Dr. Kris H. Barnhill | Dr. Kevin Sutton
5270 NW 34th Blvd. Gainesville, FL 32605 | Phone: (352) 377-2255 | Fax: (352) 377-5233
www.barnhillchiropractic.com

BARNHILL Chiropractic

PERSONAL INJURY INTAKE PAPERWORK

HELLO AND WELCOME TO BARNHILL CHIROPRACTIC! Date: ________________

Who may we thank for referring you / how did you hear about us? ______________________________

Have you received chiropractic care in the past? ❑ No ❑ Yes (from whom?) ______________________

Please fill out the following information. Remember to initial at the bottom of each page!

PERSONAL INFORMATION

Name: ____ Date of Birth: ______/_____/______

Email: ____ Age: _________ Gender: ❑ M ❑ F

Street Address: ____________________________________ Marital Status: ❑ S ❑ M ❑ D ❑ W

City/State/Zip: _____________________________________ Apt #: _________________________

Cell Phone: ____ Cell Carrier: ____________________

Work Phone: _______________________________________ Home Phone: ___________________

Driver's Lic #: ______________________________________ SSN: _________-_______-__________

Occupation: ____ Employer: ______________________

Spouse Name: ______________________________________ Spouse DOB: ______/_____/______

Hobbies: ____ Spouse SSN: ______-_____-______

PERSONAL HEALTH HISTORY

List your current:

Height: ______ ft. ______ in.

Weight: ________ lbs.

What is your typical daily work activity?

❑ Sitting ❑ Standing ❑ Light Lifting ❑ Heavy Lifting ❑ Driving

❑ Working at a Computer ❑ Manual Labor ❑ Other: _____________

Do you have any genetic disorders or disabilities? ❑ No ❑ Yes (if yes, explain): ____________________

____

Indicate if you have experienced any of the following: ❑ N/A

❑ Serious illness, operation, or health emergency

❑ Been unconscious due to an illness or injury

❑ Been in a motor vehicle accident

❑ Fractured a bone

Explain (including year(s)): ____

____

List any over-the-counter/prescription drugs and vitamins/supplements that you are currently taking:

❑ N/A | ____

____

SOCIAL HISTORY

Do you smoke?	❑ Never	❑ In the Past	❑ Occasionally	❑ Daily
Are you exposed to secondhand smoke?	❑ Never	❑ In the Past	❑ Occasionally	❑ Daily
Do you drink alcohol?	❑ Never	❑ In the Past	❑ ____ Drinks/Week	❑ Daily
Do you use recreational drugs?	❑ Never	❑ In the Past	❑ Occasionally	❑ Daily
How often do you exercise?	❑ Never	❑ In the Past	❑ Occasionally	❑ Daily

CHIEF COMPLAINT / HISTORY OF PRESENT ILLNESS

What is the MAIN reason you are seeking chiropractic care?

PROBLEM/CONCERN #1: ______________________________

- WHEN did this problem begin? ____________ Is it constant or intermittent? ______________
- Did you do something / did something happen that aggravated the problem? ❑ No ❑ Yes
  Explain: ______________________________
- WHEN is the problem at its worst? ❑ Morning ❑ Mid-day ❑ Evening ❑ Other ___________
- Does the problem RADIATE outward from a source? ______________________________
- What RELIEVES the problem? ______________________________
- What makes the problem WORSE? ______________________________

Are there any SECONDARY health concerns you wish to bring to our attention? ❑ No ❑ Yes

PROBLEM/CONCERN #2: ❑ N/A ______________________________

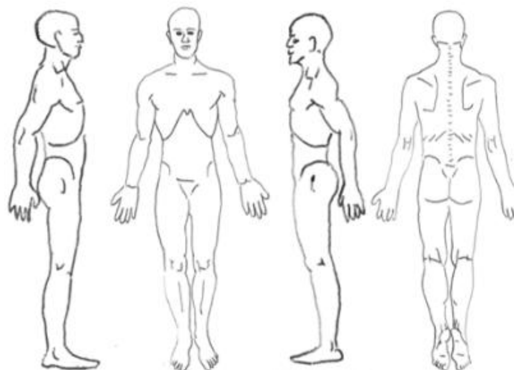
- WHEN did this problem begin? ____________ Is it constant or intermittent? _____________
- Did you do something / did something happen that aggravated the problem? ❑ No ❑ Yes
  Explain: ______________________________
- WHEN is the problem at its worst? ❑ Morning ❑ Mid-day ❑ Evening ❑ Other ___________
- Does the problem RADIATE outward from a source? ______________________________
- What RELIEVES the problem? ______________________________
- What makes the problem WORSE? ______________________________

DIRECTIONS: CIRCLE the area(s) on the diagram that relate to your pain/symptom(s)/issue(s):

How would you describe the problem(s)?

