AMERICAN CHIROPRACTIC & INJURY CENTER
4406 SOUTH FLORIDA AVE STE 25, LAKELAND, FL 33813
Phone (863) 701-0109 Fax (863) 701-0309

Patient Registration Form

Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip _____

Phone: _____ Cell: _____ Work: _____

D.O.B: _____ SSN: _____ SEX: M / F Martial Status: S, M, D, W

Email: _____ Occupation: _____

Emergency Contact: _____ Phone: _____

Major Complaint: _____

How long have you had this condition? _____

Car Accident: Y / N Work Comp: Y / N Date of Accident: _____

Insurance Information

Insurance: _____ ID/Claim # _____

Insurer: _____ D.O.B. _____

Adjuster: _____ Phone: _____

Attorney Information

Attorney: _____ Phone: _____

Address: _____ City/State: _____ Zip: _____

Patient Signature: _____ Date: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am responsible for any remaining balances. I also authorize American Chiropractic & Injury Center or insrance company to release any information required to process my claims.

MOTOR VEHICLE COLLISION/PERSONAL INJURY QUESTIONNAIRE

Please answer all questions completely

Patient Name	Date of Birth	Date of Injury	Today's Date
Street Address	City	State	Zip	Phone Number

1. Please describe the collision / injury in your own words:

2. Where did the collision / injury occur? City/Town: _____

3. Were you wearing your Seatbelt? ☐ Yes ☐ No Did the belt have a shoulder harness? ☐ Yes ☐ No

4. You were the: ☐ Pedestrian, ☐ Driver, Passenger in the ☐ front seat ☐ right rear seat ☐ left rear seat

5. Your vehicle type: _____ Other vehicle type: _____

6. Did you strike the other vehicle? ☐ Yes ☐ No Were you struck by the other vehicle? ☐ Yes ☐ No

7. Was the impact from: ☐ Front ☐ Rear ☐ Left side ☐ Right side

8. Approximate speed at the time of the impact? Your vehicle _____ mph Other vehicle _____ mph

9. Did the vehicle go into a spin or roll as a result of the impact? ☐ yes ☐ no

10. What was the weather at the time of the collision? ☐ dry ☐ wet ☐ fog ☐ night

11. Were your aware of the impending impact? ☐ yes ☐ no Did you have time to brace? ☐ yes ☐ no

12. Was your vehicle shoved: ☐ forward ☐ backward ☐ sideways

13. Were you shoved: ☐ forward ☐ backward ☐ sideways

14. Did your seat have a head restraint (headrest?) ☐ yes ☐ no

15. If yes, what was the position? ☐ low ☐ mid-position ☐ high

16. Did your head ride over the headrest? ☐ yes ☐ no

17. Upon impact you were looking: ☐ right ☐ left ☐ straight ☐ up ☐ down

18. Did your hat/glasses end up in the back seat or rear window? ☐ yes ☐ no

19. Did any other part of your body hit the interior of the vehicle?

☐ seat belt restraints ☐ steering wheel ☐ dashboard ☐ windshield ☐ airbag
☐ gearshift ☐ side window ☐ side door ☐ Other _____

20. Which part of your body?

☐ head ☐ chest ☐ shoulder R/L ☐ elbow R/L ☐ hand/wrist R/L
☐ hip R/L ☐ knee R/L ☐ foot/ankle R/L ☐ Other _____

21. How did you feel immediately (5 minutes to 1 hour) following the accident? where did you experience pain? Be specific:

22. Immediately after the accident were you: ☐ dazed ☐ conscious ☐ unconscious; how long? _____

23. Did you receive emergency services at the scene of the accident? ☐ yes ☐ no

24. Did you go to the hospital? ☐ no ☐ yes ☐ immediately ☐ next day ☐ Other _____

25. If yes, how did you get there? ☐ ambulance ☐ private transport

26. If by ambulance, were you placed in a: ☐ neck brace ☐ back brace ☐ Other _____

27. If you went to the hospital, please answer the following:

Name of hospital: _____

Name of doctor: _____

Testing/X-rays: _____

Diagnosis: _____

Treatment Received: _____

Medication / Medical supplies received: _____

28. I have increased pain with these motions / activities

☐ walking ☐ bending ☐ twisting ☐ lifting/carrying ☐ sitting ☐ standing ☐ laying down

29. The injuries incurred from this incident interfere with:

☐ activities of daily living ☐ work ☐ sleep ☐ recreation

30. Type of work / job requirements? _____

☐ Lifting _____ lbs. ☐ Walking ☐ Repetitive Bending ☐ Prolonged Standing ☐ Prolonged Sitting

