WELCOME

PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

PHONE NUMBERS

Home Phone (_____) _____

Cell Phone (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Home Phone (_____) _____

Work Phone (_____) _____

ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No

Date _____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable)

_____

PATIENT CONDITION

Reason for Visit _____

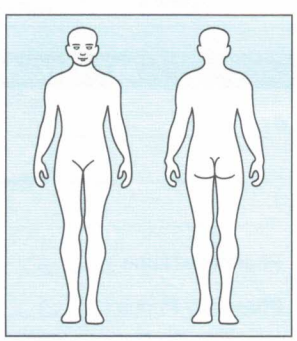
When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

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

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other



How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam_____ Spinal X-Ray_____ Blood Test_____

Spinal Exam_____ Chest X-Ray _____ Urine Test _____

Dental X-Ray_____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Alcoholism	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Measles	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Allergy Shots	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Migraine Headaches	☐ Yes	☐ No	Sexually Transmitted Disease	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Fractures	☐ Yes	☐ No	Miscarriage	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Anorexia	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Mononucleosis	☐ Yes	☐ No	Suicide Attempt	☐ Yes	☐ No
Appendicitis	☐ Yes	☐ No	Goiter	☐ Yes	☐ No	Multiple Sclerosis	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Gonorrhea	☐ Yes	☐ No	Mumps	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Gout	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Bleeding Disorders	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Tumors, Growths	☐ Yes	☐ No
Breast Lump	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	Parkinson's Disease	☐ Yes	☐ No	Typhoid Fever	☐ Yes	☐ No
Bronchitis	☐ Yes	☐ No	Hernia	☐ Yes	☐ No	Pinched Nerve	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Bulimia	☐ Yes	☐ No	Herniated Disk	☐ Yes	☐ No	Pneumonia	☐ Yes	☐ No	Vaginal Infections	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Polio	☐ Yes	☐ No	Whooping Cough	☐ Yes	☐ No
Cataracts	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Prostate Problem	☐ Yes	☐ No	Other _____		
Chemical Dependency	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No	Prosthesis	☐ Yes	☐ No			
Chicken Pox	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No			
						Rheumatoid Arthritis	☐ Yes	☐ No			

EXERCISE

☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY

☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

HABITS

☐ Smoking Packs/Day _____
☐ Alcohol Drinks/Week _____
☐ Coffee/Caffeine Drinks Cups/Day _____
☐ High Stress Level Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date_____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

MEDICATIONS

_____
_____
_____

Pharmacy Name_____

Pharmacy Phone (_____)_____

ALLERGIES

_____
_____
_____

VITAMINS/HERBS/MINERALS

_____
_____
_____

VEHICLE ACCIDENT INFORMATION

PATIENT INFORMATION

Date_____

Patient Name_____

Date of Accident_____ Time of Accident_____ ☐ a.m. ☐ p.m.

Please describe the accident in your own words:_____

_____

_____

_____

Were you the: ☐ Driver ☐ Front Passenger ☐ Rear Passenger ☐ Pedestrian

How many people were in the accident vehicle?_____

ACCIDENT SITE

Road/Street Name_____

City/State_____

Nearest intersection with road/street_____

Driving conditions ☐ Dry ☐ Wet ☐ Icy ☐ Other _____

Which direction were you headed? _____

Speed you were traveling?_____

VEHICLE

Make and model of vehicle you were in:

_____

Were you wearing a seatbelt? ☐ Yes ☐ No

If yes, what type? ☐ Lap ☐ Shoulder

Was vehicle equipped with airbags? ☐ Yes ☐ No

If yes, did it/they inflate properly? ☐ Yes ☐ No

Did your seat have a headrest? ☐ Yes ☐ No

If yes, what was the position of the headrest?

☐ Low ☐ Midposition ☐ High

IMPACT

Did your car impact another vehicle? ☐ Yes ☐ No

Did your car impact a structure? ☐ Yes ☐ No

If yes, explain_____

_____

Did any part of your body strike anything in the vehicle?

