Sickels Clinic of Chiropractic

"Health...Without a Prescription"

503 N. Orlando Ave.
Suite 105
Cocoa Beach, FL 32931
(321) 783-9400
(321) 783-9358

8041 Spyglass Hill Rd.
Suite 102
Viera, FL 32940
(321)610-8908
(321)783-9358

ACCIDENT HISTORY FORM

Worker's Compensation - Automobile Accident - I.M.E. Evaluation

Today's Date:_____

Name _____ Home Phone _____ Work Phone_____

Address_____ City_____ State_____ Zip_____

Date of Birth_____ SSN _____ Date of Accident_____

Employer_____ Wk. Add._____

Occup._____ Marital Status_____

Women: Are you Pregnant?____yes ____no ____maybe Date of last mentrual onset _____

Initials:_____

HISTORY - ACCIDENT (Patient's Description)

_____

_____

_____

_____

_____

_____

HISTORY - PERSONAL INJURY

Driver_____ Passenger_____ Pedestrian_____ Other (Describe)_____

Traveling or stopped facing: North_____ South _____ East_____ West _____

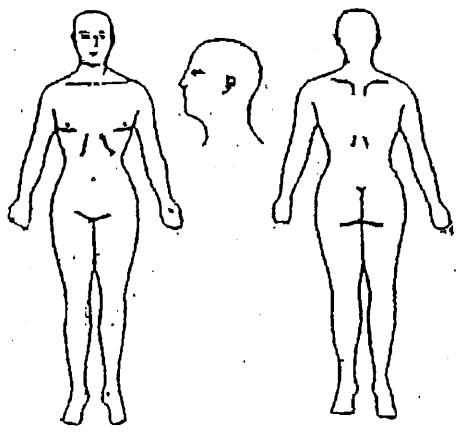
Location of Accident:Street_____ Closest Intersecting Street_____

HEALTH INSURANCE INFORMATION

Insurance Company Name _____ ID #_____

Address_____ Phone _____

Please mark your areas on figure below:



CHECK YOUR SYMPTOMS:

	Past	Present
1. Dizziness		
2. Backaches		
3. Heart Trouble		
4. Diabetes		
5. Headaches		
6. Digestive Disorders		
7. Nervousness		
8. Neck Pain		
9. Poor Circulation		
10. Stroke		

11. List current Medications/any past surgeries

_____

_____

_____

Description of Accident (Check and/or circle appropriate description ... Check ALL that apply)

- ☐ Stopped / slowed down for traffic / red light / stop sign and was struck in the rear by another vehicle.
- ☐ Was pushed into the vehicle in front of his/hers.
- ☐ Was sideswiped by another vehicle travelling in the same direction
- ☐ Another vehicle ran a red light / stop sign and struck his/her vehicle broadside / in the rear / in the front end.
- ☐ Another vehicle travelling in the opposite direction collided head-on with the vehicle in which he/she was riding
- ☐ The vehicle in which he/she was riding was struck by another vehicle causing it to spin around / roll over.
- ☐ The patient was involved in a multi-vehicle collision
- ☐ The patient was involved in a motor vehicle collision
- ☐ The driver of the vehicle in which he/she was riding lost control and struck another vehicle / ran off the road / struck another object - describe:_____
- ☐ The patient was a pedestrian and was struck by a motor vehicle
- ☐ Other (brief description): _____

Was the patient wearing a seat belt? ☐ Yes ☐ No

Did he/she strike any object inside the car? ☐ Yes ☐ No

Select from the following list, any objects which the patient's body struck at the point of impact:

☐ Head	☐ Face	☐ Chest	☐ Neck
☐ Shoulder(s) Rt / Lt	☐ Arm(s)) Rt / Lt	☐ Leg(s) Rt / Lt	☐ Back
☐ Knee(s) Rt / Lt	☐ Other: _____		

Select the objects that were struck:

☐ Windshield	☐ Back of Seat	☐ Headrest	☐ Seat broke
☐ Dash board	☐ Jarred or thrown about	☐ Steering column	☐ Can't remember details (dazed)
☐ Door frame	☐ Rendered unconscious	☐ Rear view mirror	☐ Other: _____