31. Are having difficulty with job performance or your activities of daily living? ☐ yes ☐ no _____

32. Have you lost any days of work from this injury? ☐ yes ☐ no If yes, give dates: _____

Other Symptoms:

☐ Upper back pain ☐ Upper back pain ☐ Lower back pain ☐ Upper extremity pain ☐ Lower extremity pain ☐ Numbness/Tingling in arm/leg ☐ Difficulty breathing ☐ Difficulty chewing ☐ Difficulty swallowing ☐ Difficulty sleeping	☐ Dizzy ☐ Headache ☐ Blurry/double vision ☐ Flashing lights ☐ Ringing in ears ☐ Hearing loss ☐ Hoarseness ☐ Slurred speech ☐ Confusion ☐ Seizures ☐ Tremors	**Loss of:** ☐ -balance ☐ -consciousness ☐ -memory ☐ -sense of smell ☐ Asthma ☐ Cough ☐ Chest pain ☐ Abdominal pain ☐ Indigestion	☐ Heartburn ☐ Constipation ☐ Diarrhea ☐ Abnormal stool color ☐ Painful urination ☐ Painful defecation ☐ Increased urine frequency ☐ Increased urinary hesitation ☐ Abnormal urine color ☐ Excessive thirst/hunger

_____ Patient Name

_____ Patient Signature

_____ Date

_____ Witness Name

_____ Witness Signature

_____ Date

____ Initial Exam ____ Re-eval ____ Final Exam Today's Date_____ D.O.L._____

Patient's Name: _____ D.O.B. _____

Current chief complaint, reason for visit: (description) _____

Past Medical History: Please circle if you **have ever had** any of the following:

High Blood Pressure	Cardiac Pacemaker	Heart / Liver Disease
Diabetes Mellitus	Metal Implants	Chicken Pox
Rheumatoid Arthritis	Lung/Tuberculosis	Mumps / Measles
Vascular Disease	HIV / Herpes	Gunshot Wound

List current/past **Medications** taken:

List any **Allergies**:

List any **Surgeries**:

Hospitalizations:

Social History: Tobacco: _____ Alcohol: _____ Exercise: _____

Marital Status: _____ Have Children? ☐ yes ☐ no Ages? _____

What type work do you do? _____

Have you traveled outside the country in the last year? _____

Family History: ___Asthma ___Cancer ___High Blood Pressure ___Heart Disease ___Diabetes

___Cardiac ___Lung ___Migraine Other: _____

Female History: **Any possibility** you may be pregnant? ☐ yes ☐ no

Prior motor vehicle accident? ☐ yes ☐ no If yes, how many? _____ When? _____

Were you injured? ☐ yes ☐ no Describe: _____

Other personal injury/accident? ☐ yes ☐ no If yes, describe: _____

Doctor: _____ Date: _____

4406 S. Florida Avenue, Suite 25
Lakeland, FL 33813
Ph: (863) 701-0109

CLINIC POLICIES

GENERAL POLICY

Welcome to American Chiropractic. It is our mission to provide you with quality Chiropractic care in a clean, friendly, and professional setting. Because we know that your time is very important to you, we make all efforts to run on schedule. In the event that you cannot make your scheduled appointment with the doctor or massage therapist, we kindly ask that you provide us with a 24 hour notice. There is a **$15.00 charge** for missing an appointment without a 24 hour notice.

FINANCIAL POLICY

American Chiropractic utilizes a pre-certification process to verify primary insurance coverage for your Chiropractic care. Coverage information is obtained from your insurance company using information provided by you, the patient/insured, at the time of the initial visit. We use this information to determine your financial responsibility for services provided to you at this facility.

The information provided by your insurance company is not a guarantee of payment, only an estimate of what might be covered under your policy. Final determination of benefits available under your insurance policy is determined when the claim is presented to your insurance company and we receive an explanation of benefits from them. We will send all necessary primary insurance claim forms, for you, to your insurance company for services you receive at this facility. We will send all documentation, as required by your insurance company, to ensure that your claims are processed in a timely manner.

Although we strive to be as accurate as possible in this process, we cannot and will not be responsible for any errors, omissions or false information provided to us by your insurance company. It is your responsibility, as the patient/insured, to be aware of and comply with all of t he restrictions for services provided in your policy.

After all co-pays, contracted plan reductions and insurance payment credits are applied to your account, any remaining portion will be the patient's/insured's responsibility. In the event that a particular service provided at this facility is found to not be covered service, then that particular service will be the patient's/insured's responsibility. Self-pay patients will be expected to pay for services received at this facility at the time of service. We take cash, checks, and all major credit cards. By signing below you acknowledge, and agree to, the above policies of American Chiropractic.

PRIVACY POLICY

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read and understand them or that I declined the opportunity to read them. I understand that this form will be placed in my file and maintained for six (6) years.

