AUTO ACCIDENT INFORMATION

Date and time of accident: _____ ☐ a.m. ☐ p.m.

Were you the: ☐ Driver ☐ Front Passenger ☐ Rear Passenger ☐ Other: _____

Make and model of the vehicle you were occupying? _____

If a traffic violation was issued, to whom was it issued? _____

Number of people in accident vehicle? _____

Did the police come to the accident site? ☐ Yes ☐ No Was a police report filed? ☐ Yes ☐ No

Were you wearing a seat belt? ☐ Yes ☐ No

Was this vehicle equipped with airbags? ☐ Yes ☐ No If yes, did it/they inflate? ☐ Yes ☐ No

What did your vehicle impact? ☐ Another vehicle ☐ Other: _____

Did any part of your body strike anything in the vehicle? ☐ Yes ☐ No

If yes, please describe:

_____

Make and model of the other vehicle(s) involved?

_____

Name of the location/ street on which you were traveling?

_____

In which direction were you headed? ☐ N ☐ S ☐ E ☐ W

What was the approximate speed of your vehicle? _____

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

During impact, were you facing: ☐ Right ☐ Left ☐ Forward

Approximate Speed of the other vehicle? _____

In your words, please describe the accident?

_____

_____

_____

_____

Did the accident render you unconscious? ☐ Yes ☐ No If yes, for how long? _____

Please describe how you felt immediately after the accident:

_____

Have you gone to a hospital or seen any other Doctor? ☐ Yes ☐ No

When did you go? ☐ Just after accident ☐ The next Day ☐ Other:_____

How did you get there? ☐ Ambulance ☐ Private Transportation

Name of hospital and/or attending doctor: Was he/she a: ☐ MD ☐ DC

_____

Describe any treatment you received:

_____

Were X-Rays taken? ☐ Yes ☐ No If so, what area's?_____

Other imaging? ☐ MRI ☐ CT ☐ Ultrasound If so, what area's?_____

Was medication prescribed? ☐ Yes ☐ No If so, what kind?_____

Have you been able to work since this injury? ☐ Yes ☐ No

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

Indicate the symptoms that are a result of this accident:

☐ Dizziness	☐ Memory loss	☐ Headache(s)	☐ Blurred vision
☐ Buzzing in ear	☐ Ears Ringing	☐ Difficulty Sleeping	☐ Irritability
☐ Fatigue	☐ Tension	☐ Neck Pain	☐ Neck Stiffness
☐ Jaw Pain	☐ Arm(s)/Shoulder(s) Pain	☐ Numb Hand(s)/Finger(s)	☐ Chest Pain
☐ Stomach Pain	☐ Shortness of Breath	☐ Nausea	☐ Back Pain
☐ Lower Back Pain	☐ Back Stiffness	☐ Leg Pain	☐ Numb Feet/Toe(s)

☐ Other:_____

_____

Is your condition getting worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and goes

Have you retained an attorney? ☐ Yes ☐ No

If yes, whom?_____ Phone #:_____

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature:_____ Date _____

AUTO ACCIDENT PAYMENT

Patient's
Name:_____

Medpay: This is your own auto insurance company's medical coverage. It covers the medical payments of all passengers in your vehicle if they are injured in an accident, regardless of who was at fault. It will not increase or affect your rate if you were not at fault.

Your Auto Insurance Company:_____
Policy #:_____ Accident/Injury Date:_____
Adjuster's Name: _____
Claim #:_____
Adjuster's Phone Number: _____
Insurance Carrier's Mailing Address:_____
_____

Third Party Payor: This is the other parties auto insurance company that has assumed responsibility or is at fault for the accident and injuries.

At Fault Auto Insurance Company:_____
Policy #:_____ Accident/Injury Date:_____
Adjuster's Name: _____
Claim #:_____
Adjuster's Phone Number: _____
Insurance Carrier's Mailing Address:_____
_____

Attorney Name:_____
Case Manager/Paralegal:_____
Phone Number:_____ Fax Number:_____

IRREVOCABLE ASSIGNMENT OF BENEFITS, AUTHORIZATION AND LIEN

To Whom It May Concern:

This Irrevocable Assignment of Benefits, Authorization and Lien (this "Assignment") is made by and between _____ ("Patient") **and Stephen M. Swaringen, DC** ("Health Care Provider"). With this Assignment, and in consideration of treatment without having to render concurrent payments, Patient, hereby irrevocably transfers sets over and assigns to Health Care Provider all insurance and/or litigation proceeds to which Patient is now or may hereafter become entitled, including those listed below, up to the total amount due and owing the Health Care Provider for services rendered to the Patient by reason of accident or illness, including interest thereon, as well as any other charges that are due or may become due to the Health Care Provider, Including, without limitation, requested reports, collection costs and expenses and attorney's fees, and Patient further hereby irrevocably authorizes and directs any insurance company and/or attorney to whom an original or copy of this Assignment is provided to withhold from Patient and pay directly to such Health Care Provider such amount(s) from (1) any insurance benefits payable to Patient or on Patients behalf, including, but not limited to, medical payments benefits, No Fault benefits, health and accident benefits, personal injury protection benefits, third-party liability coverage, foundation grants, governmental or agency benefits, worker's compensation benefits or any other insurance proceeds or benefits of any kind which are payable to or on behalf of the Patient, and (2) any litigation proceeds (which may include insurance proceeds) from any settlement, judgement or verdict in Patients favor as may be necessary to fully pay any and all financial obligations owed to the Health Care Provider by the Patient. This Assignment is to be complete and current transfer of Patients right, title, and interest, separate from any statutory or contractual lien or claim to which the Health Care Provider may also be entitled. Patient acknowledges that Health Care Provider has substantial pecuniary interest in the enforcement of this Assignment.

The Patient further agrees that, in the event the insurance company and/or attorney obligated hereunder to make payments to the Health Care Provider fails or refuses to make payment for the full amount due as set forth above, this Assignment is a full, immediate and complete assignment of all the Patient's rights, title, interest, remedies and benefits in and to the assigned property to the extent of the Health Care Providers total claim amount; therefore, Patient hereby irrevocably and fully assigns and transfers to the Health Care Provider any and all causes of action that Patient might have or that might exist in Patients favor against such insurance company and/or attorney with respect to the assigned property. In addition to the foregoing assignment, Patient hereby authorizes, nominates, and appoints as Patients attorney-in-fact- any officer of Health Care Provider, to prosecute said cause(s) of action either in Patients name or in the Health Care Providers name and Patient further authorizes the Health Care Provider to compromise, settle or otherwise resolve the claim(s) or cause(s) of action as it sees fit.

In further consideration of the services provided by the Health Care Provider, Patient hereby grants a lien to said Health Care Provider against any and all insurance benefits and litigation proceeds outlined in the first paragraph above which may be payable to or on behalf of the Patient as a result of the injuries or illness for which Patient has been treated by said Health Care Provider. The Patient further agrees that the statute of limitations applicable to Health Care Providers right to demand payment from the patient shall be tolled for all reasonable times that negotiations or litigation between third parties and the Patient are ongoing.

Patient hereby acknowledges that Florida law imposes a lien in the **amount of $750.00 upon** Patients Claim against the individual or entity whose negligence is alleged to have caused Patients injuries.

Notwithstanding the foregoing, the patient agrees that until Health Care Provider is paid in full, the Patient shall remain personally and fully responsible for and promises to pay the total amount due to the Health Care Provider (including principal, interest, collection costs and attorney's fees of 35%) until fully paid. The Patient further understand and agrees that this Assignment does not constitute any agreement of or consideration for the Health Care Provider to await payments from any source, and in the event the Health Care Provider deems itself in its sole discretion insecure as to the prospect payment, it may demand payments from Patient immediately upon rendering services at its option and proceed to collect same through legal means if necessary.

Patient authorizes the Health Care Provider to release this Assignment and any information pertinent to Patients case to any insurance company, adjuster or attorney to facilitate collection under this Assignment. Patient hereby nominates and appoints any officer of the Health Care Provider as Patient's attorney-in-fact to endorse/sign Patient's name on any and all checks for payment of the services provided to Patient by said Health Care Provider.

In the event that any part or provision of this Assignment shall be determined to be invalid or unenforceable, the remaining parts and provisions of this Assignment which can be separated from the invalid, unenforceable provisions shall continue in full force and effect.

Notice regarding the assignment of medical expense benefits is provided in a separate document, I have been presented with and had an opportunity to read the notice. **Acknowledged:_____(patients initials)**

Patient

Patients Signature:_____

Printed Name:_____

By:Date:_____ SS#:_____

Witness:_____

Health Care Provider

Stephen M. Swaringen, DC

Performance Spine & Sport Rehabilitation

It's Owner

Date:_____

Health Insurance Waiver for Auto Accident

Date of accident:_____.

