BAUMAN CHIROPRACTIC CLINIC OF NORTHWEST FLORIDA PA
3613 NORTH HIGHWAY 231, PANAMA CITY FLORIDA 32404
PH: 850-785-8311 FAX: 850-872-9892

THE FOLLOWING PAGES ARE REQUIRED INTAKE FORMS FOR OUR OFFICE. THE FORMS ARE FILLABLE PDF FILES THAT CAN BE FILLED OUT AND PRINTED, OR MAY BE PRINTED BLANK TO BE FILLED IN BY HAND. PLEASE BRING THESE FORMS WITH YOU TO YOUR INITIAL VISIT IN OUR OFFICE. ***PLEASE DO NOT SIGN OR DATE THE FORMS*** UNTIL YOU ARE IN OUR OFFICE WITH ONE OF OUR STAFF SO WE CAN ANSWER ANY QUESTIONS YOU MAY HAVE PRIOR TO SIGNING. SHOULD YOU HAVE ANY QUESTIONS PLEASE FEEL FREE TO CONTACT OUR OFFICE AT ANY TIME (850) 785-8311. THANK YOU!

BAUMAN CHIROPRACTIC CLINIC OF NORTHWEST FLORIDA PA
3613 NORTH HWY 231, PANAMA CITY FLORIDA 32404

ACCOUNT NUMBER:

Name: _____ DOB: _____ Date: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PHONE: (HOME)_____ (CELL) _____ (WORK) _____

EMAIL: _____ Opt out of Emails: ☐

SOCIAL SECURTY NUMBER: _____ Opt out of text messages: ☐

Employer: _____ Occupation: _____

Marital Status: ☐M ☐S ☐D ☐W ☐ Sep. Spouse Name: _____

Gender: ☐M ☐F ☐Other: _____ Language: ☐ English or _____

Race: ☐ Decline to state - ☐American Indian - ☐Alaska Native - ☐ African American - ☐Asian - ☐Native Hawaiian - ☐Other Pacific Islander - ☐White (Caucasian)

Ethnicity: Decline to state - ☐Hispanic / Latino - ☐NOT Hispanic / Latino

Emergency Contact: _____ Phone: _____

Have you been involved in an automobile accident? ☐ Yes ☐ No Date of loss: _____

If yes, were you at fault? ☐ Yes ☐ No State of loss: _____

Please provide a complete list of medications that you are currently taking including over the counter medications and supplements: ☐None or:

_____

_____

Please advise our office of any allergies: ☐ None or: _____

Are you a smoker? ☐ Yes ☐ No If Yes would you like to quit? ☐ Yes ☐ No

What measures have you taken to quit? ☐ None or: _____

Family Physician: _____ Date last seen:_____

Do you authorize our office to contact your primary care physician for the purpose of inter-office communication regarding your condition/care? ☐ Yes ☐ No

_____
Signature Date

PATIENT NAME: _____ DATE: _____

PLEASE PROVIDE A COMPLETE LIST OF MEDICATIONS THAT YOU ARE CURRENTLY TAKING INCLUDING OVER THE COUNTER MEDICATIONS AND SUPPLEMENTS:

NO CURRENT MEDICATIONS, OR: _____

_____

_____

PLEASE ADVISE OUR OFFICE OF ANY MEDICATION ALLERGIES: _____

_____

_____

ARE YOU A SMOKER? ☐ YES ☐ NO IF YES, WOULD YOU LIKE TO QUIT? ☐ YES ☐ NO

WHAT MEASURES HAVE YOU TAKEN TO QUIT? ☐ NONE, OR: _____

_____

FAMILY PHYSICIAN: _____

ADDRESS: _____

PHONE: _____DATE LAST SEEN: _____ FOR: _____

Do you authorize our office to contact your primary care physician for the purposes of inter-office communication regarding your care? ☐ YES ☐ NO

FINANCIAL ARRANGEMENT:
FEES ARE PAYABLE AT THE TIME SERVICES ARE RENDERED UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.

ORIGINAL RADIOGRAPHIC IMAGES (X-RAYS) REMAIN THE PROPERTY OF THIS CLINIC, COPIES CAN BE MADE WITH ADVANCE NOTICE AND ARE SUBJECT TO APPLICABLE FEES.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier, or third party entity, and myself. Furthermore, I understand that this office will prepary any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly 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 that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment any fees for professional services rendered to me will be immediately due and payable.

_____ **Date:** _____
Patient or legal representative signature

ACCOUNT NUMBER:

BAUMAN CHIROPRACTIC CLINIC OF NORTHWEST FLORIDA PA
3613 NORTH HWY 231, PANAMA CITY FLORIDA 32404

MEDICAL RECORDS RELEASE

RELEASE OF PROTECTED HEALTH INFORMATION AUTHORIZATION

I HEREBY AUTHORIZE BAUMAN CHIROPRACTIC CLINIC OF NORTHWEST FLORIDA P.A. TO RELEASE A COPY OF MY PATIENT RECORD, DIAGNOSTIC TESTING, AND BILLING RECORDS CONTAINING PROTECTED HEALTH INFORMATION TO:

_____

_____

_____

THIS AUTHORIZATION IS GIVEN PURSUANT TO FLORIDA STATUTE 456.057 AND HIPPA REGULATIONS. I UNDERSTAND THAT FLORIDA STATUTE 456.057(12) MAKES CLEAR THAT ANY THIRD PARTY TO WHOM RECORDS ARE DISCLOSED IS PROHIBITED FROM FURTHER DISCLOSING ANY INFORMATION IN THE MEDICAL RECORD WITHOUT THE EXPRESSED WRITTEN CONSENT OF THE PATIENT OR LEGAL REPRESENTATIVE(S).