☐ Yes ☐ No If yes, explain_____

Was impact from :

☐ Front ☐ Rear ☐ Left ☐ Right ☐ Other_____

At the time of impact were you:

☐ Looking straight ahead ☐ Looking to the right

☐ Looking to the left ☐ Looking down

☐ Looking up

Were both hands on the steering wheel? ☐ Yes ☐ No

If no, which hand was on the wheel? ☐ Right ☐ Left

Was your foot on the brake? ☐ Yes ☐ No

If yes, which foot was on the brake? ☐ Right ☐ Left

Were you: ☐ Surprised by impact ☐ Braced for impact

OTHER VEHICLE

(if applicable)

Make and model of other vehicle_____

Which direction was other vehicle headed?_____

Speed other vehicle was traveling_____

POLICE

Did the police come to the accident site? ☐ Yes ☐ No

Were there any witnesses? ☐ Yes ☐ No

Was a police report filed? ☐ Yes ☐ No

Was a traffic violation issued? ☐ Yes ☐ No

If yes, to whom?_____

PATIENT CONDITION

Were you unconscious immediately after the accident? ☐ Yes ☐ No If yes, for how long?_____

Please describe how you felt immediately after the accident:

_____

_____

TREATMENT

Did you go to the hospital? ☐ Yes ☐ No

When did you go? ☐ Immediately after accident ☐ Next day ☐ 2 days or more after the accident

How did you get to the hospital? ☐ Ambulance ☐ Private transportation

Name of hospital_____ Name of doctor_____

Diagnosis_____

_____

Treatment received_____

X-rays taken_____

SYMPTOMS/INJURIES

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

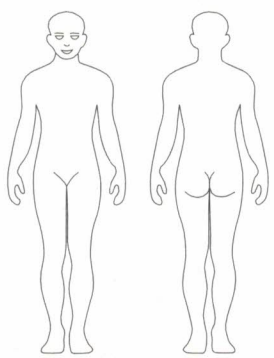
Prior to the injury were you able to work on an equal basis with others your age? ☐ Yes ☐ No

If you have had any of the following symptoms since your injury, please ☑ check:

☐ Arm/shoulder pain	☐ Feet/toe numbness	☐ Neck pain
☐ Back pain	☐ Hand/finger numbness	☐ Neck stiff
☐ Back stiffness	☐ Headaches	☐ Shortness of breath
☐ Chest pain	☐ Irritability	☐ Sleep difficulty
☐ Dizziness	☐ Jaw problems	☐ Stomach upset
☐ Ear buzzing	☐ Leg pain	☐ Tension
☐ Ear ringing	☐ Memory loss	☐ Vision blurred
☐ Fatigue	☐ Nausea	

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



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

Type of pain:

☐ Sharp	☐ Dull	☐ Throbbing	☐ Numbness
☐ Aching	☐ Shooting	☐ Burning	☐ Tingling
☐ Cramps	☐ Stiffness	☐ Swelling	☐ Other_____

How often do you have this pain?_____

Is it constant or does it come and go?_____

Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Movements that are painful to perform: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

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.**

Chiropractic examination/evaluation, Chiropractic adjustments, Physical therapies. (May include: ice, heat, ultrasound, electrical muscle stimulation, and cold laser.) Traction, and neuromusuclar re-education

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.

OIR-B1-1571
Pub. 1/2004

Dr. Ryan Johnson, D.C.
2206 Jo-An Drive, STE 1, Sarasota, FL. 34231
941-487-0266

ASSIGNMENT OF BENEFITS / LIEN AND AUTHORIZATION

I hereby authorize you, my insurance company and/or my attorney, to pay directly to, Integrated Chiropractic INC., such sums as may be due and owing Integrated Chiropractic INC., for services rendered to me, both by reason of accident or illness, and by reason of any other billed services that are due to Integrated Chiropractic INC., and to withhold such sums for any disability benefits, medical payments, No Fault benefits, or any other insurance benefits obligated to be reimbursed to me or from any settlement, judgment, or verdict, on my behalf as may be necessary to adequately protect said Integrated Chiropractic INC. I hereby further give a lien to said Assignees against any and all insurance benefits named herein and any and all proceeds for which I have been treated by Integrated Chiropractic INC. This document is to act an as assignment of my rights and benefits to extent of the Assignees' services provided and is in accordance with Florida Statutes 627.736.