I hereby acknowledge that I have read and agree to the above policies.

Print Name _____ Date _____

Signature of patient, parent or legal guardian _____

American Chiropractic
4406 S. Florida Avenue Suite 25
Lakeland, FL 33813
Phone: (863)701-0109
Fax: (863)701-0309

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

TO: _____

_____

_____

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE THE FOLLOWING RECORDS TO:

American Chiropractic
4406 S. Florida Avenue Suite 25
Lakeland, FL 33813
Phone: (863)701-0109
Fax: (863)701-0309

- ALL INITIAL REPORTS, FOLLOW-UP REPORTS, DAILY SOAP NOTES, ETC.
- COPIES OF X-RAYS, MRI, BONE SCANS, CT FILMS, etc, WITH REPORTS
- REPORTS OF ALL DIAGNOSTIC TESTS, DO NOT SEND FILMS, FAX IF POSSIBLE
- PLEASE FAX RADIOLOGY REPORTS TODAY AND SEND FILMS BY MAIL ASAP
- ONLY RECORDS FROM THE PERIOD OF _____ TO _____.
- OTHER _____.

NAME: _____ D.O.B. _____

SOCIAL SECURTIY #: _____ CLINIC#: _____

PATIENT SIGNATURE: _____ DATE: _____

WITNESS: _____ DATE: _____

American Chiropractic & Spinal Decompression
4406 S. Florida Ave. Suite #25, Lakeland, FL 33813
Ph: (863) 701-0109 * Fax (863) 701-0309
Email: nwaslyn@yahoo.com * Web: www.drwaslyn.com

LETTER OF PROTECTION DIRECTION TO PAY

PATIENT: _____
DATE OF BIRTH: _____
DATE OF INJURY: _____

IMPORTANT: THIS IS A CONTRACT. IF YOU DON'T UNDERSTAND THIS THEN CONSULT WITH AN ATTORNEY BEFORE SIGNING.

Patient authorizes and irrevocably directs his/her present and any future attorneys related to the abovereferenced
date of injury ("Attorneys") to honor this agreement. This irrevocable agreement is made in favor of the abovereferenced Medical Provider and shall be termed a "Letter of Protection." The Letter of Protection shall serve to place a continuing lien on any proceeds I recover in any legal action related to the abovereferenced
date of injury. The Direction to Pay applies to the Patient's Attorneys.

Background. Medical Provider expects to be paid from any proceeds related to the abovereferenced date of injury in exchange for providing medical care/treatment. Medical Provider also agrees not to place patient in collections until the resolution of Patient's claims related to the abovereferenced date of injury. Patient expects to receive medical care that is reasonable, related to the abovereferenced accident and medically necessary. Patient has sustained injuries as a result of injuries related to the abovereferenced date of injury
and does not have the funds to pay for the medical care which he/she needs. Patient is signing this Letter of Protection in order to receive medical care.

Insurance Benefits. In the event that there are disability benefits, medical payment benefits, NoFault benefits, health and accidental benefits, worker's compensation benefits, or any other insurance benefits available to Patient besides Bodily Injury and/or Uninsured Motorist (aka Underinsured Motorist) coverage then this Letter of Protection can be used to cover any copayments
and/or deductibles.

Protection of Medical Bills. If Patient recovers any money related to the abovereferenced date of injury then Patient's Attorney shall withhold from those funds, sufficient money pay the outstanding balance of any bill(s) owed to Medical Provider. It is understood that Attorney's fees/costs are firstinline and that this Letter of Protection does not interfere with Attorney's retainer agreement with Patient. Patient authorizes Medical Provider to provide Attorney with a copy of Patient's medical records, bills, etc. with regard to the abovereferenced date of injury.

Patient's Responsibility for Bills. Patient understands that he/she is directly responsible to Medical Provider for services rendered and that payment is not contingent on any settlement, judgment, or verdict related to the abovereferenced date of injury. Regardless of any settlement, judgment, or verdict, Patient is still responsible for paying Medical Provider's outstanding bills so long as they are reasonable and related to the abovereferenced date of injury and medically necessary.

Patient's Responsibility Regarding His/Her Attorney (Present and Future). Patient is responsible for informing each and every attorney retained by him/her of the existence of this agreement. Medical Provider has the right to notify Patient's Attorney(s) about the existence of this Letter of Protection. Upon request, Patient and Patient's Attorney shall provide status updates about any claims related to the abovereferenced date of injury as well as the contact information for any new Attorneys. It is also the Patient's responsibility to advise the Medical Provider at least 10 days prior to collecting any funds and to request a bill for any and all outstanding charges. Patient understands that if funds related to the abovereferenced date of injury are insufficient to cover the medical bill(s) then Medical Provider has the right to collect the remaining balance.