I UNDERSTAND THAT THIS INFORMATION MAY INCLUDE INFORMATION RELATING TO: ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS) OR HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTION, TREATMENT FOR DRUG OR ALCOHOL ABUSE, OR MENTAL OR BEHAVIORAL HEALTH OR PSYCHIATRIC CARE, EXCLUDING PSYCHOTHERAPY NOTES. ANY RELEASE OF SUBSTANCE INFORMATION MUST BE PURSUANT TO 42 CFR. THERE ARE OTHER SPECIAL RESTRICTIONS WHICH APPLY TO THE RELEASE OF INFORMATION REGARDING HIV, ABUSE REPORTS, ETC.

UNLESS OTHERWISE REVOKED OR EXTENDED THIS AUTHORIZATION WILL EXPIRE THREE YEARS FROM THE DATE SIGNED AT THE BOTTOM OF THIS PAGE.

****

RECORDS TO BE PICKED UP

_____

_____

I HEREBY ACKNOWLEDGE RECEIPT OF THESE RECORDS. IN CONSIDERATION OF THE FOREGOING I HEREBY RELEASE AND FOREVER DISCHARGE THE AFORESAID PHYSICIAN AND/OR CLINIC FROM ANY AND ALL RESPONSIBILITY OR LIABILITY OF ANY KIND, NATURE, OR CHARACTER WHATSOEVER ARISING FROM SAID TREATMENT.

_____ _____

SIGNATURE / RECEIPT OF RECORDS DATE

PHONE: 850-785-8311 FAX: 850-872-9892 **TAX ID 80-000-9303**

Name: _____ DOB: _____ _____

Signature Date

ACCOUNT NUMBER:

BAUMAN CHIROPRACTIC CLINIC OF NORTHWEST FLORIDA PA
3613 NORTH HWY 231, PANAMA CITY FLORIDA 32404

MEDICAL RECORDS REQUEST

I UNDERSTAND THAT THIS INFORMATION MAY INCLUDE INFORMATION RELATING TO ACQUIRED IMMUNODEFFICIENCY SYNDROME (AIDS) OR HUMAN IMMUNODEFFICIENCY VIRUS (HIV) INFECTION, TREATMENT FOR DRUG OR ALCOHOL ABUSE, OR MENTAL BEHAVIORAL HEALTH OR PSYCHIATRIC CARE, EXCLUDING PSYCHOTHERAPY NOTES. ANY RELEASE OF SUBSTANCE INFORMATION MUST BE PURSUANT TO 42 CFR. THERE ARE OTHER SPECIAL RESTRICTIONS WHICH APPLY TO THE RELEASE OF INFORMATION REGARDING HIV, ABUSE REPORTS.

BY SIGNING AT THE BOTTOM OF THIS PAGE I HEREBY AUTHORIZE YOU TO RELEASE A COPY OF MY PATIENT MEDICAL RECORD CONTAINING PROTECTED HEALTH INFORMATION.

FROM: _____

_____

_____

TO: BAUMAN CHIROPRACTIC CLINIC OF NW FL PA
3613 NORTH HWY 231
PANAMA CITY, FLORIDA 32404

_____

_____

_____

_____

DESCRIPTION OF THE INFORMATION TO BE DISCLOSED FOR THE PURPOSE OF MEDICAL CARE/TREATMENT.

THIS AUTHORIZATION IS PROVIDED PURSUANT TO FLORIDA STATUTE 456.057 AND HIPPA REGULATIONS. I UNDERSTAND THAT FLORIDA STATUTE 456.057(12) MAKES CLEAR THAT ANY THIRD PARTY TO WHOM RECORDS ARE DISCLOSED IS PROHIBITED FROM FURTHER DISCLOSING ANY INFORMATION INT HE MEDICAL RECORD WITHOUT EXPRESSED WRITTEN CONSENT OF THE PATIENT OR THE LEGAL REPRESENTATIVE(S). THIS AUTHORIZATION WILL EXPIRE THREE YEARS FROM THE DATE SIGNED BELOW. THE PATIENT HAS THE RIGHT TO REVOKE ANY AUTHORIZATION IN WRITING AT ANY TIME AND TO REQUEST A REVOKATION YOU MUST SUBMIT A WRITTEN REQUEST TO THE PRACTICES COMPLIANCE OFFICER.