I _____ elect not to use my medical health insurance for treatment of my injuries sustained in this motor vehicle accident. All treatment bills and fees are to be submitted and paid through auto med-pay, auto personal injury protection or auto third party insurances. In case the auto insurance does not reimburse this office for treatment, I understand that I am responsible for the fees incurred.

_____ _____

Patient Signature Date

Patient Demographics Form

Patient Information

First Name:_____ M.I:_____ Last Name:_____

Date of Birth:_____/_____/_____ SSN:_____

Gender (circle one): M F

Marital Status (circle one) Never Married Married Annulled Divorced Domestic Partner
Interlocutory Legally Separated Polygamous Widowed Unknown

Address:_____

City:_____ State:_____ Zip Code:_____

Phone:_____ - _____ - _____ Cell:_____ - _____ - _____

Email Address:_____

Smoking Status (check one): ____ Unknown ____ Everyday ____ Some ____ Former Smoker
____ Never Smoke ____ Smoker Status Unknown ____ Not Given by Patient.

Preferred Language (check one): ____English ____ Spanish ____ Other (specify):_____

Ethnicity (check one): ____ Hispanic or Latino ____ Not Hispanic or Latino ____ Not given by patient
____ Unknown by patient

Race (check one): ____ American Indian/Alaska Native ____ Asian ____ Black/African American ____ White
____ Native Hawaiian/Other Pacific Islander ____ Other ____ Not Given by Patient

Preferred Contact Method (check one): ____ Phone ____ Email

Occupation:_____

Employer's Name:_____

Address:_____

City:_____

State:_____ Zip Code: _____

Phone:_____

Is Patient a Minor? (check one) ____ No ____ Yes (if yes, please fill out information below)

First Name:_____ M.I:_____ Last Name:_____

Date of Birth:_____/_____/_____ SSN:_____

Gender (circle one): M F

Marital Status (circle one) Never Married Married Annulled Divorced Domestic Partner

Interlocutory Legally Separated Polygamous Widowed Unknown

Address:_____

City:_____ State:_____ Zip Code:_____

Phone:_____ - _____ - _____ Cell:_____ - _____ - _____

Email Address:_____

Next of Kin

First Name:_____ M.I:_____ Last Name:_____

Relationship to Patient:_____

Phone Number:_____

If you are currently under the care of your family physician or specialist such as a neurologist or surgeon, please complete the information below. This allows us to communicate directly with these doctors and use a team approach to treat your condition most effectively.

We routinely send these doctors an initial report as well as interim reports so they can stay familiar with your case and any progress or changes that result from our care.

Name of Family Physician/Primary Care Provider:_____

Office Location:_____ Phone Number:_____

Name of any specialist consulted/treated for your condition:

(ex: neurologist/orthopedic surgeon):_____

Office Location:_____ Phone Number:_____

Performance Spine & Sport Rehabilitation
STEPHEN M. SWARINGEN, DC
1408 N Killian Rd. Ste 106, Lake Park, FL 33403
Tel: 561-400-1528 Fax: 561-412-1277

Assignment of Benefits

Patient Name: _____ Date: _____
Claim/Group #: _____ SSN/ID#: _____

I authorize and assign to you, Stephen M. Swaringen, DC D/B/A Performance Spine & Sport Rehabilitation, the right to receive direct payment from my attorney, insurance company or any other party who may become obligated to pay us any sums. I further authorize the endorsement of my name to any drafts containing my name to which you are legally entitled.

I hereby instruct and direct my insurance company to pay electronically or by check made out and mailed directly to:

STEPHEN M. SWARINGEN, DC
D/B/A Performance Spine & Sport Rehabilitation
1408 N Killian Rd. Ste 106, Lake Park, FL 33403
EIN# 81-3413019

OR

If my current policy prohibits direct payment to the doctor, then I hereby instruct and direct you to make the check payable to me and mail it as follows:

C/O 1408 N Killian Rd. Ste 106, Lake Park, FL 33403

For professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment towards the total charges for professional services rendered. This is a direct assignment of my rights and benefits under this policy. The payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional fees for non-covered services and/or fees over and above the insurance payment or as required by my insurance policy.

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

I authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this claim.

