Demographic Intake (MVA/WC)

Title: Mr. Mrs. Ms. Miss. Sex: ☐Male ☐Female Date:________________
First Name: ________________________Middle Initial ______ Last Name:______________________________
Name that I prefer to be called:____
DOB:__/__/____Social Security Number:_____-______-_____Height:_________Weight:________lbs
Address: ____
City: ____________________________ State: ________________ Zip Code: _______________________
Marital Status: ☐ Single ☐ Married ☐Divorced ☐Widowed ☐Separated
Home #: (____) ____-________ Cell #: (____) ____-________ Email: ______________________________
Occupation:___________________ Employer:__________________ Work Phone: (_____) ____-__________
Preferred Language: ☐ English ☐ Spanish ☐ Other:____
How did you hear about us?____

Reason for your visit today

Are you having any pain? ☐ Yes ☐ No **Where: ____**
Please Circle the description of the complain/pain:
Dull Aching Sharp Shooting Burning Throbbing Deep Nagging Constant Intermittent
Do you have any numbness or tingling in your body? ☐Yes ☐No **Where?______________________________**

Primary Insurance / Or Auto Insurance *(Please provide cards to be copied)*

Company Name: ____________________________________ Through Employer: ☐ Yes ☐ No
Mailing Address: ____
Insured Name: ____
Policy Number: ____________________________________ Group Number: ____________________________
Attorney (If Applicable): _____________________________ Claim Number: ____________________________
(If you have a Secondary or Supplement Insurance – Please provide the card to be copied)

Emergency Contact Information

Contact Name: ____
Contact Phone: (______) ______-______________

HIPPA Acknowledgement

By signing below, I am acknowledging that I have received/ read a copy of the Privacy Practice Policy for this office. As well as the Appointment Policy and Insurance Policy. If I wish for anyone other than myself to have access to my personal information at this office, I shall list their name and relationship below.
Name of Person Designated to have access to my personal/ healthcare information:

Name:____ Relationship ______________________________

Signature:____________________________________ Date:_____________________________________

Confidential Patient Health & History

Patient Name: ________________________________ **Date**______________________________

Have you ever had any of the following: (Circle Y or N)

Heart Disease	Y / N	Hepatitis A, B, or C	Y / N	Mumps	Y / N
Diabetes	Y / N	Lung Disease	Y / N	Chickenpox	Y / N
Prolapsed Mitral Valve	Y / N	Rheumatic Fever	Y / N	Whooping Cough	Y / N
Glaucoma	Y / N	Arthritis	Y / N	Scarlet Fever	Y / N
Tuberculosis	Y / N	HIV/ AIDS	Y / N	Diphtheria	Y / N
Bronchitis	Y / N	Kidney Disease	Y / N	Smallpox	Y / N
Liver Disease	Y / N	Thyroid Disease	Y / N	Venereal Disease	Y / N
Measles	Y / N	Ulcers	Y / N	Anemia	Y / N
Stroke	Y / N	Mental/ Psychiatric Dis.	Y / N	Bladder Infection	Y / N
Heart Attack	Y / N	Heart Murmur	Y / N	Migraine Headaches	Y / N
Pacemaker	Y / N	Colitis	Y / N	Polio	Y / N
Metal Implants	Y / N	Epilepsy	Y / N	Hernia	Y / N
Swollen Ankles	Y / N	Artificial Prosthesis	Y / N	Blood or Plasma Transfu.	Y / N
Sinusitis	Y / N	Hearing Loss	Y / N	Back Trouble	Y / N
Asthma	Y / N	Pregnant	Y / N	High Blood Pressure	Y / N
Hemorrhoids	Y / N	Cancer	Y / N	Low Blood Pressure	Y / N
Hives or Eczema	Y / N	Mono	Y / N	Date of Last Chest X-ray	Y / N

Previous Hospitalizations/ Surgeries/ Serious Illness (Please Explain):

____

____

____

Patient Social History:

Use of alcohol: Never Rarely Moderate Daily

Use of tobacco: Never Rarely Moderate Previously/ I Quit (date) _________ or Current packs/day:__________

Use of Drugs: Never Type:______________________________ Frequency: __________________________________

Race:
- ☐ I do not wish to provide this information
- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Other

Ethnicity:
- ☐ I do not wish to provide this information
- ☐ Hispanic or Latino
- ☐ Non- Hispanic or Non- Latino
- ☐ Other

Are you currently taking any medications?