Name: _____ DOB: _____ _____ _____

Signature Date

ACCOUNT NUMBER:

BAUMAN CHIROPRACTIC CLINIC OF NORTHWEST FLORIDA PA
3613 NORTH HWY 231, PANAMA CITY FLORIDA 32404 **CLAIM: _____**

PAGE 1 OF 2 **ASSIGNMENT OF BENEFITS AND MEDICAL RELEASE**

POWER OF ATTORNEY TO ENDORSE CHECKS AND/OR TO SIGN ANY DOCUMENT WHICH WILL ENHANCE OR EXPEDITE PAYMENT TO PROVIDER FOR SERVICES RENDERED, INCLUDING BUT NOT LIMITED TO A RELEASE OF MEDICAL RECORDS AND ASSIGNMENT OF BENEFITS/AUTHORIZATION TO PAY.

Know by all these present that: The undersigned has made, constituted and appointed, and by these present does hereby make, constitute and appoint **Bauman Chiropractic Clinic of Northwest Florida PA**, and any of it's duly authorized agents and employees as and to be the undersigned's true and lawful attorney for and in the undersigned's name place and stead to endorse any and all checks, drafts, or money orders which are made payable to the undersigned alone or to the undersigned and the said **Bauman Chiropractic Clinic of Northwest Florida PA**, which checks, drafts or money orders are made payable for services which have been made by **Bauman Chiropractic Clinic of Northwest Florida PA**, at the request or with the knowledge and approval of the undersigned and/or the maker of the check, draft, or money order.

Furthermore, the undersigned allows **Bauman Chiropractic Clinic of Northwest Florida PA** or any of it's agents to sign any paper that will be necessary to enhance, expedite, and/or allow payment to said provider. This may include affidavits of non-ownership of vehicles, insurance forms, and other statements.

The undersigned by these presents does give and grant the said Bauman Chiropractic Clinic of Northwest Florida PA as attorney full power and authority to do and perform all and every act whatsoever requisite and necessary to be done in and about the premises as fully to all intents and purposes as the undersigned might or could do to personally present insofar as the endorsing and cashing of said checks are concerned as well as any other document.

MEDICAL RELEASE

A photocopy of this document shall be sufficient to authorize any person having records, medical treatment, services, or supplies pertaining to me to release true copies of the same to **Bauman Chiropractic Clinic of Northwest Florida PA** or any insurer providing coverage to me in connection with the processing of any claim for benefits made by me or by the assignee herein. A photocopy of this document shall be binding as an original signature page (valid as original). The undersigned does hereby ratify and confirm any and all actions taken by the attorney in accordance with this special power and which the said attorney shall do or cause to be done by virtue of these presents.

ASSIGNMENT OF BENEFITS

I the insured/beneficiary/patient/authorized representative do hereby authorize the insurance company listed below to make medical benefits payments otherwise payable to me for services rendered by Bauman Chiropractic Clinic of Northwest Florida PA, but not to exceed the charges of those services payable and mailed directly to : Bauman Chiropractic Clinic of Northwest Florida PA 3613 Hwy 231 North, Panama City, FL 32404

Furthermore, I hereby **IRREVOCABLY ASSIGN to BAUMAN CHIROPRACTIC CLINIC OF NORTHWEST FLORIDA 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 **Bauman Chiropractic Clinic of Northwest Florida PA**.

ASSIGNMENT OF BENEFITS AND DIRECTION TO PAY BENEFITS OWED

I, the undersigned insured or beneficiary of an insurance policy, irrevocably assign to **Bauman Chiropractic Clinic of Northwest Florida PA** (hereafter "Provider") whatever rights I have under any policy of insurance and under Florida law, including, without limitation, any and all claims for attorney's fees, costs, interest and/or damages pursuant to Florida Statute 624.155. This Assignment of Benefits (AOB) includes an assignment of any potential claim for common law or statutory bad faith. If the Insurer disputes the validity of this AOB, then the insurer is instructed to notify the provider in writing within 10 days of receipt of this document. Failure to do so shall result in the provider relying on this AOB for direct payment and could constitute a waiver by the insurer to contest the validity of this document. I do hereby confirm that this AOB is irrevocable and instruct any insurance company or other collateral source for which I am entitled to benefits to pay for monies owed as a result of medical services rendered by **Bauman Chiropractic Clinic of Northwest Florida PA** to promptly make payment in the name of and directly to **Bauman Chiropractic Clinic of Northwest Florida PA** or its chosen billing service.

Name: _____ DOB: _____ Date: _____
Signature Date

ACCOUNT NUMBER:

ASSIGNMENT OF BENEFITS AND MEDICAL RELEASE

BAUMAN CHIROPRACTIC CLINIC OF NORTHWEST FLORIDA PA
3613 NORTH HWY 231, PANAMA CITY FLORIDA 32404

Pursuant to this AOB, **Bauman Chiropractic Clinic of Northwest Florida PA** is authorized to file suit on my behalf against any insurance company that reduces or denies benefits for medical services rendered to me and to collect any damages awarded or settlement monies for services rendered, plus interest, costs, reasonable attorney's fees and a contingency fee multiplier. I understand that in any such lawsuit, my name and other identifying information will need to be included in and/or portions of my medical file attached to pleadings and/or formal discovery. I waive any confidentiality of my records and/or information but only to the extent necessary to prosecute a claim for unpaid or owed medical expenses against the insurance company or any other responsible party.