❑ Dull ache	❑ Burning	❑ Stiff/Tight
❑ Tingling	❑ Radiating	❑ Deep/Boring
❑ Pounding	❑ Numb	❑ Sharp/Stabbing

❑ Other: ______________________________



PAST HISTORY

Has your reason for seeking chiropractic care happened BEFORE? ❑ No ❑ Yes

- If yes, how many times? ❑ N/A ____
- What sort of treatment did you seek before? ❑ N/A ______________________________
- What were the results of your previous treatment? ❑ N/A _________________________

Help us identify past conditions or procedures that could be <u>related to your main issue</u>:

❑ Past surgeries ❑ Childhood diseases ❑ Past injuries ❑ N/A *Explain*: _______________

____

Have you experienced or been diagnosed with any of the following? ❑ N/A

❑ Pain that wakes you up at night ❑ Night Sweats ❑ Stroke ❑ Heart Attack ❑ Diabetes

Explain: ____

QUADRUPLE VISUAL ANALOGUE SCALE

Name: ____ **Date:** ____________________

PLEASE READ CAREFULLY

DIRECTIONS: Fill in your problem(s)/concern(s) from the previous page. *Regarding these problem(s)/concern(s),* please <u>CIRCLE</u> the number that best describes the question being asked.

PROBLEM/CONCERN #1: ______________________________________

1. What is your pain RIGHT NOW?

No Pain ____ Worst Pain

0 1 2 3 4 5 6 7 8 9 10 Possible

2. What is your TYPICAL or AVERAGE pain?

No Pain ____ Worst Pain

0 1 2 3 4 5 6 7 8 9 10 Possible

3. What is your pain AT ITS BEST (How close to "0" does your pain get at its best)?

No Pain ____ Worst Pain

0 1 2 3 4 5 6 7 8 9 10 Possible

4. What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No Pain ____ Worst Pain

0 1 2 3 4 5 6 7 8 9 10 Possible

PROBLEM/CONCERN #2: ❑ N/A ____

1. What is your pain RIGHT NOW?

No Pain ____ Worst Pain

0 1 2 3 4 5 6 7 8 9 10 Possible

2. What is your TYPICAL or AVERAGE pain?

No Pain ____ Worst Pain

0 1 2 3 4 5 6 7 8 9 10 Possible

3. What is your pain AT ITS BEST (How close to "0" does your pain get at its best)?

No Pain ____ Worst Pain

0 1 2 3 4 5 6 7 8 9 10 Possible

4. What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No Pain ____ Worst Pain

0 1 2 3 4 5 6 7 8 9 10 Possible

OTHER COMMENTS: ____

Examiner Reprinted from Spine, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science

TERMS OF ACCEPTANCE

Please read the below and if you have any questions, feel free to ask one of our staff members.

BARNHILL CHIROPRACTIC NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **P**ersonal **H**ealth **I**nformation. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as dictated by our office policy, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled '**HIPAA'** on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

PERMITTED DISCLOSURES:

1. Treatment purposes - discussion with other health care providers involved in your care.
2. Inadvertent disclosures - open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes - to process a claim or aid in investigation.
5. Emergency - in the event of a medical emergency we may notify a family member.
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement - to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons - discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders - we may call your home and leave messages regarding a missed appointment or apprize you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice.
3. To request mailings to an address different than residence.
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance.
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain one copy of your records at no charge, when timely notice is provided (72 hours). X-rays are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS: If you wish to make a formal complaint about how we handle your health information, please call Dr. Kris H. Barnhill at (352) 377-2255. If he is unavailable, you may make an appointment with our receptionist to see her within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to DHHS, Office of Civil Rights, 200 Independence Ave. SW, Room 509F HHH Building, Washington DC 20201.

Name: ____ **Date**: ____________________

Signature: ____

BARNHILL CHIROPRACTIC NOTICE OF PRIVACY PRACTICE (CONT'D)

I have received a copy of Barnhill Chiropractic Patient Privacy Notice. I understand my rights as well as the practice's duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present. I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

Signature: ____ Date: ____________________

INFORMED CONSENT

A patient, in coming to the chiropractic doctor, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by a physician at Barnhill Chiropractic, I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Signature: ____ Date: ____________________

AUTHORIZATION FOR X-RAYS

X-rays are utilized in the office to help location and analyze **vertebral subluxations**. These x-rays are not to be used to investigate for medical pathology. The doctors of Barnhill Chiropractic do not diagnose or treat medical conditions; however if any abnormalities are found, they will be brought to your attention so that you can seek proper medical advice. By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

Signature: ____ Date: __________________

(*Women Only*) Please check the box that applies to you - To the best of my knowledge:

- ❑ I AM NOT pregnant at this time
- ❑ I AM **/** believe I MAY BE pregnant, therefore I DO NOT authorize Barnhill Chiropractic to X-ray me at this time.

