



REQUIRED ACCIDENT INFORMATION

Name: _____ Today's Date: _____

Date of accident: _____

Have you reported this accident to your insurance company? _____ YES _____ NO

Have you reported an injury or opened a personal injury (medical) portion of a claim with your insurance company? _____ YES _____ NO

(If the answer to either of these questions is NO, you must call today and open a claim and/or report that you are seeking care for an injury).

Insurance Company _____ Phone# _____

Address _____ City _____ State _____ Zip _____

Claim Number _____ Policy Number _____

PIP Adjustor _____ Phone Number _____ Extension _____

Have you signed with an attorney regarding this accident? _____ YES _____ NO

If yes, whom? _____

Address _____ City _____ State _____ Zip _____

Phone# _____ Fax# _____



Patient Demographic Information

First Name: _____ Middle Initial: _____ Last Name: _____

DOB: _____ / _____ / _____ Age: _____ Today's Date: _____ / _____ / _____

Last 4 of Social Security #: _____ Race: _____ Sex: Male or Female

Phone: (_____) _____ (Cell/Work/Home) Email Address: _____

Address: _____ Apartment/Suite # (If Applicable): _____

City: _____ State: _____ Zip: _____

Marital Status: Single Married Divorced Widowed Separated Minor

Spouse's Name: _____ Number of Children: _____ Children's Ages: _____

Emergency Contact Information

First Name: _____ Last Name: _____

Relation to Patient: _____ Phone: (_____) _____

Patient Occupation Information

Occupation/Role: _____ Employer/Company: _____

Average Number of Hours Currently Worked, per Week: _____

How many hours at work per day, do you: Sit: _____ Stand: _____

Activities at work mostly involve (please circle one of each option below):

Sitting or Standing Light Labor or Heavy Labor



Health History

Please check if you currently, or have ever, had any of the following (If nothing applies, please leave blank):

- | | | |
|--|---|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Hepatitis Type A/B/C | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Herniated Disc(s) | <input type="checkbox"/> Pinched Nerve |
| <input type="checkbox"/> Asthma/Wheezing | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Psoriatic Arthritis |
| <input type="checkbox"/> Contacts/Glasses | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Psychiatric Conditions |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Migraines | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Erectile Dysfunction | <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Thyroid Issues |
| <input type="checkbox"/> Fractures | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Vaginal Dryness |
| <input type="checkbox"/> Heart Attack/Heart Issues | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Other: _____ |

Please list any prior surgeries or hospitalizations you have had (type & date):

Please list any prior imaging (eg MRI, CT, Ultrasound) you have had (type & date):

Please list any medication you are currently taking:

Previous Accident History

Excluding this most recent accident, have you ever been in a prior auto accident? No Yes

If yes, list the approximate date(s) of the accident: _____

Have you ever had a slip, fall, or other accident? No Yes

If yes, list the approximate date(s) of the accident: _____

Previous Treatments

Have you ever received:

Chiropractic Care? No Yes, state last date of treatment: _____

Physical Therapy? No Yes, state last date of treatment: _____

Injections (eg epidurals)? No Yes, state last date of treatment: _____



ACCIDENT INFORMATION:

Name: _____ Date: _____

Date of Accident: _____ State of Accident: _____

Where (Street/Intersection): _____

Were any tickets issued? **If yes**, to whom? _____

Were you the: Driver Passenger (Circle one option): Front Seat Back Seat - Left Back Seat - Right

Who else was in the car with you? No one Someone, **state whom** _____

Did the impact to your vehicle come from the: Front Rear Driver Side Passenger Side

Since the accident have you experienced any of the following?

Confusion Memory Loss Nausea Vomiting Ringing in Ear(s)

Light Sensitivity Excessive Fatigue Blackout None of the Above

Did the ambulance/paramedics arrive at the scene? No Yes

Did you go to the hospital? No Yes

If yes, were you taken to the hospital via: Ambulance Drove myself/Driven by someone else

If yes, which hospital? _____

Were **X-Rays** taken? No Yes Were **MRIs** taken? No Yes Were **CTs** taken? No Yes

If yes to any imaging above, which body parts? _____

Have you been prescribed new medication(s) since the accident? No Yes **If yes**, please list all:

Have you seen anyone else for this accident? No Yes **If yes**, who and what procedures did they do?

