Dr. Bruce Fischer, Dr. Naveed Shafi, Dr. Zahid Huq, Tamar Clarke RPT

851 Meadows Road, Suite 213, Boca Raton, Florida 33486
Telephone: 561.392.1333 Fax: 561.392.9707

Accident History
Date of Accident:_____
Today's Date _____

____ PIP
____ Workers Compensation
____ Slip & Fall
____ I. M. E.

Name: _____ Date of Birth: _____

Address: _____

City:_____ State: _____ Zip: _____

Telephone: _____Cell Telephone: _____Carrier _____ Work _____

Name of Pharmacy: _____ Pharmacy #: _____

Email Address: _____ _____ Married _____ Single _____ Divorced

Employer: _____ Occupation: _____

Address: _____ Phone: _____

Emergency Contact Person? _____ Phone _____ Relationship_____

Name of Primary Care Physician_____

Please list current medications_____

_____

LEGAL REPRESENTATION:

If you have an attorney, indicate his/her name, address and phone:

_____
_____
_____
Phone: ( ) _____

INSURANCE INFORMATION:
(MUST BE YOUR INSURANCE INFORMATION- PER FLORIDA NO-FAULT LAW)

Name of Company: _____
Claim Number: _____
Adjuster: _____
Telephone: ( ) _____

Have you reported this accident to your insurance agent or carrier?
____ Yes
____ No

Third party insurance you wish to provide:

_____
_____
_____

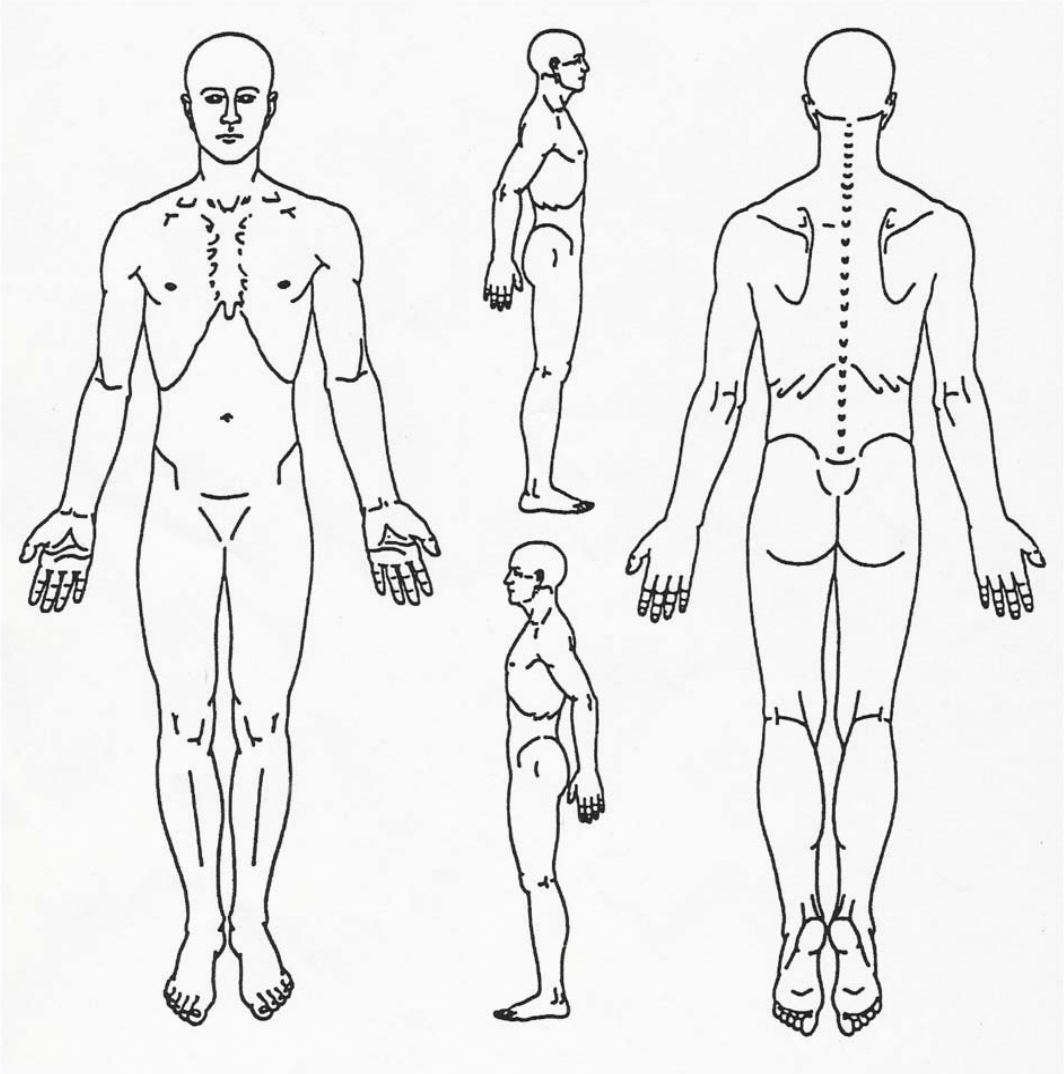
I understand and agree that health insurance policies are an arrangement between the insurance carrier and myself. Furthermore, I understand that Bruce M. Fischer, D.C., P.A. or Boca Trauma and Rehab will prepare any necessary reports or forms to assist me in making collection from my insurance carrier and that any amounts authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment.

