10 dogwood trail Suite B Debary Fl 32713

PERSONAL INJURY QUESTIONNAIRE

Name _____ Date Of Birth _____

Home Phone _____ Cell Phone _____

Address_____City_____State_____Zip._____

Email Address:_____

INSURANCE

Auto Carrier:_____ Claim#_____

Claims Mailing Address: _____

Auto Carrier Phone # _____ Ext:_____

Adjuster's Name_____ Phone # _____Ext:_____

Name on Policy (if other than self) _____ Relationship to Insured _____

ATTORNEY

Name _____ Phone _____

Address_____ City_____ State____ Zip_____

Email: _____

NATURE OF ACCIDENT:

1. Date of Accident _____ Time of Day_____ Were there any witnesses? ○Yes ○No
2. Were you: ○Driver ○Passenger ○Front Seat ○Back Seat
3. Number of people in your vehicle? _____ Were you wearing seat belts? ○Yes ○No
4. What direction were you headed? (Circle one) ○North ○East ○South ○West

Name of Street_____

5. What direction was other vehicle headed? (Circle One) ○North ○East ○South ○West

(Name of Street) _____

6. Were you struck from: (Circle One) ○Behind ○Front ○Left Side ○Right Side
7. Approximate speed of your car _____ mph Other car _____ mph
8. Were you knocked unconscious? ○Yes ○No If yes, for how long? _____
9. What position was your head at time of impact? Straight ahead___ Turned Left___ Turned Right ___

10. Were police notified? ◯Yes ◯No

11. In your own words, please describe accident:

_____

_____

_____

_____

12. Did you have any physical complaints BEFORE THE ACCIDENT? ◯Yes ◯No If yes, please describe in detail:

_____

_____

_____

_____

13. Please describe how you felt:

a. DURING the Accident:_____

b. IMMEDIATELY AFTER:_____

c. Later that day _____

d. The next day_____

14. Where were you taken after the CURRENT accident?_____

15. Have you been treated by another doctor since the accident? ◯Yes ◯No If yes, please list doctor's name and address:_____

What type of treatment did you receive? (ex: MRI, X-Ray,Meds)_____

_____

16. Since this injury occurred, are your symptoms: (Circle One) ◯Improving ◯Getting ◯Worse ◯Same

17. CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

☐ Headache	☐ Neck Pain	☐ Neck Stiff	☐ Sleeping Problems	☐ Back Pain
☐ Tension	☐ Nervousness	☐ Irritability	☐ Chest Pain	☐ Dizziness
☐ Fainting	☐ Fever	☐ Constipation	☐ Stomach Upset	☐ Cold Sweats
☐ Head Seems Too Heavy		☐ Pins & Needles in Arms		☐ Pins & Needles in Legs
☐ Numbness in Fingers		☐ Numbness in Toes		☐ Shortness of Breath
☐ Fatigue	☐ Depression	☐ Lights Bother Eyes		☐ Loss of Memory
☐ Ears Ring	☐ Face Flushed	☐ Buzzing in Ears		☐ Loss of Balance
☐ Loss of Smell	☐ Loss of Taste	☐ Diarrhea	☐ Feet Cold	☐ Hands Cold

Symptoms Other Than Above _____

18. What are your PRESENT complaints and Symptom?_____

_____

_____

19. Have you ever been involved in an accident before? ◯Yes◯No If yes, please describe, including date(s) and type(s) of accidents, as well as injury(ies) received_____

_____

_____

20. Do you have any previous illnesses which relate to this case? ◯Yes ◯No If yes, please describe:

_____

21. Do you have any congenital (from birth) factors which relate to this problem? ◯Yes ◯No If yes, please describe:

_____
_____
_____

22. Have you lost time from work as a result of this accident? ◯Yes ◯No If yes, please complete this question:

a. Last Day worked _____

b. Type of Employment _____

c. Present Salary _____

d. Are you being compensated for time lost from work? ◯Yes ◯No If yes, please state type of compensation you are receiving: _____