Was the patient:

☐ Unconscious ☐ Cut or bleeding - describe _____ ☐ Neither

If applicable, indicate any pain or abnormal sensations experienced by the patient immediately following the impact:

☐ Felt no immediate pain	☐ Pain began several hours after accident	☐ Headache
☐ Saw stars	☐ Semiconscious state	☐ Neck pain (Rt / Lt)
☐ Upper extremity pain (Rt / Lt)	☐ Lower extremity pain (Rt / Lt)	☐ Other: _____

Indicate any actions taken by the patient immediately following the accident:

☐ Went home and took it easy	☐ Went about normal business	☐ Went to physician
☐ Went to hospital	☐ Patient doctored him/herself (thinking pain would go away)	☐ Pain began later

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HOSPITALIZATION

Indicate method of delivery to hospital:
- ☐ Ambulance
- ☐ Patient drove him/herself
- ☐ Driven by spouse/relative/friend/employer
- ☐ Went home and taken later or drove. When: _____

Name of Hospital:
- ☐ Wuesthoff
- ☐ Holmes Regional
- ☐ Other: _____
- ☐ Cape Canaveral
- ☐ Patrick Air Force Base
- ☐ Jess Parrish
- ☐ Cape Kennedy Dispensary

Was the patient seen in the emergency room? ☐ Yes ☐ No

Was the patient admitted to the hospital? ☐ Yes ☐ No

Length of Stay: _____

Name of admitting Physician: _____

Indicate any procedures performed at the hospital (including the emergency room):
- ☐ Examination
- ☐ Acca
- ☐ Cervical collar
- ☐ Complete bed rest
- ☐ Stitches
- ☐ Physiotherapy
- ☐ Injection
- ☐ Other: _____
- ☐ X-Rays
- ☐ Prescription
- ☐ Wound(s) dressed

What did the patient do after his/her release from hospital?
- ☐ Returned home and took it easy
- ☐ Returned home and went to bed
- ☐ Returned home and returned to emergency room after _____ hours/days
- ☐ Returned to work

When did the patient consult a physician other than the hospital doctor?
- ☐ Same Day
- ☐ Other _____
- ☐ Following day
- ☐ None
- ☐ Within a few days _____

NOTE: IF THE PATIENT CONSULTED THIS OFFICE FIRST, SKIP TO PAST HISTORY

Who was the first physician you consulted? Dr. _____
- ☐ Family Physician
- ☐ Neurologist
- ☐ Surgeon
- ☐ Chiropractor
- ☐ Osteopath
- ☐ Other: _____
- ☐ Orthopedist
- ☐ Family Walk-In Clinic

What was done:
- ☐ X-Rays
- ☐ Traction
- ☐ Physical Therapy (ulltra sound, heat)
- ☐ Examination
- ☐ Support (belt/brace)
- ☐ Manipulation
- ☐ Other: _____
- ☐ Collar
- ☐ Rx

Did the doctor refer patient to, or has the patient been to see any other doctor? ☐ Yes ☐ No

How long was the patient under the care of his/her physician? _____

Is the patient still under his/her care? ☐ Yes ☐ No

Indicate the frequency of the patient's visits to the doctor: _____

If the patient was sent for an independent medical examination, indicate the physician: _____

*List Medications currently taking: _____

*Vitamins and Supplements currently taking: _____

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PAST HISTORY

Has the patient been involved in any previous accident of any kind? ☐ No ☐ Yes:
If so, please provide dates and details:_____

If the patient has been treated by any other physician for neck or back problems, please explain:

If the patient has been previously treated by a chiropractor, please explain:

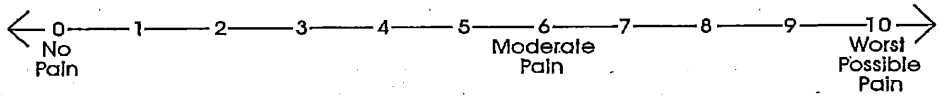
If patient has undergone any surgery or experienced any conditions that are pertinent to this condition, please explain:

Did the patient enjoy good health prior to this accident? ☐ Yes ☐ No:
Explain_____

PRESENT COMPLAINTS

What are the patient's present complaints, starting with the most severe? Describe in detail the location, intensity (mild, moderate or severe), how often each condition bothers you (constant, frequently, occasionally):

On a scale of 1 to 10, with 10 being the worst, how would you rate your pain?



