Physical Evidence Chiropractic

7035 Beracasa Way Suite 103 Boca Raton FL, 33433
Phone# (561)361-4888 Fax# (561)361-4999

Date_____ File # _____

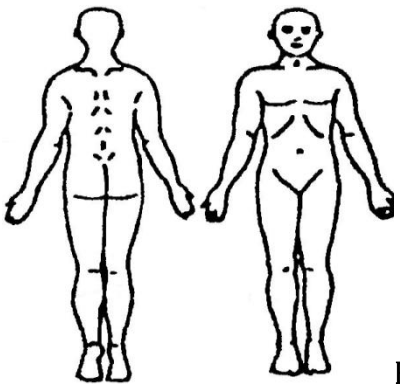
PERSONAL HISTORY

Last Name _____ First Name _____
Address _____City _____State _____ Zip _____
Date of Birth _____ Age _____ Social Security # _____
Circle One: Married Single Widowed Divorced Separated. Sex____ M _____F
Employer: _____ type of work _____
Home Phone _____ Work _____ Cell _____
Spouse Name _____ Spouse Phone _____
Email Address_____

Name & Number of Emergency Contact _____Phone _____
Relationship _____
Who is Responsible for your bill _____ Do you have Health Insurance ___Y ___N
Insurance Company _____ ID # _____

HEALTH CONDITION

What is your major complaint _____ when did this start _____
Other doctors seen for this condition? ___ Y ___N. Who? _____
Is condition ___ job Related ___ Auto Accident ___ Home Injury ___ Slip & fall ___ other ____
_____
Date of Accident _____ Time of accident _____ AM/PM
Have you reported this accident ____Yes ___No. To Whom? _____
Adjusters Name _____ Claim # _____
Have you had any Surgery? Please Describe _____
Previous Chiropractic Care ___ Y ___N Doctors name and Last visit _____



Please outline on the diagram the area of discomfort

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand the doctor's office will prepare any necessary forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to the doctor's office will be credited to my account on receipt. I the undersigned agree that I am responsible for any and all costs associated with the treatment rendered to me by the doctor even if my insurance company fails to pay, or pays a portion thereof if I become delinquent in payment of such fees due the doctor (30 days past due from the date of the original invoice) I am responsible for any and all collection costs attorney fees at the maximum legal rate with the regards to the recovery of such delinquent account I also understand that if I suspend treatment or insurance account is immediately due and payable to doctor .
I hereby authorize the doctor to treat my condition as he or she deems appropriate through the use of manipulation throughout my spine. It is understood and agreed that the amount paid to the doctor is for exam and x-rays, only the x-ray negatives will remain property of this office being on file where they may be seen at any time while a patient is at this office patient also agrees that he/she is responsible for all bills incurred at this office the doctor will not be held responsible for any pre-existing conditions nor for any medical diagnosis.

Patient's Signature: _____ Date: _____
Guardian or Spouse's Signature Authorizing Care: _____
Date: _____

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PERSONAL INJURY PATIENT HISTORY

Name: _____ Date: _____File#_____

HISTORY OF OCCURANCE

Date of Accident _____Time _____AM __PM __Driver of car_____

Where were you seated? Driver's Seat ___Front Right passenger _____Front Middle Passenger_____

Right Rear passenger _____Rear Middle Passenger _____ Rear Middle Passenger _____

Who Owns The Car? _____ Year & model of Car _____

What was the damage done to the car you were in? Mild___ Moderate___ Severe____ Total ___ Unknown___

Visibility at time of accident: Poor___ Fair___ Good___

Road Conditions At time of Accident: Snow/icy____ Wet___ Clear___ Dark____

Type of accident: Was hit in the __ Hit another car __ Rear__ Right Side __ Left Side __ Front___

NON-COLLISION (describe) _____

IMPACT/ SEAT BELT /HEADREST/ SPEED

Describe in your own words what happened to you upon impact: _____

_____

Were you aware the accident was about to happen? Yes ___ No___

Did you brace for the impact Yes ___ No___?

Were you wearing a seatbelt / shoulder harness Yes ___ No___?

Did the car you were in have a headrest? Yes ___ No___

If Yes what was the position of the headrest compared to your head before the impact

Top of head rest even with bottom of head __ Top of head rest even with top of head___

Top of head rest even with middle of neck ____

Was the car equipped with an airbag where you were seated? Yes ___ No___

If yes did the airbag inflate? Yes ___ No___

Were you injured by the inflated air bag Yes ___ No___?

