Klein Chiropractic Center

1906 Clint Moore Rd. Ste 4
Boca Raton, Fl 33496
Phone: (561) 988-1998
Fax: (561) 988-8944

Dr. Robert I. Klein

Automobile Accident Questionnaire

Date ______________
Patient ______________________________________ Social Sec. # __________________
Please explain in detail how your accident happened? ____________________________________
Your Insurance Company (if any) ____
Policy No. ___________________ Claim No. ___________________________________
Name of insurance adjuster ____
Were you the driver? _________ if not, name of driver ___________________________
Name of driver of other vehicle (if known) ___________________________________
Insurance Company ____
Policy No. ___________________________ Claim No. ___________________________
Have you retained an attorney? _______ Yes _____ No ____ Not yet
If so, his/her name, address & phone ______________________________________
Give time and date present injury occurred ________ AM PM / /
Other vehicle was heading? _____ North ___ South ____ East __ West on ________________
Numbers of people in vehicle ________________ were police notified ___ Yes ___ No
Did head strike windshield or object? _ Yes _____ No
Were you knocked unconscious ____ Yes _ No If so, for how long __________
Were you struck from _ Behind ____ Front _ Left Side ____ Right Side
You were _ Driver _ Passenger _____ Front seat _ Back seat _____ using seat belts
Did you feel pain immediately after the accident? ____________
Were you taken to the hospital? _______ What treatment was given? ____________________
Was any doctor consulted after the accident? ____________
If so, give doctor's name ____________________________________
Doctor's diagnosis ____
Was treatment given ____
How often did you see the doctor? _______ How long did you see the doctor? ______________
Have you ever had any complaints in the involved are before _________ Yes ___ No
If so, what were the complaints? ______________________
Before the injury, were you able of working on an equal basis with other your age? ______________
Are your work activities restricted as a result of this accident? ____________________
Since the injury, are your symptoms _____ improving? ___ Getting worse? _____ The same?

You are responsible for meeting the payment requirements of your policy regarding deductibles and co-payments, and also payments for services not covered by your policy. With the above exceptions, in most cases we will accept assignment and payment of benefits of the patient's insurance plans, health plans, and third party claims as payment in full for services rendered. Check type of insurance coverage:

__ Workman's Compensation **__ Automobile Insurance Policy** **__ Government Plan**
__ Group Policy **__ Personal Policy** **__ other**

It is hereby agreed by the undersigned that should be the balance owed for the service become delinquent, that is, thirty (30) days past due from the date of the original invoice, I shall remain liable for any and all collection costs, attorney's fees and/or interest as a result of collection of the delinquent account

X ____________________________________
PATIENT'S SIGNATURE

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Dr. Robert I. Klein

PERSONAL HISTORY

Date ______________________ **Social Security #** ______________________________________

Name: ______________________________________ **Address:** ______________________________________

City: ______________________________ **State:** ________________________________ **Zip** ____________

Mailing Address: ____

Home Phone: _________________________ **Work Phone:** ___________________________

Cell Phone: _________________________ **Sex:** _______________ **Height:** ____________ **Weight:** ____________

Birthdate: __________________________ **E-mail:** _____________________________

Name of Your Employer: _______________ **Type of Work:**

Check If You Are: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Name and Telephone # of Person to Contact In Case of Emergency: _____________

Name of Husband or Wife: ______________________ **Spouse's Employer's Phone #:** _________________________

Husband or Wife's Employer: ____

Ages of Your Children: ____

Referred To This Office by: ____

Who Is Responsible For Your Bill? ☐ Self ☐ Husband or Wife ☐ Employer ☐ Insurance ☐ Other: ____________

PAST HEALTH HISTORY

PLEASE CHECK APPLICABLE ITEMS:

OPERATIONS:

Appendectomy ________________ **Rectal** ________________ **Tonsillectomy** ____________________

Gall Bladder ________________ **Female Organs** ____________ **Hernia** ________________________

Others: ________________________

ACCIDENTS OR FALLS (Please describe) ____

FRACTURES OR DISLOCATIONS: ____

HABITS:

Sleep (hours) ________ **Coffee** _______ **Tea** _______ **Alcohol** ____________

Tobacco __________ **Exercise** _____ **Hobbies** ______________

Arc you now taking any drugs'? (Please name) ____________________________

Have you ever had a nervous breakdown? _________________________________

Have you or any member of your family been treated for a mental disorder? ____________________________________