☐ Not currently prescribed any medications

☐ Yes. Name: _____________________ mg________

Name: _____________________ mg________

Name: _____________________ mg________

Name: _____________________ mg________

Name: _____________________ mg________

Do you have any medication allergies?

☐No known medication allergies

☐Yes. Name: __________________________

Name: __________________________

Name: __________________________

****Are you on Birth Control Medication***? ☐Yes ☐No If Yes how long? ________________________

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ACCIDENT INJURY QUESTIONAIRRE

Today's Date: ____________ ***Date of Accident:*** _____________ **Patient Name**: ______________________________

Please explain in full detail how this accident happened? ____

____

____

What body parts were injured? ____

____

Have you ever had these complaints before? ☐Yes ☐ No If yes then when? ______________________________

____

Is this your first accident? ☐Yes ☐ No If no, please explain: ____

____

Have you lost any time from work as a result of the accident? ☐ Yes ☐ No

Have you returned to work? ☐Yes ☐ No On what date? ____

Please complete for Automobile Related Injuries:

Which direction were you heading? ☐ North ☐ South ☐ East ☐ West

On which street/intersection? ____

Which direction was the other party heading? ☐ North ☐ South ☐ East ☐ West

What type of vehicle struck you? __________________ What type of vehicle were you in? _____________________

Were the police notified? ☐ Yes ☐ No Is there a police report? ☐ Yes ☐ No

On which side were you struck? ☐ Rear ☐ Front ☐ Left ☐ Right Who was cited? ____________________

Were you the: ☐ Driver ☐ Front passenger ☐ Back Seat ☐ Other (please explain) __________________

____

Did you feel pain immediately after the accident? ☐ Yes ☐ No If yes, please explain________________

____

Were you wearing your seatbelt? ☐ Yes ☐ No Were you rendered unconscious? ☐ Yes ☐ No

Did the airbag employ? ☐ Yes ☐ No Were you treated at the accident site? ☐ Yes ☐ No

Did you seek treatment after the accident? ☐ Yes ☐ No If yes, where? ________________________________

What treatment was given? ____

Are you currently under another provider's care for this accident (please list all)? ☐ Yes ☐ No

The providers name(s) ________________________________ Phone number: (_____)________-______________

When was the last time you were treated for this accident? ____

Please list and/or explain any other relevant facts regarding your accident: ___________________________________

____

____

____

Patient/Guardian Signature

Symptom Survey

Patient Name: ____ **Date:**_____________________

Head: ***Headaches***: Mild Moderate Severe ***How Often (circle)***? ______ Times per Day Week Month

Description of Pain: Sharp Dull Achy Constant Intermittent ***Migraine***: Yes No

Location: Back of head Forehead Temples Right Side Left Side Behind Eyes

Other symptoms: Dizziness Nausea Memory loss Slurred speech Other:__________________

Jaw: ***Pain***: Right Left Both ***Clicking/Popping***: Right Left Both

Neck: ***Description of Pain***: Mild Moderate Severe ***Locations***: Right Side Left Side Both

Are you having any of following: Stiffness Muscle Spasm Grinding Sounds

Pain increased by: Fwd Movement Backward Movement Rotate Head Right

Rotate Head Left Bend Head Left Bend Head Right

Shoulder: ***Pain Location***: Right Left Both ***Pain Level***: Mild Moderate Severe

Type of Pain: Sharp Stabbing Dull

Upper: ***Upper Arm Pain***: Right Left Both ***Numbness***: Right Left Both ***Pins and Needles***: Right Left Both

Extremity: ***Forearm Pain***: Right Left Both ***Numbness***: Right Left Both

Pins and Needles: Right Left Both

Hand Pain: Right Left Both ***Numbness***: Right Left Both ***Pins and Needles***: Right Left Both

Upper Back Pain: Right Left Both ***Type of pain***: Sharp Stabbing Dull ***Spasms***: Right Left Both

Mid Back: ***Pain Location***: Right Left Both ***Numbness***: Right Left Both ***Pins and Needles***: Right Left Both

Type of Pain: Sharp Stabbing Dull ***Muscle Spasms***: Right Left Both

Low Back: ***Back Pain Level***: Sharp Stabbing Dull ***Pain Location***: Left Right Both

