Alexander Spine Center

10720 Park Blvd. Suite A
Seminole, FL 33772

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name: _____ **Last Name**: _____ **MI**: _____

Date of Birth: ____/____/____ **SSN**: _____-____-_____ **Gender**: ( ) Male ( ) Female

Email address: _____@_____ **Preferred Language**: _____

Address: _____ **Apt. #**: _____

City: _____ **State**: _____ **Zip Code**: _____

Home Phone: _____ **Work**: _____ **Cell**: _____

Marital Status: ( ) Single ( ) Married ( ) Widowed ( ) Divorced **Children, Ages**: _____

Emergency Contact:_____ **Relationship**: _____ **Phone**:_____

Your Employer: _____ **Occupation**: _____

Employers Address: _____

Smoking Status: ( ) Every Day Smoker ( ) Occasional Smoker ( ) Former Smoker ( ) Never Smoked

CMS requires providers to report both race and ethnicity

Race : ( ) American Indian or Alaska Native ( ) Asian ( ) Black or African American ( ) White (Caucasian)
( ) Native Hawaiian or Pacific Islander ( ) Other ( ) I Decline to Answer

Ethnicity: ( ) Hispanic or Latino ( ) Not Hispanic or Latino ( ) I Decline to Answer

Are you currently taking and medications? (Please include regularly used over the counter meds)

Medication Name	Dosage and Frequency (i.e. 5 mg once a day)

*If taking more than 3 medications, please continue list on back of page.

Do you have any medication allergies?

Medication Name	Reaction	Onset Date

☐ I choose to decline receipt of my clinical summary after every visit (There summaries are often blank as a result of the nature and frequency of chiropractic care.)

Patient Signature: _____ Date: _____

For office use only
Height:_____ Weight: _____ Blood Pressure: _____/_____ Heart Rate: _____

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10720 Park Blvd. Suite A
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Confidential Health Questionnaire

Patient Name: _____ **Date**: _____

What is your major complaint? _____

_____

How do you think your problem began? _____

How long have you had this problem? _____days _____months _____years

How are your symptoms changing with time? ( ) Getting Worse ( ) Staying the same ( ) Getting Better

What aggravates your problem?_____

What alleviates your problem?_____

Have you had this problem before?_____

Is this condition interfering with your: ( ) Work ( ) Sleep ( ) Daily Routine ( ) Other _____

This problem prevents me from: _____

Have you been treated for this problem in the past? ( ) No ( ) Yes Date Seen: _____

( ) Chiropractor ( ) Neurologist ( ) Massage Therapist ( ) Primary Care Physician ( ) No one

( ) ER Physician ( ) Orthopedist ( ) Physical Therapist ( ) Other: _____

List surgical operations and years: _____

_____

_____

Do you have a family physician? Name _____

Have you previously been in an auto accident, work or had any other personal injury? ( ) **Yes** ( ) **No**

Describe (Include date of occurrence): _____

_____

Health Insurance Information: (Please complete if you have insurance)

Primary Health Insurance:

Company:_____ PPO / HMO / Red / EMO / POS Insured Name: _____

Relationship to patient: Self / Spouse / Child / Other: _____ Insured DOB: _____

Policy #: _____ Group #: _____ Insured SSN: _____

Claim #: _____ Insurance Phone: _____ Insured Employer: _____

Secondary Health Insurance:

Company:_____ PPO / HMO / Red / EMO / POS Insured Name: _____

Relationship to patient: Self / Spouse / Child / Other: _____ Insured DOB: _____

Policy #: _____ Group #: _____ Insured SSN: _____

Claim #: _____ Insurance Phone: _____ Insured Employer: _____

Patient / Guardian Signature: _____ Date: _____

For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present		Past	Present		Past	Present	
☐	☐	Headaches	☐	☐	Chronic Sinusitis	☐	☐	Visual Disturbances
☐	☐	Neck Pain	☐	☐	High Blood Pressure	☐	☐	Dizziness
☐	☐	Upper Back Pain	☐	☐	Heart Attack	☐	☐	Diabetes
☐	☐	Mid Back Pain	☐	☐	Chest Pains	☐	☐	Excessive Thirst
☐	☐	Low Back Pain	☐	☐	Stroke	☐	☐	Frequent Urination
☐	☐	Shoulder Pain	☐	☐	Angina	☐	☐	Smoking/ Tobacco Use
☐	☐	Elbow/Upper Arm Pain	☐	☐	Kidney Stones	☐	☐	Drug/ Alcohol Dependence
☐	☐	Wrist Pain	☐	☐	Kidney Disorders	☐	☐	Allergies
☐	☐	Hand Pain	☐	☐	Bladder Infection	☐	☐	Depression
☐	☐	Hip Pain	☐	☐	Painful Urination	☐	☐	Systemic Lupus
☐	☐	Upper Leg Pain	☐	☐	Loss of Bladder Control	☐	☐	Epilepsy
☐	☐	Knee Pain	☐	☐	Prostate Problems	☐	☐	Dermatitis/ Eczema/ Rash
☐	☐	Ankle/Foot Pain	☐	☐	Abnormal Weight Gain/Loss	☐	☐	HIV / AIDS
☐	☐	Jaw Pain	☐	☐	Loss of Appetite	☐	☐	Pacemaker
☐	☐	Joint Pain/ Stiffness	☐	☐	Abdominal Pain			
☐	☐	Arthritis	☐	☐	Ulcer	**For Females Only**		
☐	☐	Rheumatoid Arthritis	☐	☐	Hepatitis			
☐	☐	Cancer	☐	☐	Liver/ Gall Bladder Disorder	☐	☐	Birth Control Pills
☐	☐	Tumor	☐	☐	General Fatigue	☐	☐	Hormonal Replacement
☐	☐	Asthma	☐	☐	Muscular Incoordination	☐	☐	Pregnancy ____ weeks

Have you ever been hospitalized? ( ) No ( ) Yes, why _____

Indicate if you have immediate family members with any of the following: ( ) Stroke ( ) Diabetes ( ) High Blood Pressure ( ) Rheumatoid Arthritis ( ) Lupus ( ) Heart Problems ( ) Cancer ( ) ALS

Social History – Check the boxes and fill in.

Current Weight _____ Have you recently lost or gained weight? _____

Mental Work ( ) Heavy ( ) Moderate ( ) Light Hours per day _____

Physical Work ( ) Heavy ( ) Moderate ( ) Light Hours per day_____

Exercise ( ) Heavy ( ) Moderate ( ) Light Hours per day _____ Type _____

Smoking ( ) Current ( ) Previous Packs / Day _____ No. of years _____

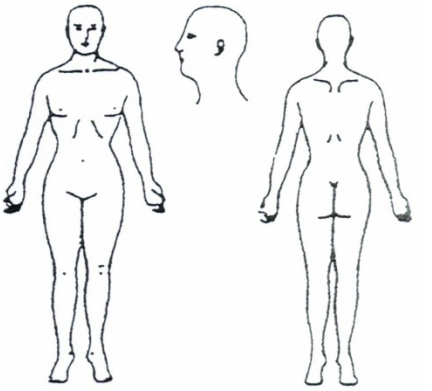
Alcohol Beer / Week _____ Liquor / Week _____ Wine / Week _____ No. of years _____

Caffeine (coffee, tea, cola) Cups / Day _____ No. of years _____

Aspirin No. / Day _____ No. of years _____

Mark the areas of your symptoms on the figure to the right. Use the following symbols:

Aches ^^^^ Numbness oooo Pins / Needles .... Stabbing ////



Intensity of your symptoms: (Circle One)

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (unbearable)

Patient / Guardian Signature: _____ Date: _____

Initial: _____

Motor Vehicle Collision/Personal Injury Questionnaire

Please answer all questions completely: (Please Print)