Pain Disability Index

Name: _____ Date: _____

Pain disability index: The rating scales below are designed to measure the degree to which aspects of your life are disrupted by pain. In other words, we would like to know how much your pain is preventing you from doing what you would normally do or from doing it as well as you normally would. Respond to each category by indicating the overall impact of pain in your life, not just when the pain is at its worst.

For each of the 7 categories of life activity listed, please circle the number on the scale that describes the level of disability you are experiencing. A score of 0 means no disability at all, and a score of 10 signifies that all of the activities in which you would normally be involved have been totally disrupted or prevented by your pain.

Family/Home responsibilities: This category refers to activities of the home or family. It includes chores/duties performed around the house (eg, yard work) and errands or favors for other family members (eg, driving the children to school).

No disability 0 1 2 3 4 5 6 7 8 9 10 Worst disability

Recreation: This category includes hobbies, sports, and other similar leisure time activities.

No disability 0 1 2 3 4 5 6 7 8 9 10 Worst disability

Social activity: This category refers to activities that involve participation with friends and acquaintances other than family members. It includes parties, theatre, concerts, dining out, and other social functions.

No disability 0 1 2 3 4 5 6 7 8 9 10 Worst disability

Occupation: This category refers to activities that are a part of or directly related to one's job. This includes nonpaying jobs as well, such as that of a housewife or volunteer worker.

No disability 0 1 2 3 4 5 6 7 8 9 10 Worst disability

Sexual behavior: This category refers to the frequency and quality of one's sex life.

No disability 0 1 2 3 4 5 6 7 8 9 10 Worst disability

Self Care: This category includes activities, which involve personal maintenance and independent daily living (eg, taking a shower, driving, getting dressed, etc.)

No disability 0 1 2 3 4 5 6 7 8 9 10 Worst disability

Life-support activity: This category refers to basic life-supporting behaviors such as eating, sleeping, and breathing.

No disability 0 1 2 3 4 5 6 7 8 9 10 Worst disability

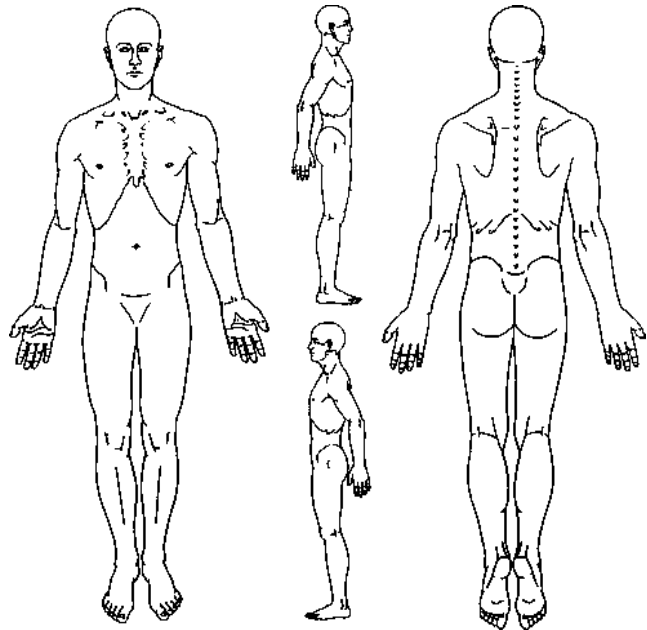
Name: _____ Date: _____

CURRENT SYMPTOMS

Please check to indicate if you are currently experiencing any of the following conditions .

- | | | |
|--|--|--|
| <input type="checkbox"/> Neck Pain/Stiffness | <input type="checkbox"/> Leg/Knee Pain | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Upper Back Pain/Stiffness | <input type="checkbox"/> Ankle/Foot Pain | <input type="checkbox"/> Light/Noise Sensitivity |
| <input type="checkbox"/> Mid Back Pain/Stiffness | <input type="checkbox"/> Numbness/Tingling in Arms | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Lower Back Pain/Stiffness | <input type="checkbox"/> Numbness/Tingling in Legs | <input type="checkbox"/> Loss of Memory |
| <input type="checkbox"/> Arm/Elbow Pain | <input type="checkbox"/> Blurred/Double Vision | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Wrist/Hand Pain | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Sleeping Difficulties |
| <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Swollen Joints |
| <input type="checkbox"/> Hip Pain | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Trouble Concentrating |
| <input type="checkbox"/> Other: _____ | | |

Please mark any areas of pain/discomfort on the diagram to the right.