I acknowledge that **Bauman Chiropractic Clinic of Northwest Florida PA** objects to any reductions or partial payments by the Insurer. Any partial or reduced payment, regardless of the accompanying language, issued by the Insurer and deposited by

Bauman Chiropractic Clinic of Northwest Florida PA shall be done under protest, at the risk of the Insurer, and the deposit shall not be deemed a waiver, accord, satisfaction, discharge, settlement, or agreement by the provider to accept a reduced amount

as payment in full. **Bauman Chiropractic Clinic of Northwest Florida PA** reserves the right to seek the full amount of the bill submitted from the insurance company(ies) or me. Accordingly, the insurer is herby instructed to set aside (escrow) any and all reduced or denied benefit payments for the medical services rendered by this provider and not pay the disputed amount to anyone until the dispute is resolved.

I further instruct my insurance company to cooperate with the above-captioned **Bauman Chiropractic Clinic of Northwest Florida PA** in resolving all medical billing disputes. Cooperation includes, but is not limited to, providing any and all declaration pages, PIP logs, payout ledgers, explanation of benefits, copies of checks, and any and all other documents or information to **Bauman Chiropractic Clinic of Northwest Florida PA** or its attorneys, employees or other representatives acting on behalf of **Bauman Chiropractic Clinic of Northwest Florida PA**. If the insurer schedules a defense examination, examination under oath (EUO) or Independent Medical Examination (IME) of the patient, the insurer is hereby instructed to send a copy of said notification to this provider and the provider's attorneys. The provider and/or the provider's attorneys are authorized to appear at any patient EUO or IME set by the insurer. **THIS ASSIGNMENT OF BENEFITS DOES NOT ASSIGN ANY RIGHTS OR OBLIGATIONS UNDER THE POLICY OF INSURANCE, TO SUBMIT TO AN EUO OR RECORDED STATEMENT.** I further direct and authorize you to speak to an attorney, employee or any other representative of **Bauman Chiropractic Clinic of Northwest Florida PA** or anyone acting on their behalf over the phone and provide them with any and all information you may have or documentation not previously listed above that they may request.

I, as the patient, agree to remain personally liable for the amounts billed by **Bauman Chiropractic Clinic of Northwest Florida PA** regardless of the amount paid by the insurance company, unless ordered by court of law. I fully understand that said health care services were provided to me in consideration for an unconditional promise to pay and for me providing these instructions to my insurance company. I, as the patient, further agree to be liable for reasonable attorney's fees and costs incurred in collecting any delinquent accounts or unpaid balances. By executing this document, I am placing my insurance company(ies) on notice that the claims for medical treatment rendered by **Bauman Chiropractic Clinic of Northwest Florida PA** are related to my injury or covered condition and should be paid directly to **Bauman Chiropractic Clinic of Northwest Florida PA** pursuant to this assignment of benefits and Florida law. Any delay in paying benefits owed under the insurance policy could adversely affect me.

BY EXECUTING THIS DOCUMENT, I AM PLACING MY INSURANCE COMPANY ON NOTICE THAT THIS IS A DIRECT ASSIGNMENT OF BENEFITS PURSUANT TO FLORIDA LAW. AS THE INSURED OR BENEFICIARY OF SAID INSURANCE POLICY, I AM IRREVOCABLY ASSIGNING WHATEVER RIGHTS I HAVE UNDER MY POLICY OF INSURANCE (LESS THE DUTY TO ATTEND AN EUO) AND UNDER FLORIDA LAW TO THIS HEALTH CARE PROVIDER.

_____ _____

NAME OF POLICY HOLDER OR CLAIMANT NAME OF INSURANCE CARRIER / COMPANY / ENTITY

BY APPLYING YOUR SIGNATURE BELOW YOU ACKNOWLEDGE THAT YOU HAVE READ AND UNDERSTAND THE ABOVE.

Name: _____ DOB: _____ _____

Signature Date

ACCOUNT NUMBER:

BAUMAN CHIROPRACTIC CLINIC OF NORTHWEST FLORIDA PA
3613 NORTH HWY 231, PANAMA CITY FLORIDA 32404

ADDITIONAL AUTHORIZATIONS AND DIRECTIONS TO INSURER

AUTHORIZATION FOR DISCLOSURE OF INSURANCE DECLARATIONS PAGE: I, the patient and/or insured, further authorize and direct any insurance company that may be obligated to pay any insurance benefits to me, or on my behalf, to provide to **Bauman Chiropractic Clinic of NW FL PA** a copy of any declarations page of any insurance policy that may provide any insurance benefits to me for the aforesaid injury/incident.

AUTHORIZATION FOR DISCLOSURE OF INSURANCE PAYMENT RECORD: I further authorize and direct any insurance company that may be obligated to pay any insurance benefits to me, or on my behalf, to provide to **Bauman Chiropractic Clinic of NW FL PA** a copy of any ledger or payment record of payments made under any insurance coverage available to me, without redacting the names of any other medical provider or entity to whom insurance benefits have been paid and without redacting the amount of any insurance benefits that have been paid.

