SYNERGY
Health & Wellness

Chiropractic Case History/Patient Information

Patient Name:_____ Date:_____

Social Security #_____ Birth Date: ___/___/____ Age:_____ Gender: F M

E-mail address:_____ Cell Phone:_____

Preferred method of appointment reminder: ☐ Email ☐ Text Cell Phone Provider_____

Height:_____ Weight:_____ Specify Right or Left Handed:_____

Have you ever been in our office before? ☐ Yes ☐ No

If you are under 18 years of age, who are your legal parents or guardian?

Father:_____ Date of Birth: ___/___/____ Phone: _____

Mother:_____ Date of Birth: ___/___/____ Phone: _____

Guardian:_____ Date of Birth: ___/___/____ Phone: _____

Marital Status: ☐ Married ☐ Separated ☐Widowed ☐Single How many children? _____

CURRENT ADDRESS

Street _____

City_____ State_____ Zip_____

Occupation_____ Employer_____

Work Address_____ Work Phone _____

Student at_____ ☐ Full Time ☐ Part Time

Name of Spouse_____ Spouse's Date of Birth : ___/___/____

Who should we contact in the event of an emergency_____ Phone Number _____

PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)

Auto Insurance Carrier:_____ **Claim Number**:_____

Adjuster Name:_____ Phone Number:_____

Health Insurance Carrier:_____

Full Name of Policy Holder:_____ Policy Holder's Date of Birth ___/___/___

28963 SR 54 Wesley Chapel, FL 33543 (813) 906-2499 F: (813) 343-6093

INJURY QUESTIONNAIRE

Date of Accident:_____ Where(Street/Intersection):_____

Were any tickets issued and to whom?

_____

Were you the: ☐ Driver ☐ Front Seat Passenger (Right) ☐ Back Seat LEFT Passenger
☐ Back Seat RIGHT Passenger

Did the impact to your vehicle come from the: ☐ Front ☐ Rear ☐ Left Side ☐ Right Side

Did the air bag deploy? ☐ Yes ☐ No Did you hit anything inside the vehicle? ☐ Yes ☐ No If yes, describe:

_____

Did you experience immediate pain? ☐ Yes ☐ No
Did the ambulance/paramedics arrive at the scene? ☐ Yes ☐ No

Were you taken to the hospital? ☐ Yes ☐ No Did you drive to the hospital? ☐ Yes ☐ No
Which hospital? _____

Were xrays taken? ☐ Yes ☐ No MRI ☐ Yes ☐ No CT ☐ Yes ☐ No
Did they prescribe medication? ☐ Yes ☐ No

Are you currently taking medication? ☐ Yes ☐ No
If yes, please name all:_____

Please describe the accident in your own words:

_____
_____
_____

Describe the condition or symptoms:

_____

Date when symptoms first appeared: _____
Have you had this condition before? _____

Did it begin Gradual? ☐ Yes ☐ No Sudden? ☐ Yes ☐ No
How long has it been going on? _____

What makes symptoms increase? _____
What relieves symptoms? _____

Type of pain: ☐ Sharp ☐ Dull ☐ Aching ☐ Burning ☐ Throbbing
How much of your day is pain? ☐10% ☐25% ☐50% ☐100%

Pain Intensity (circle): NONE 0 1 2 3 4 5 6 7 8 9 10 SEVERE

Does pain radiate into your (circle): L R Shoulder/Arm/Hand L R Buttox/Leg/Foot Does not radiate

28963 SR 54 Wesley Chapel, FL 33543 (813) 906-2499 F: (813) 343-6093

SYMPTOMS: Please check if you have experienced any of the following since this accident.

☐ Low Back Pain
☐ Pain between Shoulder Blades
☐ Neck Pain
☐ Difficulty talking
☐ Tension/Headaches
☐ Changes in Vision
☐ Difficulty swallowing
☐ Other_____

☐ Tension Across Top of Shoulders
☐ Numbness/Tingling in Arms/Hands
☐ Numbness/Tingling in Legs/Feet
☐ Dizziness
☐ Pain in the legs/feet/buttox
☐ Pain in the hand/arm/shoulders
☐ Difficulty with balance

☐ Tired/Fatigued
☐ Difficulty Sleeping
☐ Ringing in Ears
☐ Brain Fog
☐ Nausea
☐ Vomiting

Have you experienced RECENT CHANGES to:

☐ Eyes (sight) ☐ Ears (hearing) ☐ Nose (smell) ☐ Mouth (taste) ☐ Bladder
☐ Bowels ☐ Sleep ☐ Emotion ☐ Appetite
Please explain: _____

Have you missed school or work due to your injuries? ☐ Yes ☐ No

MEDICAL HISTORY

List any previous accidents (automobile, on the job injuries, slips, falls, sports, etc.) and provide the accident date:

1)_____ ___/___/___
2)_____ ___/___/___
3)_____ ___/___/___

Do you now or have you had:
☐ Heart Disease ☐ Diabetes ☐ Cancer ☐ Stroke ☐ High Blood Pressure ☐ Thyroid Problems
☐ Tuberculosis ☐ Prostate Disorder ☐ Kidney problems ☐ Asthma ☐ Ulcer ☐ Seizure Disorder

Serious illnesses or conditions not listed above? _____
When?_____

What prior surgery have you had?

