Automobile Accident Questionnaire

Please answer all questions completely

Dear Patient: This information is considered confidential. We need this information because we care enough to want to know, and your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. Thank you.

Name _____ Sex _____ Marital Status _____ Date of Birth _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Occupation _____ Who referred you to our office? _____
(Indicate if child, student, housewife, unemployed, retired)

Social Sec. # _____ Business Phone _____ Company Name _____ Location _____

Spouse's First Name _____ Spouse's Soc. Sec. # _____ Spouse's Employer _____ Location _____

Please explain in detail how your accident happened _____

Insurance Co. _____ Policy No. _____ Claim No. _____

Driver of other vehicle (if any)

Name _____ Insurance Company _____ Policy No. _____

Driver of vehicle in which you were injured (if applicable)

Name _____ Insurance Company _____ Policy No. _____

Name of your insurance adjustor _____

Have you retained an attorney? ☐ Yes ☐ No

If so, his name and address _____

You were heading ☐ North ☐ East ☐ South ☐ West on _____ (street or highway)

Other vehicle was headed ☐ North ☐ East ☐ South ☐ West on _____ (street or highway)

Were police notified? ☐ Yes ☐ No

Were you knocked unconscious? ☐ Yes ☐ No If so, for how long? _____

You were struck from ☐ Behind ☐ Front ☐ Left side ☐ Right side

You were ☐ Driver ☐ Passenger ☐ Front seat ☐ Back seat ☐ Using seat belts ☐ Other protective devices

What were the time and date of present injury? _____

Where did you feel pain immediately after the accident? _____

Where were you taken after the accident? _____

What treatment was given? _____

Was any other doctor consulted after your accident? ☐ Yes ☐ No

If so, what was the doctor's name? _____ ☐ D.C., ☐ M.D., ☐ D.O., ☐ D.D.S.

What was the diagnosis? _____

What treatment was given? _____

How often did you see the doctor? _____

How long did you see the doctor? _____

Have you ever had any complaints in the involved area before? ☐ Yes ☐ No

If so, what were the complaints? _____

Before the injury were you capable of working on an equal basis with others your age? ☐ Yes ☐ No

Are your work activities restricted as a result of this accident? ☐ Yes ☐ No

Since this injury are your symptoms ☐ Improving? ☐ Getting worse? ☐ Same?

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HEALTH QUESTIONNAIRE:

Please indicate for each of the questions below your experience by use of the following codes: 1—never had; 2—previously had; 3—presently have.

MUSCULO-SKELETAL SYSTEM

_____ Low back problems
_____ Pain between shoulders
_____ Neck problems
_____ Arm problems
_____ Leg problems
_____ Swollen joints
_____ Painful joints
_____ Stiff joints
_____ Sore muscles
_____ Weak muscles
_____ Walking problems
_____ Ruptures
_____ Broken bones

GENITO-URINARY SYSTEM

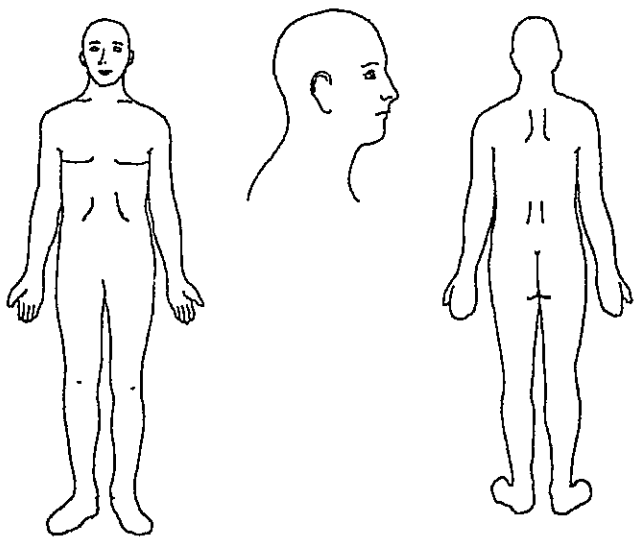
_____ Bladder trouble
_____ Excessive urination
_____ Scanty urination
_____ Painful urination
_____ Discolored urine

FEMALE

_____ Vaginal discharge
_____ Vaginal bleeding
_____ Vaginal pain
_____ Breast pain
_____ Lumps on breast

Are you pregnant?
_____ Yes _____ No

Please mark your areas of pain on the figures below.