DIRECTION NOT TO EXHAUST BENEFITS BY PAYMENTS OF OTHER CLAIMS: I further authorize and direct any insurance company that may be obligated to pay any insurance benefits to me, or on my behalf, to not exhaust insurance benefits or coverage until all claims submitted by **Bauman Chiropractic Clinic of NW FL PA** have been paid in full, or at 80% if the insurance policy is limited to pay 80% coverage of medical claims. If any insurance company obligated to pay any insurance benefits to me, or on my behalf, has denied payment of a claim submitted by **Bauman Chiropractic Clinic of NW FL PA** or made payment to **Bauman Chiropractic Clinic of NW FL PA** at an amount less than the amount billed, or less than 80% of the amount billed if my coverage is limited to 80% for medical claims, I direct the aforesaid insurance company to hold in escrow the amount in dispute, and if other claims would exhaust benefits I direct the aforesaid insurance company to hold in escrow the amount in dispute and to not exhaust benefits or coverage by payment of the amount I have hereby requested to be held in escrow. I further authorize and direct the aforesaid insurance company to notify **Bauman Chiropractic Clinic of NW FL PA** that benefits have been exhausted except for the amount held in escrow, to enable **Bauman Chiropractic Clinic of NW FL PA** to attempt to resolve the disputed claim in a manner acceptable to **Bauman Chiropractic Clinic of NW FL PA**.

DIRECTION TO INSURER TO MAINTAIN CONFIDENTIALITY: I further direct any insurance company that may be obligated to pay any insurance benefits to me, or on my behalf, to maintain the privacy and confidentiality of my medical records. I do not authorize any insurer to provide my medical records to anyone without first obtaining a written authorization from me to provide the medical records to any other entity.

AUTHORIZATION FOR RELEASE OF RECORDS TO PROVIDER: I hereby authorize any insurance company that may be obligated to pay any insurance benefits to me, or on my behalf, to release a copy of my complete medical records in possession of such insurer to **Bauman Chiropractic Clinic of NW FL PA** upon request of **Bauman Chiropractic Clinic of NW FL PA**. This authorization includes the authorization to release to **Bauman Chiropractic Clinic of NW FL PA** a copy of any medical examination or evaluation of me requested by any insurance company.

DIRECTION TO INSURER TO PROVIDE TO PROVIDER ADVANCE NOTICE OF IME OR EUO: I further authorize and direct any insurance company that may be obligated to pay any insurance benefits to me, or on my behalf, to provide at least 15 days advance notice to **Bauman Chiropractic Clinic of NW FL PA** of any physical examination or examination under oath of myself that any insurance company may schedule.

ACKNOWLEDGMENT OF SUBROGATION POLICY: I acknowledge that to the extent that my insurance company claims any right of subrogation for any portion of coverage, pursuant to Florida Statute 768.76, the insurance company will provide a statement asserting payment of benefits and right of subrogation within 30 days of the receipt of a letter requesting such. Failure to comply with the request will result in waiver of any subrogation claim.

Please read this document completely before applying your signature. If you do not completely understand this document or have any questions about this document, please ask us to explain it to you. If there is any portion of this document that you do not wish to authorize, we will remove that portion from this document. Your signature is your agreement you fully understand this document and you fully agree to the terms of this document.

Name: _____ DOB: _____ _____

Signature Date

ACCOUNT NUMBER:

Bauman Chiropractic Clinic of Northwest Florida, P.A.

PATIENT AUTHORIZATION REGARDING CHIROPRACTIC CARE BEING PROVIDED IN AN "OPEN DOOR" ADJUSTING AND THERAPY ENVIRONMENT

It is the desire of this office to provide chiropractic care in an "open door" Therapy and Adjusting environment. An "open door" approach involves the moving from patient care to patient care area and leaving the doors between patient care areas open. As a result, patients are occasionally within sight of one another and some ongoing routine details of care are discussed within ear shot of other patients and staff. This environment is used for ongoing care and is NOT the environment used for taking patient histories, performing examinations or presenting reports of findings. These procedures are completed in a private, confidential setting. We are requesting this authorization of you due to various interpretations under federal law with matters related in an "open door" environment are incidental matters. In the event you or someone else would not agree with us, we are providing this disclosure. The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care. If you choose not to be adjusted in an "open door" adjusting or "open door" therapy environment, other arrangements will be made for you. Your decision will have no adverse effect on your care from our office or on your relationship with our staff.

PATIENT AUTHORIZATION FOR APPOINTMENT REMINDERS AND SCHEDULING RELATED MATTERS

It is our desire for our staff to use your name, address, and/or telephone number for the purpose of contacting you to remind you about scheduled appointments, re-evaluations, or other appointment related issues. The use of this information is intended to make your experience with our office more efficient and productive. In addition, this office may make contact with you via e-mail for notification of changes in office policy, current health events, special offers, etc. You have the option to opt out of e-mail contact; should you choose to exercise this option, please notify this office in writing so that we may make that part of your file with us.

PATIENT AUTHORIZATION FOR INTER-PROFESSIONAL COMMUNICATION

In order to facilitate a more encompassing treatment environment, this office may contact/communicate with your primary care physician or other health care professionals that treat you; to share information, treatment plans, goals for care, etc. You have the option to opt out of this; should you choose to exercise this option, please notify this office in writing so that we may make that part of your file with us.

