Chiropractic Naturally
"Because it's about your health"

Dr. Archana Mehta
Chiropractic Physician

Dr. Gwen Pillow
Chiropractic Physician

Dr. Ashley Sooklal
Chiropractic Physician

5537 Sheldon Rd. Suite T Tampa FL 33615
Tel: 813-885-5786

13301 Orange Grove Dr. Suite A Tampa FL 33618
Tel: 813-963-3055

Fax: 813-886-0559

(AUTO) Chiropractic Case History / Patient Information

Date: _____

Name:_____ Home Phone: (___)_____-_____

Address:_____City:_____ State:_____ Zip:_____

E-mail address:_____Fax#:(___)_____-_____ Cell Phone:(___)_____-_____

Age:_____ Birth Date:_____/_____/_____ Marital Status: □M □S □W □D

Occupation:_____ Employer:_____

Office Phone:(___)_____-_____

Spouse:_____ Occupation:_____

Emergency Contact:_____ Phone:(___)_____-_____

When doctors work together it benefits you. Do we have permission to update your medical doctor regarding your care at this office? □Yes □No

Primary Doctor:_____ Phone:(___)_____-_____

HISTORY OF PRESENT ILLNESS:

Chief Complaint: Purpose of this appointment:_____

Have you ever had the same or a similar condition? □Yes □No If yes, when and describe:_____

_____

Date symptoms appeared:_____

Is this due to a recent?: □Auto □Work Other_____

Days lost from work:_____ Date of last physical examination:_____

PAST MEDICAL HISTORY:

Have you ever been diagnosed as having or have suffered from: (place a check by conditions that apply to you)

□ Broken or Fractured Bones	□ Osteoarthritis	□ Eating Disorder
□ Circulatory Problems	□ Epilepsy	□ Alcoholism
□ Rheumatoid Arthritis	□ Pace Maker	□ Drug Addiction
□ Seizures/Convulsions	□ Strokes	□ HIV Positive
□ A Congenital Disease	□ Cancer	□ Gall Bladder
□ Excessive Bleeding	□ Ruptures	□ Depression
□ High/Low Blood Pressure	□ Coughing Blood	□ Ulcers

Do you have a history of stroke or hypertension?_____

Have you had any major illness, injuries, falls, auto accidents, or surgeries? Women, please include information about childbirth (include dates):_____

Have you been treated for any health condition by a physician in the last year? ▫Yes ▫No

If yes, describe:_____

Do you have any allergies of any kind? ▫Yes ▫No If yes, describe:_____

Please list any other health problems you have, no matter how insignificant they may be: _____

_____

SOCIAL HISTORY:

Do you drink any alcoholic beverages? ▫Yes ▫No If so, how much per week?_____

Do you use any tobacco products? ▫Yes ▫No Do you smoke? ▫Yes ▫No If so, how many packs per day?_____

Do you take any vitamin supplements? ▫Yes ▫No If so, please list:_____

Do you consume caffeine? ▫Yes ▫No If so, how much per day?_____

Do you exercise? ▫Yes ▫No If yes, what is the frequency and type of exercise?_____

FAMILY HISTORY:

Father: ▫Living ▫Deceased Age if still living:____ Cause of death & age at death if deceased:_____

Mother: ▫Living ▫Deceased Age if still living:____ Cause of death & age at death if deceased:_____

FAMILY DISEASES:

Check if applicable and indicate whether family member is Father, Mother, Sister, Brother:

Tuberculosis ▫F ▫M ▫S ▫B	Cancer ▫F ▫M ▫S ▫B	Mental Illness ▫F ▫M ▫S ▫B
Diabetes ▫F ▫M ▫S ▫B	Asthma ▫F ▫M ▫S ▫B	Heart Disease ▫F ▫M ▫S ▫B
Stroke ▫F ▫M ▫S ▫B	Kidney Disease ▫F ▫M ▫S ▫B	Lung Disease ▫F ▫M ▫S ▫B
Arthritis ▫F ▫M ▫S ▫B	Liver Disease ▫F ▫M ▫S ▫B	Other _____

Please check any and all insurance coverage that may be applicable in this case: ▫Major Medical ▫Auto Accident ▫Worker's Compensation ▫Medicaid ▫Medicare ▫Medical Savings Account & Flex Plans ▫Other

Name of Primary Insurance Company_____

Name of Secondary Insurance Company (if any):_____

AUTHORIZATION AND RELEASE: I hereby instruct and direct _____ Insurance Company to pay directly to Chiropractic Naturally, the professional or medical expense benefits allowable and otherwise payable to me under my current Insurance Policy as payment toward the total charge for professional services rendered. There is a DIRECT ASSIGNMENT OF RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee and I have agreed to pay, in the current manner, any balance of said profession service charges over and above this insurance coverage. I also understand that I am responsible for all cost of chiropractic care, regardless of Insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