Patient's Signature _____ Date_____

PAIN DRAWING

Please mark the figures below with the letters that best describe the sensation or pain you are feeling. Please mark areas where pain radiates or spreads with a ↑, ↓, or ←, → arrow to indicate the direction of radiating pain. (Include all affected areas)

A =	**Ache**	**B =**	**Burning**	**R =**	**Radiating Pain**	**D =**	**Dull Pain**
N =	**Numbness**	**S =**	**Stabbing**	**P =**	**Pins & Needles**	**O =**	**Other**



Please indicate how you would rate your pain (LOW) 0 1 2 3 4 5 6 7 8 9 10 (HIGH)

NAME: (please print)_____

How long have you experienced neck/back pain? _____ Years _____ Months _____ Weeks

Is this your first episode of neck/back pain? _____ YES _____ NO

SIGNATURE:_____ DATE:_____

KLD 01/06

6 HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV ☐ Yes ☐ No	Chicken Pox ☐ Yes ☐ No	Liver Disease ☐ Yes ☐ No	Rheumatoid Arthritis ☐ Yes ☐ No
Alcoholism ☐ Yes ☐ No	Diabetes ☐ Yes ☐ No	Measles ☐ Yes ☐ No	Rheumatic Fever ☐ Yes ☐ No
Allergy Shots ☐ Yes ☐ No	Emphysema ☐ Yes ☐ No	Migraine Headaches ☐ Yes ☐ No	Scarlet Fever ☐ Yes ☐ No
Anemia ☐ Yes ☐ No	Epilepsy ☐ Yes ☐ No	Miscarriage ☐ Yes ☐ No	Stroke ☐ Yes ☐ No
Anorexia ☐ Yes ☐ No	Fractures ☐ Yes ☐ No	Mononucleosis ☐ Yes ☐ No	Suicide Attempt ☐ Yes ☐ No
Appendicitis ☐ Yes ☐ No	Glaucoma ☐ Yes ☐ No	Multiple Sclerosis ☐ Yes ☐ No	Thyroid Problems ☐ Yes ☐ No
Arthritis ☐ Yes ☐ No	Goiter ☐ Yes ☐ No	Mumps ☐ Yes ☐ No	Tonsillitis ☐ Yes ☐ No
Asthma ☐ Yes ☐ No	Gonorrhea ☐ Yes ☐ No	Osteoporosis ☐ Yes ☐ No	Tuberculosis ☐ Yes ☐ No
Bleeding Disorders ☐ Yes ☐ No	Gout ☐ Yes ☐ No	Pacemaker ☐ Yes ☐ No	Tumors, Growths ☐ Yes ☐ No
Breast Lump ☐ Yes ☐ No	Heart Disease ☐ Yes ☐ No	Parkinson's Disease ☐ Yes ☐ No	Typhoid Fever ☐ Yes ☐ No
Bronchitis ☐ Yes ☐ No	Hepatitis ☐ Yes ☐ No	Pinched Nerve ☐ Yes ☐ No	Ulcers ☐ Yes ☐ No
Bulimia ☐ Yes ☐ No	Hernia ☐ Yes ☐ No	Pneumonia ☐ Yes ☐ No	Vaginal Infections ☐ Yes ☐ No
Cancer ☐ Yes ☐ No	Herniated Disk ☐ Yes ☐ No	Polio ☐ Yes ☐ No	Venereal Disease ☐ Yes ☐ No
Cataracts ☐ Yes ☐ No	Herpes ☐ Yes ☐ No	Prostate Problem ☐ Yes ☐ No	Whooping Cough ☐ Yes ☐ No
Chemical Dependency ☐ Yes ☐ No	High Cholesterol ☐ Yes ☐ No	Prosthesis ☐ Yes ☐ No	Other _____
	Kidney Disease ☐ Yes ☐ No	Psychiatric Care ☐ Yes ☐ No	_____