Signature of Patient/Guardian

Date

Print Name

X-ray Questionnaire: For WOMEN ONLY

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary, we would like to confirm that you are not pregnant at this time.

Please select one of the options below.

- Yes, I am definitely pregnant
- There is a possibility that I may be pregnant at this time
- No, I am definitely not pregnant
- I request that x-ray films not be taken because: _____

Date of last menstrual period: _____

Patient's Signature

Date



Patient Authorization and Consent for Treatment

(Also Used for Minors/Wards)

Patient/Minor/Ward Name: _____

Patient/Minor/Ward D.O.B: _____

I, the undersigned patient ("Patient") or parent or legal guardian ("Guardian") of the minor child/ward ("Minor /Ward"), as the case may be, by this written authorization authorize and give my consent to RejuvenX ("RejuvenX"), its physicians and their authorized clinical personnel ("Clinical Staff") to evaluate and administer medical, chiropractic, and therapeutic treatment, which may consist of examinations, and various forms of treatment including physical and physiotherapy, and diagnostic x-rays or other diagnostic imaging, to, me the Patient, or if my Minor/Ward is the person receiving care, to my Minor/Ward in those situations indicated by me below where I am not physically present with my Minor/Ward.

I understand that there are some risks in the practice of medicine and chiropractic care, including, without limitation, adverse side effects from medications, fractures, disc injuries, strokes, dislocations, and sprains, and I do not expect the Clinical Staff to be able to anticipate and explain all risks and complications. I wish to rely upon the Clinical Staff to utilize their best judgment during treatment in doing what is in my or my Minor's/Ward's best interest based upon the facts then known to the Clinical Staff.

(Please skip the section in this box if the person receiving care is not a Minor/Ward)

To be Completed by Guardian of Minor/Ward

I have read and have had the opportunity to ask questions about this consent, and by signing below I agree to proceed with all aspects of the care and treatment outlined above. As initialed below to indicate my consent and/or the delegation of my authority to consent to the medical, chiropractic, and therapeutic evaluation, diagnosis, and treatment of me the Patient, or my Minor/Ward, I agree to and authorize the following actions by Clinical Staff, until such time as I revoke in writing such authorizations and consents:

(Initials) _____

I authorize Clinical Staff to see, examine, evaluate and treat my Minor/Ward, in accordance with the personal requests of my Minor's/Ward's following family member (other than mother or father), if I am not present, in accordance with the consent communicated by the following individual(s) to Clinical Staff pursuant to the delegation of my authority granted here, and consistent with the Clinical Staff's professional judgment of my Minor's/Ward's medical and/or therapeutic needs.

Note: If you are acting in the capacity as a court ordered and appointed legal guardian, kindly supply us with a certified copy of the guardianship order evidencing such authority.

Names of Other Authorized Family Members: Relation of Authorized Family Member(s) to Minor/Ward:

Nothing herein shall be deemed a request, direction, authorization, or consent for Clinical Staff to administer or deliver any examination, diagnostic testing, treatment, or other services that Clinical Staff, in their sole professional judgment, deem to be inappropriate.

This document is intended to be a valid authorization and consent pursuant to Florida Medical Consent Law, Fla. Stat. s. 766.103, and other applicable law, and shall remain in force until revoked by me in writing.

Signature of Patient/Guardian

Relation to Patient/Minor/Ward (If person receiving care is not a Minor/Ward, write "Self")

Print Patient/Guardian Name

Date



PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ DOB: _____

I acknowledge that I have reviewed the Notice of Privacy Practices of RejuvenX LLC. (Please initial **one of the following options** below.)