CLINIC CONCEALED CARRY POLICY

We respect your right to bear arms under the second amendment of the constitution and subject to state law. We respectfully request that you lock your weapon in your vehicle before entering the building, or should you choose to bring your weapon into the office, please check your weapon (gun,knife, taser, pepper spray, etc.) at the front desk to be placed in a secure lock box while you are receiving care. You will be allowed to hold the key to the lock box while in the building; and your weapon will be returned to you as you check out. Thank You!

PATIENT AUTHORIZATION FOR CONTRACTING CHIROPRACTIC CARE, RELATED HEALTH SERVICES AND/OR RELATED HEALTH PRODUCTS

It is our desire for our staff to use your name, address, and/or telephone number for the purpose of contacting you to advise you about health related products, workshops, and health meetings. The use of this information is intended to make your experience with our office more efficient and productive; and to further enhance your access to quality health care. You are also authorizing the doctors of Bauman Chiropractic Clinic of Northwest Florida, Inc. to prescribe and provide you with chiropractic care. This authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our system to be completed.

The current pricing of the Lumbar Support **(HLB**), Cervical traction unit (**CTU**), and **TENS** unit have been discussed with the patient. Pt initial:_____

ACKNOWEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and I have read and understand them or declined the opportunity to read and understand the Notice of Privacy Practices. This form will be placed in my client chart and maintained for six years.

ACKNOWLEDGMENT OF CELL PHONE USE IN CLINIC

It is our desire to accommodate each patient in a clean, comfortable, and professional clinic setting. We ask that you turn off your cell phone while in this clinic receiving uninterrupted quality care also assuring that the other patients can relax and enjoy their treatments. Please make every effort to show consideration to other treating patients. However, if you receive a call while on an attended therapy, your treatment time will be adjusted. We do understand that emergencies do arise and you may need to use a phone. We have provided a phone in our lobby for your convenience.

ACKNOWLEDGEMENT OF MEDICATION USE IN THE CLINIC

While we understand that you may be co-treating with many physicians of different specialties, we ask that you refrain from taking powerful pain medication prior to presenting to our office for care. Certain forms of therapy provided in this office require feedback from the patient. Prescription medications may alter your perception making these therapies dangerous to you. We reserve the right to refuse certain treatments if you indicate or represent that you have taken prescription medications. You further understand and acknowledge the risks involved with various forms of therapy should your feedback be impaired by prescription medications.

THERAPY SCHEDULE ACKNOWLEDGMENT

Our appointments for therapy are scheduled for both time of day and length of session. This is done not only to save time for your therapy, but to expedite the appointments of those patients scheduled around your appointment. If you must miss a scheduled appointment, 24 hours notice of cancellation is required. This allows us to use your cancelled session time for another patient if necessary. Should you fail to cancel an appointment within the 24 hour period, your appointment will be rescheduled one time. Should you miss 2 appointments without notice; your therapy will only be performed on a "walk-in" basis. In other words, if you present for treatment, and time is available, you will be seen. If no time is available, no therapy will be provided.

APPOINTMENT CANCELATION POLICY Patient initial:_____

Bauman Chiropractic Clinic of NW Florida P.A. reserves the right to charge a fee for missed appointments, or appointments that are cancelled later than 8:30am the day of your appointment. Please cancel or reschedule appointments by 8:30am of the day of your appointment.

YOUR SIGNATURE INDICATES YOUR AUTHORIZATION AND ACKNOWLEDGMENT OF THE ABOVE MENTIONED ACTIVITIES.

_____ _____

Signature Date

Name: _____ DOB: _____

ACCOUNT NUMBER:

BAUMAN CHIROPRACTIC CLINIC OF NORTHWEST FLORIDA PA
3613 NORTH HWY 231, PANAMA CITY FLORIDA 32404

FAMILY HISTORY FORM

Please indicate any condition(s) that a close blood relative has experienced, or is currently experiencing. If no conditions are applicable please leave the space blank. **PLEASE PRINT**

FAMILY MEMBER	ILLNESS / CONDITION - PLEASE PRINT
MOTHER	
FATHER	
MATERNAL GRANDMOTHER	
MATERNAL GRANDFATHER	
PATERNAL GRANDMOTHER	
PATERNAL GRANDFATHER	
SISTERS/BROTHERS (please specify)	
AUNTS, UNCLES (please specify)	
CHILDREN	

By having your signature applied below, you the patient, acknowledge filling out this form on the date listed below. If the form is blank, your signature below indicates that there are no applicable conditions to be listed and the form is complete.

Name: _____ DOB: _____

_____
Signature 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 upcoded, unbundled**, or constitutes an invalid **or not medically necessary diagnostic test** as defined by Section 627.732(14) and (15), 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.

