LaRocca CHIROPRACTIC

Patient Information

Patient: _____
Email Address: _____
Address:
_____
Sex: M or F
Age: _____
Birthdate:_____
Social Security #: _____
Occupation: _____
Employer:
_____

Phone Numbers

Home : _____
Cell: _____
Work: _____
Emergency Contact
Name: _____
Relationship: _____
Contact Phone Number_____

Pregnancy Disclaimer:

Women: Is there any chance you are pregnant?

Yes _____ **Due date:** _____
No_____

Medical Information

Primary Care Physician:
_____
PCP phone # _____

Are you presently taking an medications (Over the counter or Prescription) or vitamins?

1._____
2._____
3._____
4._____

What treatment have you already received for this condition you are coming in for today? (Circle)

Medication Surgery PT None

Chiropractic Injections

If currently being treated, by whom and when for this condition?

_____

_____

Trauma or Accidents Information:
Is condition due to accident? Y/N
Date_____
__Auto __Work __ Home __ Other

Please Be Sure to Give the Receptionist a copy of your Insurance Cards and Drivers License

Christopher LaRocca, DC

5465 Commercial Way Spring Hill, FL 34606 / 43 W. Fort Dade Ave Brooksville, FL

Phone: 352-835-7985 Fax: 352-835-7987 / Phone: 352-593-5937 Fax: 352-593-5939

Website: www.laroccachiro.com

LaRocca CHIROPRACTIC

Patient Name: _____ Date: _____

General Information about Condition

What is the main reason for coming in? _____

When did the symptoms appear? _____

How did you injure the area? _____

Headaches: How many times per day/ week? Location? _____

Neck: Type of Pain: __ Sharp __ Dull__ Stabbing __Aching ___Radiating __ burning __ Throbbing __ Numbness __ Tingle __ Weakness

Pain Radiates Into: Shoulder / Arm / Hand ___ Right ___Left __ both

Severity of Pain: ___ Mild ___ Moderate ___ Severe

Mid back: Type of Pain: __ Sharp __ Dull__ Stabbing __Aching ___Radiating __ burning __ Throbbing __ Numbness __ Tingle __ Weakness

Severity of Pain: ___ Mild ___ Moderate ___ Severe

Low Back: Type of Pain: __ Sharp __ Dull__ Stabbing __Aching ___Radiating __ burning __ Throbbing __ Numbness __ Tingle __ Weakness

Pain Radiates Into: Hip / Leg / Feet ___ Right ___Left __ both

Severity of Pain: ___ Mild ___ Moderate ___ Severe

Other area: _____ Type of Pain: __ Sharp __ Dull__ Stabbing __Aching ___Radiating __ burning __ throbbing __ Numbness __ Tingle __ Weakness

Severity of Pain: ___ Mild ___ Moderate ___ Severe

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Medical History:

Have you missed work or school due to injury? Y / N

Do you smoke? Y / N If yes, number of packs _____

Do you drink? Y / N If yes, number of drinks _____

Have you been to this office before? Y / N

If yes list dates and reasons:

1. _____ __/__/__
2. _____ __/__/__
3. _____ __/__/__

Past Surgeries or Hospitalizations:

4. _____ __/__/__
5. _____ __/__/__
6. _____ __/__/__

Allergies: Y / N

_____

Please mark any conditions that you currently have or conditions that you have had in the past: Please check "P" for past and "C" for current!!!

P / C	P / C	P / C
__ /__ AIDS/HIV	__/__ Hepatitis__	__/__ Rheumatoid Arthritis
__ /__ Prostate Problems	_ _/__ Heart Burn	__/__ Osteoarthritis
__ /__ Asthma	_ _/__ Herniated disc	__/__ Pneumonia
__ /__ Osteoporosis	__/__ Multiple Sclerosis	__/__ Hernia
__ /__ High Cholesterol	_ _/__ Heart Attack	__/__ Cancer Type_____

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Medical Release Information

I, _____, Authorize LaRocca Chiropractic LLC to receive copies of all my medical records / and or x-ray films and reports for the purpose of Dr. Christopher LaRocca to view as part of my treatment.