_____ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office.

_____ I wish to receive a paper copy of Privacy Notice.

_____ I wish to receive an electronic copy of Privacy Notice.

To receive an electronic copy of Privacy notice, my email address is: _____@_____.com

OUR OFFICE WILL CONTACT YOU VIA A PHONE CALL, TEXT MESSAGE OR EMAIL TO CONFIRM AN APPOINTMENT, MAKE APPOINTMENT REMINDERS, TREATMENT UPDATES AND PROVIDE BILLING INFORMATION:

Please do not use the following means of communication listed above: _____

Please initial **both** of the lines below:

_____ I acknowledge that it is the policy of RejuvenX LLC to leave reminder messages on my answering machine or with another person in my home. I may make a request of an alternative means of communication (within reason) in writing.

_____ I acknowledge that if I should have a problem or question in regard to my rights, I may speak with the Privacy Officer, Chase Fifarek, about my concerns.

Signature of **Patient**/Guardian

Date

Print Name



**ACKNOWLEDGEMENT OF LIABILITY
ASSIGNMENT OF BENEFITS & RECORDS RELEASE**

The undersigned patient and/or responsible party, hereby acknowledges personal responsibility and liability for all the medical services which are provided by RejuvenX LLC. This personal obligation is not affected by any obligation of insurance companies to pay health care costs. If an insurance company pays, the payment(s) shall be credited to your account. If no insurance payment is received, you are completely responsible to pay for all medical treatments. In addition to continuing personal responsibility, and in consideration of treatment rendered or to be rendered, the undersigned hereby assigns to the physician or facility named above the following rights, power, and authority.

CONSENT FOR TREATMENT: The undersigned hereby consents to provision of examination, fitness evaluations, treatment, therapies, medical and laboratory procedures, and drugs and supplies to the patient as ordered by the patient’s healthcare provider RejuvenX LLC, their physicians, nurse practitioners, physical therapist, chiropractors or staff and acknowledges that no guarantee or assurance has been made to the results of such treatments, procedures or examinations.

RECORD RELEASE AND RELEASED INFORMATION: I authorized RejuvenX LLC to release and to permit the examination or copying of any of my medical records, x-rays, laboratory reports, and the results of all tests of any type or character to such person(s) as the Physician and or Facility deems appropriate. I hereby authorize and request you to release my complete pertinent accident medical records to RejuvenX LLC.

ASSIGNMENT OF RIGHTS: You are assigned to exclusive, irrevocable rights. Any cause of action that exists in my favor against any insurance company or other person or entity to the extent of your bill for total services, including the exclusive, irrevocable right to receive payment for such services, make demand in my name for payments, and prosecute and receive penalties, interest, court costs, or other legally compensable amounts owned by an insurance company or other person or entity. I, as the patient and or responsible party further agree to cooperate, provide information as needed, and appear as needed, wherever to assist in the prosecution of such claims for benefits upon request. The physician and or facility is also assigned the exclusive, irrevocable right to request and receive from any insurance company or health care plan any and all information and documents pertaining to my policies including a copy of such policy and my information or supporting documentation concerning or touching upon the handling, calculation, processing or payment of any claim.

DEMAND FOR PAYMENT: As to any insurance company providing benefits of any kind to me/us for treatment rendered by the physician/facility names above, you are hereby tendered the right to demand payment in full the bill for services rendered by the physician/facility named above following your receipt of such bill for services to extent such bills are payable under the terms of my/our policy for benefits, less any amount which I/we owe personally which are not payable under the terms of your policy.

THIRD PARTY LIABILITY: If patient(s) treatments for injuries are the result of the negligence of any third party, then patient(s) grant a secured interest (lien) against any recovery from such third party(s) to the extent of the bills for treatment in favor of the physician/facility named above.

In the event that any provision of this Agreement is determined to be invalid or unenforceable, all other provisions of this Agreement shall remain enforceable.

A PHOTOCOPY OF THIS INSTRUMENT SHALL SERVE AS ORIGINAL

Signature of patient and/or responsible party.

Patient Signature: _____ Date: _____

Print Name: _____ Date of Accident: _____ Relationship to Patient: _____



Co-Payment's & Deductible & Services Rendered

Following your initial visit RejuvenX will bill your Insurance Company for the services and goods you have received during that visit. You are responsible for any CO-PAYMENT, DEDUCTIBLE and/or unpaid amounts exceeding available no-fault benefits. We have not agreed, nor do we intend to waive Insurance Policy deductibles or co-pays, or other unpaid amounts.

