Lucha Chiropractic Quality Center

1350 Louisiana Ave. Ste D, St. Cloud, FL 34769
Phone: 407-593-8052 Fax: 407-593-9014

Patient Intake Form

Patient LEGAL Name:_____
(Last Name) (First Name) (Middle Initial)

Date Of Birth: ____/____/_____ **Age:**_____ **Sex:** M / F **Social Security #:**_____

HT:_____ WT:_____ OCCUPATION:_____ **Marital Status:** Single / Married / Divorced / Widowed

Address: _____ City:_____ State/ZIP:_____

Cell Phone: _____ Email: _____

Primary Care Physician:_____ Phone:_____

Emergency Contact Name:_____ Phone: _____

I, _____, give Lucha Chiropractic Quality Center permission to Call / Email me regarding appointment reminders and any other communication or updates regarding my treatment plan. Lucha Chiropractic Quality Center will not release or speak with anyone else regarding your information or treatment plan without a signed medical release.
Patient / Guardian Signature: _____ Date: _____

Pain is result of: **Auto Accident** **Slip & Fall** **Work Accident** **Everyday Pain**

If Pain is due to an Auto Accident, Slip & Fall or Work Accident **PLEASE** fill out rest of this form.

Do you have an Attorney on this case? _____ **Date of the Accident:** _____/_____/_____

Auto Insurance Company Name:_____ **Claim Number:**_____

Policy ID: _____

At the time of the accident you were: **DRIVER / PASSENGER / PEDESTRIAN**

WAS THERE ANYONE ELSE IN THE CAR WITH YOU? Yes / No

WHERE DID YOU GO AFTER THE ACCIDENT? HOME / WORK / HOSPITAL ***If hospital, which hospital?*** _____
How did you get there? [ ] Drove self [ ]Someone else [ ]Police [ ]Ambulance
Were X-rays or CT Scans taken? [ ]Yes [ ]No

The above information is true to my knowledge. I authorize my insurance benefits to be paid directly to the physician, Dr. Samuel Lucha and/or Lucha Chiropractic Quality Center . I understand that I am financially responsible for any balance. I also authorize the Lucha Chiropractic Quality Center and/or insurance company to release my information required to process my claims.

Patient / Guardian Signature: _____ **Date:** _____

AUTO ACCIDENT DESCRIPTION

PLEASE ANSWER THE QUESTIONS BELOW TO THE BEST OF YOUR ABILITY

What was your vehicle doing at time of accident: [ ]Stopped at intersection / Traffic light [ ]Parking [ ]Proceeding along [ ]Making turn Right/Left [ ]Slowing down [ ] Accelerating [ ]Other_____

Who hit who: [ ]You hit other vehicle [ ]Other vehicle hit you [ ] You hit...(object)_____

Did you see the accident coming? [ ]Yes [ ]No **Did you brace for the impact?** [ ]Yes [ ]No

Did you have a seat belt on? [ ]Yes [ ]No **Did airbags deploy?** [ ]Yes [ ]No

Direction of your head at impact: [ ]Facing forward [ ]Turned to the right [ ]Turned to the left

Did your body strike the inside of vehicle? [ ]Yes [ ]No **Did you lose consciousness?** [ ]Yes [ ]No

Check off any and all symptoms immediately & days following accident: [ ]Neck stiffness [ ]Mid back pain [ ]Neck pain [ ]Low back pain [ ]Headache [ ]Ringing in ears [ ]Loss of taste/smell [ ]Dizziness [ ]Fainting [ ]Diarrhea [ ]Fatigue [ ]Nausea [ ]Chest Pain [ ]Irritability [ ]Shortness of breath [ ]Confusion [ ]Tension [ ]Anxious /Nervousness [ ]Toe numbness [ ]Pain in eyes [ ]Depression [ ]Constipation [ ]Sleeping problems [ ]Shoulder pain R / L [ ]Knee pain R / L [ ]Wrist pain R / L [ ]Ankle pain R/ L [ ]Hip pain R / L [ ] Elbow pain R / L [ ]Other_____

Circle Current Pain Complaint	No Pain	0	1	2	3	4	5	6	7	8	9	10 Unbearable Pain
Range of Pain over the last week?	No Pain	0	1	2	3	4	5	6	7	8	9	10 Unbearable Pain