GASTRO-INTESTINAL SYSTEM

_____ Poor appetite
_____ Excessive hunger
_____ Difficult chewing
_____ Difficult swallowing
_____ Excessive thirst
_____ Nausea
_____ Vomiting food
_____ Vomiting blood
_____ Abdominal pain
_____ Diarrhea
_____ Constipation
_____ Black stool
_____ Bloody stool
_____ Hemorrhoids
_____ Liver trouble
_____ Gall bladder problems
_____ Weight trouble

NERVOUS SYSTEM

_____ Numbness
_____ Loss of feeling
_____ Paralysis
_____ Dizziness
_____ Fainting
_____ Headaches
_____ Muscle jerking
_____ Convulsions
_____ Forgetfulness
_____ Confusion
_____ Depression

CARDIO-VASCULAR-RESPIRATORY

_____ Chest pain
_____ Pain over heart
_____ Difficult breathing
_____ Persistent cough
_____ Coughing phlegm
_____ Coughing blood
_____ Rapid heartbeat
_____ Blood pressure problems
_____ Heart problems
_____ Lung problems
_____ Varicose Veins

EYE, EAR, NOSE, AND THROAT

_____ Eye strain
_____ Eye inflammation
_____ Vision problems
_____ Ear pain
_____ Ear noises
_____ Ear discharge
_____ Hearing loss
_____ Nose pain
_____ Nose bleeding
_____ Nose discharge
_____ Difficult breathing thru nose
_____ Sore gums
_____ Dental problems
_____ Sore mouth
_____ Sore throat
_____ Hoarseness
_____ Difficult speech

_____
Patient's Signature

DO NOT WRITE BELOW THIS LINE

Patient accepted? Yes_____ No_____ Doctor's signature_____

SOAP NOTE

NAME: _____ DATE: _____

ADDRESS: _____ PHONE: ( ) _____

SUBJECTIVE COMPLAINTS

PRIMARY COMPLAINT: _____ INTENSITY: BETTER <1 2 3 4 5 6 7 8 9 10> WORSE

DESCRIPTION: _____ FREQUENCY: _____

ONSET: _____ CAUSE: _____

PATIENT/GUARDIAN SIGNATURE: _____

I HAVE RECEIVED ALL TREATMENTS OR SUPPORTS LISTED BELOW. I ALSO, REPRESENT THE SUBJECTIVE COMPLAINTS THAT I HAVE ARE EXISTENT AND TRUE ACCORDING TO THE LEVELS INDICATED, AND UNDERSTAND THE LIABILITY OF PERJURY.

ADDITIONAL DOCTOR'S NOTE: PLEASE NOTE THAT SORENESS FOR SEVERAL DAYS AFTER AN ADJUSTMENT IS TO BE CONSIDERED NORMAL DUE TO THE NATURE OF THE TREATMENT.

OBJECTIVE FINDINGS:

⇧⇩ _____ RANGE OF MOTION

TENDERNESS NOTED AT _____

MUSCLE SPASM AT _____

JOINT FIXATIONS AT _____

TRIGGER POINTS AT _____

SHORT LEG: RIGHT / LEFT

SENSATION: ⇧ ⇩ _____

ANTALGIC LEAN TO THE: RT / LT

VERTEBRAL SUBLUXATION COMPLEX:

OCCIPUT,C1,C2,C3,C4,C5,C6,C7,T1,T2,T3,T4, T5,T6,T7,T8,T9,T10,T11,T12,L1,L2,L3,L4,L5, SACRUM

ABNORMAL POSTURE EVALUATION

___LORDOSIS ___KYPHOSIS ___SCOLIOSIS

ASYMMETRICAL MUSCLE CONTRACTION

R/L CERVICAL R/L THORACIC R/L LUMBAR

POSITIVE TEST:

___ORTHOPEDIC ___NEUROLOGICAL

_____

_____

_____

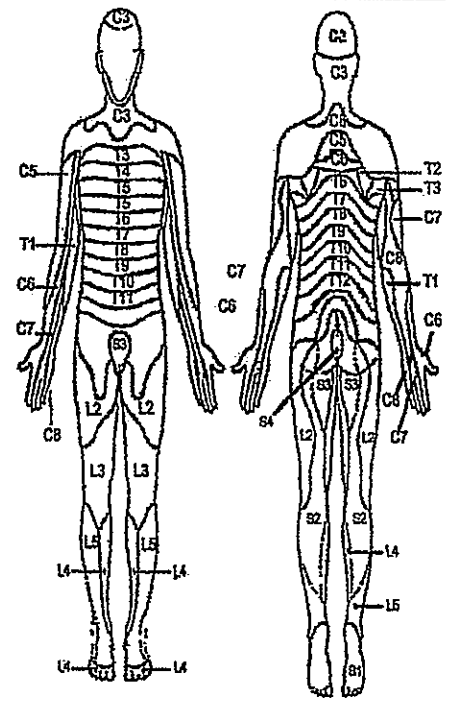
__CHANGE IN MEDS __NO CHANGE IN MEDS

_____

_____

SUBJECTIVE AREAS OF PAIN:

_____



_____

OBJECTIVE SCALE OF FINDINGS:

(DETERMINED BY X-RAYS)

_____1. EXCELLENT-LITTLE CHANCE OF SURGERY. 50/50 CHANCE OF LONG TERM.

_____2. GOOD-SLIGHT CHANCE OF SURGERY. 50/70 CHANCE OF LONG TERM.

_____3. POOR-MODERATE CHANCE OF SURGERY. 80% CHANCE OF LONG TERM.

_____4. GUARDER-MARKED CHANCE OF SURGERY. 90% CHANCE OF LONG TERM.

_____5. CLINICALLY UNSTABLE-PROBABILITY OF SURGERY. SURGERY CONSULT INDICATED.

CARE PLAN:

_____3X FOR 3 WEEKS THEN RE-EVALUATE

_____2X FOR 3 WEEKS THEN RE-EVALUATE

_____1X FOR 3 WEEKS THEN RE-EVALUATE

_____OTHER _____

GOALS:

⇩PAIN ⇩TENDERNESS ⇩SWELLING

⇩FIXATIONS ⇩SPASMS

⇧ROM ⇧STRENGTH ⇧STABILITY

⇧COORDINATION ⇧POSTURE

_____

ASSESSMENT:

_____Heat/Ice: 97010___; EMS: G0283___

_____Ult-sound: 97035__; Aid EMS: 97032__

_____Massage: 97124

_____NMR: 97112__; Man Thera__97140-59

_____Mechanical Traction: 97012

_____Ther Activ: 97530__; ADL: 97535__

_____Sp D, (C/L): S9090; _____SW 0101T

_____Therapeutic Isotonic Rehab: 97110

_____Spinal Manip: 98940___; or 98941___

_____Extremity Adjustment: 98943-AT-59

Occiput C1 C2 C3 C4 C5 C6 C7
T1 T2 T3 T4 T5 T6 T7 T8 T9 T10 T11 T12
L1 L2 L3 L4 L5 S1 Illium

ACTIVITIES OF DAILY LIVING:

(SUBJECTIVELY)

THINGS THAT MAKE YOU WORSE: _____

_____

_____

_____

_____

THINGS THAT MAKE YOU BETTER: _____

_____

_____

_____

_____

BODY ANALYSIS:

AGE: _____ FAT: _____

HT: _____ MUSC: _____

WT: _____ KCAL: _____

BMI: _____ VISC FAT: _____

DIAGNOSIS:

_____

_____

_____

_____

_____NEW CONDITION _____DOI

_____RE-EXACERBATION _____DOI

_____MAINTENANCE CARE_____DOS

TIME IN: _____ OUT: _____

BOCA HEALTH & WELLNESS CENTER
3350 NW BOCA RATON BLVD. SUITE A24
BOCA RATON, FL 33431
OFFICE: (561) 447-2228/FAX (561) 447-2230

Ernest S Caruso D.C.

ERNEST S CARUSO D.C,P.A.

GENERAL EXAMINATION

Time: IN _____ OUT _____

Height Ft Inches | Weight Lbs | Blood Press | HR | Temp. | Pulse

Vascular Tests
VBI [+] [-] / Peripheral _____

Body Type
- [ ] Ectomorph
- [ ] Mesomorph
- [ ] Endomorph
- [ ] Obese

Systems Review (WNL / Deferred)
- EENT
- CV System
- Resp System
- GI/Abdominal
- GU

Significant Findings:

Observations

AP Curve	WNL	Decreased	Increased
Cervical			
Thoracic			
Lumbar			

Scoliosis

	Convex L	Convex R	Absent	Mild	Moderate	Marked
Cervical						
Thoracic						
Lumbar						
Other:						

Postural Symmetry

	Left	Right	Absent
Head Tilt			
High Shoulder			
Rib Hump			
High Iliac Crest			

Antalgic Lean: Left | Right | Anterior | Lumbar | Cervical

Subluxation: _____

Spinal Palpation (Tenderness) 1-4

Level	L	M	R

Level	L	M	R

Soft Tissue Evaluation

List Region/Muscle	L	R	Hypertonicity 0 1 2 3 4 5	Atrophy 1 2 3 4	Tender	Trig Pts. A L	Strength: 0 1 2 3 4 5 6

Additional Info: _____

CERVICAL ROM ☐ WNL

	Active°	Passive°	A	D	S	L	M	R	Limit/Pain
Flexion (50°)									
Extension (70°)									
LL Lat Flex (45°)									
RL Lat Flex (45°)									
LL Rotation (85°)									
RL Rotation (85°)									

THORACIC ☐ WNL

	Active°	A	D	S	L	M	R	Limit/Pain
Flex/Ext (90°)								
LL Trunk Rot. (45°)								
RL Trunk Rot. (45°)								

A = Absent D = Dull S = Sharp
L = Left M = MidLine R = Right

LUMBOPELVIC ☐ WNL

	Active°	A	D	S	L	M	R	Limit/Pain
Flexion (90°)								
Extension (30°)								
LL Lat Flex (35°)								
RL Lat Flex (35°)								
LL Rotation (30°)								
RL Rotation (30°)								

ORTHOPEDIC/NEUROLOGICAL

CERVICAL

Stretch Tests	+	-	Dull	Sharp	Left	Midline	Right	Cervical	Shoulder	Arm/Hand	Thoracic
LL Shoulder Depression											
RL Shoulder Depression											
Soto Hall Test											

Compression Tests	+	-	D	S	L	M	R
LL Cervical Comp.							
RL Cervical Comp.							