23. Do you notice any activity restrictions as a result of this injury? ◯Yes ◯No If yes, please describe, in detail:

_____
_____
_____

24. Other pertinent Information:

_____
_____

25. Please list all medications you are taking:

_____
_____
_____

26. List any types of surgeries and dates:

_____
_____

27. Liquor consumed on a weekly basis: _____

28. Do you smoke? _____ If yes, how much per day? _____

29. Any significant family medical history:

_____
_____

Patient Signature_____ Date:_____

Assignment of Benefits and Direction to Pay Benefits Owed

I, the undersigned insured or beneficiary of _____Insurance, Policy# _____, irrevocably assign to Health In Motion Chiropractic 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 Health In Motion Chiropractic to promptly make payment in the name of and directly to Health In Motion Chiropractic or its chosen billing service.

Pursuant to this AOB, Health In Motion Chiropractic 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 or 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 Health In Motion Chiropractic 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 Health In Motion Chiropractic 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. Health In Motion Chiropractic reserves the right to seek the full amount of the bill submitted from the insurance company(ies) or me. Accordingly, the insurer is hereby instructed to set aside (escrow) any and all reduced or denied benefit payments for 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 Health In Motion Chiropractic in resolving all medical billing disputes. Cooperation includes, but is not limited to, providing any and all declaration pages, PIP logs, payout ledgers, explanations of benefits, copies of checks, and any and all other documents or information to Health In Motion Chiropractic or its attorneys, employees or other representatives acting on behalf of Health In Motion Chiropractic. 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 Health In Motion Chiropractic 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 Health In Motion Chiropractic regardless of the amount paid by the insurance company, unless ordered by a 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 Health In Motion Chiropractic are related to my accident (or my covered conditions) and should be paid directly to Health In Motion Chiropractic 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 NSURANCE 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. A photocopy of this assignment shall be considered as effective and valid as the original.

_____ _____

Patients Name Signature

_____

Date

Informed Consent

CONSENT TO CHIROPRACTIC SERVICES

I hereby request and consent to chiropractic manipulation, neuromuscular therapy, exercise and other procedures including various modes of physiotherapy, diagnostic x-rays, and/or tests by Health In Motion Chiropractic and staff who now or in the future will treat me (or on the named patient below, for whom I am legally responsible) while employed by this office. I hereby authorize and provide full consent to Health In Motion Chiropractic to obtain and verify all medical and insurance information to which includes but is not limited to diagnostics test results, patient files, x-rays, etc. from any health care provider. I have had an opportunity to discuss with the physician and/or with any other clinic personal nature and the purpose of treatment indicated. I understand that results are not guaranteed and informed that, as in the practice of medicine, with the practice of chiropractic there are some risks of treatment, including but not limited to: fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications and wish to rely on the doctor to exercise judgment during the course of any procedure which the doctor feels at the time is in my best interest. I have read or have had read to me, the full consent above and have had an opportunity to ask questions about its content, and that by signing below I agree to the above terms and procedures. I intend this consent to cover any treatment for my present condition and for future conditions for which I seek treatment by this clinic and/or employed staff.

Patient Consent For Use and Disclosure of Protected Health Information

I hereby give my consent for Health In Motion Chiropractic to use and disclose protected health information about me to carry out treatment, payment and healthcare operations.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Dr. Jenette Auchter reserves the right to revise the Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Dr. Jenette Auchter, 10 Dogwood Trail Suite B, Debary, FL 32713. With this consent, Dr. Auchter or her staff my call my home or any alternative location and leave a message/voicemail or discuss in person any times that assist the practice in appointment reminders, insurance, and any calls pertaining to my clinical care. With this consent, Dr. Auchter or her staff may mail my home or email any patient statements and/or appointment reminders. I have the right to request that Dr. Auchter restrict how it uses or discloses my PHI to carry out office procedure. I may revoke my consent in writing except to the extent that the practice has already made disclosure in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Dr. Auchter may decline to provide treatment to me.