Are you currently taking any medication for pain, prescribed or over the counter? [ ]Yes [ ] No

PRIOR SYMPTOMS HISTORY

[ ] I have **NOT** had any prior symptoms similar to my current complaints
[ ] My current complaint **DID** exist before, but they have not been bothering me
[ ] My current complaint **ALREADY** existed and were **WORSENED** by this accident

Check each activity that causes you pain since the accident from

Housework
__ Cooking
__ Vacuuming
__ Washing dishes/ Laundry
__ Mowing lawn
__ Gardening / yard work
__ Caring for Pet/ Children
__ Shopping/Carrying groceries

Personal Grooming
__ Combing hair
__ In/Out bathtub
__ Brushing teeth
__ Dressing

Travel
__ Driving
__ Riding as Passenger
__ Getting in / out of car
__ Plain travel

General Movements
__ Walking/ Running
__ Reading / Using computer
__ Kneeling/ Squatting
__ Lifting Child
__ Exercising
__ Climbing Stairs
__ Sports/ Hobbies

__ School Work
__ Standing/ Sitting
__ Computer Work
__ Bending
__ Sleeping
__ Sexual Intercourse

Other:_____

I certify the above information is complete and accurate to the best of my knowledge. I agree to notify the doctor immediately whenever I have changes in my health condition.

_____ DOB:_____ Date: _____

Patient / Guardian Signature

_____ _____

Witness **Date**

Lucha Chiropractic Quality Center

PERSONAL HEALTH HISTORY

PATIENT NAME: _____

Please check all that apply

GENERAL
[ ] Allergy
[ ] Anemia
[ ] Appendicitis
[ ] Cancer
[ ] Convulsions
[ ] Depression / Nervousness
[ ] Diabetes
[ ] Epilepsy
[ ] Fainting
[ ] Heart disease
[ ] Herpes
[ ] Hepatitis
[ ] HIV/AIDS
[ ] Loss of sleep
[ ] Loss of weight
[ ] Multiple sclerosis
[ ] Neuralgia
[ ] Pacemaker
[ ] Pleurisy
[ ] Stroke
[ ] Tuberculosis
[ ] Tremors
[ ] Ulcers
[ ] Swelling of ankles

EYE, EAR, NOSE & THROAT
[ ] Tonalities
[ ] Deafness
[ ] Earache
[ ] Ear Discharge
[ ] Enlarged Glands / Thyroid
[ ] Eye Pain
[ ] Nose Bleeds
[ ] Failing Vision

SKIN
[ ] Boils
[ ] Bruise easily
[ ] Hives / Rash
[ ] Varicose Veins

CARDIOVASCULAR
[ ] Hardening of Arteries
[ ] High Blood Pressure
[ ] Low Blood Pressure
[ ] Pain over Heart
[ ] Poor Blood Circulation
[ ] Rapid / Slow Heartbeat
[ ] Heart Attack

GENITOURINARY
[ ] Bed wetting
[ ] Blood in Urine
[ ] Frequent Urination
[ ] Lack of Bladder control
[ ] Kidney Infection
[ ] Prostate Problems
[ ] Pus in Urine

GASTROINTESTINAL
[ ] Colon trouble
[ ] Constipation / Diarrhea
[ ] Gallbladder trouble
[ ] Vomiting Blood
[ ] Liver trouble / disease
[ ] Stomach pain
[ ] Vomiting

RESPIRATORY
[ ] Chest pain
[ ] Asthma / Wheezing
[ ] Difficulty Breathing
[ ] Spitting up blood / phlegm

WOMEN ONLY
[ ] *Congested breasts*
[ ] *Irregular cycle*
[ ] *Menopause*
[ ] *Lumps in breast*

ARE YOU PREGNANT? YES / NO
If so, how many months? _____

[ ] OTHERS:_____

_____

I certify the above information is complete and accurate to the best of my knowledge. I agree to notify the doctor immediately whenever I have changes in my health condition.

