Welcome to our practice!

Please Read Before Printing

Adult patients print pages 2 – 9

Auto accident patients print pages 2 – 15

Pediatric patients print pages 16 – 22

HCW
HORNBACK CHIROPRACTIC
& WELLNESS, P.A.

PATIENT INFORMATION

Name: _____ **Date of Birth:** _____ **Social Security:** _____-___-_____

Address: _____ **Marital Status:** S M W D **Race:** _____

_____ **Email Address:** _____

Home phone: _____ **Cell Phone**: _____ **Cell Carrier:** _____

Work phone: _____ **Extension:** _____

Occupation: _____ **Employer:** _____

Spouse: _____ **How many children?** _____ **Names and ages:** _____

Name of nearest relative: _____ _____

Address: _____ **Phone number:** _____

_____

Family Medical Doctor: _____ **Phone number:** _____

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

By signing below, you acknowledge that periodic communications sent by HCW via text message, phone, and email, could potentially cause additional charges for you under your cell phone or other data plan. In the event that you do not want to receive such periodic communications, please notify us in writing of your desire to be removed from such communications.

****

INSURANCE

Please check any and all insurance coverage(s) that may be applicable in this case:

___ Major Medical ___ Medicare ___ Auto Accident ___ Worker's Comp. ___ Medical Savings/Flex Plan

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 payers 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.

Is it ok to release your medical information to anyone other than yourself? Y N

Can we leave voicemail regarding your medical information? Y N **If so, where?**_____

Please list who we may speak with regarding your chiropractic care and account (please note that we CANNOT speak with or release any information to anyone that is not listed below.)
Name(s): _____ _____ _____

Patient/Guardian Signature: _____ **Date:** _____

CURRENT CONDITION

Chief complaint/Purpose of Visit: _____

Do you have radiating symptoms? Y N **If so, where to?** _____

Rate your pain: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 [0 = no pain; 10 = worst pain you have ever felt]

Frequency of symptoms: ___ Constant ___ Intermittent ___ Frequent ___ With activities

Quality: ___ Aching ___ Burning ___ Dull ___ Sharp ___ Shooting ___ Stabbing ___ Throbbing ___ Tightness ___ Tingling ___ Other:_____

Pain exacerbated/made worse by:

___ Bending ___ Movement ___ Standing
___ Coughing ___ Extreme motion ___ Twisting
___ Driving ___ Physical Activity ___ Walking
___ Lifting ___ Sitting ___ Other_____
___ Lying down ___ Sneezing

Pain improves with:

___ Bending ___ Manipulation ___ Sitting
___ Heat ___ Massage ___ Standing
___ Ice ___ Movement ___ Walking
___ Lying down ___ OTC medications ___ Other _____

Date Symptoms appeared/accident happened: _____

Are your symptoms due to: ___ Auto Accident ___ Work ___ Other:_____

****

HEALTH HISTORY

Please list all medical conditions/illnesses/diagnoses (related or unrelated to your chief complaint) and date of diagnosis: _____

_____

Previous surgeries and date of surgery:_____

_____

Previous injuries and date of injury:

___ Back injury _____ ___ Fracture _____

___ Fall _____ ___ Auto Accident _____

Previous Treatments (for your chief complaint or other condition):

___ Chiropractic ___ Physical Therapy

___ Acupuncture ___ Other

WOMEN: Are you pregnant? Y N (If yes, please complete section below)

Due date: _____ Weeks pregnant: _____ Baby gender: _____

OBGYN/Doula/Midwife: _____Baby position: ___ Breech ___ Transverse ___ Head down

Previous child birth dates: _____ Chiropractic care with previous pregnancy? Y N

Complications: _____

REVIEW OF SYSTEMS

Please place the letter C by your CURRENT conditions/symptoms and the letter P by any PREVIOUS conditions/symptoms:

___ Neck pain
___ Back pain
___ Joint stiffness
___ Muscle spasms
___ Shoulder/Arm pain
___ Arthritis
___ Rheumatoid Arthritis
___ Osteopenia/Osteoporosis
___ Stroke
___ Incoordination
___ Dysphasia
___ Seizure
___ Numbness
___ Tingling
___ Smell disturbance
___ Memory loss
___ Weakness
___ Concussion
___ Loss of taste
___ Syncope
___ Cataracts
___ Glaucoma
___ Visual Disturbance
___ Headaches
___ Hearing loss
___ Tinnitus
___ Vertigo
___ Sinusitis/Sinus Pain
___ Dental Pain
___ Lump in throat
___ Bowel changes
___ GERD
___ Heartburn
___ Indigestion
___ Ulcers
___ Bladder changes
___ COPD
___ Emphysema
___ Myocardial Infarction
___ Shortness of breath
___ Asthma
___ Chest pain
___ Chest tightness
___ Heart palpitations
___ Irregular heartbeat
___ Hypertension
___ Hyperlipidemia
___ Anxiety
___ Bipolar disorder
___ Dementia
___ Depression
___ Abnormal thyroid
___ Diabetes [type 1/type 2]
___ Fatigue

****

FAMILY HISTORY

Please inform us of any medical conditions/illnesses/diagnoses that are current health problems of the family member.