This authorization is given pursuant Florida Statute 456.057 and HIPPA regulations. I understand that Florida Statute 4566.057(10) makes clear that third party to whom records are disclosed and prohibited from further disclosing any information in the medical record request without the expressed written consent of the patient or patient's legal representatives.

Patient Signature: _____

Patients Date of Birth: _____

Today's Date: _____

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____ acknowledge that I was provided with copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be in my patient file for 6 years.

Patient / Guardian Signature: _____ Date: _____

LaRocca Chiropractic may leave messages on my answering machine or cell phone: Y / N

Patient / Guardian Signature: _____ Date: _____

In addition to the allowable disclosures described in the "Notice of Privacy Practices", I specifically authorize disclosure of my protected health information to the following:

Please print name and what is your relationship to said person:

1. _____
2. _____
3. _____

For treatment period between _____ and _____ **"If left blank we may release all dates"**

Patient / Guardian Signature: _____ Date: _____

Office Staff Witness Signature: _____ Date: _____

Dr. Christopher LaRocca, DC

5465 Commercial Way Spring Hill, FL 34606 / 43 W. Fort Dade Ave Brooksville, FL

Phone: 352-835-7985 Fax: 352-835-7987 / Phone: 352-593-5937 Fax: 352-593-5939

Our Financial Policy:

Thank you for choosing LaRocca Chiropractic LLC as your healthcare provider. Our staff and I are committed to providing the best quality of care possible. The staff will work promptly to make sure your paperwork is filed accurately in a timely manner.**I understand that the Health and Accident insurance policies are an arrangement between the insurance company and me the policy holder. I understand that the services provided by LaRocca Chiropractic LLC is in no way a promise of payment by my insurance company. If my insurance company denies my claim(s) for any reason or misquotes my benefits to LaRocca Chiropractic LLC, the balance of the account will be billed to me and due to LaRocca Chiropractic LLC.** Direct payments made from the insurance companies to the Doctor's office will be credited to my account upon receipt and any balances due will be my responsibilities. All services rendered by LaRocca Chiropractic LLC to me are my personal responsibility and I agree to make payment for services to the Doctor's office. **I understand that if I suspend or terminate my care and treatment any and all fees for services rendered will be immediately due and payable.** Should third party collection become necessary, I agree to pay all fees involved in the collections process. I have read and fully understand the financial policy as written. I authorize the doctor at LaRocca Chiropractic LLC to examine and treat my condition as deemed appropriate through the use of Chiropractic Health Care. I give permission for these procedures to be performed.

I am the responsible party and or legal guardian for payment and treatment received on this account. The doctor provides only Chiropractic Care and is not responsible for any pre-existing medically diagnosed conditions or for making any medical diagnosis.

Print Patietnts Name: _____ **Date:** _____

Patient's /Guardians Signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____

Authorization and Assignment:

By LaRocca Chiropractic LLC providing care to me, I agree to the following:

1. Authorization to release any medical information deemed appropriate concerning my condition to any insurance company, attorney or adjustor in order to process any claim for reimbursement for charges incurred.
2. I authorize the direct payment to LaRocca Chiropractic LLC for the monetary summed owed by my attorney out of any settlements of my case.
3. In the event an insurance company is obligated by contractual agreement to make payment to me, or to you for the charges made for service rendered and refuses to make payment upon demand by you, I hereby assign and transfer to you the cause of action that exist in my favor against any such company and authorize you to prosecute said action earlier in my name as you see fit and further authorize you to compromise, settle or otherwise resolve said claim as you see fit. It is understood, however that all reasonable efforts have been made to collect the sums due from the insurance company or companies contractually obligated, you will refrain from attempt and efforts to collect he amounts owed directly from me. I understand that whatever amounts you do not collect from insurance company's proceeds, whether it be all or part of what is due, I personally owe you.
4. In addition to the above, I hereby waive the statute of limitations on collections and/or recovery in this state of Florida.
5. I further agree that this authorization is irrevocable until all monies owed to LaRocca Chiropractic LLC are paid in full.
6. I authorize the use of this signature on all insurance submissions.