_____ DOB:_____ Date: _____
Patient / Guardian Signature

_____ _____
Witness **Date**

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Patient Name:_____ Date of Birth:_____

Social Security Number (at least last 4):_____

Receipt/ Release of Medical Records

I, _____ , hereby request and authorize the following medical documents/ records to be released/disclosed
from_____ and records be promptly transferred to the above listed office at Lucha Chiropractic Quality Center.
I understand that I may revoke this release of records at any time by notifying Lucha Chiropractic Quality Center in writing. Further, I agree that a copy of this authorization may be used in place of the original.

__X__ Complete Medical file __X__ Mental Health Records __X__ Radiology Reports
__X__ Medical Records __X__ Including HIV/AIDS ____ Radiology Films
__X__ Daily Notes __X__ Date of Injury/ Loss _____

This authorization is effective through____/_____/____, one year from date signed, unless revoked or terminated by the patient or patient's personal representative.

Patient Signature:_____ Date:_____

Release of Medical Records

I, _____ , hereby authorize Lucha Chiropractic Quality Center, above listed office to release any and/or all information contained in my medical records file to another physician, my attorney and/or my insurance company on my behalf. I understand that I may revoke this release of records at any time by notifying Lucha Chiropractic Quality Center in writing. Further, I agree that a copy of this authorization may be used in place of the original.

Patient Signature:_____
Date:_____

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

I, _____, have read, understand and received a copy of this office's Notice of Privacy Practices. This notice explains how my medical information will be used and disclosed and how I may obtain access to this information.

Patient Signature:_____
Date:_____

Witness Signature:_____ Date:_____

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Informed Consent

I have been informed it is not uncommon for patients to have some increased discomfort after an adjustment. If that happens, I will apply ice to the area and rest. If I am concerned about this discomfort or develop any new symptoms, I can call the office for attention. If I am out of town or unable to contact the aforementioned number, I can present, myself to the emergency room. I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various methods of therapy. Listed below are some of the therapies performed in our office.

Chiropractic Adjustments- important to start adjustments to the injured area before scar tissue starts to form so that the issue doesn't become worse.
Manual Therapy- Important to get range of motion in the injured area, relieve pain, reduce swelling, reduce muscle tension, and improve circulation.
Therapeutic Exercise- Important to restore strength and coordination to the muscles and maintain mobility in the joints. These exercises will help to decrease pain, prevent muscle deterioration, promote joint health, increase stability and range of motion.
Heat / Cold Therapy- depending on your injury, you will receive heat therapy and/or cold pack therapy. Heat therapy is used to deeply penetrate and relax your muscles. Along with relieve pain and soreness in joints. Cold therapy is used to decrease and prevent swelling and reduce the pain.
EMS/ TENS Therapy- Used to prevent muscle spasms and muscle atrophy, increasing local blood circulation by stimulating muscle tissue, and strengthen muscle tissue to promote healing.
Mechanical Traction- Spinal traction uses mechanically created forces to stretch and mobilize the spine. Traction may alleviate pain by stretching tight spinal muscles that result from spasm and widen intervertebral foramen to relive nerve root impingement.
Posture Pump- Used to help relieve stiffness and restore cervical posture. Helps restore the natural curvature of the cervical spine to decompress the discs and relieve pain.

I further understand and I am informed that, as in all health and chiropractic medicine there are some slight risks to treatment including, but not limited to, muscle strains and sprains, disc injuries, and stroke. I do not expect the doctor to be able to anticipate and explain all the risks and complications. I wish to rely on the doctor to exercise judgment during the course of procedure which the doctor feels at the time based upon facts then known, is in my best interest.

OUR OFFICE POLICY: We believe that a clear definition of our office polices will allow you, our patient and our office, to concentrate on the big issue- **REGAINING AND MAINTANING YOUR HEALTH.**
If any tests were performed outside of this office (laboratory or diagnostic procedures), I understand the doctor will notify me of the results at my next appointment or when the reports are available.
Staff is not authorized to change or alter your prescribed treatment plan, only the doctor. Our office does appointment reminder calls, texts and/or emails. If you do not wish to receive communication about your appointment in one or more of these manners, please let us know.
Upon final or discharge of care, medical record will only be provided to you the patient, another doctor or attorney with a **signed** medical release form. Medical records will not be released directly to the patient without a written request.