If yes what were the injuries? _____

Was your foot on the brake pedal? Yes ___ No___

Was your car moving at the time of the accident? Yes ___ No___

If yes how fast would you estimate you were going ____ MPH (estimate)

How fast was the other car traveling _____MPH (estimate?)

HEAD/BODY POSITION/ ABLE TO MOVE BODY

Head/Body position at time of impact: Head Turned ___ Right ___Left ___ Head Looking back ___

Head Straight forward ___ Body Straight sitting position ____Body Rotated Left ___ Right ___

At the time of the accident, Recall what parts of your head or body hit what parts on the inside of the car: _____

As a Result of the accident you were: Rendered unconscious ____ Dazed, Circumstances Vague __ Shaken Up but could think clearly and function____

Could you move all parts of your body? Yes ___ No___

If no what part could you not move and why? _____

Were you able to get out of the car and walk unaided? _____

Did you receive any medical assistance at the scene of the accident Yes ___ No___

Did you have any bleeding cuts form this accident? _____

Did you get any Bruises from this Accident? _____

Please describe how you felt Please be specific:

Immediately after accident _____

The next Day _____

Check the symptoms apparent since the accident:

___Headaches __Dizziness ___Loss of memory __ sleeping problems __ Constipation

___Neck Pain/ Stiffness __Fainting __Fatigue __Numb Toes ___Chest Pain ___Midback pain

___Ringing in ears __Loss of balance ___Numb Fingers __Nervousness ___ Low back Pain

___Tension ___Shortness of breath ___Cold hands ___ Cold Sweats ___Los s of smell

___Irritability ___Cold Feet ___Eyes sensitive to light ___Anxious ___Pain Behind Eyes

___loss of taste ___Depression ___Diarrhea

WORK STATUS HISTORY

Occupation: _____ Employer: _____

Have you missed time from work? ____Yes ___No

If yes, full time off of work: _____

If yes, Part time off of work: _____

____Been able to work since accident.

FIRST DOCTOR/ HOSPITAL / CLINIC SEEN

Did you go seek medical help immediately / soon after accident? ___yes ___no

If yes, who did you first get treatment from? Doctor/ Hospital/ Clinic Seen:
_____

Date of first visit: _____ were you examined ___yes ___no were X-rays taken ___yes ___ no

Were you given treatment___ yes ___no if yes what treatment was given to you?
_____

What benefits did you receive from treatment? _____

Date of last treatment? _____

PRIOR SIMILAR SYMPTOMS

Did you have any physical complaints just before the accident ____ yes ____no?

If yes, what physical symptoms just before the accident? _____

PRIOR to this accident have you EVER had symptoms similar to what you're experiencing now ___yes ___No If yes please explain (briefly include past falls, injuries, accidents operations etc.)

_____

ACTIVITES OF DAILY LIVING

Do you notice any of your home activities that are different now than before the accident __yes __ no?

If yes, List them as:

Those activities that you are now unable to do are (be specific) _____

Those activities that are now painful to do are (be specific) _____

Those activities that are now difficult to do are (be specific) _____

ATTORNEY ON CASE

Do you have an attorney on this case ____Yes ____ No

If yes who? Name _____ Phone _____

Address: _____City:_____ State: _____ Zip: _____

Patient Signature: _____ Date: _____

AUTOMOBILE ACCIDENT- INSURANCE DATA

Patient's Insurance company information (you)

Company Name: _____ Policy # _____

Claim # _____ Address: _____

City: _____ State: _____ Zip: _____

Adjusters Name: _____ Phone# _____Fax#_____

Insured's insurance company information (driver of car you were in if not you)

Company Name: _____ Policy # _____

Claim # _____ Address: _____

City: _____ State: _____ Zip: _____

Adjusters Name: _____ Phone# _____Fax#_____

Other Drivers insurance company information (other car's driver)

Company Name: _____ Policy # _____

Claim # _____ Address: _____

City: _____ State: _____ Zip: _____

Adjusters Name: _____ Phone# _____Fax#_____

Physical Evidence Chiropractic
Dr. David Lipman

HIPPA FORM

Consent for purposes of treatment, Payment & health care operations (3/03)

In this document, "I" and "my" refers to the patient.
And "chiropractor" refers to Dr. David Lipman DC.

I consent to the use or disclosure of my protected health information by the chiropractor for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of chiropractor. I understand that analysis, diagnosis or treatment of me by chiropractor may be conditioned upon my consent as evidenced by my signature below

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment of health care operations of the practice. Chiropractor is not required to agree to the restrictions that I may request. However, if chiropractor agrees to a restriction that I request, the restriction is binding on chiropractor.