	Age(s)	Medical conditions/illnesses/diagnoses	Deceased?
Father			
Mother			
Spouse			
Brother(s)			
Sister(s)			
Children			

****

SOCIAL HISTORY

Exercise:

___ Does not exercise
___ Avoids exercise due to pain
___ Exercises regularly
___ Participates in aerobic activity
___ Exercise habits are frequent and heavy
___ Exercises occasionally
___ Participates in sports

Work Environment:

___ No problems
___ Stressful
___ Requires constant sitting
___ Requires constant standing
___ Requires heavy typing or data entry
___ Requires lifting

Smoking Status:

___ Former smoker
(years since quitting: _____; years smoked: _____)
___ Never smoker
___ Heavy smoker (years smoked: _____)
___ Light smoker (years smoked: _____)
___ Lives with smoker

Alcohol Use:

___ None ___ Heavily ___ Moderately
___ Frequently ___ Lightly ___ Rarely

Caffeine consumption:

___ None ___ Heavily ___ Moderately
___ Frequently ___ Lightly ___ Rarely

Current medications (please note dosage and frequency): _____

_____

Allergies: _____

****

ADDITIONAL INFORMATION

Additional information you would like the doctor to know: _____

_____

_____

I certify that all of the information provided is accurate to the best of my knowledge.

Patient/Guardian Signature: _____ **Date:** _____

PATIENT HEALTH INFORMATION CONSENT FORM

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. 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 HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions of the use of their PHI. Our office is obligated to agree to those restrictions only to the extent they coincide with state and federal law.
3. A patient's written consent need only be obtained one time for all subsequent care given to the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. Our office may contact you periodically regarding appointments, treatments, products, services, or charitable work performed by our office. You may choose to opt-out of any marketing or fundraising communications at any time.
6. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
7. Patients have the right to file a formal complaint with our privacy official and the Secretary of HHS about any possible violations of these policies and procedures without retaliation by this office.
8. Our office reserves the right to make changes to this notice and to make the new notice provisions effective for all protected health information that it maintains. You will be provided with a new notice at your next visit following any change.
9. This notice is effective on the date stated below.
10. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Name of patient: _____ Date: _____

Signature of patient: _____

For further information regarding this notice, please contact our office at (941)744-1585 or (941)210-7057

FINANCIAL POLICY

SCHEDULING

- While we do schedule appointments during regular hours (to reduce waiting time for you and others), patients are welcome to stop in at any time. Please be aware, however, that walk-in patients will be seen after all regularly scheduled patients have been treated.
- Although we do not charge for missed or canceled chiropractic appointments, we do request 24 hours' notice. In consideration of our other patients, we will be unable to schedule further appointments if three consecutive appointments are missed without notification or canceled without 24 hours' notice.

PAYMENT

- Payment is expected in full at the time services are rendered. We do offer a credit guarantee option for patients who prefer to pay once a week, as opposed to each visit.
- For your convenience we accept cash, checks, Visa, MasterCard, and Discover.
- Should care be discontinued for any reason other than discharge by the doctor, any outstanding balance will become immediately due and payable in full.

INSURANCE

- Our office verifies insurance coverage in an effort to determine chiropractic coverage under your current policy. As benefits quoted are not a guarantee of coverage or benefits, it is the responsibility of the patient to contact their insurance if there is a discrepancy or error in benefits processing. Kindly keep in mind that you, as the patient, are responsible for any and all charges incurred in our office.
- Please provide us with your most current insurance card and information. If your insurance changes during the year, please let us know so that we may bill using the most current insurance information.
- Although we are not obligated to accept insurance payments on assignment from all carriers, we may do so as a courtesy to you, based on our experience with your insurance carrier.
- The patient/insured is responsible for any portion of the claim not covered by insurance.
- Please remember it that insurance coverage is a contract between you and your insurance company.
- Please provide any secondary insurance information so we may file on your behalf.

REFUNDS

- If there is a credit due, the patient will have the option of using the credit towards future visits or calling the office and requesting a refund.

It is the goal of this office to provide you with the finest quality chiropractic care available. If you have any questions with regard to your health or any of our policies, please let us know. We welcome your referrals and look forward to a doctor-patient relationship that works for our mutual benefit.