LL Roos [+] [-] RL Roos [+] [-]

Distraction Tests

Cervical [+] [-] LL Bakody's [+] [-] RL Bakody's [+] [-]

Reflexes (0-5)

	L	R
Biceps		
Brachio		
Triceps		
Patellar		
Achilles		

Sensory

	WNL	Left	Right	Description

LOW BACK

Stretch Tests	Degrees	+	-	Dull	Sharp	Left	Midline	Right	Lumbar	Gluteal	Above Knee	Below Knee
LL SLR												
RL SLR												
LL Braggard's												
RL Braggard's												
LL Bechterew's Test												
RL Bechterew's Test												

Compression Tests	+	-	D	S	L	M	R
LL Kemp's							
RL Kemp's							
Milgram's							
Valsalva Test							

Mechanical Tests	+	-		+	-		+	-
LL Gaenslen			LL Fabere			LL Yeoman		
RL Gaenslen			RL Fabere			RL Yeoman		

Neurological Eval/Other Tests: _____

RADIOGRAPHIC EVALUATION

VIEWS TAKEN _____ DATE _____ WHERE IF NOT THIS CLINIC _____ ADDITIONAL VIEWS REQUESTED

Subluxation (Yes/No)

Scoliosis Location/ Apex | L | R | Cobbs | Rotation

	L	T	R
AP Cervical Curve			
Thoracic			
AP Lumbar Curve			

Sacral Base Angle _____
LL Short Leg (mm) _____
RL Short Leg (mm) _____

OD	OS	Level	Joint Involvement	Hypomobile
Osteoporosis:				

Other Findings/Recommendations: _____

Comments/Additional clinical information: _____

All the information provided above is a true, accurate and complete representation of _____ PATIENTS NAME

D.C SIGNATURE _____ DATE _____

BOCA HEALTH & WELLNESS CENTER
Dr. Ernest S. Caruso
CHIROPRACTIC PHYSICIAN

PLUMTREE CENTRE
3350 NW BOCA RATON BLVD., SUITE A24
BOCA RATON, FL 33431

OFFICE: (561) 447-2228
FAX: (561) 447-2230

NOTICE OF INTENTION OF TREATMENT

DATE

Attn: Adjuster
x Insurance Company
address
address

VIA U.S. CERTIFIED/REGISTERED MAIL RETURN RECEIPT REQUESTED:
CERTIFIED MAIL #

Our Patient: Claim Number:
Date of Accident: Dates of Service:

Dear Mr./Ms. _____:

This letter will serve as formal writtten notice of medical treatment and/or services rendered by this office to the above referrenced patient. This patient's first date of treatment and/or services was _____.

Pursuant to Florida Statute 627.736, this notice is being sent within the first 21 days of treatment and/or services and therefore this office is permitted not more than 75 days from the date of the first treatment and or service, to submit the bill or statement.

Enclosed for your records is an Assignment of Benefit Form signed by the patient.

Very Truly Yours,

Authorized Representative for
Ernest Caruso, D.C.

Enc. AOB

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

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

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

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

   _____

   _____

2. I have the right and the **duty to confirm** that the services have already been provided.
3. I was **not solicited** by any person to seek any services from the medical provider of the services described above. This means that no person has initiated contact with me and/or persuaded me to use the doctor or licensed professional, clinic, or medical institution that provided the services.
4. The medical provider has **explained** the services to me for which payment is being claimed.
5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to $500.

The undersigned licensed medical professional affirms the statement numbered 1 above and also:

A. I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.

B. I have **explained** the services rendered to the insured person, or his or her guardian, **sufficiently** for that person to sign this form with informed consent.

C. The accompanying statement or bill is **properly completed** in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to **truthfully, accurately,** and in a **substantially complete** manner.

D. The coding of procedures on the accompanying statement or bill is proper. This means that **no service has been upcoded, unbundled,** or constitutes an invalid **or not medically necessary diagnostic test** as defined by Section 627.732 (15) and (16), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

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

Name *(PRINT or TYPE)*	Signature	Date

Licensed Medical Professional Rendering Treatment *(Signature by his or her own hand):*

Name *(PRINT or TYPE)*	Signature	Date

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of Claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234(1)(b), Florida Statutes.

Note: The **original** of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may **not** be electronically furnished. Failure to furnish this form may result in non-payment of the claim.

Dr. Ernest S. Caruso
CHIROPRACTIC PHYSICIAN

ASSIGNMENT OF INSURANCE BENEFITS, RELEASE, & DEMAND

Insurer and Patient Please Read the Following in its Entirety Carefully!