INSURANCE PLAN

You are responsible for meeting the payment requirements of your policy regarding deductibles and co-payments, and also payment for services not covered by your policy. With the above exceptions, in most cases we will accept assignment and payment of benefits of the patient's Insurance benefits, health plans, and third party claims as payment in full for services rendered. Check type of Insurance coverage:

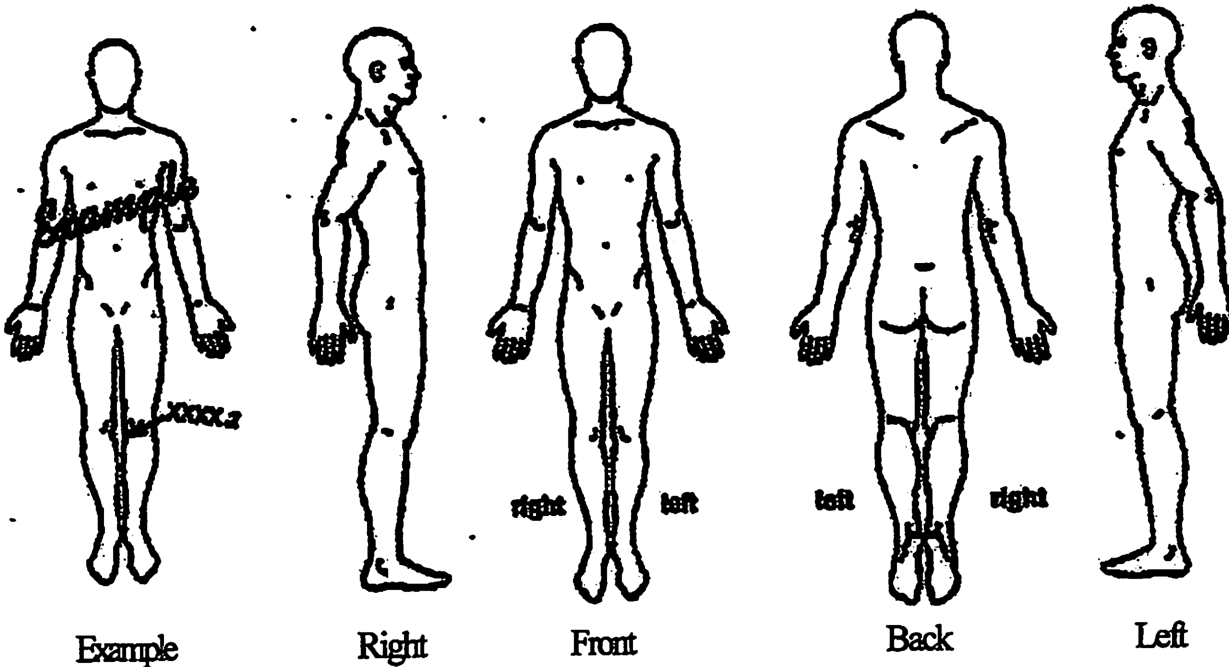
☐ Workman's Compensation ☐ Automobile Insurance Policy
☐ Government Health Plan ☐ Group Policy
☐ Personal Policy ☐ Other

It is hereby agreed by the undersigned that should the balance owed for service become delinquent, that is, thirty (30) days past due from the date of the original invoice, I shall remain liable for any and all collection costs, attorneys fees and/or Interest as a result of collection of the delinquent account.

PATIENT'S SIGNATURE ____

PAIN CHART

PLEASE MARK AREA(S) OF INJURY OR DISCOMFORT AS ILLUSTRATED BELOW.



USING THE SCALE BELOW, PLEASE INDICATE THE DEGREE OF PAIN USING A SCALE OF 1 (MILD DISCOMFORT) TO 10 (EXTREME PAIN)

1 2 3 4 5 6 7 8 9 10 11 12

□ We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient

□ Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for any expenses incurred in collecting your account

□ 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 in my medical status.

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Dr. Robert L Klein

STANDARD DISCLOSURE AND ACKNOWLEDGEMENT FORM Personal Injury Protection - Initial Treatment or Service Provided

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

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

__Office Visit/Exam
__Ultra Sound
__Electrical Stim.
__Kinetic Activities
__Hot/Cold Pack
__X-rays
__Therapeutic Exe.
__Other:________
__Spinal Manipulation
__Massage therapy
__Traction
__Extremity Manipulation
__Manual Therapy
__Neuromuscular re-ed

2. I acknowledge that I have the right and affirmative duty to confirm that services listed was actually rendered.
3. I was not solicited by this medical facility or any of its employees to seek medical treatment for injuries sustained as a result of this accident.
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 $500.00.