1. Name:_____ Date:_____

2. Please describe the collision in your own words:

_____

_____

_____

3. Where did the collision occur? City/Town:_____ State: _____

4. Date of collision:_____ Time:_____ AM / PM

5. Were you the: ☐ driver ☐ passenger ☐ pedestrian

6. If passenger, were you in the ☐ front seat ☐ right rear seat ☐ left rear seat

7. What type of vehicle were you in?_____

8. What type was the other vehicle?_____

9. Did your vehicle strike the other vehicle? ☐ Yes ☐ No

10. Was your vehicle struck by the other vehicle? ☐ Yes ☐ No

11. Was the impact from: ☐ the front ☐ the rear ☐ the left side ☐ the right side

12. What was the approximate speed at the time of impact?

Your vehicle_____ mph Other vehicle_____ mph

13. What was the weather at the time of the collision? ☐ Dry ☐ Wet ☐ Icy

14. Was your vehicle in: ☐ Park ☐ Neutral ☐ In gear ☐ Moving ☐ Stopped

15. Were your brakes being applied? ☐ Yes ☐ No

16. Was your vehicle shoved: ☐ Forward ☐ Backwards ☐ Sideways

17. At impact were you shoved: ☐ Forward ☐ Whipped Backwards ☐ Both

18. Did your seat have a head restraint (headrest)? ☐ Yes ☐ No

If yes, what was the position: ☐ Low ☐ Mid-Position ☐ High

Did your head ride over the headrest? ☐ Yes ☐ No

19. Did your hat/glasses end up in the back seat or rear window? ☐ Yes ☐ No

20. Did any part of your body hit the interior of the vehicle? ☐ Yes ☐ No

If yes, please specify what you struck: _____

_____

21. Did the vehicle go into a spin or roll as a result of the impact? ☐ Yes ☐ No

22. How much damage was there to the outside of the vehicle? ☐ None ☐ Some ☐ A Lot

23. How much damage was there inside the vehicle? ☐ None ☐ Some ☐ A Lot

24. At the point of impact, where did you experience pain? Be specific:

_____

_____

_____

Have you had any similar problems before? ☐ Yes ☐ No

Have you previously been in any motor vehicle accidents? ☐ Yes ☐ No

If so, list the dates of the previous accidents: _____

_____

25. Immediately after the accident were you: ☐ Conscious ☐ Dazed ☐ Unconscious

If you lost consciousness? For how long? _____

26. Were you wearing a seat belt? ☐ Yes ☐ No

27. Did the belt have a shoulder harness? ☐ Yes ☐ No

If yes, did it contribute to the pain you are experiencing? ☐ Yes ☐ No

Was your vehicle equipped with air bag(s)? ☐ Yes ☐ No

If yes, did it deploy? ☐ Yes ☐ No

28. At the time of impact were you: ☐ Looking Straight Ahead ☐ Looking to the Right ☐ Looking to the Left ☐ Looking Down ☐ Looking Up

29. Did your seat break as a result of the impact? ☐ Yes ☐ No

30. Were you braced for the impact? ☐ Yes ☐ No

31. Were you surprised by the impact? ☐ Yes ☐ No

32. Did you go to the hospital? ☐ Yes ☐ No

If yes, when? ☐ Right after the accident ☐ the next day ☐ other _____

If yes, how did you get there? ☐ Ambulance ☐ other _____

If by ambulance, did the ambulance attendants place you in a: ☐ Neck Brace ☐ Back Brace ☐ on a back board ☐ other _____

Did the ambulance attendants give you any medications or medical supplies? ☐ Yes ☐ No

If so what was given to you? _____

Name of the hospital that you went to? _____

Were x-rays taken at the hospital? ☐ Yes ☐ No

Were any special diagnostic tests performed i.e. MRI or CT scans? ☐ Yes ☐ No

Did you receive any medications while at the hospital? ☐ Yes ☐ No

When discharged from the hospital where you provided with a prescription for medications for home use? ☐ Yes ☐ No

33. At the time of the accident of record were you employed? ☐ Yes ☐ No

If employed at the time of the accident of record who was your employer?

_____

What type of work do you do? _____

What are your job requirements? _____

Have you lost any days of work due to this accident of record? ☐ Yes ☐ No

If yes, give dates or number of days lost:_____

Does your work require ☐ light ☐ moderate ☐ heavy mental requirements?

Does your work require ☐ light ☐ moderate ☐ heavy physical requirements?

How many days per week do you work? _____ How many hours per day?_____

34. Do you exercise, if so what type, and how many days per week and the number of hours? _____

(Signature and Today's Date) _____

Patient's Name_____ Number_____ Date_____

NECK DISABILITY INDEX

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. **Please answer every section and mark in each section only ONE box** which applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box which MOST CLOSELY describes your problem.**

Section 1 - Pain Intensity

- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

Section 2 -- Personal Care (Washing, Dressing, etc.)

- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally but it causes extra pain.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help every day in most aspects of self care.
- ☐ I do not get dressed, I wash with difficulty and stay in bed.