I have the right to revoke this consent, in writing, at any time, except to the extent that chiropractor has taken action in reliance on this consent.

My "protected health information" means health information, including me demographic information, collected form me and created or received by my physician, another health care provider, a health plan, my employer or health care clearing house. This protected health information relates to my past, present of future physical or mental health or condition and identifies or there is a reasonable basis to believe the information my identify me.

I have been provided with a copy of the Notice of Privacy Practices of Chiropractor and understand that I have a right to review the Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of chiropractor. The notice of privacy practices for chiropractor is also posted in the office of Dr. David Lipman's office. The notice of privacy practices also describes my rights and duties of the chiropractor with respect to my protected health information.

Chiropractor reserves the right to change the privacy practices that are described in the notice of privacy practices. I may obtain a revised notice of privacy practices by calling the office of chiropractor and requesting a revised copy to be sent in the mail or asking for one at the time of my next appointment.

Name: _____ Signature: _____

Date: _____ Witness Signature: _____

David Lipman D.C.

Informed Consent for Chiropractic care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understands both the objective and the method that will be used to obtain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and, alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as the relationship may effect the restoration and preservation of health. **Health** is a state of physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called **vertebral Subluxation**. This occurs when one or more of the 24 vertebra in the spinal column becomes misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an **adjustment**. An adjustment is the specific application of forces to correct and/or reduce vertebral Subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually performed by hand but maybe performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

All health care procedures carry some risk. Risks associated with chiropractic care may include, but are not limited to, muscle or ligament injuries, nerve injuries, vascular injuries, and fractures. Alternatives to chiropractic care may include medications, surgery and other alternative treatments.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

Print Name_____ Signature _____ Date _____

Consent to evaluate and adjust a minor child:

I, _____being the patient or legal guardian of_____

Have read and fully understand the above consent and hereby grant permission for my child to receive chiropractic care.

Pregnancy release: This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle. _____

Signature_____ Date: _____

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Informed Consent for Active Release Technique

What is Active Release Technique?

It is a hands-on touch and case-management system that allows a practitioner to diagnose and treat soft-tissue injuries. Soft tissue refers primarily to muscle, tendons, fascia and nerves. Specific injuries that apply are repetitive strains, traumas, adhesions, tissue hypoxia and joint dysfunction.

What do you expect from an Active Release Technique treatment?

Every session is actually a combination of examination and treatment. Dr. Lipman uses his hands to evaluate the texture, tension, movement and function of muscles, fascia, tendons, ligaments and nerves. Abnormal tissues are treated by combining precisely directed tension and pressure with very specific patient movements.

How Long Are Treatments?

Treatments take about 8-15 minutes for each area being treated. A condition may require two to ten Visits before full functionality is restored. Manipulation of the spine and extremity joints is almost always carried out in conjunction with Active Release Therapy to increase treatment effectiveness. Whenever possible we have our patients perform active movements during the treatment process. Active motions stimulate neurological pathways in the spinal cord that help to reduce pain during treatment. Motion also helps to reproduce the stresses the patient will actually be under during normal active motion.

Is it safe?

Yes it is.

Are there any side effects?

Active Release Therapy is a non-invasive, safe and virtually no side effects and comes with a record of very good results. In a small percentage of patients, symptoms can become worse before improving. This is generally a sign that healing has begun. In some cases Active Release Therapy can cause bruising and tenderness in the region that is being treated. If during the treatment session you find it to be too uncomfortable, please bring it to Dr. Lipman's attention immediately so the treatment can be modified. If worsening of symptoms or the bruising that may ensue is concerning you or lasts more than a few days, contact Dr. Lipman to discuss.

I _____ (Full name) Have read and understood the above Information. I consent to receive Active Release Technique treatment within this practice. I agree to

This consent remaining valid until such time as I withdraw that consent.

Signed _____Date_____

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Assignment of Insurance Benefits

I, _____, hereby assign the benefits under policy/Claim # _____, of _____, otherwise payable to me, but not to exceed the health care provider's reasonable charges, to David Lipman DC.

I authorize and direct that payment for covered services to be made by my insurer to David Lipman DC PA.

I understand that I am financially responsible to David Lipman DC for all charges whether or not covered by my insurance coverage.

_____
Date

_____ _____
Patient Name Patient Signature

_____ _____
Witness Name Witness Signature