In the event my insurance company fails to make payments for me for charges made by Integrated Chiropractic INC. for services, upon demand by me or Integrated Chiropractic INC., I hereby assign and transfer Integrated Chiropractic INC., any and all causes of action that I might have or that exist in my favor against such company and authorize Integrated Chiropractic INC., to prosecute said cause of action either in my name or in the Assignees' name, and further I authorize Integrated Chiropractic INC. to compromise, settle, or otherwise resolve said claim or cause of action as they see fit. To avoid exhaustion of No Fault benefits while Integrated Chiropractic INC. pursues its right under this assignment, I direct my insurance company to set aside and place in escrow any disputed amounts or reductions until the resolution of such dispute.

I understand that I remain personally responsible for any deductibles or co-payments associated with my insurance coverage. Furthermore, I understand that if this Assignment, Lien and Authorization is deemed invalid by a court of competent jurisdiction, then I remain personally responsible for the total amounts due to Integrated Chiropractic INC. for their services. I further understand and agree that this Assignment, Lien and Authorization does not constitute any consideration for Integrated Chiropractic INC. to await payments of any deductibles or co-payments and they may demand these payments from me immediately upon rendering services at their option. It is also agreed that this Assignment, Lien and Authorization be deemed invalid, then Integrated Chiropractic INC. may immediately demand payment from me for the full amount due to Integrated Chiropractic INC.

I authorize Integrated Chiropractic INC. to release any information pertinent to my case to any insurance company, adjuster, or attorney to facilitate collection under this Assignment, Lien and Authorization. I agree that the above mentioned Assignees be given Special Power of Attorney to endorse/sign my name on any and all checks and claim forms for payment of my bills. I also agree under the terms of HIPPA that Integrated Chiropractic INC. may use my personal health information as needed to collect on said debts.

I understand that if this account is assigned to an attorney for collection and/or suit, the Assignees shall be entitled to reasonable attorney's fees and cost of collection if they prevail under the PIP statute. I also understand that if any bad check is written, I agree to pay any return service fees and to make good on the checks within 5 days of obtaining notice of the bad checks from my bank or from Integrated Chiropractic INC.

Date: _____

_____ _____

Signature of Claimant Print Name

Name _____ Date:_____ Age: _____

L or R handed? Left Right

Height: _____

Weight: _____

Any unexplained weight loss? Yes No

Has pain been greater the last 4 weeks? Yes No

Does pain improve with rest? Yes No

Have you had failure to respond to conservative care in the past? Yes No

Any prolonged use of corticosteroids? Yes No

If yes, which type? _____

Any intravenous drug use? Yes No

Any recent / current infection? Yes No

If yes, what type: URI, UTI, Sinus, Ear, Other: _____

Immunosuppression condition / medication? Yes No

If yes, what type? _____

Any sunburns or open wounds? Yes No

If yes, please specify where: _____

Any muscle weakness? Yes No

Any bowel problems? Yes No

Any urinary problems? Yes No

Any history of cardiac problems? Yes No

Any history of seizures? Yes No

For women, any chance you're pregnant? Yes No

Is this your first Chiropractic visit? Yes No

If no, when / where was last visit? _____

Integrated Chiropractic

2206 Jo-An Drive STE 1
Sarasota, FL 34231
(941) 487-0266

Dr. Ryan Johnson, D.C.

Informed Consent to Chiropractic Treatment

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named above and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed above or any other office or clinic. I have had an opportunity to discuss with the doctor of chiropractic named above and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic care, there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all the risks and complications, and I wish to rely upon the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. I understand that there are other medical treatments and options available to me at this time including but not limited to medications, injections, or surgeries. I am choosing to receive chiropractic care and acknowledge that I am of sound mind at the time of signing this document.