Section 3 – Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4 – Reading

- ☐ I can read as much as I want to with no pain in my neck.
- ☐ I can read as much as I want to with slight pain in my neck.
- ☐ I can read as much as I want with moderate pain.
- ☐ I can't read as much as I want because of moderate pain in my neck.
- ☐ I can hardly read at all because of severe pain in my neck.
- ☐ I cannot read at all.

Section 5-Headaches

- ☐ I have no headaches at all.
- ☐ I have slight headaches which come infrequently.
- ☐ I have slight headaches which come frequently.
- ☐ I have moderate headaches which come infrequently.
- ☐ I have severe headaches which come frequently.
- ☐ I have headaches almost all the time.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered a significant activities of daily living disability.
(Score___ x 2) / (____Sections x 10) = _____ %ADL_____

Section 6 – Concentration

- ☐ I can concentrate fully when I want to with no difficulty.
- ☐ I can concentrate fully when I want to with slight difficulty.
- ☐ I have a fair degree of difficulty in concentrating when I want to.
- ☐ I have a lot of difficulty in concentrating when I want to.
- ☐ I have a great deal of difficulty in concentrating when I want to.
- ☐ I cannot concentrate at all.

Section 7—Work

- ☐ I can do as much work as I want to.
- ☐ I can only do my usual work, but no more.
- ☐ I can do most of my usual work, but no more.
- ☐ I cannot do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I can't do any work at all.

Section 8 – Driving

- ☐ I drive my car without any neck pain.
- ☐ I can drive my car as long as I want with slight pain in my neck.
- ☐ I can drive my car as long as I want with moderate pain in my neck.
- ☐ I can't drive my car as long as I want because of moderate pain in my neck.
- ☐ I can hardly drive my car at all because of severe pain in my neck.
- ☐ I can't drive my car at all.

Section 9 – Sleeping

- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed (less than 1 hr. sleepless).
- ☐ My sleep is moderately disturbed (1-2 hrs. sleepless).
- ☐ My sleep is moderately disturbed (2-3 hrs. sleepless).
- ☐ My sleep is greatly disturbed (3-4 hrs. sleepless).
- ☐ My sleep is completely disturbed (5-7 hrs. sleepless).

Section 10 – Recreation

- ☐ I am able to engage in all my recreation activities with no neck pain at all.
- ☐ I am able to engage in all my recreation activities, with some pain in my neck.
- ☐ I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
- ☐ I am able to engage in a few of my usual recreation activities because of pain in my neck.
- ☐ I can hardly do any recreation activities because of pain in my neck.
- ☐ I can't do any recreation activities at all.

Comments_____
%ADL

Reference: Vernon, Mior. JMPT 1991; 14(7): 409-15

FORM 501

Patient's Name_____ Number_____ Date_____

LOW BACK DISABILITY QUESTIONNAIRE (REVISED OSWESTRY)

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage in everyday life. **Please answer every section and mark in each section only ONE box** which applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box which MOST CLOSELY describes your problem.**

Section 1 - Pain Intensity

- ☐ I can tolerate the pain without having to use painkillers.
- ☐ The pain is bad but I can manage without taking painkillers.
- ☐ Painkillers give complete relief from pain.
- ☐ Painkillers give moderate relief from pain.
- ☐ Painkillers give very little relief from pain.
- ☐ Painkillers have no effect on the pain and I do not use them.

Section 2 -- Personal Care (Washing, Dressing, etc.)

- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally but it causes extra pain.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help every day in most aspects of self care.
- ☐ I do not get dressed, I wash with difficulty and stay in bed.

Section 3 – Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4 – Walking

- ☐ Pain does not prevent me from walking any distance.
- ☐ Pain prevents me from walking more than one mile.
- ☐ Pain prevents me from walking more than one-half mile.
- ☐ Pain prevents me from walking more than one-quarter mile
- ☐ I can only walk using a stick or crutches.
- ☐ I am in bed most of the time and have to crawl to the toilet.

Section 5 -- Sitting

- ☐ I can sit in any chair as long as I like
- ☐ I can only sit in my favorite chair as long as I like
- ☐ Pain prevents me from sitting more than one hour.
- ☐ Pain prevents me from sitting more than 30 minutes.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ Pain prevents me from sitting almost all the time.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered significant activities of daily living disability.
(Score___ x 2) / (____Sections x 10) = _____ %ADL

Section 6 – Standing

- ☐ I can stand as long as I want without extra pain.
- ☐ I can stand as long as I want but it gives extra pain.
- ☐ Pain prevents me from standing more than 1 hour.
- ☐ Pain prevents me from standing more than 30 minutes.
- ☐ Pain prevents me from standing more than 10 minutes.
- ☐ Pain prevents me from standing at all.