I have read and agree to the guidelines of this financial/insurance policy.

I, the undersigned, have insurance coverage with _____ Insurance Company and assign directly to Hornback Chiropractic and Wellness all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all changes whether or not paid by insurance. I hereby authorize HCW to release all information necessary to secure the payment of benefits. I authorize the use of the signature on all my insurance submissions whether manual or electronic.

Signature of Patient: _____ Date: _____

HCW
HORNBACK CHIROPRACTIC
& WELLNESS, P.A.

Informed Consent

Please read the document in its entirety prior to signing. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

A patient, in coming to Hornback Chiropractic and Wellness, PA, gives the doctors permission and authority to care for the patient in accordance with the chiropractic exam, analysis, diagnosis, and treatment of the joints and soft tissues.

As with any healthcare procedure, there are certain complications which may arise during the chiropractic adjustment and other clinical procedures. The chiropractic manipulation and other therapy are usually beneficial and seldom cause any problems. In rare cases, possible complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and physical therapy burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications, including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. We will make every reasonable effort during the examination to screen for contraindications to care; however, it is the responsibility of the patient to make it known, or to learn through health care procedures whatever he or she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the doctors.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which is screened for during the consultation, examination, and x-ray. The incidences of stroke are exceedingly rare and are estimated to occur between once in one million and once in ten million cervical adjustments. Once in a million is about the same chance as getting hit by lightning, once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death.

Other treatment options for your condition may include:

- Self-administered, over the counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants, and pain killers
- Hospitalization
- Surgery

Remaining untreated may allow the formation of adhesions and arthritis and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

I have read or have had read to me the above informed consent and I understand that if I am accepted as a patient by the doctors at Hornback Chiropractic and Wellness, PA, I am authorizing them to proceed with any treatment that may be necessary. Any questions I have had regarding these procedures have been answered to my satisfaction prior to my signing the consent form. I have made my decision voluntarily and freely.

_____ _____

Patient's Name Signature of Parent or Guardian (if a minor)

_____ Dated: _____

Patient's Signature

HORNBACK CHIROPRACTIC & WELLNESS, P.A.

Authorization for the Release of Medical Records

Patient Name: _____ Date of Birth: _____

I hereby request and authorize:

Hornback Chiropractic and Wellness. P.A.

11023 Gatewood Drive, Suite 101
Bradenton, FL 34211
Ph: (941) 744-1585
Fax: (941) 744-1572
E-mail: frontdesk@hornbackchiro.com

8386 Market Street
Lakewood Ranch, FL 34202
Ph: (941) 210-7057
Fax: (941) 210-7056
E-mail: marketst@hornbackchiro.com

_____To Disclose information to: _____To Receive Information from:

Physician/Medical Facility/Hospital: _____
Address: _____ Phone Number: _____
_____ Fax Number: _____

Information to be disclosed includes copies of:

_____ Entire Record
_____ Progress Notes
_____ Physical Exam forms
_____X-ray Reports
_____X-ray Films
_____Other, specify: _____
_____

Purpose for Disclosure:
_____ Treatment, Payment, OR _____ Other, Specify: _____

This authorization will be effective after the date signed, unless cancelled in writing. I understand that the cancellation will have no effect on information released prior to receiving the cancellation. A copy of this authorization is as valid as the original.

_____ Date: _____
Signature of Patient

OR

_____ Date: _____
Signature of Parent/Guardian/Legal Representative

If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law.

Notice to recipient of information: This information has been disclosed to you from confidential records, which are protected by law. Unless you have further authorization, laws may prohibit you from making any further disclosures of this information without the specific written consent of the patient or legal representative.

HORNBACK CHIROPRACTIC & WELLNESS, P.A.

AUTO ACCIDENT/INJURY FORM

NAME_____ DATE_____

Date of Accident_____ Time: _____ am/pm Location of Accident_____

AUTO INJURY

Were You: ___Driver ___ Passenger [___Front ___ Right Rear ___ Left Rear] ___Pedestrian

Were you struck from: ___ Behind ___ Right Side ___ Left Side ___ Front ___ Parked

Did your car strike the others involved: ___ Yes ___ No ___ Undetermined

Did the other car strike yours: ___ Yes ___ No ___ Undetermined

Were you wearing your seatbelt? ___ Yes ___ No

Did you strike anything in the vehicle at the time of impact? ___ Yes ___ No

If yes what? _____

Traffic Conditions: ___ Heavy/Congested ___ Normal ___ Rush Hour

Weather Conditions: ___ Normal ___ Raining ___ Foggy ___ Poor visibility

Vehicle Information (Make and Model): _____

As a result of the Accident, were traffic citations issued to you? ___ Yes ___ No