I authorize and consent to the above chiropractic care and Disclosure of PHI as deemed necessary to:

Patient name (please print): _____

Relationship to patient (ie: self, mother, legal guardian, etc.): _____

PATIENT SIGNATURE: _____ DATE: _____

WITNESS SIGNATURE: _____ DATE: _____

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.

By checking the lines below I authorized being contacted for practice reminders by:

Email at email address: _____
Telephone number(s)_____
By text message_____

By checking the lines below, I authorized the doctor to personally discuss with me products that may benefit my health condition_____.

_____ _____
Patient Name (please PRINT) Date

_____
Name of Patient, Guardian or Patient's legal representative

_____
Signature of Patient, Guardian or Patient's legal representative

THIS FORM WILL BE PLACE IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.

List below the names and relationship of people to whom you authorized the Practice to release PHI.

_____ _____

_____ _____

10 Dogwood Trail, Suite B
Debary, FL 32713
386-320-0325
Fax: 386-320-0318

REQUEST FOR LETTER OF PROTECTION FROM ATTORNEY

Attorney's Name _____

I hereby authorize and direct you, my attorney, to pay Health In Motion Chiropractic any unpaid balances due from any settlement, judgment, or verdict for services rendered to me in my care and treatment for injuries sustained by me on _____.

This letter of protection is irrevocable and being entered into with knowledge of and on behalf of _____, the patient. In return for this letter Health In Motion Chiropractic agrees it will not pursue its claim against the patient until settlement, at which time payment is due.

I understand that this does not relieve me of my personal responsibility for all such charges in the event there is no recovery.

The undersigned patient agrees to observe all the above terms, and requests that his/her attorney withhold such sum from any settlement, judgment, verdict or other sources that may become available to protect the patient's outstanding bills from this office.

Patient's Signature_____ Date_____

Doctor's Signature_____ Date_____

Attorney's Signature_____ Date_____

Heath In Motion Chiropractic

10 Dogwood Trail. Suite B
Debary, FL 32713
Phone: 386-320-0325
Fax: 386-320-0318

Records Release

AUTHORIZATION FOR USE AND DISCLOSER OF INFORMATION

Patient Name:_____ Date of Birth: _____

Street Address:_____ City / Zip: _____

Telephone: Cell:_____ Home:_____ Work:_____

RELEASE TO: **Health In Motion Chiropractic**
Email: health@drauchter.com
Fax: 386.320.0318

SPECIFIC DESCRIPTION OF INFORMATION TO BE USED AND DISCLOSED

Please indicate the time period you are requesting records for. Dates of Service: _____to_____

☐ Entire Medical Records ☐ Billing Information ☐ Diagnosis/Treatment Notes

☐ Lab/Imaging ☐ Physical Forms ☐ Referral

PATIENT AGREEMENT

I authorize the use and disclosure of my individually identifiable health information as described above, including verbal and written exchanges about the information unless I indicated otherwise, to Health In Motion Chiropractic. I understand that this authorization is voluntary. I understand that if the person or organization I authorize to receive the information is not a health plan or health care provider, the released information my no longer be protected by federal privacy regulations and could be re-disclosed. I understand that my health care and payment for my health care will not be affected if I do not sign this form. I release _____ from all legal responsibility and/or liability that may arise from the release of the records I have specified. I authorize _____ to use or disclose of protected health information as described above. This authorization is given pursuant to Florida Statute 456.057 and HIPPA regulations.

_____ _____
Signature of Patient or Representative Date

NO SHOW/MISSED APPOINTMENT POLICY

Health In Motion Chiropractic values each of our patients and prides ourselves on providing the highest quality of care to everyone. To ensure that each patient is given the proper amount of time allotted for their visit, it is very important for each patient to attend their scheduled appointments on time. While we also understand that sometimes it may be necessary for you to cancel or reschedule your appointment, we ask that you kindly notify us within 24 hours to avoid cancellation fees.