Signature: ____ Date: __________________

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I authorize Barnhill Chiropractic to release all necessary information concerning my health condition to my billing company, insurance company, attorney, and/or adjuster in order to process any claim for reimbursement of charges incurred by me. In addition, I authorize Barnhill Chiropractic to release any information regarding my health condition to other health care providers involved in my care. This assignment will remain in effect until revoked by me in writing. I agree that a photocopy of this form is to be considered as valid as the original. I confirm that all information I have provided is true and correct to the best of my knowledge. I confirm that I have read and fully understand this agreement and authorize Barnhill Chiropractic to proceed with chiropractic tests, diagnosis, analysis, and adjustments.

Signature: ____ **Date**: ___________________

MEDICAL INFORMATION RELEASE FORM

Release of Information:

❑ I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

❑ Spouse: _____________________________________ ❑ Child(ren): _____________________________________

❑ Other: ______________________________________ ❑ Information is not to be released to anyone.

This **release of information** will remain in effect until terminated by me in writing.

Signature: ____ **Date**: ___________________

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AUTOMOBILE / PI ACCIDENT INTAKE PAPERWORK

Patient's Name: ____

Date: ________________________________ Date of Birth: _______/________/________

This information is considered confidential. Your answers will help us determine if chiropractic care can help your condition. We will not accept your case if we do not believe your condition will respond satisfactorily to care. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. Thank you!

Please answer all questions completely.

Please explain in detail how your accident happened:

____

____

What were the time and date of the accident?

____

Where did you feel pain immediately after the accident?

____

____

List the extent of your injuries as you know them:

____

____

Did you require post-accident hospitalization? ❑ Yes ❑ No

Check symptoms you have noticed since the accident:

❑ Headache	❑ Constipation	❑ Problems Sleeping	❑ Nervousness
❑ Fatigue	❑ Face Flushed	❑ Loss of Balance	❑ Pins & Needles in Legs
❑ Diarrhea	❑ Irritability	❑ Numbness in Toes	❑ Fever
❑ Memory Loss	❑ Chest Pain	❑ Cold Sweats	❑ Shortness of Breath
❑ Pins & Needles in Arms	❑ Dizziness	❑ Stomach Upset	❑ Tension
❑ Numbness in Fingers	❑ Neck Pain	❑ Depression	❑ Other: ______________
❑ Face Flushed	❑ Ears Ringing	❑ Neck Stiffness	______________________

AUTO INSURANCE INFORMATION

Full Name: ____

Auto Insurance Company: ____

Auto Insurance Address:

____

____

Auto Insurance Phone #: ____

Policy #: ____

Claim #: ____

Adjuster: ____

Attorney (if applicable): ____

Attorney Address:

____

____

Attorney Phone #: ____

Have you been to another chiropractor, physical therapist, or other medical professional in relation to this accident before coming to this office? ❏ Yes ❏ No

If so, who did you treat with? ____

AUTOMOBILE / PI ACCIDENT INTAKE PAPERWORK (CONT'D)

Where were you taken after the accident?

____

Hospitalized? ❏ Yes ❏ No If yes, admitted? ________________ How long? __________________

Name of Hospital: ____

What treatment were you given? ____

Was any other doctor consulted after your accident? ❏ Yes ❏ No

If so, what was the doctor's name? ____

What was the diagnosis? ____

What treatment was given? ____

How often did you see the doctor? ____

How long did you see the doctor? ____

Before the injury were you capable of working on an equal basis with others your age? ❏ Yes ❏ No

Are your work activities restricted as a result of this accident? ❏ Yes ❏ No

Since this injury are your symptoms: ❏ Improving ❏ Getting Worse ❏ Stayed the Same

Driver of vehicle in which you were injured (if applicable):
Name:
____
Insurance Company: ____
Policy #: ____
Name of Insurance Adjustor: ____
Have you retained an attorney? ❑ Yes ❑ No
If so, his/her name and address:
____
____
Were police notified? ❑ Yes ❑ No
You were struck from: ❑ Behind ❑ Front ❑ Left Side ❑ Right Side
You were: ❑ Driver ❑ Passenger ❑ Back Seat Behind Driver ❑ Back Seat Behind Passenger
❑ Middle Back Seat
Were you wearing your seatbelt? ❑ Yes ❑ No