Location after the accident: ___ Home ___ Hospital ___ Urgent Care (Walk-in clinic)

Have you lost any days of work? ___ Yes ___ No If Yes, _____ through _____

Describe the accident: _____

_____

_____

CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT

__Headache
__Neck Pain
__Neck Stiff
__Dizziness
__Back Pain
__Nervousness
__Tension
__Irritability
__Chest Pain

__Sleeping Problems
__Head Too Heavy
__Pins & Needles in Arms
__Pins & Needles in Legs
__Numbness in Fingers
__Numbness in Toes
__Shortness of Breath
__Fatigue
__Depression

__Lights Bother Eyes
__Loss of Memory
__Ears Ringing
__Face Flushed
__Buzzing in Ears
__Loss of Balance
__Fainting
__Loss of Smell
__Loss of Taste

__Diarrhea
__Feet Cold
__Hands Cold
__Stomach Upset
__Constipation
__Cold Sweats
__Fever
__Other _____
_____

INSURANCE INFORMATION

Your Insurance Company _____ Address: _____

Have you been contacted by an insurance adjustor regarding this claim? ___ Yes ___ No

If yes, name of adjustor: _____ Phone Number: _____

Claim number: _____

Do you have an attorney that has advised you in this case? ___ Yes ___ No

If yes, attorney's name: _____ Address: _____

Phone number: _____

Patient/Guardian Signature: _____ Date: _____

HORNBACK CHIROPRACTIC & WELLNESS, P.A.

POWER OF ATTORNEY

POWER OF ATTORNEY TO ENDORSE CHECKS AND/OR 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 these present that: The undersigned has made, constituted and appointed, and by these presents does hereby make, constitute and appoint **HORNBACK CHIROPRACTIC & WELLNESS, P.A.**, and any of its 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 **HORNBACK CHIROPRACTIC & WELLNESS, P.A.**, which checks, drafts or money orders are made payable for services which by **HORNBACK CHIROPRACTIC & WELLNESS, P.A.**, 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 **HORNBACK CHIROPRACTIC & WELLNESS, P.A.**, 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 presents does give and grant the said HORNBACK CHIROPRACTIC & WELLNESS, P.A. as attorney the full the 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.

_____

Patient's Name

_____ _____

Patient's Signature Date

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 **HORNBACK CHIROPRACTIC & WELLNESS, P.A.** 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 actions 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.

_____

Patient's Name

_____ _____

Patient's Signature Date

HCW
HORNBACK CHIROPRACTIC
& WELLNESS, P.A.

Letter of Protection

The purpose of a Letter of Protection is to provide a courtesy to a patient who requires treatment but is not able to afford the prescribed care. Our office will extend a courtesy of time if the patient cannot afford deductibles, reductions, or services in excess of available personal injury protection coverage or health insurance. This courtesy is extended to the patient, who has been injured by the fault of another, and who remains compliant with health care provider's recommendations.

A patient receiving care in our office is ultimately responsible for payment of all services rendered, regardless of whether a recovery is made against a third-party insurance carrier.

I, _____, authorize and direct my attorney, to disburse directly to Cynthia L. Hornback, D.C. all sums necessary to pay any outstanding balance due for care and treatment rendered to me, from any gross proceeds recovered as a result of bodily injury, uninsured motorist, or personal injury protection benefits, for injuries sustained on _____.

By signing below, I hereby acknowledge that the health care provider's forbearance in the receipt of payment for medical services rendered, even though some or all of said medical services may be reimbursed by personal injury protection benefits or third party insurance coverage, is good, valuable, and sufficient consideration for the promises contained herein from myself and my attorney.

I agree to be responsible for any litigation costs and attorney fees necessary to enforce the payment of any outstanding balance and/or bills due.

This Letter of Protection may be delivered to my attorney for his/her signature and acknowledgement. I hereby request and direct my attorney to sign this Letter of Protection acknowledging they will abide by the terms of this LOP in my behalf. This letter is binding on any attorney who may represent me for the above stated injuries.

_____
Date

_____
Patient Signature

By signature below, I acknowledge receipt of the above Letter of Protection and agree to abide by its terms and applicable Florida Law.
Dated this _____ day of _____, _____.

_____
Attorney Signature

_____
Attorney's Name (Print)

HORNBACK CHIROPRACTIC & WELLNESS PA
11023 Gatewood Drive Suite 101 8386 Market Street
Bradenton, FL 34211 Lakewood Ranch, FL 34202

ASSIGNMENT OF INSURANCE BENEFITS, RELEASE, & DEMAND

Insurer and Patient Please Read the Following in its Entirety Carefully!