PLEASE REVIEW THE FOLLOWING POLICY:

1. Please contact our office at 386.320.0325 to cancel your appointment with at least a 24 hours' notice.

2. If less than a 24-hour cancellation is given and or if you do not present to the office for your schedule appointment time, this will be documented as a "No-Show" appointment.

3. After the first "No-Show/Missed" appointment, you will receive a phone call advising that a "No-Show" has been documented on your account and we will be happy to assist you in rescheduling your appointment.

4. If you have 2 or more "No-Show/Missed" appointments within a one-year time period, you will be assessed a $25.00 fee for each chiropractic visit that is missed.

MASSAGE APPOINTMENT POLICY

Our Massage Therapists dedicate an hour or more of their time to ensure each of our patients receive optimum care. It is very important for each scheduled patient to commit to and attend their scheduled visits on time.

Therefore, to avoid lost time in our Therapists schedules due to No Show / Cancellations, we will now require a credit card to be on file when scheduling Massages. Should you no show or cancel your appointment with less than a 24-hour notice, a fee of $40.00 will be charged immediately to the card on file.

I have read the above and agree to the terms within this policy.

Patient Name (Please Print)_____

Patient Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICIAL INFORMATION ABOUT YOU MAY BE USED AND DISCI.OSED AND HOW YOU CAN GET ACCESS TO THAT INFORMATION

PLEASE REVIEW THIS NOTICE CAREFULLY

This Practice is committed to maintaining the privacy of your protected health information ("PHI"), which includes information about your health condition and the care and treatment you receive from tile Practice. The creation of a record detailing the care and services you receive helps this office to provide you with quality health care. This Notice details how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI. The privacy of PHI In patient file;; will be protected when the files are taken to and from the Practice by placing the files in a box or briefcase and kept within the custody of a doctor or employee of the Practice authorized to remove the file, from the Practice's office. It may be necessary to take patient files to a facility where a patient is confined or to a patient's home where the patient is to be examined 01' treated.

NO CONSENT REQUIRED

The Practice mal' use and/or disclose your PHI for the purposes of:

(a) Treatment· In order to provide you with the health care you require, the Practice will provide your PHI to those health care professionals, whether on the Practice's staff or not, directly involved in your care so that they may understand your health condition and needs. For example, a physician treating you for a condition or disease may need to know the results of your latest physician examination by this office.

(b) Payment· In order to get paid for services provided 1:0 you, the Practice will provide your PHI, directly or through a billing service, to appropriate third party payers, pursuant to their billing and payment requirements. For example,)\1e Practice may need to provide the Medicare program with information about health care services that you receive from the Practice so that the Practice can be properly reimbursed. The Practice may also need to tell your insurance plan about treatment y Ou are going to receive so that it can determine whether or not is will cover the treatment expense.

c) Health Care Operations . In order for the Practice to operate in accordance with applicable law and insurance requirements and in order for the Practice to continue to provide quality and efficient care, It may be necessary for the Practice to compile, use and/or disclose your PHI. For example, the Practice may use your PHI in order to evaluate the performance of the Practice's personnel in providing care to you.

1. The Practice may use and/or' disclose your PHI, without " written Consent from you, in the following additional instances:

(a) De-·identified Information· Information that does not id('ntif~1 you and, even without your name, cannot be ? used to identify YOU.

(b) Business Associate. To u business associate if tile Practice obtains satisfactory written assurance, in accordance with Applicable law, that the business associate will appropriately safeguard your PHI. A business associate is an entity that assists the Practice in undertaking some essential function, such as a billing company that assists tt1e office submitting claims for payment to insurance companies or other payers.

(C) Personal Representative - To a person who, under applicable law has the authority to represent you in making decisions related to your health care.