_____ **Initials**

I acknowledge that I will be receiving statements & EOB's (Explanation of Benefits) from my insurance company which reflect the amount being billed for the services rendered. I acknowledge that I will receive copies of billing and medical records upon request or as periodically submitted by RejuvenX.

I, _____ **(Patient Name)**, understand I am financially responsible to pay for all services provided to me a part of my treatment, including any deductibles, copayments or other amounts not covered by personal injury protection and medical payments coverage insurance benefits for the services rendered.

Signature

Date



RejuvenX Marketing and Staffing, Florida Imaging, and Precision Pain Management, Authorization for Release of Health Information Pursuant to HIPAA

Section A: This section must be completed for all Authorizations.		
Patient Last Name:	First Name:	MI:
Date of Birth:	Social Security Number (optional):	
My health information may be released to (name of recipient):		
Address:		
City:	State:	Zip:
I hereby authorize the use or disclosure of protected health information as described below:		
Description of information being disclosed for the following date(s) of service:		
<input type="checkbox"/> Complete health record	<input type="checkbox"/> Abstract/Pertinent Information	<input type="checkbox"/> Consultation Reports
<input type="checkbox"/> History/physical exam	<input type="checkbox"/> HIV/AIDS Information	<input type="checkbox"/> Laboratory Reports
<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Drug/Alcohol Treatment Information	<input type="checkbox"/> Other:
<input type="checkbox"/> Radiology Reports	<input type="checkbox"/> Discharge summary	
Purpose of the Disclosure: (Example: "At the request of the patient"): _____ _____		
Expiration: If the health information to be disclosed contains HIV/AIDS or drug and alcohol abuse treatment records, this Authorization expires within sixty (60) days. Otherwise, you may select either of the following expiration events:		
<input type="checkbox"/> 1 year from the date in which I, or my legal representative, signs this Authorization.		
<input type="checkbox"/> Upon the happening of the following event: _____ _____		
(Example: "Upon release of the above records")		
In addition to the authorization for release of my PHI described above in this Authorization, I authorize disclosure of information regarding my billing, condition, treatment and prognosis to the following individual(s):		
Name: _____	Phone: _____	Relationship: _____
Name: _____	Phone: _____	Relationship: _____
Name: _____	Phone: _____	Relationship: _____



RejuvenX Marketing and Staffing, Florida Imaging, and Precision Pain Management, Authorization for Release of Health Information Pursuant to HIPAA

I understand that:

1. I may revoke this Authorization at any time by providing written revocation to RejuvenX Marketing and Staffing. I understand that I may revoke this authorization except to the extent that action has already been taken in reliance on this authorization.
2. Signing this authorization is voluntary. My treatment, payment, enrollment, or eligibility for benefits will not be conditioned upon whether I sign this authorization.
3. The information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by HIPAA upon its release to the recipient.
4. I have the right to inspect or copy the health information to be used or disclosed pursuant to this Authorization.

TO BE COMPLETED BY THE ORGANIZATION IF THIS AUTHORIZATION IS FOR MARKETING, FUNDRAISING, RESEARCH, OR SALE OF PROTECTED HEALTH INFORMATION:

The organization will receive financial or in-kind compensation in exchange for using or disclosing the health information described above:

- Yes
 No

Signatures: I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient (or Patient’s Representative):	Date:
Print Name of Patient (or Patient’s Representative):	
If you are the representative of a patient, check the scope of your authority to act on the patient’s behalf:	
<input type="checkbox"/> Power of Attorney <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Surrogate Decision-Maker <input type="checkbox"/> Executor or Personal Representative <input type="checkbox"/> Parent <input type="checkbox"/> Other:	
For internal use only: Records were delivered by: <input type="checkbox"/> Fax <input type="checkbox"/> Mail <input type="checkbox"/> Personal Delivery on the date of:	

TO THE RECIPIENT: This information has been disclosed to you from confidential records protected by Federal Law. You are prohibited from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. If you have received this information in error, please notify RejuvenX Marketing and Staffing immediately.



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**.

99203 E0730 98940 98941 97140 97110

72040 72050 72052 72070 72100 72110

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.