I, the undersigned patient/insured knowingly, voluntarily and intentionally irrevocably assign the rights and benefits of my automobile Insurance, also known as Personal Injury Protection (hereinafter PIP), Uninsured Motorist and Medical Payments policy of insurance to the above health care provider. I understand it is the intention of the provider to accept this assignment of benefits in lieu of demanding payment at the time services are rendered. I understand this document will allow the provider to file suit against an insurer for payment of the insurance benefits or an explanation of benefits and to seek §627.428 damages from the insurer. This assignment of benefits includes transportation, medications, supplies, overdue interest and any potential claim for common law or statutory bad faith/unfair claims handling. If the insurer disputes the validity of this assignment of benefits then the insurer is instructed to notify the provider in writing within five days of receipt of this document. Failure to inform the provider shall result in a waiver by the insurer to contest the validity of this document. Failure to inform the provider shall result in a waiver by the insurer to contest the validity of this document. The undersigned directs the insurer to pay the health care provider the maximum amount directly without any reductions & without including the patient's name on the check. To the extent the PIP insurer contends there is a material misrepresentation on the application for insurance resulting in the policy of insurance is declared voided, rescinded, or canceled, I as he named insured under said policy of insurance, hereby assign the right to receive the premiums paid for my PIP insurance to this provider and to file suit for recovery of the premiums. The insurer is directed to issue such a refund check payable to this provider only. Should the medical bills not exceed the premium refunded, then the provider is directed to mail the patient/named insured a check which represents the difference between the medical bills and the premiums paid.

Disputes: The insurer is directed by the provider and the undersigned to not issue any checks or drafts in partial settlement of a claim that contain or are accompanied by language releasing the insurer or its insured/patient from liability unless there has been a prior written settlement agreed to by the health provider (specifically the office manager) and the insurer as to the amount payable under the insurance policy. The insured and provider hereby contests and 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. The insurer is hereby placed on notice that this provider reserves the right to seek the full amount of the bills submitted. If the PIP insurer states it can pay claims at 200% of the Medicare Fee Schedule or any other fee schedule contained within F.S. 627.736 then the insurer is instructed & directed to provide this provider with a copy of the policy of insurance within 10 days. Any effort by the insurer to pay a disputed debt as full satisfaction must be mailed to the address above, after speaking with the office/billing manager and mailed to the attention of the office/billing manager. *See Fla. Stat. §673.3111*.

EUOs and IMEs: If the insurer schedules a defense examination or examination under oath (hereinafter "EUO") the insurer is hereby INSTRUCTED to send a copy of said notification to this provider. The provider or the provider's attorney is expressly authorized to appear at any EUO or IME set by the insurer. The health care provider is not the agent of the insurer or the patient for any purpose.

This assignment applies to both past and future medical expenses and is valid even if undated. A photocopy of this assignment is to be considered as valid as the original. I agree to pay any applicable deductible, co-payments, for services rendered after the policy of insurance exhausts and for any other services unrelated to the automobile accident. The health care provider is given the power of attorney to: endorse my name on any check for services rendered by the above provider; and to request and obtain a copy of any statements or examinations under oath given by patient.

Release of information: I hereby authorize this provider to: furnish an insurer, an insurer's intermediary, the patient's other medical providers, and the patient's attorney via mail, fax, or email, with any and all information that may be contained in the medical records; and for my insurance carrier to **send insurance coverage information (declaration sheet & policy of insurance) in writing and telephonically to the above-named provider**; request from any insurer all explanation of benefits (EOBs) for all providers and non-redacted PIP payout sheets; obtain any written and verbal statements the patient or anyone else provided to the insurer; obtain copies of the entire claim file and all medical records, including but not limited to, documents, reports, scans, notes, bills, opinions, X-rays, IMEs, and MRIs, from any other medical provider or any insurer. The provider is permitted to produce my medical records to its attorney in connection with any pending lawsuits. The insurer is directed to keep the patient's medical records from this provider private and confidential. The insurer is not authorized to provide these medical records to anyone without the patient's and the provider's prior express written permission. **PLEASE NOTE: The insurer is not authorized to release protected health information (PHI) to third party vendors that schedule independent medical examinations or independent medical examination physicians**.