I, the undersigned patient/insured knowingly, voluntarily and intentionally assign the rights and benefits of my automobile insurance, a/k/a Personal Injury Protection (hereinafter PIP), Uninsured Motorist, and Medical Payments policy of insurance to the above health care provider. I understand it is the intention of the provider to accept this assignment of benefits in lieu of demanding payment at the time services are rendered. I understand this document will allow the provider to file suit against an insurer for payment of the insurance benefits or an explanation of benefits and to seek §627.428 damages from the insurer. If the provider's bills are applied to a deductible, I agree this will serve as a benefit to me. This assignment of benefits includes the cost of transportation, medications, supplies, overdue interest and any potential claim for common law or statutory bad faith/unfair claims handling. If the insurer disputes the validity of this assignment of benefits then the insurer is instructed to notify the provider in writing within five days of receipt of this document. Failure to inform the provider shall result in a waiver by the insurer to contest the validity of this document. The undersigned directs the insurer to pay the health care provider the maximum amount directly without any reductions & without including the patient's name on the check. To the extent the PIP insurer contends there is a material misrepresentation on the application for insurance resulting in the policy of insurance is declared voided, rescinded, or canceled, I, as the named insured under said policy of insurance, hereby assign the right to receive the premiums paid for my PIP insurance to this provider and to file suit for recovery of the premiums. The insurer is directed to issue such a refund check payable to this provider only. Should the medical bills not exceed the premium refunded, then the provider is directed to mail the patient/named insured a check which represents the difference between the medical bills and the premiums paid.

Disputes: The insurer is directed by the provider and the undersigned to not issue any checks or drafts in partial settlement of a claim that contain or are accompanied by language releasing the insurer or its insured/patient from liability unless there has been a prior written settlement agreed to by the health provider (specifically the office manager) and the insurer as to the amount payable under the insurance policy. The insured and the provider hereby contests and objects to any reductions or partial payments. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by the provider shall be done so 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. The insurer is hereby placed on notice that this provider reserves the right to seek the full amount of the bills submitted. If the PIP insurer states it can pay claims at 200% of Medicare then the insurer is instructed & directed to provide this provider with a copy of the policy of insurance within 10 days. **Any effort by the insurer to pay a disputed debt as full satisfaction must be mailed to the address above, after speaking with the office manager, and mailed to the specific attention of the Office Manager. See Fla. Stat. §673.3111.**

EUOs and IMEs: If the insurer schedules a defense examination or examination under oath (hereinafter "EUO") the insurer is hereby INSTRUCTED to send a copy of said notification to this provider. The provider or the provider's attorney is expressly authorized to appear at any EUO or IME set by the insurer. The health care provider is not the agent of the insurer or the patient for any purpose. This assignment applies to both past and future medical expenses and is valid even if undated. A photocopy of this assignment is to be considered as valid as the original. I agree to pay any applicable deductible, co-payments, for services rendered after the policy of insurance exhausts and for any other services unrelated to the automobile accident. The health care provider is given the power of attorney to: endorse my name on any check for services rendered by the above provider; and to request and obtain a copy of any statements or examinations under oath given by patient.

Release of Information: I authorize this provider to: furnish an insurer, an insurer's intermediary, the patient's other medical providers, and the patient's attorney via mail, fax, or email, with any and all information that may be contained in the medical records; to obtain insurance coverage information (declaration sheet & policy of insurance) in writing and telephonically from the insurer; request from any insurer all explanation of benefits (EOBs) for all providers and non-redacted PIP payout sheets; obtain any written and verbal statements the patient or anyone else provided to the insurer; obtain copies of the entire claim file, the property damage file, and all medical records, including but not limited to,

PLUMTREE CENTRE
3350 NW BOCA RATON BLVD., SUITE A24, BOCA RATON, FL 33431
OFFICE: (561) 447-2228 FAX: (561) 447-2230

documents, reports, scans, notes, bills, opinions, X-rays, IMEs, and MRIs, from any other medical provider or any insurer. The provider is permitted to produce my medical records to its attorney in connection with any pending lawsuits. The insurer is directed to keep the patient's medical records from this provider private and confidential. The insurer is not authorized to provide these medical records to anyone without the patient's and the provider's prior express written permission.

Demand: Demand is hereby made for the insurer to pay all bills within 30 days without reductions and to mail the latest non-redacted PIP payout sheet and the insurance coverage declaration sheet to the above provider within 15 days. The insurer is directed to pay the bills in the order they are received. However, if a bill from this provider and a claim from anyone else is received by the insurer on the same day the insurer is directed to not apply this provider's bill to the deductible. If a bill from this provider and claim from anyone else is received by the insurer on the same day then the insurer is directed to pay this provider first before the policy is exhausted. In the event the provider's medical bills are disputed or reduced by the insurer for any reason, or amount, the insurer is to: set aside the entire amount disputed or reduced; escrow the full amount at issue; and not pay the disputed amount to anyone or any entity, including myself, until the dispute is resolved by a Court. Do not exhaust the policy. The insurer is instructed to inform, in writing, the provider of any dispute.

Certification: I certify that: I have read and agree to the above; I have not been solicited or promised anything in exchange for receiving health care; I have not received any promises or guarantees from anyone as to the results that may be obtained by any treatment or service; and I agree the provider's prices for medical services, treatment and supplies are reasonable, usual and customary.

Caution: **Please read before signing. If you do not completely understand this document please ask us to explain it to you. If you sign below we will assume you understand and agree to the above.**

Patient's Name _____ Patient'sSignature_____
(Please Print) (If patient is a minor, signature of parent/guardian)

Date _____

Boca Health & Wellness Center
Dr. Ernest S. Caruso
3350 NW Boca Raton Blvd. Suite A24
Boca Raton, FL 33431
(561) 447-2228

LETTER OF PROTECTION
DIRECTION TO PAY

PATIENT: _____

DATE OF BIRTH: _____

DATE OF INJURY: _____

IMPORTANT: THIS IS A CONTRACT. IF YOU DON'T UNDERSTAND THIS THEN CONSULT WITH AN ATTORNEY BEFORE SIGNING.