PAYMENT OF BILL: We will require that you honor financial agreements you make with our office. insurance checks sent to your home should be brought or sent to our office within three days, along with the stub or statement to indicate which services were paid.
**Our office will submit your insurance claims for you as a courtesy. However, your insurance is an agreement between you and your company, not between our office and your insurance company.

I have read and understand the above consent, and by signing below, I agree to the above name procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition for which I seek treatment.

_____	_____	___/___/___	_____
Patient Name (please print)	**Patient/ Guardian Signature**	**DOB**	**Date**

_____	_____
Witness	**Date**

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Tax ID#: 85-1635998

Assignment of Benefits

I, the undersigned patient/insured, knowingly, voluntarily, and intentionally assign and transfer any and all rights and benefits of my automobile insurance policy (i.e. Personal Injury Protection ("PIP") and Medical Payments benefits) to the above-stated Health Care Provider(s) with which I have treated. I understand it is the intention of the Health Care Providers to accept this Assignment of Benefits in lieu of demanding payment at the time services are rendered. I understand that this document will allow the Health Care Providers to file suit against the insurer either in my name or the providers' names for payment of the insurance benefits, to obtain an explanation of benefits and to seek attorneys' fees and costs under Fla. Stat. §§627.736(8), 627.428 and 57.041 from the insurer. This Assignment of Benefits includes, but is not limited to, the cost of medical care, transportation, medication, supplies, overdue interest and any potential claim for common law or statutory bad faith/unfair claims handling. If the insurer disputes the validity of this Assignment of Benefits, then the insurer is instructed to notify the Health Care Providers in writing within five (5) days of receipt of this document advising of its basis for such dispute. Failure to inform the Health Care Providers shall result in a waiver by the insurer to contest the validity of this Assignment of Benefits. The undersigned patient/insured directs the insurer to pay the Health Care Providers the maximum amount of the policy benefits directly to the Health Care Providers without any reductions and without including the undersigned patient's/insured's name on the check. It is the Health Care Providers' contention that the charges are reasonable.

This Assignment of Benefits applies to past, present and future medical expenses and is valid even if not dated. A photocopy of this Assignment of Benefits is to be considered as valid as the original. I, the undersigned patient/insured, agree to pay any applicable deductible or co-payments for services rendered, including payment for services after the policy of insurance exhausts and for any other services unrelated to the date of injury. The above-stated Health Care Providers are given Powers of Attorney to: (1) endorse my, the undersigned patient's/insured's, name on any check for services rendered by the above-stated Health Care Provider, (2) to request and obtain copies of any recorded statements or Examinations Under Oath given by me, the undersigned patient/insured, and (3) to request and obtain copies of any Independent Medical Examination report and/or peer review report pertaining to me, the undersigned patient/insured.

Disputes

The insurer is directed by the Health Care Providers and the undersigned patient/insured not to issue any checks or drafts in partial settlement of a claim that contain or are accompanied by language releasing the insurer or its insured/patient from liability unless there is a written settlement agreement between the Health Care Providers, specifically the Office Manager, and the insurer as to the amount to be paid by the insurer for the services rendered only to the undersigned patient/insured. The undersigned patient/insured and the Health Care Providers hereby contest and object to any reductions or partial payments made by the insurer. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by the Health Care Providers 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 Health Care Providers to accept a reduced amount as payment in full. The insurer is hereby placed on notice that the Health Care Providers reserve the right to seek payment in full for the bills submitted

Release of Information

I, the undersigned patient/insured, hereby authorize the Health Care Providers to: furnish an insurer, an insurer's intermediary, my other medical providers and my attorney(s) via mail, facsimile or e-mail, with any and all information that may be contained within my medical records to: obtain insurance coverage information (i.e. declarations page and policy of insurance) in writing and telephonically from the insurer, request from any insurer all Explanation of Benefits/Review forms (EOBs) for all of my medical providers, obtain a non-redacted PIP payout sheet, obtain written and verbal statements that I or anyone else provided to the insurer, obtain copies of the entire claim file and all medical records, including, but not limited to: documents, reports, scans, notes, bills, opinions, x-rays, IMEs, peer reviews and MRIs from any of my medical providers or any insurer. The Health Care Providers are permitted to produce my medical records to its attorney in connection with pursing a legal action. The insurer is directed to keep my, the undersigned patient's/insured's medical records confidential. The insurer is not authorized to provide my, the undersigned patient's/insured's, medical records to anyone without my, the undersigned patient's/insured's and the Health Care Providers' express written permission.