Patients / Guardians Signature _____ **Date** _____

LaRocca CHIROPRACTIC

Patient Questionnaire – Auto-Accident

Patient Name: _____ Today's Date: ___/___/___

Basic Information about the Accident:

Date Accident Occurred or Started: ___/___/___ Time of Day when Accident Occurred or Started: ___:____ AM / PM

Describe how the Accident took place: _____

_____

_____

_____

Describe the condition or symptoms caused by the Accident: _____

_____

_____

_____

Auto-Accident Specific Information:

Were you the: ☐ Driver ☐ Passenger ☐ Pedestrian

Automobile you were in: Year _____ Make _____ Model _____

Damage to your car: ☐ Front ☐ Rear ☐ Pedestrian ☐ Driver Side ☐ Passenger Side ☐ Bumper ☐ Fender

Damage Amount Estimate: $_____ : ☐ Minor ☐ Major ☐ Totaled

Other Automobile: Year _____ Make _____ Model _____

Damage to other car: ☐ Front ☐ Rear ☐ Pedestrian ☐ Driver Side ☐ Passenger Side ☐ Bumper ☐ Fender
☐ Minor ☐ Major ☐ Totaled

Where did the accident happen? Street Names: _____ City/State _____

Was it? ☐ Controlled Intersection ☐ Uncontrolled ☐ Not Intersection

Was there a traffic light? ☐ None ☐ Green ☐ Red ☐ Turn Arrow ☐ Stop Sign

Were you: ☐ Slowly Moving ☐ Moving ☐ Stopped

Weather Conditions: ☐ Sunny ☐ Rainy ☐ Cloudy

Street Surface: ☐ Dry ☐ Wet ☐ Slick ☐ Icy ☐ Pavement ☐ Other _____

Type of Impact: ☐ Rear end ☐ Front ☐ Side Impact ☐ Roll Over

Brakes on Impact: ☐ Locked Tight ☐ Loosely Applied ☐ Foot not on brake

How far did your car move? ☐ Did not move ☐ Moved 1-5 ft ☐ Moved 6-10 ft ☐ Moved over 10 ft

Where were you seated in the vehicle: _____ Wearing Seat belt? ☐ Yes ☐ No

Shoulder harness: ☐ Yes ☐ No Headrest: ☐ Yes ☐ No Headrest Position: ☐ Up ☐ Down

Is the car equipped with airbags? ☐ Yes ☐ No Did they deploy? ☐ Yes ☐ No

Did you see the impact coming? ☐ Yes ☐ No Did you brace yourself for impact? ☐ Yes ☐ No

On impact, your head was looking: ☐ Ahead ☐ Behind ☐ Up ☐ Down ☐ To the Right ☐ To the Left

On impact were you: ☐ Thrown forward ☐ Thrown backwards ☐ Thrown sideways ☐ Other _____

Did your body hit anything inside the car? ☐ Yes ☐ No Body Part: _____

What did it hit? _____

Head trauma? ☐ Yes ☐ No Loss of Consciousness? ☐ Yes ☐ No For how long? _____

Do you remember the accident happening? ☐ Yes ☐ No

Hospital? ☐ Yes ☐ No Name of hospital: _____ how long there? _____

Taken by ambulance? ☐ Yes ☐ No

X-rays taken? ☐ Yes ☐ No X-ray areas: ☐ Neck ☐ Mid-back ☐ Low-back ☐ Other X-rays _____

Medication Given? ☐ Yes ☐ No RX: _____

Other instruction: _____ Follow-up: _____

Please indicated any other healthcare providers who the Patient has seen for the condition or symptoms:

Name	Type of Licensure	Date of Last Visit
_____	_____	___/___/___
_____	_____	___/___/___

Prior to the accident did you suffer from the symptoms that you are currently seeking care for? ☐ Yes ☐ No

Have you missed work or school due to your injuries? ☐ Yes ☐ No

Notes: _____

_____

_____

_____

ASSIGNMENT OF BENEFITS FORM:

Pursuant to Florida Statute 627.736(5) the undersigned patient hereby **assigns** the benefits of insurance and any and all causes of action available under the policy of automobile insurance with, _____ Insurance Company to LaRocca Chiropractic to receive payment for services rendered to the undersigned and which are payable under Personal Injury Protection Coverage (PIP) and/or Medical Payments Coverage of the policy of automobile insurance provided by _____ Insurance Company. In the event that my Insurance Company reduces and/or makes partial payment of any medical bills submitted on my behalf, this shall serve as notice to my Insurance Company that I do not agree with such reductions and/or partial payments and I direct my Insurance Company to place the disputed amount in escrow so that my benefits do not exhaust before this dispute is resolved.