Section 7 -- Sleeping

- ☐ Pain does not prevent me from sleeping well.
- ☐ I can sleep well only by using tablets.
- ☐ Even when I take tablets I have less than 6 hours sleep.
- ☐ Even when I take tablets I have less than 4 hours sleep.
- ☐ Even when I take tablets I have less than 2 hours sleep.
- ☐ Pain prevents me from sleeping at all.

Section 8 – Social Life

- ☐ My social life is normal and gives me no extra pain.
- ☐ My social life is normal but increases the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing.
- ☐ Pain has restricted my social life and I do not go out as often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have no social life because of pain.

Section 9 – Traveling

- ☐ I can travel anywhere without extra pain.
- ☐ I can travel anywhere but it gives me extra pain.
- ☐ Pain is bad but I manage journeys over 2 hours.
- ☐ Pain is bad but I manage journeys less than 1 hour.
- ☐ Pain restricts me to short necessary journeys under 30 minutes.
- ☐ Pain prevents me from traveling except to the doctor or hospital.

Section 10 – Changing Degree of Pain

- ☐ My pain is rapidly getting better.
- ☐ My pain fluctuates but overall is definitely getting better.
- ☐ My pain seems to be getting better but improvement is slow at the present.
- ☐ My pain is neither getting better nor worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

Comments_____

Reference: Fairbank, Physiotherapy 1981; 66(8): 271-3, Hudson-Cook. In Roland, Jenner (eds.), Back Pain New Approaches To Rehabilitation & Education. Manchester Univ Press, Manchester 1989: 187-204

Alexander Spine Center
10720 Park Blvd, Suite A
Seminole, FL 33772
Ph: 727.397.3000

Pain Disability Questionnaire (PDQ)

Name: _____ **Date:** _____

(Please Print Your Name)

Instructions: These questions ask for your views about how your pain currently affects how you function in everyday activities. Please answer every question and circle the ONE number on EACH scale that best describes how you feel.

1. Does your pain interfere with your normal work inside and outside the home?
Work normally *Unable to work at all*
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

2. Does your pain interfere with personal care (such as washing, dressing, etc.)?
Take care of myself completely *Need help with all my personal care*
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

3. Does your pain interfere with your traveling?
Travel anywhere I like *Only travel to see doctors*
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

4. Does your pain affect your ability to sit or stand?
No problems *Cannot sit / stand at all*
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

5. Does your pain affect your ability to lift overhead, grasp objects, or reach for things?
No problems *Cannot do at all*
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

6. Does your pain affect your ability to lift objects off the floor, bend, stoop, or squat?
No problems *Cannot do at all*
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

7. Does your pain affect your ability to walk or run?
No problems *Cannot walk / run at all*
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

8. Has your income declined since your pain began?
No decline *Lost all income*
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

Please initialize _____

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Ph: 727.397.3000

9. Do you have to take pain medication every day to control your pain?
No medication needed *On pain medication throughout the day*
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

10. Does your pain force you to see doctors much more often than before your pain began?
Never see doctors *See doctors weekly*
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

11. Does your pain interfere with your ability to see the people who are important to you as much as you would like?
No problem *Never see them*
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

12. Does your pain interfere with recreational activities and hobbies that are important to you?
No interference *Total interference*
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

13. Do you need the help of your family and friends to complete everyday tasks (including both work outside the home and housework) because of your pain?
Never need help *Need help all the time*
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

14. Do you now feel more depressed, tense, or anxious than before your pain began?
No depression / tension *Severe depression / tension*
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

15. Are there emotional problems caused by your pain that interfere with your family, social, and / or work activities?
No problems *Severe problems*
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

_____
Signature

Administering the Pain Disability Questionnaire
If you as the examinee fail to mark a question, the default score for that question is 0.

Alexander Spine Center

10720 Park Blvd. Suite A.
Seminole, FL 33772

ASSIGNMENT AND AUTHORIZATION

You are hereby authorized to disclose and/or furnish my attorney(s) with any and all medical information, bills, and/or records in your possession which they request in reference to any illnesses and injuries which I have suffered.