Signature: ____ **Date**: _______________________

RELEASE OF AUTHORIZATION AND LETTER OF PROTECTION

I, ____________________________, hereby authorize this office to furnish my attorney, _______________________, and/or_____________________ Insurance Company, or the designee of either, any medical information requested concerning the condition or treatment of injuries sustained by me and/or my children, on _____________________.
I authorize and direct my attorney to pay from any insurance or other proceeds for any recovery made as a result of said injury; any unpaid balance due said doctor for professional services as a result of any treatment to myself, or my children. I understand that this in no way relieves me of my personal primary responsibility to pay my doctor for service when a statement is rendered and that I will receive customary billing for said services.
I authorize my attorney or any third-party liability carrier to disclose the settlement status, settlement statement and/or a copy of the settlement check if requested for our purposes. At the time of the settlement, the attorney is instructed that this office shall be furnished separate checks for the medical services which they have rendered for full balance due at that time.
Upon settlement of the underlying, the attorney's office will disburse funds directly to Barnhill Chiropractic. The patient hereby acknowledges that should the net recovery to the patient not be sufficient to pay in full all amounts due this office with respect to the above stated matter, then the patient shall remain personally responsible for any unpaid balance
1. I understand that I am being treated for injuries sustained in a motor vehicle accident and that failure

to keep my appointments may jeopardize the insurance carrier's responsibility for medical costs and/or compensation for pain and suffering.
2. I understand that this office is extending me credit for treatment and that if I miss two (2) office visits without a reasonable excuse all bills may be due immediately.
3. I understand that if I sever ties with my attorney before settlement or my attorney will no longer represent my case, all bills may be due immediately.
4. Once released from care, if my case is not settled within six months, I will begin making payments of $50.00 a month to this office toward my bill.
5. If my bill is not paid within 30 days after the settlement, my balance will then be turned over to a collection attorney and all attorney's fees will be the responsibility of the patient.

Signature: ____ **Date**: ________________________

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT

I hereby instruct and direct the _____________________________ Insurance Company to pay by the check made out and mailed directly to:

Barnhill Chiropractic Clinic
5270 NW 34th Blvd
Gainesville, FL 32605

If my current policy prohibits direct payment to the doctor, then I hereby also instruct and Direct you to make out the check to me and mail it as follows:

See Above Address

For the professional or chiropractic expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for Professional services rendered.
THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.
A photocopy of this assignment shall be considered as effective and valid as the original.
I also authorize the release of any information of pertaining to my case to any insurance Company, adjuster, or attorney involved in this case.

Date: ____

Signature of Policyholder: ____

Signature of Claimant (if other than Policyholder): ____

MED PAY BENEFITS

Many people have medical benefits (medical payments coverage or "Med Pay") included in their automobile policies. This benefit would be listed on the Declarations Page (The "Dec Page") of your insurance policy and it might also appear on the insurance card that you are required to carry as proof of insurance. Our office encourages you to use these benefits since you are already paying for them and since this is exactly their intended use: to provide for your needed medical care without your incurring any penalty or having to pay a deductible. Here are several reasons why we recommend that you use your med pay benefits:

1. Med Pay is exactly like health insurance in that using it does not cause your rates to increase. If your rates do increase it is not because you filed your med pay. Instead it is likely that: (a) the accident was determined to be your fault by your insurance company; (b) you received a police citation at the time of the police report; (c) you have been involved in numerous reported auto accidents within a brief period of time and you are now considered a "high risk".
2. Filing your Med Pay does not relieve the other party from having to pay in full for your loss. Filing Med Pay will help to ensure that you are not left to pay medical bills if the other driver's insurance company refuses to make payment to you for any reason.

If for any reason your Med Pay account does not pay, we will advise you and you can choose to file on your major medical insurance at that time. Your account balance will still be your responsibility.

OUR OFFICE FINANCIAL POLICY

As long as our office is filing your med pay and health insurance and as long as these companies are continuing to cover your charges, we will waive collection of payment from you at the time of service. If we receive overpayment on your account we will be happy to refund you the difference, provided we are not under a duty to refund the insurance company.

PAYMENT AGREEMENT

I understand that I am being treated for injuries sustained in a motor vehicle accident. I am aware that I do not have medical coverage benefits (Med Pay) on my automobile insurance policy which is the primary insurance in the event of an automobile accident. I further understand that my health care insurance becomes my secondary insurance in the event of an accident however your insurance company may not cover chiropractic care and they are not responsible for any bills incurred due to a motor vehicle accident that are on an attorney lien or may be in the process of litigation and may deny all claims. After reading the above statements I am fully aware that I am responsible for any bills incurred for the treatment due to the motor vehicle accident and I am also aware that Barnhill Chiropractic is extending me a credit for treatment until my settlement is complete. Once released from care and I have settled my case I agree to come in within 10 days and pay my balance in full.

Patient Name (Printed): ____

Signature: ____

Date: ____

Witness: ____

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.