Patient authorizes and irrevocably directs his/her present and any future attorneys related to the above-referenced date of injury ("Attorneys") to honor this agreement. This irrevocable agreement is made in favor of the above-referenced Medical Provider and shall be termed a "Letter of Protection." The Letter of Protection shall serve to place a continuing lien on any proceeds I recover in any legal action related to the above-referenced date of injury. The Direction to Pay applies to the Patient's Attorneys.

Background. Medical Provider expects to be paid from any proceeds related to the above-referenced date of injury in exchange for providing medical care/treatment. Medical Provider also agrees not to place patient in collections until the resolution of Patient's claims related to the above-referenced date of injury. Patient expects to receive medical care that is reasonable, related to the above-referenced accident and medically necessary. Patient has sustained injuries as a result of injuries related to the above-referenced date of injury and does not have the funds to pay for the medical care which he/she needs. Patient is signing this Letter of Protection in order to receive medical care.

Insurance Benefits. In the event that there are disability benefits, medical payment benefits, No-Fault benefits, health and accidental benefits, worker's compensation benefits, or any other insurance benefits available to Patient besides Bodily Injury and/or Un-insured Motorist (aka Underinsured Motorist) coverage then this Letter of Protection can be used to cover any co-payments and/or deductibles.

Protection of Medical Bills. If Patient recovers any money related to the above-referenced date of injury then Patient's Attorney shall withhold from those funds, sufficient money pay the outstanding balance of any bill(s) owed to Medical Provider. It is understood that Attorney's fees/costs are first-in-line and that this Letter of Protection does not interfere with Attorney's retainer agreement with Patient. Patient authorizes Medical Provider to provide Attorney with a copy of Patient's medical records, bills, etc. with regard to the above-referenced date of injury.

Patient's Responsibility for Bills. Patient understands that he/she is directly responsible to Medical Provider for services rendered and that payment is not contingent on any settlement, judgment, or verdict related to the above-referenced date of injury. Regardless of any settlement, judgment, or verdict, Patient is still responsible for paying Medical Provider's outstanding bills so long as they are reasonable and related to the above-referenced date of injury and medically necessary.

Patient's Responsibility Regarding His/Her Attorney (Present and Future). Patient is responsible for informing each and every attorney retained by him/her of the existence of this agreement. Medical Provider has the right to notify Patient's Attorney(s) about the existence of this Letter of Protection. Upon request, Patient and Patient's Attorney shall provide status updates about any claims related to the above-referenced date of injury as well as the contact information for any new Attorneys. It is also the Patient's responsibility to advise the Medical Provider at least 10 days prior to collecting any funds and to request a bill for any and all outstanding charges. Patient understands that if funds related to the above-referenced date of injury are insufficient to cover the medical bill(s) then Medical Provider has the right to collect the remaining balance.

Disputes. If the Patient fails to pay the Medical Provider's full outstanding balance and Medical Provider is the prevailing party in an action to enforce this Letter of Protection then Medical Provider shall have the right to recover all attorney fees and costs including post-judgment proceedings. Binding arbitration is an option if both parties agree in writing.

Direction to Pay. ATTENTION ATTORNEY: THIS IS AN IRRECOVABLE DIRECTION TO PAY MY MEDICAL PROVIDER. Patient irrevocably directs his/her Attorneys to pay any outstanding medical bills in connection with the above-referenced date of injury. Patient hereby directs Attorneys to provide a status update in writing within 15 days of receiving a request from Medical Provider.

Effective Date. This agreement becomes effective when the Patient signs the agreement below.

Patient Signature	Date
Attorney Signature	Date

Dr. Ernest P. Caruso
CHIROPRACTIC PHYSICIAN

OFFICE CONFIDENTIALITY

I. STATEMENT OF PURPOSE

a. To protect the patient from invasion of privacy by preventing indiscriminate and unauthorized access to confidential health information.

b. To promote appropriate usage and maintenance of confidentiality when health information is requested.

II. STATEMENT OF POLICY

a. The medical record is the property of and shall be maintained to serve the patient, the health care providers and this facility in accordance with legal, accrediting, and regulatory agency requirements.

b. The information contained in the medical record belongs to the patient and the patient is entitled to have that information protected.

c. All patient information shall be regarded as confidential, whether written, verbal or observed and available only to authorized users.

III. PROCEDURE

Access to patient records is limited to practitioners, and other health care professionals and insurers and their representatives with legitimate resons for accessing the chart.

a. Release of information
Confidential information regarding the patient's admission, condition, and case management details (including all records, tests and reports within the medical record) will be discussed only with the patient or his/her designee.