Lower: ***Upper Leg Pain***: Right Left Both ***Numbness***: Right Left Both ***Pins and Needles***: Right Left Both

Extremity: ***Low Leg Pain***: Right Left Both ***Numbness***: Right Left Both ***Pins and Needles***: Right Left Both

Foot Pain/Ankle: Right Left Both ***Numbness***: Right Left Both ***Pins and Needles***: Right Left Both

****Other issues not listed***: ____

____

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Patient Name: ____________________________________ **Date**:_________________________

1. Please list any and all other problems you are having as a result of this injury: ____
____
____

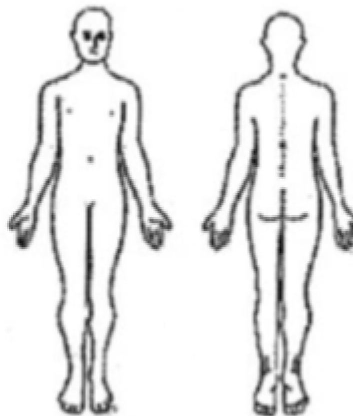
2. Briefly describe how your daily activities have changed due to this injury: ____
____
____

3. Briefly describe how your issues began and when: ____
____
____

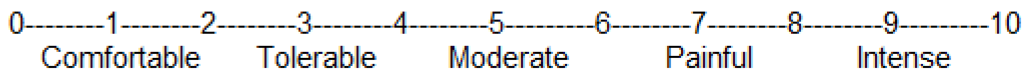
Pain Questionairre

Using the appropriate symbols, please indicate on the figure the location and sensation of your pain today.

Numbness	(N)
Tingling	(T)
Burning	(B)
Stabbing	(G)
Aching	(A)
Stiffness	(S)
Pins/Needles	(PN)
Other	(O)



My pain level today is:



Any additional information about your symptoms please explain here: ______________________________
____
____
____

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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 Patient/Guardian Date

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

A. 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.

B. 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.

C. 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**):*

Theresa Troiani, DC / Joseph Troiani, DC

______________________________ ____________/____________ ____________

Name *(PRINT or TYPE)* Signature of Physician/s 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.

OIR-B1-1571

Pub. 1/2004

Notice of Initiation of Treatment

Name of Insured Patient: ____

Name of PIP Insurer: ____

Policy Number: ____

Claim Number: ____

Name of Health Ins.: ____

Health Member #: ____

Please fill in below if involved in a Motor vehicle accident!

Pursuant to Florida statue 627.736(5)(c)1., you are herby notified that treatment on your insured, ____ was initiated on ____/_____/_____ for injuries sustained in an automobile accident on

____/_____/_____.

All patients must sign Initiation of Treatment!

____

Patient/Guardian signature

______________________________________ ______________

Dr. Joseph Troiani, DC. / Dr. Theresa Troiani, DC Date

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

INSURANCE CARRIER: _______________________ **DATE OF LOSS:**_____________________________
AUTO CLAIM NUMBER: _______________________ OR HEALTH MEMBER#: _________________________

For and in consideration of Advanced Spine & Injury Center 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 Advanced Spine & Injury Center 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 Advanced Spine & Injury Center 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 Advanced Spine & Injury Center 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 Advanced Spine & Injury Center 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 Advanced Spine & Injury Center 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 Advanced Spine & Injury Center including, but not limited to, disclosing my medical condition, being available for factual discovery or other cooperation.

This assignment concerns only the bills for Advanced Spine & Injury Center 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, Advanced Spine & Injury Center 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 Advanced Spine & Injury Center 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 Advanced Spine & Injury Center at the address on the bill. Advanced Spine & Injury Center 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 Advanced Spine & Injury Center. I further instruct my insurance company to make payment for charges submitted by Advanced Spine & Injury Center in priority to any other requests to escrow benefits, including a request by myself to reserve benefits for pending disability claims. I hereby give Advanced Spine & Injury Center limited power of attorney to endorse and sign my name on any draft for payment to Advanced Spine & Injury Center or myself if said draft represents payment for charges related to services rendered by Advanced Spine & Injury Center.

I further direct my insurance carrier or responsible other entity to provide information to Advanced Spine & Injury Center 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 Advanced Spine & Injury Center. 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/ Guardian 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.