Disputes. If the Patient fails to pay the Medical Provider's full outstanding balance and Medical Provider is the prevailing party in an action to enforce this Letter of Protection then Medical Provider shall have the right to recover all attorney fees and costs including postjudgment proceedings. Binding arbitration is an option if both parties agree in writing.

Direction to Pay. ATTENTION ATTORNEY: THIS IS AN IRRECOVABLE DIRECTION TO PAY MY MEDICAL PROVIDER. Patient irrevocably directs his/her Attorneys to pay any outstanding medical bills in connection with the abovereferenced date of injury. Patient hereby directs Attorneys to provide a status update in writing within 15 days of receiving a request from Medical Provider.

Effective Date. This agreement becomes effective when the Patient signs the agreement below.

_____

Patient Signature

_____

Date

_____

Attorney Signature

_____

Date

ACKNOWLEDGMENT 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.

By checking the lines below I authorize being contacted for practice reminders by:
Mail _____;
Email_____; at email address
_____;
Telephone numbers_____;
_____;
By voice mail _____;
By text message _____;
By FaceBook address _____.

By checking this checking the lines below I authorize being contacted for birthday greetings or promotions about the practice by:
Mail _____;
Email _____ at email address
_____;
Telephone numbers_____;
_____;
By voice mail _____;
By text message _____;
By FaceBook address _____.

By checking this checking the lines below I authorize the doctor to personally discuss with me products that may benefit my health or condition. _____

_____ _____
Patient Name (please print) Date

_____
Name of Parent, Guardian or Patient's legal representative

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.

_____	_____
_____	_____
_____	_____

ASSIGNMENT OF BENEFITS, AUTHORIZATION TO SETTLE CLAIM AND DIRECTION TO PAY MEDICAL PROVIDER DIRECTLY

By my signature below, for good and valuable consideration (including but not limited to the extension of credit to me), I hereby assign, transfer and convey to **(PROVIDER)** _____ (hereinafter "the Provider") all of my rights, title and interest in and to medical expense reimbursement in whatever form, including but not limited to any automobile liability medical expense payments or other health benefits indemnification and/or agreement otherwise payable to me. This payment shall not exceed my indebtedness to the above named assignee and I acknowledge that I will timely pay any indebtedness owed by me to the assignee that is not otherwise satisfied by the above-mentioned assigned proceeds. I also acknowledge that any medical expenses not covered under my insurance policy will be my responsibility.

I further authorize the Provider to negotiate, collect and settle any claim with any insurance carrier or other third party payor with regard to these services, which authorization shall include authority to: 1) request and receive from any insurer or any other party any and all documentation and records that I am empowered to request regarding this claim, including, without limitation, a statement of coverage, policy declarations page and insurance policy pursuant to Section 627.4137. In addition, the provider has the authority to request and receive any Independent Medical Examination Reports, notices sent to me regarding appointments for Independent Medical Examinations and Examinations Under Oath (including proof of mail), Records Review Reports, coverage denial letters, Explanations of Benefits, and Benefit Payment Sheets or Logs (P.I.P. Payout Sheets), without regard as to whether such documentation has already been provided to me and 2) to endorse in my name any check issued for payment where benefits were assigned. By way of this assignment and notice, I further instruct you, the insurer, to furnish to Provider copies of all future notices affecting Provider's interest in this claim, including, without limitation, any notices of requested medical examinations or statements.

The Provider hereby objects to any reductions or partial payments. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by the provider shall be done so under protest, at the risk of the insurer, and the deposit *shall not* be deemed a waiver, *accord, satisfaction*, discharge, settlement or agreement by the provider to accept a reduced amount as payment in full.

I further direct my insurer to direct all payments for services rendered by the Provider directly to Provider at the billing address contained on Provider's medical bills.

THIS IS A DIRECT AND IRREVOCABLE ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER MY POLICY OF INSURANCE.

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

I have read the foregoing and understand and agree to each of the above provisions:

_____ _____

Patient'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 (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

AMERICAN CHIROPRACTIC
NICHOLAS A. WASLYN, DC, MUAC, PA
4406 SOUTH FLORIDA AVE STE 25
LAKELAND, FL 33813
Phone # 863-701-0109 Fax # 863-701-0309

NOTICE OF INITATION OF TREATMENT

Patient Name: _____

Auto (PIP) Insurance: _____

Claim Number: _____

Pursuant of Florida Statute 627.736, you are hereby notified that treament on your insured, _____, was initiated on _____ for the injuries sustanied in an automobile accident on _____ .

_____ _____

Dr. Nicholas Waslyn, D.C. Date