EXERCISE
- ☐ None
- ☐ Moderate
- ☐ Daily
- ☐ Heavy

WORK ACTIVITY
- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ Heavy Labor

HABITS
- ☐ Smoking — Packs/Day _____
- ☐ Alcohol — Drinks/Week _____
- ☐ Coffee/Caffeine Drinks — Cups/Day _____
- ☐ High Stress Level — Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date _____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

7 MEDICATIONS

_____

_____

_____

Pharmacy Name _____

Pharmacy Phone (____) _____

ALLERGIES

VITAMINS/HERBS/MINERALS

Dr. Bruce Fischer, Dr. Naveed Shafi, Dr. Zahid Huq, Tamar Clarke RPT

851 Meadows Road, Suite 213, Boca Raton, Florida 33486
Telephone: 561.392.1333 Fax: 561.392.9707

ASSIGNMENT OF BENEFITS

I, (first/last name)_____ HEREBY AUTHORIZE_____
TO MAKE MEDICAL BENEFITS PAYMENTS OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED BY BRUCE M. FISCHER DC PA OR BOCA TRAUMA & REHAB BUT NOT TO EXCEED THE CHARGES OF THOSE SERVICES PAYABLE TO AND MAILED DIRECTLY TO BRUCE M FISCHER DC PA OR BOCA TRAUMA & REHAB, 851 MEADOWS RD. SUITE 213, BOCA RATON FL 33486. FURTHERMORE, I IRREVOCABLY ASSIGN TO BRUCE M FISCHER DC PA THE RIGHTS AND BENEFITS UNDER ANY POLICY OF INSURANCE, INDEMNITY AGREEMENT OR ANY OTHER COLLATERAL SOURCE AS DEFINED IN FLORIDA STATUTES FOR ANY SERVICE AND OR CHARGES PROVIDED BY BRUCE M FISCHER DC PA OR BOCA TRAUMA & REHAB

IN WITNESS THEREOF, THE UNDERSIGNED HAS/HAVE EXECUTED THIS ASSIGNMENT OF BENEFITS _____ DAY OF _____

_____ _____
PATIENT'S NAME PATIENT'S SIGNATURE

Dr. Bruce Fischer, Dr. Naveed Shafi, Dr. Zahid Huq, Tamar Clarke RPT

851 Meadows Road, Suite 213, Boca Raton, Florida 33486
Telephone: 561.392.1333 Fax: 561.392.9707

DOCTOR'S LIEN

To: Attorney Name /Law Office

Patient Name :_____

Re: Medical Reports and Doctor's Lien

I do hereby authorize Dr. Bruce M. Fischer and Boca Trauma & Rehab to furnish you with a 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 to pay directly to Dr. M. Fischer and Boca Trauma & Rehab such sums as may be due and owing him for medical service rendered me both by reason of this accident and by reason of any other bills that are due to his office and to withhold such sums from settlement, judgment or verdict as may be necessary to adequately protect Dr. Bruce M. Fischer and Boca Trauma & Rehab. And I hereby further give a lien on my case to Dr. Bruce M. Fischer and Boca Trauma & Rehab against any and all proceeds or any settlement, judgment or verdict, which may be paid to you 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 Dr. Bruce M. Fischer and Boca Trauma Rehab for all medical bills submitted by him for service rendered me and that this agreement is made solely Dr. Bruce M. Fischer's and Boca Trauma & Rehab additional protection and in consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

Dated_____ Patient's Signature_____

The undersigned does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may necessary to adequately protect Dr. Bruce M. Fischer and Boca Trauma & Rehab

Dated_____ Attorney's Signature _____

Health Insurance Portability & Accountability Act – Information required by the Federal Government for Medical patients.