Demand: Demand is hereby made for the insurer to pay all bills within 30 days without reductions and to mail the latest non-redacted PIP payout sheet and the insurance coverage declaration sheet, and the insurance policy to the above provider within 15 days, as well as notify the provider pursuant to F.S. 627.736(6)(f) when benefits have been exhausted. The insurer is directed to pay the bills in the order they are received. However, if a bill from this provider and a claim from anyone else is received by the insurer on the same day the insurer is directed to not apply this provider's bill to the deductible. If a bill from this provider and claim from anyone else is received by the insurer on the same day then the insurer is directed to pay this provider first before the policy is exhausted. In the event the provider's medical bills are disputed or reduced by the insurer for any reason, or amount, the insurer is to: set aside the entire amount disputed or reduced; escrow the full amount at issue; and not pay the disputed amount to anyone or any entity, including myself, until the dispute is resolved by a Court. Do not exhaust the policy. The insurer is instructed to inform, in writing, the provider of any dispute.

Certification: I certify that: I have read and agree to the above; I have not been solicited or promised anything in exchange for receiving health care; I have not received any promises or guarantees from anyone as to the results that may be obtained by any treatment or service; I agree the provider's prices for medical services, treatment and supplies are reasonable and customary.

Caution: Please read before signing. **If you do not completely understand this document please ask us to explain it to you. If you sign below we will assume you understand and agree to the above.**

Patient's Name _____ Patient's Signature _____
(Please Print) (If patient is a minor, signature of parent/guardian)

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.**

Therapeutic activity, Therapeutic exercise, Exam, X-ray, Electric Stimulation, Ultrasound, Traction

Spinal manipulation, Manual therapy, Neuromuscular re-education, ice/heat

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.

HCW
HORNBACK CHIROPRACTIC
& WELLNESS, P.A.

Pediatric Patient Information

Child's Name _____ Childs Date of Birth: _____ Sex: ❑ M ❑ F

Mother's Name _____ Date of Birth_____

Father's Name _____Date of Birth_____

Address _____City/Town _____State ____ Zip _____

Home Phone ( ) _____

Mother's Work Phone ( ) _____ Mother's Cell Phone ( ) _____E-Mail _____

Father's Work Phone ( ) _____ Father's Cell Phone ( ) _____E-Mail_____

# of Siblings _____ Referred by _____

By signing below, you acknowledge that periodic communications sent by HCW via text message, phone, and email, could potentially cause additional charges for you under your cell phone or other data plan. In the event that you do not want to receive such periodic communications, please notify us in writing of your desire to be removed from such communications.

AUTHORIZATION FOR CARE OF MINOR

I HEREBY AUTHORIZE THIS OFFICE AND ITS DOCTORS TO ADMINISTER CARE AS THEY DEEM NECESSARY TO MY SON/DAUGHTER/WARD (UPON APPROVAL OF PARENT OR GUARDIAN).

Signature _____Witness _____Date_____

Birth History:

Age _____ Birth Weight: _____ Birth Length: _____

Current Weight: _____ Current Length/Height: _____

Complications during pregnancy: _____

Third Trimester Presentation ❑ Vertex ❑ Breech ❑ Transverse ❑Face/Brow

Birth Location ❑ Home ❑ Birthing Center ❑ Hospital

Type of Birth ❑ Normal Vaginal ❑ Forceps ❑ Cesarean ❑ Suction Cup/Vacuum

Problems during Labor/Delivery: _____ Apgar scores _____

Presence at birth of Jaundice (Yellow)? _____ Cyanosis (Blue)? _____Congenital Anomalies/Defects? _____

Infant Feeding ❑ Breast ❑ Bottle If bottle, which formula? _____

Sleeping # Hours Sleeping/Night _____ **Quality of Sleep**: ❑ Good ❑ Fair ❑ Poor

Medical History:

Obstetrician/Midwife _____ Pediatrician/Family M.D. _____

Date of Last Visit _____Purpose of Visit _____

Doses of Antibiotics Your Child Has Taken: During the past 6 months: _____ during his/her lifetime: _____

Prior Chiropractor _____Date of Last Visit _____ Purpose of Visit _____

Milestones- At what age did the child:

Respond to Sound ___ Hold Head Up_____ Stand ___

Sit Alone ____ Crawl ___

Walk Independently ____

At what age, if ever, did the child suffer from the following childhood diseases?

❑ Chickenpox: ❑ Measles: ❑ Mumps: ❑ Rubella: ❑ Whooping:

Has the child ever suffered the following spinal traumas *(please check all that apply)*?

❑ Fall Baby Walker ❑ Fall off Swing or Monkey Bars ❑ Fall from Bed, Couch, Crib

❑ Fall from Highchair/Chair ❑ Fall down Stairs ❑ Fall off Skates/Skateboard

❑ Fall off Slide ❑ Fall off Bicycle ❑ Other: _____

Has the child suffered from any of the following (please check all that apply)?