The undersigned licensed medical professional affirms the statement numbered 1 above and also:

A. I have not solicited or caused the injured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.
B. I have explained the services rendered 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 herein; 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(15) and (6), Florida Statutes or Section 627.736(5) (b) 6, Florida Statutes.

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

Name (print) ______________ Signature ______________________ Date __________

Licensed Medical Professional Rendering Treatment (signature by his/her own hand)

Name (print) ______________ 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:

CIRCLE ANY OR THE FOLLOWING DISEASES YOU HAVE HAD;

Appendicitis	Malaria	Chicken Pox	Alcoholism
Scarlet Fever	Tuberculosis	Diabetes	Venereal Infection
Diphtheria	Whooping Cough	Cancer	Arthritis
Typhoid Fever	Anemia	Heart Disease	Epilepsy
Pneumonia	Measles	Goiter	Mental Disorder
Rheumatic fever	Mumps	Influenza	Lumbago
Polio	Small Pox	Pleurisy	Eczema

Please Underline All of the Following Symptoms You Have Had Previously. Please Circle All of the Following Symptoms You Have Now

GENERAL SYMPTOMS

Headache
Fever
Chills
Sweats
Fainting
Dizziness
Convulsions
Loss of Sleep
Fatigue
Nervousness
Loss of Weight
Numbness or pain in arms, hands, or legs Allergy
Wheezing
Neuralgia

E.E.N.T.

Failing vision
Near sightedness
Far sightedness
Crossed eyes
Eye pain
Deafness
Earache
Ear noises
Ear discharge
Nose bleeds
Nasal obstruction
Sore throat
Hoarseness
Asthma
Dental decay
Gum trouble
Frequent colds
Enlarged thyroid
Tonsillitis
Sinus infection
Nasal drainage
Enlarged glands
Hay Fever

SKIN

Skin Eruptions
Itching
Bruises easily
Dryness
Boils
Varicose Veins
Sensitive Skin
Hives or Allergy

RESPIRATORY

Chronic cough
Spitting up phlegm
Spitting up blood
Chest pain
Difficult breathing

CARDIOVASCULAR

Rapid beating heart Slow beating heart High blood pressure Low blood pressure Pain over heart Previous heart stroke Hardening of arteries Swelling of ankles Poor circulation Paralytic stroke

MUSCLE & JOINT SYMP.

Stiff neck
Backache
Swollen joints
Tremors
Painful tail bone
Foot trouble
Pain between shoulders
Hernia
Spinal curvature
Faulty posture

GENITOURINARY SYMPTOMS

Frequent urination
Painful urination
Blood in urine
Pus in urine
Kidney Infection or Stones
Bed Wetting
Inability to Control Urine
Prostate Trouble

GASTROINTESTINAL * SYMPTOMS

Poor appetite
Difficult digestion
Excessive hunger
Belching or gas
Nausea
Vomiting
Vomiting of blood
Pain over stomach
Distention of abdomen
Constipation
Diarrhea
Colon trouble
Hemorrhoids (Piles)
Intestinal worms
Liver trouble
Gall bladder trouble
Jaundice
Colitis

FOR WOMEN ONLY

Painful menstrual periods
Excessive flow
Hot flashes
Irregular cycle
Cramps or backache
Previous miscarriage
Vaginal discharge
Lumps in breast
Menopausal symptoms
Are you pregnant? ☐ Yes ☐ No

Patient Consent for Use and Disclosure of Protected Health Information

Klein Chiropractic Center

I hereby give my consent to Klein Chiropractic Center to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

Klein Chiropractic Center's Notice of Privacy Practice provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Klein Chiropractic Center reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Klein Chiropractic Center 1906 Clint Moore Rd. Ste 4, Boca Raton, Fl 33496

With this consent, Klein Chiropractic Center may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Klein Chiropractic Center may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Klein Chiropractic Center restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Klein Chiropractic Center's use and disclosure of PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Klein Chiropractic Center may decline to provide treatment to me.

Signature of Patient or Legal Guardian________________________ Date __________________

Receipt of Notice of Privacy Practices Written Acknowledgement Form

I,____________________________________, have read a copy of Klein Chiropractic Center's Notice of Privacy Practices.