1)_____ ___/___/___
2)_____ ___/___/___
3)_____ ___/___/___

What medications or drugs are you taking?_____
_____

Do you have any allergies to any medications? ☐ Yes ☐ No
If yes, describe:_____
Do you have any allergies of any kind? ☐ Yes ☐ No
If yes, describe:_____

28963 SR 54 Wesley Chapel, FL 33543 (813) 906-2499 F: (813) 343-6093

Do you have any Congenital Condition? ☐Yes ☐ No If YES, Describe _____

Do you smoke? ☐Yes ☐ No If Yes, number of packs _____

Do you drink? ☐Yes ☐ No If Yes, number of drinks _____

WOMEN ONLY: ☐ There is a possibility I may be pregnant ☐Yes, I am definitely pregnant
☐No, I am definitely not pregnant

I certify the information provided is accurate to the best of my knowledge:

Name of Patient _____

Signature of Patient/Legal Guardian _____ Date: _____

28963 SR 54 Wesley Chapel, FL 33543 (813) 906-2499 F: (813) 343-6093

SYNERGY
Health & Wellness

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Name_____ Date_____

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersigned does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

Dated this _____ day of _____, 20_____

By_____
Patient's Signature

If patient is a minor or under a guardianship order as defined by State law:

By_____
Signature of Parent/Guardian (circle one)

28963 SR 54 Wesley Chapel, FL 33543 (813) 906-2499 F: (813) 343-6093

SYNERGY
Health & Wellness

INFORMED CONSENT

William Abrahams, D.C.
28963 State Road 54, Wesley Chapel, FL 33543
813-906-2499

I hereby request and consent to the performance of chiropractic procedures, including various modes of physio therapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed above or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named above and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, 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 I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if I wish to cancel the treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Name of Patient:_____
Signature of Patient:_____
Date:_____

Name Printed of Guardian/Parental and Relationship to Patient:_____
Guardian/Parental Signature:_____
Date:_____

SYNERGY
Health & Wellness

Medical Release of Information Form

TO WHOM IT MAY CONCERN:

Please furnish to Synergy Health and Wellness and/or any or all its personnel, information, copies of any and all hospital and medical record or reports of any sort, charts, notes, xrays, lab reports, and prescription information. Synergy Health and Wellness is to be furnished with any and all other information without limitation pertaining to any examination, treatment or condition of myself, including medical, examinations, or counseling for any condition, medical, dental or psychological.

This AUTHORIZATION shall be considered as continuing and you may rely upon it in all respects unless you have previously been advised by me in writing to the contrary. It is expressly understood by the undersigned and you are hereby authorized to accept a photocopy of this MEDICAL AUTHORIZATION with the same validity as though am original had been presented to you.

Dated this_____ day of _____, 20_____.

Signature:_____

Printed Name: _____

Date of Birth:_____ Last 4 of SSN:_____

28963 State Rd. 54
Wesley Chapel, FL 33543
Telephone: 813-906-2499 Fax: 813-343-6093
www.synergywesleychapel.com

ASSIGNMENT OF BENEFITS,LIENS, DIRECT PAYMENT AUTHORIZATION, AUTHORIZATION TO RELEASE INSURANCE INFORMATION, AND AUTHORIZATION TO ESCROW UNPAID MEDICAL& PIP BENEFITS

SYNERGY HEALTH AND WELLNESS

INSURANCE CARRIER:_____ POLICY NUMBER: _____DATE OF LOSS: _____

For and in consideration of SYNERGY HEALTH AND WELLNESS agreeing to pursue the responsible automobile insurance carrier for payment of benefits due and not requiring prepayment for services, I hereby irrevocably assign all rights and benefits to SYNERGY HEALTH AND WELLNESS for Personal Injury Protection, extended Personal Injury Protection, Medical Payment Coverage, and other benefits which I may have in accordance with Florida Statute §627.736. This includes any benefits from my insurance company and any other entity which may be responsible for medical expenses incurred. I further authorize SYNERGY HEALTH AND WELLNESS to collect payments & prosecute any necessary actions to collect payment for services as they see fit and allowable by law and contract. THIS DOCUMENT CONSTITUTES AN ASSIGNMENT OF RIGHTS AND BENEFITS.