❑ Behavioral issues	❑ Poor Appetite	❑ Heart Trouble	❑ Reflux	❑ Bed Wetting
❑ ADD/ADHD	❑ Ruptures/Hernia	❑ Chronic Earaches	❑ Backaches	❑ Anemia
❑ Headaches	❑ Muscle Pain	❑ Sinus Trouble	❑ Poor Posture	❑ Hypertension
❑ Dizziness	❑ Growing Pains	❑ Asthma	❑ Leg Problems	❑ Other: _____
❑ Fainting	❑ Stomachaches	❑ Colic	❑ Joint Problems	❑ Allergies: _____
❑Seizures	❑ Orthopedic Problems	❑ Colds/Flu	❑ Arm Problems	
❑ Digestive Disorders	❑ Constipation	❑ Broken Bones	❑ Neck Problems	
	❑ Diarrhea	❑ Scoliosis	❑ Walking Trouble	

Has the child ever been treated on an emergency basis? ❑ Yes (if yes, explain below) ❑ No

_____

Has the child ever sustained injuries from an automotive accident? ❑ Yes (if yes, explain below) ❑ No

_____

Has the child ever sustained an injury playing organized sports? ❑ Yes (if yes, explain below) ❑ No

_____

Family History _____

Medications/Surgery _____

Chief Complaint/Purpose of Visit: _____

Quality: O Aching O Burning O Constant O Dull O Intermittent O Radiating to _____

O Sharp O Shooting O Stabbing O Throbbing O Tightness O Other: _____

Severity: O Mild O Mild to Moderate O Moderate O Moderate to Severe O Severe

Does it interfere with your routine daily activities? Y N

Rate your pain: 0 = No Pain, 10 = Worst pain you have ever felt: 0 --- 1 --- 2 ---3 --- 4 --- 5 --- 6 ---- 7 --- 8 --- 9 --- 10

Date symptoms appeared/accident happened: _____ **Due to**: _____

Pain timing: Exacerbated/Worse by: O Bending/Stooping O Coughing O Driving O Lifting O Movement

O Extreme Motion O On Feet O Physical Activity O Resting O Sitting O Sneezing O Standing

O Twisting O Walking O Walking Up Stairs O Weight Bearing O Other: _____

Pain timing: Improves with: O Bending/Stooping O Getting Off Feet O Heat O Ice O Manipulation of Joint/Spine

O Massage O Movement O OTC Medications O Physical Activity O Other: _____

HCW
HORNBACK CHIROPRACTIC
& WELLNESS, P.A.

Permission To Examine and Treat a Minor

I _____ hereby give my consent to the doctors
(Name of parent or guardian)

of Hornback Chiropractic and Wellness, P. A. for Chiropractic examination and treatment of

_____.
(Name of minor)

I understand that a guardian shall be present during all procedures being performed at Hornback Chiropractic & Wellness, 11023 Gatewood Drive, Suite 101, Bradenton FL 34211.

_____ _____
Parent/Guardian Signature Date

_____ _____
Witness Signature Date

PATIENT HEALTH INFORMATION CONSENT FORM

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. 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 HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions of the use of their PHI. Our office is obligated to agree to those restrictions only to the extent they coincide with state and federal law.
3. A patient's written consent need only be obtained one time for all subsequent care given to the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. Our office may contact you periodically regarding appointments, treatments, products, services, or charitable work performed by our office. You may choose to opt-out of any marketing or fundraising communications at any time.
6. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
7. Patients have the right to file a formal complaint with our privacy official and the Secretary of HHS about any possible violations of these policies and procedures without retaliation by this office.
8. Our office reserves the right to make changes to this notice and to make the new notice provisions effective for all protected health information that it maintains. You will be provided with a new notice at your next visit following any change.
9. This notice is effective on the date stated below.
10. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Name of patient: _____ Date: _____

Signature of patient: _____

For further information regarding this notice, please contact our office at (941)744-1585 or (941)210-7057

FINANCIAL POLICY

SCHEDULING

- While we do schedule appointments during regular hours (to reduce waiting time for you and others), patients are welcome to stop in at any time. Please be aware, however, that walk-in patients will be seen after all regularly scheduled patients have been treated.
- Although we do not charge for missed or canceled chiropractic appointments, we do request 24 hours' notice. In consideration of our other patients, we will be unable to schedule further appointments if three consecutive appointments are missed without notification or canceled without 24 hours' notice.

PAYMENT

- Payment is expected in full at the time services are rendered. We do offer a credit guarantee option for patients who prefer to pay once a week, as opposed to each visit.
- For your convenience we accept cash, checks, Visa, MasterCard, and Discover.
- Should care be discontinued for any reason other than discharge by the doctor, any outstanding balance will become immediately due and payable in full.

