Patient Information

Name: _____ DOB: _____ SS#: _____ M/F

Address: _____

Phone: _____ Cell: _____ Email: _____

Occupation: _____Employer: _____

HEALTH INSURANCE INFORMATION:

Insurance Co: _____

Insured: _____ Patient Relationship: _____

ID #: _____ Group #: _____

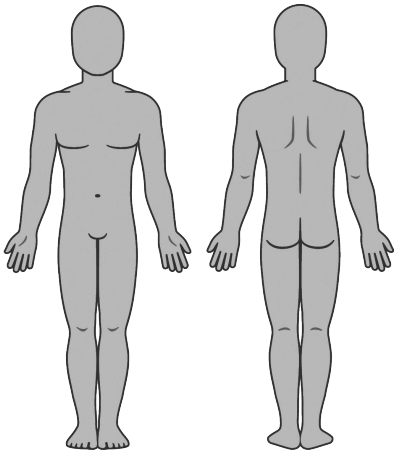
ATTORNEY INFORMATION

Firm Name:_____Attorney Name:_____

Firm Phone:_____ Firm Fax: _____

Why You Are Here

Chief Complaint: _____When did it begin? _____



Please mark with an X areas of pain on image.

Circle all that apply below:

DULL ACHING SHARP SHOOTING BURNING THROBBING DEEP NAGGING STABBING

Other:_____

Grade Intensity/Severity: 0= none 10 = worst

0 1 2 3 4 5 6 7 8 9 10

Does the pain radiate, travel or shoot into any areas of the body? Y ___ N ____

If yes, describe: _____

On image above, circle areas with numbness or tingling.

Frequency (circle one): Constant Intermittent How long does it last? _____

Please list previous injuries/trauma: _____

Have you ever broken a bone? Y ___ N ___ If yes, which one? _____

Allergies: _____

Female Patients: Date of last menstrual period? _____ Could you be pregnant? Y ___ N ___

Current Health Conditions: _____

List any medications you are currently taking: Continue on back if needed (please check if using back) _____

Medication Name	Dosage	Frequency
Medication Name	Dosage	Frequency

List any surgeries you have had: **Continue on back if needed (please check if using back) _____**

Procedure: _____ Date: _____

Procedure: _____ Date: _____

FAMILY HEALTH HISTORY

Mother: Alive: Y N If N: Date of death: _____Current Age/ Age at death: _____

Cause of death: _____ Health/Medical conditions:_____

Father: Alive: Y N If N: Date of death: _____Current Age/ Age at death: _____

Cause of death: _____ Health/Medical conditions:_____

Sibling #1 : Alive: Y N If N: Date of death: _____Current Age/ Age at death: _____

Cause of death: _____ Health/Medical conditions:_____

Sibling #2 : Alive: Y N If N: Date of death: _____Current Age/ Age at death: _____

Cause of death: _____ Health/Medical conditions:_____

Continue on back if needed : (please check if using back) _____

Social/Occupational History

Education: (circle) High School Some College College Graduate Post Graduate

Job Description: _____

Work Schedule: _____

Recreational Activities: _____

I have read the above information and certify it to be true and correct to the best of my knowledge and hereby authorize this medical office to provide me with chiropractic care in accordance with the state's statutes.

Signature: _____Date: _____

Parent/Guardian: _____ Date: _____

Dr. Signature: _____Date: _____

Advanced Wellness Solutions LLC FEI# 37-1768800

ASSIGNMENT OF BENEFITS, AUTHORIZATION TO SETTLE CLAIM AND DIRECTION TO PAY MEDICAL PROVIDER DIRECTLY

By my signature below, for good and valuable consideration (including but not limited to the extension of credit to me), I hereby assign, transfer and convey to **Advanced Wellness Solutions LLC** (hereinafter "the Provider") all of my rights, title and interest in and to medical expense reimbursement in whatever form, including but not limited to any automobile liability medical expense payments or other health benefits indemnification and/or agreement otherwise payable to me. This payment shall not exceed my indebtedness to the above named assignee and I acknowledge that I will timely pay any indebtedness owed by me to the assignee that is not otherwise satisfied by the above-mentioned assigned proceeds. I also acknowledge that any medical expenses not covered under my insurance policy will be my responsibility.