I hereby further give a lien to SYNERGY HEALTH AND WELLNESS 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 SYNERGY HEALTH AND WELLNESS as a result of the above stated loss date. This document acts as an irrevocable absolute assignment of my rights and benefits to the extent of the charges for services provided. I agree to cooperate with SYNERGY HEALTH AND WELLNESS and their attorney's (at their choosing), and to do all things reasonable to effect payment of the bills by the insurance company or other entity to SYNERGY HEALTH AND WELLNESS including, but not limited to, disclosing my medical condition, being available for factual discoveryor other cooperation.

This assignment concerns only the bills for SYNERGY HEALTH AND WELLNESS and those costs including, but not limited to, attorney's fees, other costs, and interest necessary in procuring payment from the above-named insurance company and/or other entities. This assignment is not intended to assign any other causes of action that may belong to the undersigned patient. I agree to pay any applicable deductible or co-payment not covered by any policy of insurance cited above. I understand that as a benefit and convenience to me, SYNERGY HEALTH AND WELLNESS will bill and pursue collection against the insurance company or other responsible entity on my behalf. I hereby instruct and direct my insurance company to pay my benefits directly to SYNERGY HEALTH AND WELLNESS at the address provided on the bill. If my current policy prohibits direct payment to doctors, then I hereby instruct and direct my insurance company or other responsible entity to make the check payable to me and mail it to SYNERGY HEALTH AND WELLNESS at the address on the bill SYNERGY HEALTH AND WELLNESS' medical care is being provided for a reasonable fee for treatment causally related to the above loss date and is medically necessary. I instruct my insurance carrier or other responsible entity to pay these bills to the full extent of my available benefits under the insurance policy and Florida law. If any portion of the charge for these services is either reduced or denied in whole or in part, my insurance company or other entity is to place funds equal to the amount of the reduced or denied charges into escrow and hold the escrowed funds until agreement or resolution of legal action by SYNERGY HEALTH AND WELLNESS. I further instruct my insurance company to make payment for charges submitted by SYNERGY HEALTH AND WELLNESS in priority to any other requests to escrow benefits, including a request by myself to reserve benefits for pending disability claims. I hereby give SYNERGY HEALTH AND WELLNESS limited power of attorney to endorse and sign my name on any draft for payment to either SYNERGY HEALTH AND WELLNESS or myself if said draft represents payment for charges related to services rendered by SYNERGY HEALTH AND WELLNESS.

I further direct my insurance carrier or responsible other entity to provide information to SYNERGY HEALTH AND WELLNESS which is otherwise available to me including but not limited to a copy of any applicable insurance policy, declaration page, all applicable endorsements, transcripts and/or copies of any recorded statements, examinations under oath and requests for same, independent medical evaluations and requests for same, peer review reports, and a listing of all PIP benefits paid to date which shall include when claims were made, when the claims were received, the payment or denial of each claim, the amount of the deductible and the claims applied thereto, and whether benefits have been exhausted and the amount of PIP benefits available, commonly known as a "PIP log". This request includes the name of other medical providers to whom payments have been under my policy of insurance. This agreement is intended to serve as an assignment of rights and benefits under my policy of insurance in favor of SYNERGY HEALTH AND WELLNESS. If any language within this agreement has the effect of invalidating this agreement, that language shall be deemed void and the remainder of the assignment shall maintain full force and effect. A photocopy of this assignment shall be considered as effective and valid as the original.

Patient Signature	Date	Patient Name

If patient is incapacitated or under the age of 18, please indicate the patient name, guardian name and relation to patient, and obtain guardian signature.

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

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

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

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

_____

_____

2. I have the right and the **duty to confirm** that the services have already been provided.

3. I was **not solicited** by any person to seek any services from the medical provider of the services described above.

4. The medical provider has **explained** the services to me for which payment is being claimed.

5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to $500.

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

_____	_____	_____
Name *(PRINT or TYPE)*	Signature	Date

The undersigned licensed medical professional or medical director, if applicable, affirms the statement numbered 1 above and also:

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

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

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

D. The coding of procedures on the accompanying statement or bill is proper. This means that **no service has been upcoded, unbundled**, or constitutes an invalid **or not medically necessary diagnostic test** as defined by Section 627.732(14) and (15), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Licensed Medical Professional Rendering Treatment/Services or Medical Director, if applicable *(Signature by his/ her **own hand**):*

William Z.T. Abrahams, DC	_____	_____
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.