I further, irrevocably assign to you, and authorize and direct said attorneys to pay from the proceeds of any recovery in my case all reasonable fees for services provided by you, including fees for preparation and testimony, as a result of the injury or condition heretofore mentioned. I understand that this in no way relieves me of my personal primary obligation to pay for such services and that the signing of this form does not prohibit customary billing by you. All bills shall be paid promptly in the usual manner. This specifically includes but is not limited to any and all Pip, Med-Pay, or Med-Expense payments. I hereby further give a lien on my case to said doctors against any and all proceeds of any settlement, judgment, or verdict which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated or injuries in connection therewith

It is further understood that there is a Statute Of Limitations applicable to any civil claim you may bring. In view of this, I hereby agree that the Statute Of Limitations with respect to any claim for services mentioned above will not begin to run until I send you a denial, in writing, of any outstanding balance. Said written denial *must* be mailed certified mail, return receipt requested, and said return receipt will be required to show proof of the notice of this denial.

Signature: _____ Date: _____

Witness: _____

THE UNDERSIGNED ATTORNEY FOR THE PATIENT REFERRED TO ABOVE HEREBY AGREES TO COMPLY FULLY WITH THE FOREGOING "AUTHORIZATION AND ASSIGNMENT" AND AGREES TO ADVISE THE NAMED ASSIGNEE IN WRITING THE STATUS OF THE CLAIM OF THE ATIENT WITHIN TEN (10) DAYS OF THE REQUEST, AND AGREES TO NOTIFY THE ASSIGNEE IF THE ATTORNEY CEASES TO REPRESENT THIS PATIENT AND/OR IF THE CLAIM IS DROPPED OR DENIED.

_____
Attorney

Alexander Spine Center

10720 Park Blvd Suite A
Seminole, FL 33772

ASSIGNMENT OF BENEFITS AND RIGHT TO SUE FOR PIP

To Whom It May Concern:

I hereby authorize and direct any insurance company with whom I may make a claim for PIP or Med-Expense benefits, and/or my attorney, to pay directly **Alexander Chiropractic Center**, (hereinafter referred to as "this health provider"), any money that is owed to this health provider for services provided to me.

In the event that any insurance company that is obligated to reimburse me for charges I incur with this health provider refuses to make such payments after demand is made by either me or this health provider, I hereby assign and transfer to this health provider any and all causes of action that I have against said insurance company, including but not limited to the right to bring a lawsuit, for the failure to pay the available PIP and/or Med-Expense benefits up to the amount of this health provider's full bill.

I authorize this health provider to bring any such cause of action either in my name or in this health provider's name. I further authorize this health provider to compromise, settle or otherwise resolve any such claim arising out of the insurance company's failure to pay to this health provider the full limit of available PIP or Med-Expense benefits up to the amount to its full bill.

I understand that I remain personally responsible for the total amounts due to this health provider for its services. I understand that payment is due at the time services are rendered, and that this health provider is providing a *courtesy* to me by trying to have the bill paid through alternative sources. I agree that this document does not constitute any consideration for this health provider to await payment, and that payment may be demanded from me immediately upon the rendering of services.

I authorize this health provider to release any information pertinent to my case to any insurance company or attorney to facilitate the collection of my bill. I agree that this health provider be given Power of Attorney to endorse or sign my name on any and all checks for payment of my doctor bill.

Patient: _____

Date: _____

Alexander Spine Center

10720 Park Blvd Suite A. Ph: 727-397-3000
Seminole, FL 33772 Fax:727-397-3004

Authorization To Pay Physician

I, _____, hereby authorize the _____ insurance company to pay by check made out and mailed directly to:

Alexander Spine Center
10720 Park Blvd. Suite A.
Seminole, Florida 33772

The medical and surgical expense benefits allowable and otherwise payable to me under my current insurance policy, as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to the above-mentioned assignee, and I agree to pay, in a current manner, the balance of said professional service charges over and above this insurance payment.

If my current policy prohibits direct payment to the doctor, I authorize you to make the check out to me and mail it as follows:

_____
C/O Alexander Spine Center
10720 Park Blvd. Suite A.
Seminole, Florida 33772

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. A photocopy of this assignment shall be considered as effective and valid as the original.

I understand that ultimately I am financially responsible for all services rendered to me.

I hereby give my permission to **Alexander Spine Center** to release any information requested by my insurance company acquired in the course of my examination and treatment.