Signature of policy holder: _____ Date: _____

Performance Spine & Sport Rehabilitation
STEPHEN M. SWARINGEN, DC
1408 N Killian Rd. Ste 106, Lake Park, FL 33403
Tel: 561-400-1528 Fax: 561-412-1277

PATIENT PREGNANCY DISCLAIMER

This certifies that concerns regarding pregnancy and radiation exposure have been explained to my satisfaction. I understand the clinical necessity of having x-rays taken at this time and grant permission for this procedure. In doing so, I release the doctor/clinic from responsibility for potential damage arising from this procedure.

At this present time, (*Please at the corresponding line*)

_____ I am sure that **I am not pregnant.**

_____ It is possible that **I could be pregnant.**

_____ **I am pregnant.**

_____ _____
Signature—Patient Date

_____ _____
Signature—Witness Date

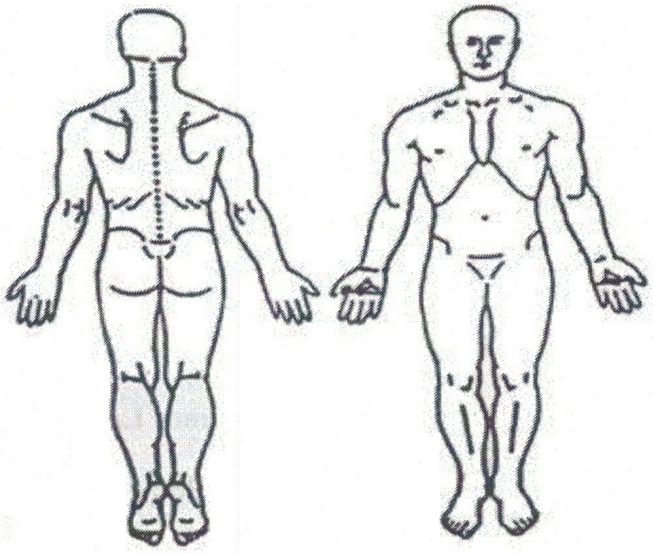
PERFORMANCE SPINE & SPORT REHABILITATION
Dr. Stephen M. Swaringen, DC

Reasons for Visit: _____
Date of injury or symptoms? _____ How did it start? _____
What Makes it better? _____ Worsened by: _____
The pain is: constant / frequent/ occasional Are you Pregnant? ☐ Yes ☐ No, _____weeks
Is there anything you can not do due to your condition? _____
_____
Past Medical History (medical conditions, illness, significant injuries, surgeries, previous treatments): _____
_____
Personal History (type of work, social activities, physical activities): _____
_____
Family Medical History (arthritis, cancer, auto-immune diseases, diabetes, etc): _____
Medications:
Name: _____ Name: _____
Name: _____ Name: _____
Medication Allergies:
Name: _____ Name: _____
Name: _____ Name: _____
Primary Care Physician/ Surgeon: _____ Location: _____

By using the key below, indicate on the body diagram where you are experiencing the following symptoms:

(#) Numbness
(0) Pins & Needles / Tingling
(X) Burning
(S) Sharp Pain
(/) Stabbing Pain
(+) Dull Ache

Please mark neck to each symptom area the intensity using numbers from 1-10 (1 is minimal to 10 is unbearable).



Name: _____ Date: _____

Performance Spine & Sport Rehabilitation
STEPHEN M. SWARINGEN, DC
1408 N Killian Rd. Ste 106, Lake Park, FL 33403
Tel: 561-400-1528 Fax: 561-412-1277

Consent to Evaluation and Treatment

I hereby request and consent to the performance of chiropractic adjustments, various modes of physical therapy and diagnostic X-rays, on me (or the patient named below, for whom I am legally responsible) by Stephen M. Swaringen, DC and/or other licensed Doctors of Chiropractic or Physical Therapists or those working at the clinic or office who now or in the future treat me while employed by, working or associated with, or serving as a backdrop for Stephen M. Swaringen, DC. I understand and I am informed that, in the practice of chiropractic and physical therapy that there are some risks to examination and treatment including, but not limited to, bruising, soreness, fractures, disc injuries, strokes, dislocations, sprains, and increased symptoms and pain or no improvement of symptoms or pain. 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 judgement during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatments. I intend this consent form to cover the entire course of treatment of my present condition and for any future conditions(s) for which I seek treatment. I understand that I may refuse treatment at any time and that I am responsible for my healthcare choices.

Our Privacy Policy

The office of Stephen M. Swaringen, DC is committed to upholding the security and confidentiality of personal information that you provide to us. We take our responsibility of safeguarding your information very seriously. We do not share or sell patient information with anyone outside of our office without your written consent. This policy covers information including personal, financial, or health information about a consumer or customer relationship. I hereby authorize that my records of evaluation and treatment with the office of Stephen M. Swaringen, DC may be forwarded to referring physicians, specialists, or therapists who are also involved in my healthcare.