1. Information submitted, collected and prepared for the purpose of evaluating and improving patient care, determining the health care services professionally indicated or performed in compliance with applicable standards shall be deemed confidential.

b. Fax Transmission
Prior to fax transmission of any data that contains patient/medical record information, it must be confirmed that the requesting party has the consent of the patient (Independent Health may obtain their members' records, as all members sign such an agreement upon joining the HMO).

2. Confirm the fax number before transmitting to avoid non-transmissioins and errors. The fax cover sheet is labeled "Confidential Material." Verification that the data was received by the proper party should be done.

Any proven breach of confidentiality represents a failure to meet professional and ethical standards. Appropriate action will be taken to address the confidentiality breach.

I have read, fully understand and agree to comply with the confidentiality policy as stated above.

Name: _____ Date: _____

PLUMTREE CENTRE
3350 NW BOCA RATON BLVD., SUITE A24, BOCA RATON, FL 33431
OFFICE: (561) 447-2228 FAX: (561) 447-2230

Boca Health and Wellness Center
3350 NW Boca Raton Blvd. Suite A24
Boca Raton, Fl 33431

NOTICE OF PRIVACY PRICTACES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSEED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION
PLEASE REVIEW IT CAREFULLY

Effective April 14. 2003

The privacy of your medical information is important to us. You may be aware that the U.S. government regulators established privacy rule "HIPAA" governing protected health information (PHI). This notice tells you about how it may be used and about certain rights that you have.

Use and Disclosure of Protected Information.

Federal law provides that we may use medical information (protected health information – PHI) for treatment of you, without further specific notice to you or written authorization by you. For example, if we refer you to a specialist, we may provide laboratory or test data to that specialist (subject to more stringent Florida State laws, such as restriction on disclosure of information concerning HIV/AIDS).

Federal law provides that we may use your medical information to obtain payment for our services without further specific notice to you or written authorization by you. For example, under your health plan, we are required to provide them with a diagnosis code for your visit and a description of the services rendered.

Federal law provides that we may use your medical information for health care operations without further specific notice to you or written authorization by you. For example, our accountants may see your name, dates of treatment and procedure codes during audits of our books or we may use your information for financial services, quality assurance, risk reduction and claim management purposes with our medical professional liability insurer.

We may use or disclose your medical information, without further notice to you or specific authorization by you, where:

1. **required by law ;**
2. **required for public health purposes;**
3. **required by law to report child abuse;**
4. **where required by a health oversight agency for oversight activities authorized by law, such as the Department of Health, Office of Professional Discipline or Office of Professional Medical Conduct;**
5. **required by law in Judicial or administrative proceedings;**
6. **required for law enforcement purposes by a law enforcement official;**
7. **required by a coroner or a medical examiner;**
8. **permitted by law to a funeral director;**
9. **permitted by law for organ donation purposes;**
10. **permitted by law to avert a serious threat to health or safety;**
11. **permitted by law and required by military authorities if you are a member of the U.S. armed forces**

Florida State law provides additional protection for information regarding HIV/AIDS. We will continue to follow Florida State Law with respect to such information.

We may contact you by mail or phone, at your residence, to remind you of appointments or to provide information about treatment alternatives. Unless you instruct us otherwise, we may leave a message for you on any answering devise or with any person who answers the phone at your residence.

We may release PHI to a friend or a family member involved in your care or who assists in caring for you. For example, if a family member or a babysitter brings a child to the office for treatment, we may discuss the child's treatment and they may have access to protected information.

You can make reasonable requests, in writing, for us to use alternative methods of communicating with you in a confidential manor.

Other uses or disclosures of your medical information will be made only with your written authorization. You have the right to revoke any written authorization that you give.

Rights That You Have

You have the right to request restrictions on certain of the uses or disclosures described above. Except as stated bellow, we are not required to agree to such restrictions.

You have the right to inspect and obtain copies of your medical information (a reasonable fee will be charged).

You have the right to request amendments to your medical information. Such requests must be in writing and must state the reason for the requested amendment. We will notify you whether we agree and disagree with the requested amendment. If we disagree with any requested amendment, we will further notify you of your rights.

You have the right to request an accounting of any disclosures of your medical information, except for: disclosures we make to you, or to carry out treatment, payment or health care operations, or as requested by your written authorization, or as permitted or required under 45 CFR 164.502, or for emergency or notification purposes, or for national security or intelligence purposes as permitted by law, or to correctional facilities or law enforcement officials as permitted by law (or for public health purposes after being de-identified or limited to remove personally identifiable information) or disclosures made before April 14, 2003.

You have the right to obtain a paper copy of this notice from this office.

Obligations That We Have

We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices.

We are required to abide by the terms of this notice as long as it is in effect.

We reserve the right to revise this notice and to make a notice effective for all protected health information we maintain. Any revised notice will be posted in our office and copies will be available there.

If you feel your privacy rights have been violated, you have the right to file a complaint with the Secretary of the Department of Health and Human Services of the United States. You may also file a complaint with us.

If you would like further information about our privacy policies or have any questions or concerns, please contact our privacy officer bellow:

Dr. Ernest S Caruso – Business Owner
Plumtree Centre
3350 NW Boca Raton Blvd. Suite A 24
Boca Raton, FL 33431
(561) 447-2228

No retaliatory action will be taken against you for any complaint that you make.