I hereby give my permission to **Alexander Spine Center** to file formal grievances with the Florida Insurance Commissioner when necessary on my behalf, should my insurance company deny payment of all or part of my medical bills.

_____ _____
Patient / Guardian Signature Witness Signature

_____ _____
Claimant Signature Today's Date

Alexander Spine Center

10720 Park Blvd. Suite A. Seminole, FL 33772
Phone: 727-397-3000 Fax: 727-397-3004
Dr. Daniel W. Alexander, DC

Medical Records Release Authorization

I, _____, hereby release any hospital, physician, health care provider or facility and authorize _____ to furnish Alexander Spine Center any and all information with respect to any illness, disease, injury, history, or treatment and a copy of all records concerning the same.

A Photostat reproduction of this Medical Records Release Authorization shall serve, for all purposes, the same as the original hereof.

_____
Patient Signature

_____
Street Address

_____ _____
Date of Birth

_____
City, State and Zip

_____
Social Security Number

_____
Today's Date

_____
Date of Injury

_____
Witness Signature

ALEXANDER SPINE CENTER

Patient Guidelines

Welcome to our office! We are pleased that you have decided to care for your health with natural, conservative chiropractic and physical therapy care. The doctors and staff are committed to getting you healthy and keeping you that way.

Consistency for Best Results

1. It is important to understand the benefits of following through with your treatment plan as well as the consequences of stopping care early. Invest in the health of your spine and be committed to protecting your investment. Be consistent with your adjustments. If the doctor recommends (3) adjustments per week, please follow the recommendation. It takes time to retrain the muscles of your body to "hold" the adjustment. Consistency will yield the best results for maximum correction. Not following through the doctor's treatment plan is a loss of time and money.

Maintain Your Spine

1. Once the doctor has achieved correction of your spine, you will need to maintain those invested results with a scheduled maintenance program. Maintaining the health of your spine is like maintaining the performance of your car – a regular maintenance program will keep you and your car in optimal condition.

Missed Appointment Guideline

1. Please give the office a call if you are going to be late or if you have to miss an appointment. If you miss an appointment, please make it up within one week. Being consistently late or failing to show for a scheduled appointment without calling is unacceptable. We make every effort to schedule your appointments at a time that is convenient for you, we only ask that you show the same courtesy and respect when needing to reschedule an appointment.
2. It is our policy to recall patients who have missed appointments and have not rescheduled. Our recall program is designed to keep you "on track" with the treatment plan that the doctor has recommended for you.
3. We reserve the right to charge and we will charge a fee of $15 for each appointment cancelled or broken without 24 hours advance notice.

Payment Policies

1. Payment is due at the time of service. We accept most insurance and file the claims for you; however, it is your responsibility to verify your benefits in addition to the benefits we quote you from the insurance company. You are responsible for any amount not covered by the insurance company. If you do not have health insurance, our office has a "cash plan" that is designed to make care affordable to you. We accept cash, personal check, or charge (Visa/MC…with a balance of $10 or more).

Helping Others / Family Policy

1. Chiropractic adjustments are helping people everywhere find relief from their symptoms. If you have a friend or loved one who is in pain, do your part and tell them about chiropractic. Even if they are not in pain, everyone can benefit from having their spines checked on a regular basis. Just as you visit the dentist regularly to care for your teeth and gums, you should see a doctor of chiropractic regularly to care for your spine. You are never too old or too young to benefit from an adjustment. "An ounce of prevention equals a pound of care."

I have read and understand the above guidelines.

PrintName: _____ Signature:_____ Date: _____

ALEXANDER SPINE CENTER

PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patient), and may have to disclose personal health information for purposes of treatment, payment or health care operations. These entities are most often not required to maintain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you, should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer, Kimberly Welch.

You have the right to review our privacy notice, to request restrictions and revoke consent, in writing, after you have reviewed our privacy notice.

Print Name: _____ Signature: _____ Date: _____

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To Our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation and money. We want you to know that all of our employees, managers, clinicians, and physicians continually undergo training so that they may understand and comply with government rules and regulation regarding the Health Insurance Portability and Accountability Act (HIPPA) with particular emphasis on the "Privacy Rule". We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine uses of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way, to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect. Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients.