DISABILITY

Has the patient lost time from work since the accident? ☐ No ☐ Yes Number of days lost: _____
Is the patient still off from work? ☐ No ☐ Yes Indicate date patient returned to work: _____
Patient's job description:_____
What is it that patient can not do at work due to pain? Explain in detail: _____

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Activities of Daily Livinig

PATIENT NAME:_____ PATIENT #_____ DATE:_____

FUNCTIONAL ACTIVITIES

Please indicate how long you could both previously and now present perform the functional activities described below:

	BEFORE	NOW		BEFORE	NOW
Sit Continuously	___ hr. ___ min.	___ hr. ___ min.	Drive Continuously	___ hr. ___ min.	___ hr. ___ min.
Stand Continuously	___ hr. ___ min.	___ hr. ___ min.	Walk Continuously	___ hr. ___ min.	___ hr. ___ min.

PERSONAL ACTIVITIES

As a result of yourr injury, do you have any difficulty with the following activities (Please mark Yes or No):

Dressing	☐ Yes	☐ No	☐ Partial	Gardening	☐ Yes	☐ No	☐ Partial
Bathing/Showering	☐ Yes	☐ No	☐ Partial	Mowing Lawn/Yard Work	☐ Yes	☐ No	☐ Partial
Wash/Dry Hair	☐ Yes	☐ No	☐ Partial	Wash/Wax Vehicle	☐ Yes	☐ No	☐ Partial
Going to Toilet	☐ Yes	☐ No	☐ Partial	Kneeling/Squatting	☐ Yes	☐ No	☐ Partial
Desk/Computer Work	☐ Yes	☐ No	☐ Partial	Climbing Stairs	☐ Yes	☐ No	☐ Partial
Vacuuming/Sweeping	☐ Yes	☐ No	☐ Partial	Sex	☐ Yes	☐ No	☐ Partial
Making Bed	☐ Yes	☐ No	☐ Partial	Child Care	☐ Yes	☐ No	☐ Partial
Ironing	☐ Yes	☐ No	☐ Partial	Reading	☐ Yes	☐ No	☐ Partial
Preparing Meals	☐ Yes	☐ No	☐ Partial	Laundry	☐ Yes	☐ No	☐ Partial
Taking out Garbage	☐ Yes	☐ No	☐ Partial	Load/Unload Dishwasher	☐ Yes	☐ No	☐ Partial
Window Washing	☐ Yes	☐ No	☐ Partial	Shoveling Snow	☐ Yes	☐ No	☐ Partial
Carrying Large/Heavy Purse	☐ Yes	☐ No	☐ Partial	Heavy Briefcase/Laptop	☐ Yes	☐ No	☐ Partial
Other	☐ Yes	☐ No	☐ Partial	Sitting for long periods	☐ Yes	☐ No	☐ Partial

(Explain): _____

RECREATIONAL ACTIVITIES

List hobbies/recreational activities you enjoyed prior to injury. Place an X by those you can no longer perform because of injury:

1) _____ ☐
2) _____ ☐
3) _____ ☐
4) _____ ☐
5) _____ ☐
6) _____ ☐

WORK ACTIVITIES

Check ALL that apply:

LIFT FROM	☐ FLOOR	☐ WAIST	☐ OVERHEAD
TWIST WITH WEIGHT FROM	☐ FLOOR	☐ WAIST	☐ OVERHEAD
TWIST WITHOUT WEIGHT FROM	☐ FLOOR	☐ WAIST	☐ OVERHEAD
PUSH FROM	☐ FLOOR	☐ WAIST	☐ OVERHEAD
PULL FROM	☐ FLOOR	☐ WAIST	☐ OVERHEAD
OTHER	☐ DRIVE	☐ TYPE/COMPUTER WORK	☐ PHONE USE