Dr. Ernest S. Caruso
CHIROPRACTIC PHYSICIAN

NOTICE TO ALL PATIENTS

WE WILL FILE YOUR INSURANCE AS A COURTESY

"AS OF JANUARY 1, 2013, UNDER NEW PIP GUIDELINES, MASSAGE THERAPY IS NOT A COVERED SERVICE AND WILL HAVE TO BE PAID BY CASH OR UNDER THE BODILY INJURY (B.I.) PORTION OF YOUR INSURANCE COVERAGE. (REASONABLE AND CUSTOMARY FEE). IT IS YOUR OPTION TO RECEIVE THIS SERVICE."

HOWEVER

IF WE DO NOT RECEIVE PAYMENT, IT IS YOUR RESPONSIBILITY TO CONTACT THEM AND FOLLOW UP ON THIS MATTER

ALSO

IN THE EVENT THAT YOUR INSURANCE REIMBURSES YOU DIRECTLY, IT IS YOUR RESPONSIBILITY TO FORWARD PAYMENT TO OUR OFFICE WITHIN THE NEXT 10 DAYS

YOU WILL BE RESPONSIBLE FOR ANY CHARGES INCURRED

_____

Person responsible for payment Date

PLUMTREE CENTRE
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NOTICE OF EMERGENCY MEDICAL CONDITION

The undersigned licensed medical provider, hereby affirms:

The below injured patient, has in the opinion of this medical provider, suffered an Emergency Medical Condition, as a, result of the patient's injuries sustained in an automobile accident that occurred on _____.

The basis for the finding of an Emergency Medical Condition is that the patient has sustained acute symptoms of sufficient severity, which may include severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following: a) serious jeopardy to patient health. b) serious impairment to bodily functions; or c) serious dysfunction of a bodily organ or part.

I hereby attest that I am a physician licensed under chapter 458 or 459 and that the facts are true and correct.

_____ _____ _____

Name (Print/Type) Signature Date

The undersigned injured person or legal guardian of such affirms:

The symptoms I reported to the medical provider are true and accurate.

I understand the medical provider has determined I sustained an Emergency Medical Condition as a result of the injures I suffered in the car accident.

The medical provider has explained to my satisfaction the need for future medical attention and the harmful consequences to my health which may occur if I do not receive future treatment.

Injured patient receiving this diagnosis or legal guardian of said injured patient:

_____ _____ _____

Patient Name (Print) Signature (Patient/Guardian) Date

Dr. Ernest P. Caruso
CHIROPRACTIC PHYSICIAN

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care. We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable. Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being. It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. In pertaining to strokes, the reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit. I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

X Patient Name: _____ Signature: _____ Date:

Parent or Guardian: _____ Signature: _____ Date:

Witness Name: _____ Signature: _____ Date:

PLUMTREE CENTRE
3350 NW BOCA RATON BLVD., SUITE A24, BOCA RATON, FL 33431
OFFICE: (561) 447-2228 FAX: (561) 447-2230

ERNEST S. CARUSO D.C. P.A.
3350 NW 2nd Avenue, Suite A24
Boca Raton, FL 33431

Code	Description	Regular Price/per unit
72040	CERVICAL SPINE X-RAY, 2-3 VIEWS	$125
72070	THORACICSPINE X-RAY, 2 VIEWS	$150
72100	LUMBAR SPINE X-RAY, 2-3 VIEWS	$150
73100	X-RAY WRIST, 2 VIEWS	$125
73560	X-RAY – KNEE 1-2 VIEWS	$125
97010	HOT/COLD PACK	$40
97012	TRACTION	$75
97014/G0283	ELECT MUSCLE STIMULATION	$40
97035	ULTRASOUND 15 MIN	$40
97110	THERAPEUTIC EXERCISE 15 MIN	$75
97112	NEUROMUSCULAR RE-ED 15 MIN	$75
97124	MASSAGE THERAPY 15 MIN	$50
97140	MANUAL THERAPY 15 MIN	$75
97530	THERAPEUTIC ACTIVITIES	$75
98940	SPINE MANIPULATION 1-2 REGIONS	$75
98941	SPINE MANIPULATION 3-4 REGIONS	$85
98943	EXTRA SPINAL ADJ 1 REGION	$70
99070	SUPPLIES (LUMBAR CUSHION, ETC)	$60
99202	OFFICE VISIT NEW PATIENT	$200
99203	OFFICE VISIT NEW PATIENT (CAN ONLY)	$250
99204	INTIAL VISIT (PIP ONLY)	$360
99211	OFFICE VISIT BRIEF (RE-EVAL)	$150
99213	OFFICE VISIT NEW PATIENT – FINAL EXAM	$300
99214	OFFICE VISIT – ESTABLISHED PT	$50
S9090	SPINAL DECOMPRESSION	$150

Cash Courtesy Adjusted Amount: _____

Total Paid Today: _____

Due to financial hardship and/or not having health insurance, I am requesting a cash pay discount.

X Patient Signature: _____