(d) Emergency Situation"

(I) for tile purpose of obtaining of rendering emergency treatment to you provided that the Practice attempts to obtain your Consent as soon as possible; or

(iI) TO a public or private entity authorized by law or by it's charter to assist in disaster relief efforts, for the purpose of coordinating your care with such entities

(e) Communication Barriers If, due to substantial cornmunlcation barriers lll' inability to communicate, the Practice has been unable to obtain your Consent and the Practice determines, in the exercise of its professional judgment, the your Consent to receive treatment is clearly inferred from the circumstances.

(f) Public Heath Activities· Such activities include, for example, information collected by a public health authority, as authorized by law, to prevent or control disease and that does not identify you and, even without your name, cannot be used to identify you.

(g) Abuse, neglect or Domestic Violence. "0 a government authority if the Practice is required by law to make such disclosure: if the Practice is authorized by law to make SUd1 a disclosure, it will do so if it believes that the disclosure is necessary to prevent serious harm.

(h) Health Oversight Activities· Such activities, which must be required by law, involve government agencies and may include, for example, crtrnlr.at investigations, disciplinary actions, or general oversight activities relating to the community's health care system.

(I) Judicial and Administrative Proceeding· For example, the practice may be requires to disclose your PHI in response to a court order or a lawfully issued subpoena.

(j) Law Enforcement Purposes· in certain instances, your PHI may have to be disclosed to a law enforcement official. For example, your PHI may be the subject of a grand jury subpoena, or, the Practice may disclose your PHI ii the Practice believes that your death was the result t of criminal conduct.

(k) Coroner or Medical Examiner' The Practice may disclose your PHI to a coroner or medical examlner for the purpose of identifying YOll or determining your cause of death,

(I) Organ, Eye or Tissue Donation· If you are an organ donor, the Practice may disclose your PHI to the entity to whom -YOIJ have agreed to donate your organs.

(m) Research· If the Practice is involved in research activities, your PHI may be used, but such use is subject to numerous governmental requirement intended to protect the privacy of your PHI and that does not identify YOU and, even without your name, cannot be used to identify you.

(n) Avert a Threat to Health or Safety. The Practice may disclose tour PHI if it believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to the health or Safety of a person or the public on" the disclosure is t t0 an individual who is reasonably able to prevent or lessen the threat.

(0) Workers' Compensation If you are involved in a Worker' Compensation claim, the Practice may be required to disclose your PHI to an individual or entity that is part; of the Workers' Compensation system.

APPOINTMENT REMINDER

The Practice may, from time to time, contact you to provide appointment reminders or Information about treatment alternatives or other health-related benefits and services that may be of interest to you. The following appointment reminders are used by the Practice: a) a postcard mailed to I'OU at the address provided by you; and b) telephoning your home and leaving a message on your answering machine or with the individual and answering the phone.

Sign in Log

The Practice maintains a sign-in log for individuals seeking care and treatment in the office. The sign-in log is located in a position where staff can readily see who is seeking care in the office suite. This information may be seen by, and is accessible to, others who are seeking care or services in the Practice's offices,

FAMILY/FRIENDS/REFERRAL BOARD

The Practice may disclose to your family member, other relative, a close personal friend, or any other person identified by you , your PHI directly relevant to such person's involvement with your care or the payment for your care. / The Practice may also use or disclose your PHI to notify or assist in the notification (including identifying or locating) a family member, a personal representative, or another person responsible for your care, of your location, general condition or death. However, in both cases the following conditions will apply:

(a) If you are present at or prior to the use or disclosure of your PHI, the Practice may use or disclose your PHI if you agree, or if the Practice can reasonably infer from the circumstances, based on the exercise of its professional judgment, that you do not object to the use or disclosure.

(b) If you are not present, the Practice will, in the exercise of professional judgment, determine whether the use or disclosure is in your best interests and, if so, disclose only the PHI that is directly relevant to the person's involvement with your case.

(c) If you refer a friend or family member in our office, your Name may be put on our referral board.

(d) If one of our patients referred you to our practice we may send a postcard to our patient to say ' thank you for your referral.