INSURANCE

- Our office verifies insurance coverage in an effort to determine chiropractic coverage under your current policy. As benefits quoted are not a guarantee of coverage or benefits, it is the responsibility of the patient to contact their insurance if there is a discrepancy or error in benefits processing. Kindly keep in mind that you, as the patient, are responsible for any and all charges incurred in our office.
- Please provide us with your most current insurance card and information. If your insurance changes during the year, please let us know so that we may bill using the most current insurance information.
- Although we are not obligated to accept insurance payments on assignment from all carriers, we may do so as a courtesy to you, based on our experience with your insurance carrier.
- The patient/insured is responsible for any portion of the claim not covered by insurance.
- Please remember it that insurance coverage is a contract between you and your insurance company.
- Please provide any secondary insurance information so we may file on your behalf.

REFUNDS

- If there is a credit due, the patient will have the option of using the credit towards future visits or calling the office and requesting a refund.

It is the goal of this office to provide you with the finest quality chiropractic care available. If you have any questions with regard to your health or any of our policies, please let us know. We welcome your referrals and look forward to a doctor-patient relationship that works for our mutual benefit.

I have read and agree to the guidelines of this financial/insurance policy.

I, the undersigned, have insurance coverage with _____ Insurance Company and assign directly to Hornback Chiropractic and Wellness all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all changes whether or not paid by insurance. I hereby authorize HCW to release all information necessary to secure the payment of benefits. I authorize the use of the signature on all my insurance submissions whether manual or electronic.

Signature of Patient: _____ Date: _____

HCW
HORNBACK CHIROPRACTIC
& WELLNESS, P.A.

Informed Consent

Please read the document in its entirety prior to signing. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

A patient, in coming to Hornback Chiropractic and Wellness, PA, gives the doctors permission and authority to care for the patient in accordance with the chiropractic exam, analysis, diagnosis, and treatment of the joints and soft tissues.

As with any healthcare procedure, there are certain complications which may arise during the chiropractic adjustment and other clinical procedures. The chiropractic manipulation and other therapy are usually beneficial and seldom cause any problems. In rare cases, possible complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and physical therapy burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications, including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. We will make every reasonable effort during the examination to screen for contraindications to care; however, it is the responsibility of the patient to make it known, or to learn through health care procedures whatever he or she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the doctors.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which is screened for during the consultation, examination, and x-ray. The incidences of stroke are exceedingly rare and are estimated to occur between once in one million and once in ten million cervical adjustments. Once in a million is about the same chance as getting hit by lightning, once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death.

Other treatment options for your condition may include:

- Self-administered, over the counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants, and pain killers
- Hospitalization
- Surgery

Remaining untreated may allow the formation of adhesions and arthritis and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

I have read or have had read to me the above informed consent and I understand that if I am accepted as a patient by the doctors at Hornback Chiropractic and Wellness, PA, I am authorizing them to proceed with any treatment that may be necessary. Any questions I have had regarding these procedures have been answered to my satisfaction prior to my signing the consent form. I have made my decision voluntarily and freely.

_____ _____

Patient's Name Signature of Parent or Guardian (if a minor)

_____ Dated: _____

Patient's Signature

HCW
HORNBACK CHIROPRACTIC
& WELLNESS, P.A.

Authorization for the Release of Medical Records

Patient Name: _____ Date of Birth: _____

I hereby request and authorize:

Hornback Chiropractic and Wellness. P.A.

11023 Gatewood Drive, Suite 101
Bradenton, FL 34211
Ph: (941) 744-1585
Fax: (941) 744-1572
E-mail: frontdesk@hornbackchiro.com

8386 Market Street
Lakewood Ranch, FL 34202
Ph: (941) 210-7057
Fax: (941) 210-7056
E-mail: marketst@hornbackchiro.com

_____To Disclose information to: _____To Receive Information from:

Physician/Medical Facility/Hospital: _____
Address: _____ Phone Number: _____
_____ Fax Number: _____

Information to be disclosed includes copies of:

_____ Entire Record
_____ Progress Notes
_____ Physical Exam forms
_____X-ray Reports
_____X-ray Films
_____Other, specify: _____
_____

Purpose for Disclosure:
_____ Treatment, Payment, OR _____ Other, Specify: _____

This authorization will be effective after the date signed, unless cancelled in writing. I understand that the cancellation will have no effect on information released prior to receiving the cancellation. A copy of this authorization is as valid as the original.

_____ Date: _____
Signature of Patient

OR

_____ Date: _____
Signature of Parent/Guardian/Legal Representative

If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law.

Notice to recipient of information: This information has been disclosed to you from confidential records, which are protected by law. Unless you have further authorization, laws may prohibit you from making any further disclosures of this information without the specific written consent of the patient or legal representative.