PLEASE EXPLAIN OTHER

SIT	☐ 0 - 2 HRS	☐ 2 - 4 HRS	☐ 4 - 6 HOURS	☐ 6 - 8 HRS	☐ 10+ HRS
STAND/WALK	☐ 0 - 2 HRS	☐ 2 - 4 HRS	☐ 4 - 6 HOURS	☐ 6 - 8 HRS	☐ 10+ HRS

I TAKE A_____ BREAK EVERY_____ ☐ MINUTES -or- ☐ HOURS

Do you have an exercise program or sport in which you are currently active? ☐ Yes ☐ No

Please explain:_____

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Legal Representation

Name of representing attorney: _____

Address: _____

_____

Phone: _____

Fax: _____

Additional Comments:

_____

_____

_____

_____

_____

Insurance Information:

Company: _____

Claim Number: _____

Adjuster: _____

Address: _____

_____

_____

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ASSIGNMENT OF NO-FAULT INSURANCE BENEFITS

I hereby authorize, direct and demand that my personal injury protection insurance pay directly to my assignee:

_____

_____

such sums as may be due and owing in this Office for service rendered to me, both by reason of accident or illness and by reason of any other bills that are due this Office, and to withhold such sums from any disability benefits, medical payment benefits, No-Fault benefits, health and accident benefits, workmen's compensation benefits, or any other insurance benefits obligated to reimburse me or from any settlement, judgment or verdict on my behalf as may be necessary to adequately protect said Office. I hereby further give a lien to said Office against any and all insurance benefits named herein, and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by said Office. This is to act as an assignment of all my rights, benefits and privileges under my insurance policy to my assignee for any and all amounts owed.

I hereby assign and transfer to this my assignee/health care provider any and all causes of action that I may have or that might exist in my favor against my insurance company and authorize this Office to prosecute said cause of action either in my name or in the Office's name, and further I authorize this Office to compromise, settle or otherwise resolve said claim or cause of action as they see fit.

I authorize the Office to release pursuant to Privacy Rule, 45C.F.R. parts 160 and 164 promulgated pursuant to the HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 ("HIPPA"), Pub. L. No. 104-191, 110 Stat. 1936 (1996), any information including, but not limited to, medical records, insurance information or documents otherwise pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under this Assignment.

Date:_____ Signed_____

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DOCTOR-PATIENT RELATIONSHIP IN CHIROPRACTIC
INFORMED CONSENT

CHIROPRACTIC

It is important to acknowledge the difference between the health care specialties of chiropractic, osteopathy and medicine. Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the chiropractic doctor's procedures often depends on environment, underlying causes, physical and spinal conditions. It is important to understand what to expect from chiropractic health care services.

ANALYSIS

A doctor of chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Syndrome (VSS) or Vertebral Subluxation Complexes (VSC). When such VSS and VSC complexes are found, chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. Due to the complexities of nature, no doctor can promise you specific results. This depends upon the inherent recuperative powers of the body.

DIAGNOSIS

Although doctors of chiropractic are experts in chiropractic diagnosis, the VSS and VSC, they are not internal medical specialists. Every chiropractic patient should be mindful of his/her own symptoms and should secure other opinions if he/she has any concern as to the nature of his/her total condition. Your doctor of chiropractic may express an opinion as to whether or not you should take this step, but you are responsible for the final decision.

INFORMED CONSENT FOR CHIROPRACTIC CARE

A patient, in coming to the doctor of chiropractic, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give a chiropractic adjustment, or health care, if he/she is aware that such care may be contraindicated. Again, it is the responsibility of the patient to make it known or to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the doctor of chiropractic. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The doctor of chiropractic provides a specialized, non-duplicating health service. The doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

RESULTS

The purpose of chiropractic services is to promote natural health through the reduction of the VSS or VSC. Since there are so many variables, it is difficult to predict the time schedule or efficacy of the chiropractic procedures. Sometimes the response is phenomenal.