ACCOUNT NUMBER:

BAUMAN CHIROPRACTIC CLINIC OF NORTHWEST FLORIDA PA
3613 NORTH HWY 231, PANAMA CITY FLORIDA 32404
Phone: (850) 785-8311 Fax: (850) 872-9892

TO MY ATTORNEY:

I, THE BELOW NAMED/SIGNED PATIENT, AM RECEIVING TREATMENT FOR INJURIES SUSTAINED IN AN AUTOMOBILE ACCIDENT. AS MY ATTORNEY I AM REQUESTING AND AUTHORIZING YOU TO SEND A LETTER OF PROTECTION (LOP) TO MY DOCTOR AT BAUMAN CHIROPRACTIC CLINIC OF NORTHWEST FLORIDA PA. ALSO, AS MY ATTORNEY, I AM AUTHORIZING YOU TO PROVIDE MY UNDERINSURED MOTORIST COVERAGE (UM) AND THE BODILY INJURY COVERAGE (BI) LIMITS TO BAUMAN CHIROPRACTIC CLINIC OF NORTHWEST FLORIDA PA UPON RECEIPT OF SAID INFORMATION.

RELEASE OF PATIENT RECORDS AUTHORIZATION

I HEREBY AUTHORIZE BAUMAN CHIROPRACTIC CLINIC OF NORTHWEST FLORIDA PA. TO RELEASE A COPY OF MY PATIENT RECORDS CONTAINING PROTECTED HEALTH INFORMATION TO MY ATTORNEY. THIS AUTHORIZATION IS PURSUANT TO FLORIDA STATUTE 456.057 AND HIPPA REGULATIONS. I UNDERSTAND THAT FLORIDA STATUTE 456.057(12) MAKES CLEAR THAT ANY THIRD PARTY TO WHOM RECORDS ARE DISCLOSED IS PROHIBITED FROM FURTHER DISCLOSING ANY INFORMATION IN THE MEDICAL RECORD WITHOUT THE EXPRESSED WRITTEN CONSENT OF THE PATIENT OR LEGAL REPRESENTATIVE(S). THIS AUTHORIZATION WILL EXPIRE WHEN THE CASE IS SETTLED. THE PATIENT HAS THE RIGHT TO REVOKE AUTHORIZATION IN WRITING AT ANY TIME AND TO REQUEST REVOCATION THE PATIENT MUST SUBMIT A WRITTEN REQUEST TO THE PRACTICE'S COMPLIANCE OFFICER.

Name: _____ DOB: _____ Date: _____ _____
Signature

ACCOUNT NUMBER:

Bauman Chiropractic Clinic of Northwest Florida, P.A.

NECK PAIN DISABILITY INDEX

Please read: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but PLEASE, JUST CIRCLE THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.

PLEASE RATE THE SEVERITY OF YOUR NECK PAIN BY CIRCLING A NUMBER BELOW:

SECTION 1 – Pain Intensity

A O I have no pain at the moment
B O The pain is very mild at the moment
C O The pain is moderate at the moment
D O The pain is fairly severe at the moment
E O The pain is very severe at the moment
F O The pain is the worst imaginable at the moment

SECTION 2 – Personal Care

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

SECTION 3 – Lifting

A O I can lift heavy weight without extra pain
B O I can lift heavy weight but it gives me extra pain
C O Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned
D O Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
E O I can lift very light weights
F O I cannot lift or carry anything at all

SECTION 4 – Reading

A O I can read as much as I want with no pain in my neck
B O I can read as much as I want with slight pain in my neck
C O I can read as much as I want with moderate pain in my neck
D O I can't read as much as I want because of moderate pain in my neck
E O I can hardly read at all because of severe pain in my neck
F O I cannot read at all

SECTION 5 – Headaches

A O I have no headaches at all
B O I have slight headaches, which come infrequently
C O I have moderate headaches, which come infrequently
D O I have moderate headaches, which come frequently
E O I have severe headaches, which come frequently
F O I have headaches almost all the time

SECTION 6 – Concentration

A O I can concentrate fully when I want to with no difficulty
B O I can concentrate fully when I want with slight difficulty
C O I have a fair degree of difficulty in concentrating when I want
D O I have a lot of difficulty in concentrating when I want
E O I have a great degree of difficulty in concentrating when I want
F O I cannot concentrate at all

SECTION 7 – Work

A O I can do as much as I want
B O I can only do my usual work, but no more
C O I can do most of my usual work, but no more
D O I can hardly do any work at all
E O I cannot do my usual work
F O I cannot do any work at all

SECTION 8 – Driving

A O I can drive my car without any neck pain
B O I can drive my car as long as I want with slight pain in my neck
C O I can drive my car as long as I want with moderate pain
D O I cannot drive my car as long as I want because of moderate pain
E O I can hardly drive at all because of severe pain in my neck
F O I cannot drive my car at all

SECTION 9 – Sleeping

A O I have no trouble sleeping
B O My sleep is slightly disturbed (less than 1hour sleeplessness)
C O My sleep is mildly disturbed (1-2 hours sleeplessness)
D O My sleep is moderately disturbed (2-3 hours sleeplessness)
E O My sleep is greatly disturbed (3-5 hours sleeplessness)
F O My sleep is completely disturbed (5-7 hours sleeplessness)

SECTION 10 – Recreation

A O I am able to engage in all recreational activities with no neck pain
B O I am able to engage in all my recreational activities with some pain in my neck
C O I am able to engage in most, but not all my usual recreational activities because of pain in my neck
D O I am able to engage in a few of my usual recreational activities because of pain in my neck
E O I can hardly do any recreational activities because of pain
F O I cannot do any recreational activities at all

NO PAIN 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 UNBEARABLE PAIN 0

I understand that the information I have provided above is current and complete to the best of my knowledge.