Signature of Patient or Legal Guardian________________________ Date________________________

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Dr. Robert I. Klein

POWER OF ATTORNEY and MEDICAL RELEASE

POWER OF ATTORNEY TO ENDORSE CHECKS AND OR SIGN ANY PAPER WHICH WILL ENHANCE OR EXPEDITE PAYMENT TO PROVIDER FOR SERVICES RENDERED, INCLUDING BUT NOT LIMITED TO A RELEASE OF MEDICAL RECORDS and ASSIGNMENTS OF BENEFITS/AUTHORIZATION TO PAY.

Know by all these present that: the undersigned has made, constituted and appointed, and by these present does hereby make, constitute and appoint Dr. Robert I. Klein and any of it's duly authorized agents and employees as and to be the undersigned's true and lawful attorney for and in the undersigned's name, place and stead to endorse any all checks, drafts or money orders which are made payable for services which have been made by Dr. Robert I. Klein at the request or with the knowledge and approval of the undersigned and/or the maker of the maker of the check, draft or money order.

Furthermore, the undersigned allows Dr. Robert I. Klein or any of its agents to sign any paper that will be necessary to enhance, expedite and/or allow payment to said provider. This may include affidavits of non-ownership of vehicles, insurance forms and other statements.

The undersigned by these present does give grant the said Dr. Robert I. Klein as attorney the full power and authority to do and perform all and every act whatsoever requisite and necessary to be done in and about the premises as fully to all intents and purposes as the undersigned might or could do to personally present insofar as the endorsing and cashing of said checks are concerned as well as any other document.

MEDICAL RELEASE

A photocopy of this document shall be sufficient to authorize any person having records of medical treatment, services, or supplies pertaining to me to release true copies of same to Dr. Robert I. Klein or any insurer providing coverage to mi in connection with the processing of any claim for benefits made by me or by the assignee herein. A photocopy of this document shall be as binding as an original signature page.

The undersigned does hereby ratify and confirm and all actions taken by the said attorney in accordance with this special power and which the said attorney shall do or cause to be done by virtue of these present.

Release of Information: I hereby authorize this medical provider to: furnish my insurance company or companies and the patient's attorney with any and all information that may be contained in my medical records; to obtain coverage information telephonically from my insurer; to request a written non-redacted PIP payout sheet from the insurer; and to obtain copies of my medical records, including but not limited to, documents, reports, scans, notes, opinions, X-rays, and MRI's received from any other medical provider or any insurance company. The insurer is directed to keep the patient's medical records private and confidential. The insurer is NOT authorized to provide these medical records to anyone, including but not limited to, third party vendors without the patient's and the provider's prior express written permission.

ASSIGNMENT OF BENEFITS

I, ______________________ hereby authorize ________________________

Payable and mailed directly to: Dr. Robert I. Klein
1906 Clint Moore Rd. Ste 4
Boca Raton, Fl 33496

The medical benefits otherwise payable to me for their services, but not to exceed the charges of those services, I hereby IRREVOCABLY ASSIGN to YOUR COMPANY HERE any benefits under any policy of insurance, indemnity agreement, or any other collateral source so defined in Florida Statutes for any service and or charges provided by Dr. Robert I. Klein IN WITNESS WHEREOF, the undersigned have hereunto set their hands, this, _____ day of ______________ , 2009.

Patient's Signature____________________ Patient's Name (Print)____________________

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Dr. Robert I. Klein

DOCTOR'S LIEN

To: ____________________

____

____

____

RE: ______________________

Doctor: Robert I. Klein, D.C.

1906 Clint Moore Rd. Ste 4

Boca Raton, Fl 33496

I do hereby authorize the above doctor to furnish you, my attorney/insurance carrier, with a full report of his case history, examination, diagnosis, treatment, and prognosis of myself in regard to my accident/illness which occurred/began on_ __________________ .

I hereby give a lien to said doctor on any settlement, claim, judgement, or verdict as a result of said accident/illness, and authorize and direct you, my attorney/insurance carrier, to pay directly to said doctor such sums as may be due and owing him for services rendered me, and to withhold such sums from such settlement, claim, judgement, or verdict as may be necessary to protect said doctor adequately.

I fully undersigned that I am directly and fully responsible to said doctor for all chiropractic bills submitted by him for service rendered me, and that this agreement is made solely for said doctor's additional protection and in consideration of his waiting payment. And I further understand that such payment is not contingent on any settlement, claim, judgement, or verdict by which I may eventually recover said fee.

Dated: __________________________ Patient's Signature: ___________________________

The undersigned, being attorney of record or authorized representative of insurance carrier for the above patient does hereby acknowledge receipt of the above lien, and does agree to honor the same to protect adequately said above named doctor.

Dated: __________________________ Authorized signature: _________________________