Dr. Daniel W. Alexander
10720 Park Blvd. Suite A.
Seminole, Florida 33772

DIAGNOSTIC IMAGING CONSULTANTS

Rudy N. Heiser, DC, MS, DACBR, Richard A. Leverone, DC, DACBR, FICC
Terry Sandman, DC, MPH, DACBR, A. Scott Thorpe, DC, DACBR

REFERRING DR.: ALEXANDER SPINE CENTER
10720 PARK BLVD., SUITE A SEMINOLE, FL 33772 **DANIEL ALEXANDER, D.C.**
PH: 727-397-3000 Fax: 727-397-3004 EMAIL: alexanderspinecenter@yahoo.com
Films/Date Exposed _____ ***Medical History***_____

****Please print and complete form with patient's signature****

Patient Name _____ Date of Birth _____ Sex ___M___F
Address _____ City/State/Zip _____
Phone _____ SS# _____ Case/Acct# _____

BILL: ____ PIP ____ Health/Other Ins. ____DR. ____Atty. ____Patient

Primary Insurance: _____ Phone _____
Adjuster_____ ID/Claim#_____
Address_____ Insured _____
City/State/Zip_____ Date of Injury____/____/____

Attorney: _____ Phone_____
Address_____City/State/Zip_____

****

ASSIGNMENT, LIEN AND AUTHORIZATION/INSURANCE BENEFITS

For and in consideration of receiving services by "Assignee" and for other good and valuable consideration, I hereby agree to the following: I authorize assignee to release any information pertinent to my case to any insurance company, adjuster, or attorney to facilitate collection under this Assignment, Lien, Reservation of Benefits and Authorization.

ASSIGNMENT OF BENEFITS, RESERVATION AND REQUEST TO ESCROW ANY DISPUTED BENEFITS:

I HEREBY ASSIGN MY insurance benefits and any and all causes of action available under my policy of automobile insurance to, DIAGNOSTIC IMAGING CONSULTANTS OF ST. PETERSBURG, P.A d/b/a DIAGNOSTIC IMAGING CONSULTANTS hereinafter, collectively referred to as the Assignee. Additionally, both the assignee and the undersigned patient acknowledge they are foregoing or assuming certain rights under this agreement that they would not otherwise have under normal circumstances, and as such, agree the same serves as additional consideration for this assignment of benefits to the provider/assignees. In the event my insurance company, obligated to make payments to me upon charges made by assignee for services, refuses to make or reduces such payments and in order to maximize the benefits available under my policy coverage, I hereby request the insurance company (assuming there is coverage remaining at the time the company receives the Assignees' bill and if the company fails to pay Assignee the full amount of the bill(s) submitted), to avoid exhaustion of coverage while Assignee pursues its rights under this Agreement, both parties to this agreement (the Assignee and I) further authorize, direct, notice and request the Insurance Company to set aside and place in escrow an amount equal to the full amount of any such denial or reduction, and to hold that amount in escrow until the dispute is resolved in the appropriate forum.

IN THE EVENT MY insurance company obligated to make payments to me upon the charges made by Assignee for their services refused to make such payments, upon demand by me or Assignee, I hereby assign and transfer to Assignee any and all causes of action that I might have or that might exist in my favor against such company and authorize Assignee to prosecute said cause of action either in my name or in Assignee name and further I authorize Assignee to compromise, settle or otherwise resolve said claim or cause of action as they see fit.

I AUTHORIZE ASSINGEE to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under this Assignment, Lien and Authorization. I agree that the above mentioned Assignee be given Special Power of Attorney to endorse/sign my name on any and all checks and claim forms for payment of my bill.

I UNDERSTAND THAT I remain personally responsible for the total amounts due the Assignee for their services as insurance coverage may only pay a certain percentage of the bill; as, I may have an insurance deductible or my insurance benefits may exhaust or otherwise be limited. I further understand and agree that this Assignment, Lien and Authorization does not require Assignee to await payments and they may demand payments from me immediately upon rendering services at their option, although the Assignee agrees to first demand immediate payment from the insurance company as their first means of pursuing payment for services rendered. Also, I understand that if this account is assigned to an attorney for collection and/or suit, the assignee shall be entitled to reasonable attorney fees and costs of collection. I also understand that, if any bad check is written, I agree to pay for those added costs.

Dated this _____ day of _____, 20 ___.

Patient Signature_____Printed Name_____Witness_____

5136 Central Ave., St. Petersburg, FL 33707
Phone: 727-579-2500 Toll Free: 877-579-8800 Fax 727-579-1060