In most cases there is more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same chiropractic care. Many medical failures find quick relief through chiropractic. In turn, we must admit that conditions which do not respond to chiropractic care may come under the control or be helped through medical science. The fact is that the science of chiropractic and medicine may never be so exact as to provide definite answers to all problems. Both have made great strides in alleviating pain and controlling disease.

TO THE PATIENT

Please discuss any questions or problems with the doctor before signing this statement of policy.

I have read, and understand the foregoing.

_____ DATE

_____ SIGNATURE

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PATIENT _____

AUTHORIZATION and RELEASES

CONSENT FOR TREATMENT:

I, the undersigned, hereby authorize Dr. Daniel L. Sickels and whomever he may designate as his assistant(s) to perform diagnostic treatments including but not limited to radiographs and to administer treatment as necessary. I also certify that no guarantee or assurance has been made to the results that may be obtained.

I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse remittances for the conveyance of credit to my account. HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME (OR MY CHILD) ARE CHARGED DIRECTLY TO ME, AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT. WE RESERVE THE RIGHT TO CHARGE 18% OF TOTAL BILL FOR ALL ACCOUNTS OVER THIRTY (30) DAYS OLD.

Patient's Signature _____ Date _____

Witness _____

IMPORTANT INSURANCE INFORMATION

IT IS YOUR RESPONSIBILITY TO CONTACT YOUR INSURANCE COMPANY REGARDING YOUR CHIROPRACTIC COVERAGE. WE WILL CALL AS A COURTESY, BUT ARE NOT RESPONSIBLE FOR MISREPRESENTATION GIVEN BY INSURANCE COMPANIES.

I HAVE READ THE ABOVE INSURANCE STATEMENT AND CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME (OR MY CHILD) ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT.

Patient's Signature _____ Date _____

Guardian's Signature _____ Date _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize the release of any medical information necessary to process my insurance claim(s) and also certify all insurance information given to this clinic is correct and complete.

Patient's Signature _____ Date _____

Witness _____

Permission to Bill Insurance

I assign all medical benefits to Dr. Daniel L. Sickels, from any health plans including Medicare, all major medical, and supplemental insurances. I understand that I am responsible for all claims and expected to pay Co-pays and deductibles in advance. I agree to the release of any information necessary to process these claims.

Name Printed _____

Signature IF adult _____ Date _____

Signature guardian if appropriate _____ Date _____

Guardian relationship _____

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

_____ _____

Patient Name (please print) Date

_____

Parent, Guardian or Patient's legal representative
(please print)

_____

Signature

****

***THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS

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Consent for Communication And/Or Disclosure

I request the following alternatives or limitations relating to communications directed to me by my healthcare provider or employee.

Do we have permission to:

Call you at home? YES NO

If yes, can we leave the following information on your answering machine or voicemail:

Appointment information YES NO Billing information YES NO Medical Information YES NO

Can we call you at work? YES NO

If yes, can we leave the following information on your answering machine or voicemail:

Appointment information YES NO Billing information YES NO Medical Information YES NO

I give my permission to share the following information with the person(s) names below:

Name_____ Relationship_____

Appointment: YES NO Billing: YES NO Medical: YES NO

Name_____ Relationship_____

Appointment: YES NO Billing: YES NO Medical: YES NO

Patient Signature_____ **Date**_____

Witness_____ **Date**_____

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HIPPA Information and Consent Form

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matter related to your care is handled appropriately. This specifically includes the sharing of information with other health care provider, laboratories and health insurance payers as is necessary and appropriate for your care. Patients files may be stored in open files racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc... Those records will not be available to persons other than office staff. You agree to the normal procedures within the office for the handling of charts, patient's records, PHI (Protective Health Information) and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, US mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentially rules of HIPPA.
4. You understand and agree to inspections of the office and reviews of documents which may include PHI government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal practices to conform to your request.

I,_____Date_____do hereby consent and acknowledge my agreement to the terms set forth in the HIPPA INFORMATION FORM and any subsequent changes in office policy.

I understand that this consent shall remain in force from this time forward.

Office Staff Witness/Signature_____Date_____