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-Rays; on myself (or the patient named below, for whom I am legally responsible for) by the doctor of Advanced Spine & Injury Center and/ or other licensed doctors of Advanced Spine & Injury Center facility, who now of in the future treat me while employed by ,working with, associated with or serving as a back-up for the doctor of Advanced Spine & Injury Center, including those working within Advanced Spine & Injury Center.

I have had an opportunity to discuss with the doctor of Advanced Spine & Injury Center and or with other office or clinic personnel, the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that as with the practice of chiropractic, carries 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 I wish to rely on the doctor to exercise judgment during the course of the procedure of which the doctor feels at the time, based upon the facts then known, and is in my best interest.

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

To be completed by patient:

_________________________________ _____________________

Print Patient's Name Date Signed

_________________________________ _______________________________

Signature of Patient Signature of Patient's Guardian

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Appointment Agreement

We want to thank you for choosing us as your chiropractic health provider. In order to provide you and our other patients with the best optimal spinal care, we request that you follow our guidelines regarding broken and/or cancelled appointments. Please remember that we have reserved appointment times especially for you. Therefore, we request at least 24 hours' notice to reschedule your appointment. This will enable us to offer your cancelled time to other patients that desire to get their treatment completed. When you cancel your appointment at the last minute, everyone loses – you, the doctor, and other patients that would like to have utilized your appointment time.

Since our office does not charge for broken or cancelled appointments, please realize how important it is to keep your reserved time. Thank you for your consideration of our policies and for the opportunity to be your chiropractic office of choice.

____ ____________________

Patient/Guardian Signature Date

Insurance Agreement

The first visit charges are payable when services are rendered, unless another arrangement has been made with this facility. The fee paid for treatment X-rays is for analysis only. The film itself is property of this office. Once films are used for treatment purposes, they cannot be released. Copies may be made if necessary.

I understand and agree that health and accident insurance policies are an arrangement between insurance carrier and myself. Furthermore, I understand that Advanced Spine & Injury Center will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to Advanced Spine & Injury Center will be credited to my account upon receipt. However, ***I clearly understand and agree that I am personally responsible for payment.***

I have read the above information and certify all my insurance information to be true and correct to the best of my knowledge and herby authorize this office to provide me with care in accordance with this states' statutes.

____

Patient/Guardian Signature Date

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Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is obligated to agree to those restrictions only to the extent they coincide with state and federal law.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. Our office may contact you periodically regarding appointments, treatments, products, services, or charitable work performed by our office. You may choose to opt-out of any marketing or fundraising communications at any time.
6. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
7. Patients have the right to file a formal complaint with our privacy official and the Secretary of HHS about any possible violations of these policies and procedures without retaliation by this office.
8. Our office reserves the right to make changes to this notice and to make the new notice provisions effective for all protected health information that it maintains. You will be provided with a new notice at your next visit following any change.
9. This notice is effective on the date stated below.
10. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

______________________________	____________________________	_______________
Patient Name	Signature of Patient/Guardian	Date

Request for LOP

ATTORNEY: ____

DATE: ____

PATIENT: ____

PATIENT/GUARDIAN SIGNATURE: ______________________________

DATE OF ACCIDENT: ______________________________________

We are treating your client for injuries sustained in a motor vehicle accident. Please forward a LETTER OF PROTECTION and any Insurance information at your earliest convenience.

Thanking you in advance for your assistance in this matter.

Sincerely,

_________________________________ _______________

Dr. Joseph Troiani, DC. Date

Dr. Theresa Troiani, DC.

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Patient Request for Records

Today's Date: ____

To (Doctor/ Hospital): ____

Address of Facility: ____

City: ____________________________ **State:** __________ **Zip:** ___________

I hereby authorize the release of ANY and ALL medical records in your facility to be copied/sent/transferred to:

Dr. Joseph Troiani, DC.
Dr. Theresa Troiani, DC.
Advanced Spine & Injury Center
10205 Wilsky Blvd
Tampa, FL 33625
Telephone: 813-265-8555
Fax: 813-265-8645

Print Patient Name: ____

Date of Records: ____

Patient Date of Birth: ____

Patient Social Security Number: ____

______________________________________ ______________________

Patient/Guardian Signature **Date**