By signing below, I have read, or have had read to me, the above consent to evaluation and treatment statement, that I am aware of the privacy policy, and that I certify that my medical information above is correct to the best of my knowledge.

Patient Signature: _____ Date: _____

Consent to Treatment of Minor/Child

I hereby authorize Stephen M. Swaringen, DC and his staff to administer chiropractic and/or physical therapy treatments as deemed necessary to my _____ (indicate relationship of child), _____.
(Name of child)

Patient or Guardian Signature: _____ Date: _____

MEDICAL RECORDS RELEASE

Patient Name: _____ Date of Birth: _____

I hereby request and authorize:

Performance Spine & Sport Rehabilitation
Stephen M. Swaringen, DC
1408 N Killian Rd. Ste 106, Lake Park, FL 33403
Tel: 561-400-1528 Fax:

☐ To provide copies of records to **Self**.
☐ To **Disclose** information to: ☐ To **Receive** Information from:

Name of Doctor/Provider: _____
Address: _____
City/State/Zip Code: _____
Phone: _____ Fax: _____ Email: _____

Information to be disclosed include copies of:
☐ Entire Record ☐ Progress Notes ☐ Daily Notes ☐ Lab Results/Test
☐ MRI / Reports ☐ X-Rays / Reports
☐ Other, specify: _____

* X-ray films are originals (considered medical records) and must be returned to this office within 30 days. Digital x-rays on CD are copies and need not be returned.

Purpose for disclosure: ☐ Treatment/Payment OR ☐ Other, specify: _____

This authorization with be effective for one year after the date signed, unless cancelled in writing. I understand that the cancellation will have no effect on information released prior to receiving the cancellation. A copy of this authorization is as valid as the original. **I understand that I may be charged a fee for record copies.**

_____ **Date:** _____
Signature of Patient

_____ **Date:** _____
Signature of Legal Representative/Relationship
(If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law.)

Notice to recipient of information: This information has been disclosed to you from confidential records, which are protected by law. Unless you have further authorization, laws may prohibit you from making any further disclosures of this information without the specific written consent of the patient or legal representative.

RockBlade, Massage, Manual Therapy Questionnaire and Informed Consent

Please answer the following questions. Read the statements concerning *RockBlade, Massage, and/or Manual Therapy*, and sign below. If you have any questions, please speak with your clinician.

1. Do you bruise easily? ☐ Yes ☐ No
2. Do you bleed for a long period of time after you cut yourself? ☐ Yes ☐ No
3. Are you taking blood thinners or anticoagulants? ☐ Yes ☐ No
4. Do you take aspirin on a regular basis? ☐ Yes ☐ No
5. Do you take cortisone on a regular basis? ☐ Yes ☐ No
6. Have you ever had inflamed veins or blood clots? ☐ Yes ☐ No
7. Do you have surgical implants in your body? ☐ Yes ☐ No
8. Do you have diabetes or kidney disease? ☐ Yes ☐ No
9. Do you currently have any infections? ☐ Yes ☐ No
10. Do you have uncontrolled high blood pressure? ☐ Yes ☐ No

RockBlade, Massage, and/or Manual Therapy are forms of treatment used to break up or mobilize myofascial adhesions, increase lymphatic drainage and circulation, and reduce discomfort or pain thus allowing for the return of normal function in the area being treated.

RockBlade, Massage, and/or Manual Therapy may produce the following:

1. Local discomfort during the treatment.
2. Reddening of the skin.
3. Superficial tissue bruising.
4. Post treatment soreness.

RockBlade, Massage, and/or Manual Therapy techniques are designed to minimize discomfort; however, the above reactions are normal, and in some instances unavoidable.

RockBlade, Massage, and/or Manual Therapy techniques have several basic components. Your clinician will determine the protocol for you.

1. Warm up of the treatment area.
2. RockBlade, Massage, and/or Manual Therapy assisted soft tissue manipulation.
3. Joint Mobilization.
4. Therapeutic Modalities.
5. Static Stretching.
6. Dynamic Mobility.
7. Isometric Exercise.
8. Resistance Training.
9. Impact Training.

All components of RockBlade, Massage, and/or Manual Therapy have been explained to me. I understand the risks of the procedure and I give my full consent for treatment.

Print your name: _____ Date: _____

Your signature: _____