As prescribed by Florida Statute 627.730-627.741, all payments shall be overdue if not paid within 30 days after the insurer is furnished written notice of the fact of a covered loss and the amount of same. All overdue payments shall bear simple interest at the rate of 10% per annum.

By virtue of this assignment, the undersigned directs that all payments should be issued solely in the provider's name and forwarded directly to the office of LaRocca Chiropractic.

In the event of a dispute involving payment of my physician's bill, in order to maximize the benefits available under my policy coverage, and to continue to receive necessary treatment while the dispute is being resolved, I request the company adhere to the following: Assuming there is coverage remaining at the time the Company receives the physician's bill, if the company fails to pay LaRocca Chiropractic the full amount of the treatment bills submitted, to avoid the exhaustion of coverage while this provider pursues its rights under this **Assignment, I authorize and direct the Insurance Company, to set aside and place is escrow, an amount equal to the full amount of any such reduction, and to hold that amount in escrow until the dispute is resolved in the appropriate forum.**

It is acknowledged and agreed that in the event I have a wage loss claim, that LaRocca Chiropractic assignment takes precedence.

Further, I authorize and direct my Insurance Company to provide LaRocca Chiropractic and/or their Attorney, an updated copy of the PIP and Medical Payments coverage payment record as needed.

It is agreed that this assignment will remain in full force until 48 hours after LaRocca Chiropractic receives written notice that it is being revoked. It is specifically agreed that any such revocation of this Assignment will not apply to any treatment or associated expenses incurred on or before appropriate notice of the revocation is received by LaRocca Chiropractic, LLC.

The undersigned agrees to pay any applicable deductible or co-payment by the available PIP and/or Medical Payments insurance coverage. Further, the undersigned agrees to pay all outstanding balances in excess of the available insurance coverage limits.

_____

Patient's Signature Date

_____

Print Patient Name

The undersigned hereby accepts the above assignment of Insurance benefits, including any an all causes of action available to the above mentioned patient under said policy provided by _____ Insurance Company for bills and expenses for services provided to this patient. The Insurance Company should make any and all payments for such bills and expenses solely to me, and send the payment to my office.

_____

Practice Name Date

LaRocca CHIROPRACTIC

Law Firm: _____

_____

TO: Attorney _____
Address:_____
Phone: _____

RE: Health Reports and Doctor's Lien

Patient Name: _____
Date of Accident/Injury: _____

I hereby authorize the above doctor to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him for his professional services rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgement or verdict as may be necessary adequately to protect said doctor. I hereby further give a lien on my case to said doctor against any and all proceeds of any settlement, judgement or verdict which may be paid to you, my attorney, or to any subsequent attorney or law firm who may represent me, or myself as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all professional bills submitted by him for service rendered me and that this agreement is made solely for said doctor's additional protection and in consideration on any settlement, judgement or verdict by which I may eventually recover said fee. This agreement is irrevocable.

Patients Signature: _____ Dated: _____
Witness: _____ Dated: _____

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgement or verdict as may be necessary adequately to protect the said doctor named above.

Attorney's Signature: _____ Dated: _____

A photocopy or facsimile of this agreement shall have the same force as an original.

Attorney: Please date, sign and return the original to the Doctor's office at once.

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 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. This means that no person has initiated contact with me and/or persuaded me to use the doctor or licensed professional, clinic, or medical institution that provided the services.
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.

The undersigned licensed medical professional 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. I have **explained** the services rendered 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.

Insured Person (patient receiving treatment) or Guardian of Insured Person:

_____	_____	_____
Name *(PRINT or TYPE)*	Signature	Date

Licensed Medical Professional Rendering Treatment *(Signature by his or 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.