCTOR'S LIEN

To Attorney: _____
_____
_____

Re: Medical Reports and Doctor's Lien Patient _____

I do hereby authorize the above doctor to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him for medical service rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor. And I hereby further, give a lien on my case to said doctor against any and all proceeds of any settlement, judgment, or verdict which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated or injuries in connection therewith.

I agree to notify said doctor within one week of any change or addition of attorney used by me in connection with this accident, and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted or added attorney(s). The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from the settlement, judgment or verdict as may be necessary to adequately protect said doctor above named.

Dated: _____ Patient's Signature: _____

Dated: _____ Patient's Signature: _____

The undersigned being attorney of record for the above named patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from settlement, judgment or verdict as may be necessary to adequately protect said doctor above named. I agree to notify said doctor one week of any change or addition of attorney used by me in connection with this accident, and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted or added attorney.

Dated: _____ Attorney's Signature: _____

ATTORNEY: Please date, sign and return one copy to doctor's office at once.
Remember to keep one copy for your records. Thank you.

Marshall Webb, D.C.

POWER OF ATTORNEY AND MEDICAL RELEASE

POWER OF ATTORNEY TO ENDORSE CHECKS AND/OR TO SIGN ANY PIECE OF PAPER WHICH WILL ENHANCE OR EXPEDITE PAYMENT TO PROVIDER FOR SERVICES RENDERED, INCLUDING BUT NOT LIMITED TO A RELEASE OF MEDICAL RECORDS AND ASSIGNMENT OF BENEFITS/AUTHORIZATION TO PAY.

Know by all present that: The undersigned has made, constituted and appointed, and by these presents does hereby make, constitute and appoint MARSHALL WEBB, D.C., and any of it's duly authorized agents and employees as and to be the undersigned's true and lawful attorney for and in the undersigned's name, place and stead to endorse any and all checks, drafts or money orders which are made payable to the undersigned alone or to the undersigned and the said MARSHALL WEBB, D.C., which checks, drafts or money orders are made payable for services which have been made by MARSHALL WEBB, D.C., at the request or with the knowledge and approval of the undersigned and/or the maker of the check, draft, or money order.

Furthermore, the undersigned allows MARSHALL WEBB, D.C., or any of Its agents to sign any paper that will be necessary to enhance expedite and/or allow payment to said provider. This may include affidavits of non-ownership of vehicles, insurance forms and other statements.

The undersigned by these present does give and grant the said MARSHALL WEBB, D.C. as attorney the full power and authority to do and perform all and every act whatsoever requisite and necessary to be done in and about the premises as fully to all intents and purposes as the undersigned might or could do to personally present insofar as the endorsing and cashing of said checks are concerned as well as any other document.

MEDICAL RELEASE

A photocopy of this document shall be sufficient to authorize any person having records of medical treatment, services, or supplies pertaining to me to release true copies of same to MARSHALL WEBB, D.C. or any insurer providing coverage to me in connection with the processing of any claim for benefits made by me or by the assignee herein. A photocopy of this document shall be as binding as an original signature page.

The undersigned does hereby ratify and confirm any and all activities taken by the said attorney in accordance with this special power and which the said attorney shall do or cause to be done by virtue of these presents.

ASSIGNMENT OF BENEFITS

I, _____ Hereby authorize _____
(Name of Insured/Patient) (Name of Insurance Carrier)

To make medical benefits payments otherwise payable to me for services rendered by MARSHALL WEBB, D.C., but not to exceed charges of those services, payable and mailed directly to:

Dr. Marshall Webb
3430 Cleveland Avenue
Fort Myers, FL 33901

Furthermore, I hereby IRREVOCABLY ASSIGN to MARSHALL WEBB, D.C. the rights and benefits under any policy of insurance, indemnity agreement, or any other collateral source as defined in Florida Statutes for any service and or charges provided by MARSHALL WEBB, D.C.

IN WITNESS WHEREOF the undersigned have hereunto set their hands, this _____ day of _____, 2021.

_____ _____
Patient's Signature Patient's Name (Please Print)

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

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