Signature: _____Date:_____

Name: _____ DOB: _____

ACCOUNT NUMBER:

Bauman Chiropractic Clinic of Northwest Florida, P.A.

PAIN DISABILITY QUESTIONNAIRE - Page 600 of the AMA Guides 6th edition

PLEASE READ: This survey asks for your views about how your pain now affects how you function in everyday activities. This information will help you and your doctor know how you feel and how well you are able to do your daily tasks at this time. **Please answer every question by making an "X" along the line, or select a number from the drop down menu, to show how much your pain problem has affected you (from having no problems at all to having the most severe problems you can imagine).** **BE SURE TO ANSWER *ALL* QUESTIONS.**

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

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

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

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

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

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

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

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

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

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

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

12. Does your pain interfere with recreational activities and hobbies that are important to you?
0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10 [0]
Normal activity — No recreation/hobbies at all

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?
0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10 [0]
Never need help — Need help all the time

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

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

Patient Signature: _____ Date _____

Name: _____ DOB: _____

ACCOUNT NUMBER:

Bauman Chiropractic Clinic of Northwest Florida, P.A.

THE REVISED OSWESTRY LOW BACK PAIN QUESTIONNAIRE

Please read: This questionnaire is designed to enable us to understand how much your pain has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but PLEASE, JUST CIRCLE THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.

PLEASE RATE THE SEVERITY OF YOUR LOW BACK PAIN BY CIRCLING A NUMBER BELOW:

SECTION 1 – Pain Intensity A The pain comes and goes and is very mild B The pain is mild and does not vary much C The pain comes and goes and is moderate D The pain is moderate and does not vary much E The pain comes and goes and is severe F The pain is severe and does not vary much	SECTION 6 – Standing A I can stand as long as I want without pain B I have some pain on standing but it does not increase with time C I cannot stand for longer than 1 hour without increasing pain D I cannot stand for longer than ½ hour without increasing pain E I cannot stand for longer than 10 minutes without increasing pain F I avoid standing because it increases the pain immediately
SECTION 2 – Personal Care A I do not have to change my way of washing or dressing in order to avoid pain. B I do not normally change my way of washing or dressing even though it causes some pain. C Washing and dressing increases the pain but I manage not to change my way of doing it D Washing and dressing increases the pain and I find it necessary to change my way of doing it. E Because of the pain I am unable to do some washing and dressing without help F Because of the pain I am unable to do any washing and dressing without help.	SECTION 7 – Sleeping A I get no pain in bed B I get pain in bed, but it does not prevent me from sleeping well C Because of my pain my normal night sleep is reduced by less than ¼ D Because of my pain my normal night sleep is reduced by less than ½ E Because of my pain my normal night sleep is reduced by less than ¾ F Pain prevents me from sleeping at all
SECTION 3 – Lifting A I can lift heavy weight without extra pain B I can lift heavy weight but it gives me extra pain C Pain prevents me from lifting heavy weights off the floor D Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned E Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned F I can only lift very light weights at the most	SECTION 8 – Social Life A My social life is normal and gives me no pain B My social life is normal but increases the degree of my pain C Pain has no significant effect on my social life apart from limiting my more energetic interests. e. g. dancing, etc. D Pain has restricted my social life, I do not go out very often E Pain has restricted my social life to my home F I have hardly any social life because of the pain
SECTION 4 – Walking A I have no pain on walking B I have some pain on walking but it does not increase with distance C I cannot walk more than 1 mile without increasing pain D I cannot walk more than ½ mile without increasing pain E I cannot walk more than ¼ mile without increasing pain F I cannot walk at all without increasing pain	SECTION 9 – Travel A I get no pain while traveling B I get some pain while traveling, but none of my usual forms of travel make it any worse C I get extra pain while traveling, but it does not compel me to seek alternative forms of travel D I get extra pain while traveling, which compels me to seek alternative forms of travel E Pain restricts all forms of travel F Pain prevents all forms of travel except that done lying down.
SECTION 5 – Sitting A I can sit in any chair as long as I like B I can only sit in my favorite chair as long as I like C Pain prevents me from sitting more than 1 hour D Pain prevents me from sitting more than ½ hour E Pain prevents me from sitting more than 10 minutes F I avoid sitting because it increases pain straight away	SECTION 10 – Changing degree of pain A My pain is rapidly getting better B My pain fluctuates but overall is definitely getting better C My pain seems to be getting better but improvement is slow D My pain is neither getting better or worse E My pain is gradually worsening F My pain is rapidly worsening

NO PAIN 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 UNBEARABLE PAIN	0

I understand that the information I have provided above is current and complete to the best of my knowledge.

Signature: _____ Date: _____

Name: _____ DOB: _____