I further authorize the Provider to negotiate, collect and settle any claim with any insurance carrier or other third-party payor with regard to these services, which authorization shall include authority to:
(1) request and receive from any insurer or any other party any and all documentation and records that I am empowered to request regarding this claim, including, without limitation, a statement of coverage, policy declarations page and insurance policy pursuant to Section 627.4137. In addition, the provider has the authority to request and receive any Independent Medical Examination Reports, notices sent to me regarding appointments for Independent Medical Examinations and Examinations Under Oath (including proof of mail), Records Review Reports, coverage denial letters, Explanations of Benefits, and Benefit Payment Sheets or Logs (P.I.P. Payout Sheets), without regard as to whether such documentation has already been provided to me and,
(2) to endorse in my name any check issued for payment where benefits were assigned. By way of this assignment and notice, I further instruct you, the insurer, to furnish to Provider copies of all future notices affecting Provider's interest in this claim, including, without limitation, any notices of requested medical examinations or statements.

The Provider hereby 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.

I further direct my insurer to direct all payments for services rendered by the Provider directly to Provider at the billing address contained on Provider's medical bills.

THIS IS A DIRECT AND IRREVOCABLE ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER MY POLICY OF INSURANCE.

A photocopy of this form shall be considered as effective and valid as the original.

I have read the foregoing and understand and agree to each of the above provisions:

_____ _____
Patient's signature Date

Accident Questionnaire

What was the date of the incident? _____
What time did the incident occur? _____
Where did the incident occur? _____

Please describe what occurred:

_____
_____
_____

Did you hit any part of your body? Yes /No If yes, please describe

_____
_____

Did you lose consciousness during the incident? Yes /No If yes, please describe

_____
_____

Did you go to the hospital and/ or any other doctor's office? Yes /No
If yes, please describe

_____
_____

How did you get there? (circle one) Drove myself/Someone else drove me/ Ambulance

What was done or prescribed? (X-Rays, Medication, etc) :

_____
_____
_____

2500 S Kanner Hwy Suite 3, Stuart, FL 34994

CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy and, if necessary, diagnostic x-rays on myself by the chiropractic physician and/or anyone working in this office authorized by the chiropractic physician.

I further understand that such chiropractic services may be performed by the Advanced Wellness associate and/or other licensed Physicians of Chiropractic who may treat me now or in the future at this office.

I understand that results are not guaranteed. I also understand and am informed that, as in the practice of medicine and all healthcare, the practice of chiropractic carries some risks of treatment including but not limited to fractures, disc injuries, strikes (CVA), dislocations, and sprains. I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I was to rely upon the physician to exercise judgement during the procedure which the physician feels are in my best interests at the time, based upon the facts then known.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents and by signing below, I agree to the treatment plan recommended by my physician. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

PRINT PATIENT NAME: _____

PATIENT SIGNATURE: _____ Date: _____

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

Advanced Wellness Solutions

PICA

PICA

1. MEDICARE (Medicare#)	MEDICAID (Medicaid#)	TRICARE (ID#/DoD#)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (ID#)	FECA BLK LUNG (ID#)	OTHER (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX M F	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other	7. INSURED'S ADDRESS (No., Street)
CITY / STATE	8. RESERVED FOR NUCC USE	CITY / STATE
ZIP CODE / TELEPHONE (Include Area Code)		ZIP CODE / TELEPHONE (Include Area Code)
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES NO	a. INSURED'S DATE OF BIRTH MM DD YY / SEX M F
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES NO PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM / MM DD YY TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. / 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM / MM DD YY TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? YES NO / $ CHARGES
21. *DIAGNOSIS OR NATURE OF ILLNESS OR INJURY* Relate A-L to service line below (24E) ICD Ind.		22. RESUBMISSION CODE / ORIGINAL REF. NO.
A. B. C. D. E. F. G. H. I. J. K. L.		23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS / MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO	28. TOTAL CHARGE $	29. AMOUNT PAID $	30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # ( )
SIGNED DATE	a. b.	a. b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

RECORDS RELEASE AUTHORZATION

DOCTOR/HOSPITAL: _____

PHONE # _____

FAX # _____

I HERBY AUTHORIZE AND REQUEST THE RELEASE OF MY MEDICAL RECORDS TO:

Advanced Wellness Solutions

2500 S Kanner Hwy Suite 3

Stuart, FL 34994

P: 855-509-5400 (F): 321-373-2062

PLEASE FAX ANY MEDICAL RECORDS AND/ OR XRAY

REPORT FOR DATE OF ACCIDENT: _____

DOCTOR WAITING

THANK YOU IN ADVANCE AND REQUEST OF MY MEDICAL RECORDS TO:

_____ _____

PATIENT'S SIGNATURE DATE

_____ _____

PATIENT'S NAME (PLEASE PRINT) D.O.B.

_____ _____

IF PATIENT IS A MINOR SIGNATURE OF PARENT OR LEGAL GAURDIAN RELATIONSHIP TO PATIENT

_____ _____

WITNESS TO THE ABOVE SIGNATURE PLEASE PRINT NAME