Certification

I, the undersigned patient/insured, certify that: I have read and agree to the above; I have not been solicited or promised anything in exchange for receiving health care from the above-stated Health Care Provides; I have not received any promises or guarantees from anyone as to the results that may be obtained by any treatment or service provided; and I agree that the Health Care Providers' prices for the medical services, treatment and supplies provided are reasonable, usual and customary.

Caution: Please read this document carefully before signing. Please ask to review a copy of the above-stated Health Care Providers' charges. If you do not completely understand this document, please ask the front desk personnel or the medical provider to explain it to you. If you sign below it will be understood that you understand and agree with the contents of this Assignment of Insurance Benefits.

Patient Name:_____ (Please print)

Patient Signature:_____ (If patient is a minor, signature of parent/guardian)

_____ Date

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LETTER OF PROTECTION

Patient Name:_____ Date of Birth:_____

Date of Accident:_____

I do hereby authorize **Lucha Chiropractic Quality Center** to furnish my attorney with a full report of this examination, diagnosis, treatment, prognosis, etc., regarding myself for medical conditions related to the accident dated above.

I hereby authorize and direct you, my attorney, to pay directly to the doctor such sums may be due and owing him for reasonable and necessary medical services rendered to me for the evaluation or treatment for the conditions related to this accident. I hereby further give a lien on my case to the doctor against any and all proceeds of my settlement, judgment or the verdict which may be paid to you by my attorney or myself as a result of the injuries of which I have been treated or injuries in connection therewith.

I fully understand that I am responsible to the doctor for all reasonable medical bills submitted by him for necessary services rendered to me and the payments for such bills will be paid solely out of my settlement, judgment or verdict. I further understand that his agreement is made for the doctor's protection in consideration of his awaiting payment. I understand and agree that my directions to you, as my attorney, are irrevocable until either the satisfaction of my financial account with Lucha Chiropractic Quality Center occurs or Lucha Chiropractic Quality Center releases such Letter of Protection.

I agree to promptly notify the doctor of any change or addition of attorney(s) used by me in connection of the accident and instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted or added attorney.

Please acknowledge this letter by signing below and return it to the doctor's office.

Patients Signature:_____ Date:_____

I, being the attorney of record for the above patient, do hereby agree to observe all the terms of the above and agree to withhold such sums for any settlement, judgment, or verdict as may be necessary to adequately protect and fully compensate the doctor named above in payment of his fees.

Attorney's Name:_____

Attorney's Signature:_____ Date:_____

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HARDSHIP AGREEMENT

To Whom It May Concern,

The Clinic Named above has agreed to accept assignment on the undersigned patient. The mentioned office has also conditionally agreed to accept what the insurance pays only as full payment for services rendered to the undersigned patient.

It has been established that this patient is in need of Medical Care and Corrective Chiropractic treatment; However, He/She is unable to pay out of pocket for these services at this time due to a drastic Financial Hardship.

In the event that the undersigned patient's income increases, a settlement is made, or other financial gain occurs, and He/She is able to pay the co-payment or any other part of the outstanding balance, This Agreement will be null and void at that time.

Patient Name:_____

Patient Signature:_____ Date:_____

Witness Signature:_____ Date:_____

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AFFIDAVIT OF INJURY

I hereby affirm that I sustained injuries/ pain as a result of an incident on _____ (Date of accident). No one has offered or given me any money, incentive, remuneration, anything of value, or any other form of inducement for the purpose of treating at this clinic.

No one has made any promises or guarantees with regard to my medical treatment or any other aspect of my case and/or claim. I understand that I have a choice regarding where I seek treatment for my injuries, and I have chosen, of my own free will, to seek treatment at this clinic.

_____ _____ _____
Signature of patient and/or responsible parties Date Date of Birth

_____ _____
Witness Date

NOTARIZED BEFORE ME

Sworn to and subscribed before me on this _____ day of_____, 20_____.

_____ ____personally known to me
____ Provided _____ as identification

Notary Public in and for: Osceola

The State of: Florida

My commission expires: _____