I have read, or have had read to me, the above consent, and by signing below I agree to the above-named procedures, I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Print Patient's Name _____

Patient (Legal Guardian) Signature _____

Date _____

Office Signature _____ Date _____

integrated CHIROPRACTIC

BRAIN. BODY. BALANCE.

2206 Jo-An Drive, STE 1

Sarasota, FL. 34231

941-487-0266

Dear Patient:

Please read, initial, and sign:

We **do not accept** 3rd party health insurances such as Blue Cross, Cigna, or Aetna.

Insurances we accept are Medicare Part B, PIP (Auto), VA (Veterans) and Meritain (Sarasota Memorial.)

New patient Consultation, Review of History, Examination, and a Report of Findings (with a detailed treatment plan) is $140.

Returning patients are considered a new patient after 3 years of no appointments. After a year of no appointments, or with a new issue, a re-examination is required.

A routine office visit can vary from $32 - $100 (estimated) depending on what services (and/or products) are rendered, as required by your treatment plan.

Our office policy regarding cancellations and rescheduled appointments is as follows:

1. For cancelled appointments, without a prior 24-hour notice, there will be a $60.00 charge to the patient's personal account for chiropractic services, and or nutritional appointments. We understand emergencies can occur and will address those on an as needed basis.
   Initial _____

2. As per OSHA regulations, as well as for the safety of our patients, no returns are allowed on any nutritional supplements purchased from this office.
   Initial _____

Notice

I understand that I am responsible for payment of my account at the time services are rendered, and that I am financially responsible for all charges whether or not paid by insurance. If Integrated Chiropractic INC. is forced to take any action for collection of a balance owed, either by lawsuit or by other means, I agree to pay all collection costs, including attorney's fee(s) and an interest charge of 1.5 % per month (18% annually) on the amount owed until paid.

Print Name: _____

Signature: _____ 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 decline 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.

By checking the lines below I authorize being contacted for practice reminders by:

Email: _____@_____.com
Phone Calls (_____) _____-_____
Text message (_____) _____-_____ same
Cell Phone Carrier: sends text reminder day before your scheduled appointment

Please circle: AT&T Boost Mobil Cricket Metro PCS Nextel Sprint
T-Mobil US Cellular Verizon Virgin Mobile Other:_____

_____ By initialing, I authorize being contacted for birthday greetings, or promotions by Integrated Chiropractic.
_____ By initialing, I authorize Dr. Johnson to personally discuss with me products that may benefit my health or condition

_____ _____
Patient Name (Print Please) Name of Parent, Guardian or Legal representative

_____ _____
Signature of Patient/Parent/Guardian/representative Date

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

List below the names and relationship of people to whom you authorize the Practice to release PHI

_____ _____
_____ _____
_____ _____
_____ _____

Health and Wellness Analysis

Do you any have children? ❑Yes ❑No If yes, please list ages _____

Please list all food cravings: _____

_____

Do you eat organic foods: ❑Yes ❑No

- If yes, what percent of total food intake is organic? _____

Do you avoid certain foods? ❑Yes ❑No

- If so, please list which: _____

Do you eat the recommended 7-13 servings of fruits/vegetables daily? ❑Yes ❑No

Do you have any food allergies? ❑Yes ❑No

- If yes, please list with severity (Scale 1-10) _____

_____

How many bowel movements do you have per day? _____

- If not daily, how many per week? _____

Please circle/list any other digestive issues you frequently experience:

Gas Bloating Belching Acid reflux _____

On Average:

- What time do you go to bed? _____
- How many hours of sleep do you get per night? _____

Do you sleep through the night? ❑Yes ❑No

- If awakened, what is the time/reason? _____

Rate your energy level: (1=low, 10=high)

1 2 3 4 5 6 7 8 9 10

Would you like to experience weight gain or weight loss? ❑Yes ❑No

- If yes, how many pounds? _____

On average, how often do you exercise? _____

On a scale from 1-10 (1=low, 10=high), how would you rate your willingness to be coached and make changes to your currently lifestyle to address your health challenges?

1 2 3 4 5 6 7 8 9 10