Provider Notice of Information Practices

Uses and Disclosures of Health Information

We use health information about you for treatment (diagnostic testing, referral), to obtain payment (submit claims and/or encounters to billing services and/or clearinghouses, collection agencies, only if necessary), for administrative purpose (reporting utilization management, quality improvement). We may disclose health information about you without your authorization in emergencies, such as Emergency Room situations, and if required by law enforcement. In any other situation, we will contact you and ask for written authorization before disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures. We may apply a change to our policies at any time. Before we make a change in our policies, we will post a notice in the waiting room. You may request a copy of our notice at any time and contact our office for further information on our privacy practices.

Individual rights

You have the right to obtain a copy of your reports for your records. There may be a charge for this. You have the right to receive a list of written instances in which we have disclosed protected health information about you for reasons other than treatment, payment or other related administrative purposes. If you believe that information in your record is incorrect or incomplete, you have the right to request in writing that we amend the existing information. You may request in writing that we restrict and/or not use or disclose your information for payment and administrative purposes, except when specifically authorized by you. When required by law or in emergency situations. We will consider your request, but are not legally required to agree to it.

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, please contact our office or direct inquiries to:

Privacy Manager
Boca Trauma & Rehab
851 Meadows Rd. Suite 213
Boca Raton, FL 33486
(561) 392-1333

You may send a written complaint to the U.S. Department of Health and Human Services, call our office for the address.

Our Legal Duty

We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices as described in this notice.

I have reviewed the above information.

Patient Signature_____ **Date**___/__/___

Dr. Bruce Fischer, Dr. Naveed Shafi, Dr. Zahid Huq, Tamar Clarke RPT

851 Meadows Road, Suite 213, Boca Raton, Florida 33486
Telephone: 561.392.1333 Fax: 561.392.9707

MEDICAL RECORDS RELEASE AUTHORIZATION

PATIENT NAME: _____

DATE OF BIRTH: _____

TO: _____

This is you authority to release any and all records, x-rays, and medical information to Boca Trauma and Rehab, Bruce M. Fischer, D.C. P.A.

RECORDS REQUESTED: _____

MEDICAL RECORDS: _____

X-RAYS/MRI FILMS: _____

LABS/EKG: _____

PATIENT SIGNATURE OR
GUARDIAN SIGNATURE:_____

DATE:_____

Disclosure & Consent for Chiropractic Adjustments and Medical Care

To the Patient: You have a right to be informed about your condition and the recommended chiropractic adjustments and the other physical and medical procedures to be used so that you may make the decision whether or not to undergo the procedure after knowing the potential risks hazards inherent to the procedure.

I hereby request and consent to the performance of chiropractic adjustments and other medical procedures, including various modes of physical therapy, which includes heat, ice, electric muscle stimulation, ultrasound, therapeutic exercises, taping, laser therapy, massage therapy, diagnostic x-rays, injections and prescription medication on me or (the patient named below whom I am legally responsible for) by the Chiropractic Doctor of Chiropractic, Physical Therapist and Medical Doctor.

I have had the opportunity to discuss with Dr Bruce Fischer and /or Dr Naveed Shafi and/or Dr. Zahid Huq and/or Tamar Clarke RPT, my diagnosis, the nature and purpose of the Chiropractic adjustments, physical therapy, medical procedures and other therapy listed above as well as the risks and benefits of my chiropractic treatment, medical treatment and physical therapy and the risks and benefits of alternative treatment, including not treatment at all.

I understand and I am informed that, in the practice of chiropractic there are some risks to exam and treatment including but not limited to:

___Fractures ___Disc or Spinal injuries ___Strokes ___Dislocations ___Sprains/Strains ___Possible increase symptoms or pain ___No improvement of symptoms or pain ___Infections ___Other_____

I do not expect the Doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the Doctor to exercise judgment during the course of the procedure, which the Doctor feels at the time, based on the facts known, and is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment.

TREATMENT PLAN:

_____

_____

_____

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions, and all my questions have been answered fully and satisfactorily. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

To be completed by the patient:

_____
Print Name

_____
Signature of Patient

_____
Date Signed

To be completed by the patient's representatives:

_____
Print name of patient

_____
Print name of patient's representative

_____
Signature of patient's representative

as: _____
Relationship/authority of Patient's Representative

_____
Date signed

To be completed by doctor or staff:

_____ _____
Witness of patient's signature Date

_____ _____
Translated by Date

OFFICE OF INSURANCE REGULATION
Bureau of Property & Casualty Forms and Rates

Standard Disclosure and Acknowledgement Form
Personal Injury Protection - Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

1. The services or treatment set forth below were **actually rendered.** This means that those services have **already been provided.**

   _____

   _____

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 up coded, 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.