Patient Signature:_____ Date:_____

Print Name:_____

Guardian's Signature Authorizing Care:_____ Date:_____

Witness Signature:_____ Date:_____

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PAIN DRAWING

Name:_____ Date:_____

Date of Birth:_____ Examiner:_____

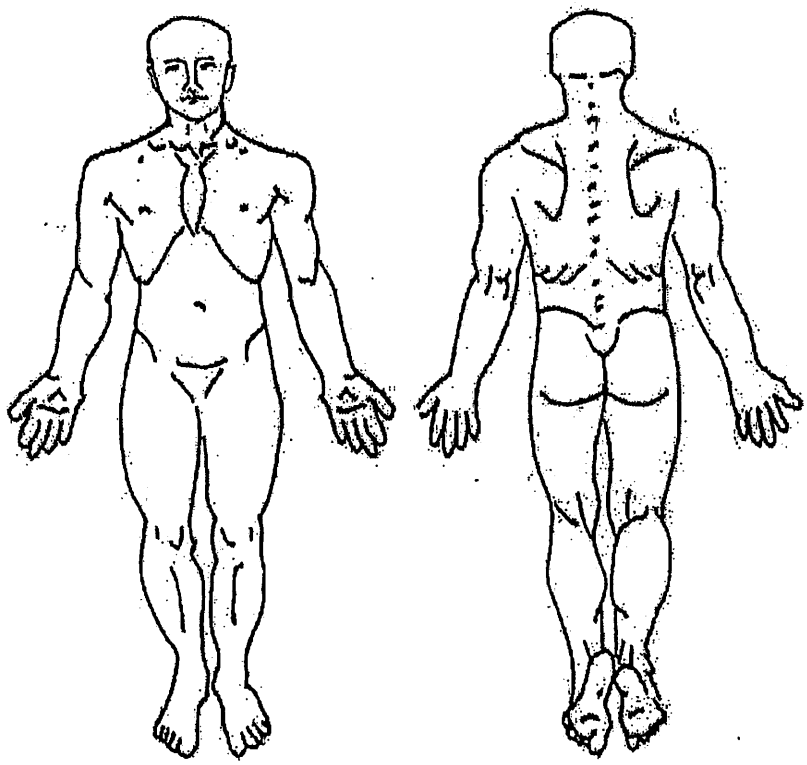
TELL US WHERE YOU HURT

Please read carefully:

Mark the areas on your body where you feel pain. Include all affected areas. Mark areas of radiation. If you pain radiates, draw an arrow from where it starts to where it stops. Please extend the arrow as far as the pain travels. Use appropriate symbol(s) listed below.

Ache >>>>>>>>>>>> Numbness ========== Pins & Needles oooooooo

Burning xxxxxxxxxx Stabbing //////////////// Throbbing ~~~~~~~~~~~~



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Assignment and Instruction for Direct Payment for Private Car Insurance

I hereby instruct _____ Insurance Company to pay by check made out and mailed directly to:

Chiropractic Naturally
Archana Mehta, DC
5537 Sheldon Rd
Suite T
Tampa, FL 33615

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

c/o Chiropractic Naturally
Archana Mehta, DC
5537 Sheldon Rd
Suite T
Tampa, FL 33615

The professional or medical expense benefits allowable and otherwise payable to me under my, as payment toward any deductible or twenty percent or both, not cover by my personal car insurance policy. This payment will not exceed my indebtedness to the above mentioned assignee and I have agreed to pay, in the current manner, any balance of said professional service charges over this insurance payment.

A photocopy of this assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.

Dated on this _____ day of _____ 20___

_____ _____
Signature of Policyholder Witness

_____ _____
Print name Signature of Claimant, if other than policyholder

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Power of Attorney

Power of attorney to endorse checks and/or to sign any piece of paper that 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.

Known by all these present that: the undersigned has made, constituted and appointed, and by these presents hereby make, constitute and appoint Chiropractic Naturally and any of its 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 and all checks, drafts or money orders which are made payable to the undersigned alone or to the undersigned and the said Chiropractic Naturally, which checks, drafts, or money orders are made payable for services which have been made by Chiropractic Naturally at the request or with the knowledge and approval of the undersigned and/or the maker of the check, draft or money order.

Furthermore, the undersigned allows Chiropractic Naturally, 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 or non-ownership of vehicles, insurance forms and other statements.

The undersigned by these presents does give and grant Chiropractic Naturally, 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 chasing of said checks are concerned as well as any other document.

Medical Release

A photocopy of these 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 Chiropractic naturally or any insurer providing coverage to me 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 original signature page.

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

Authorization of Benefits

I, _____, hereby authorize _____
(Name of insured/patient) (Name of insurance carrier)

to make medical benefits payments otherwise payable to me for services rendered by Chiropractic Naturally, but not to exceed the charges of those services, payable to and mailed directly to:

Chiropractic Naturally

5537 Sheldon Rd Suite T

Tampa, FL 33615

Furthermore, I hereby irrevocably assign to Chiropractic Naturally, the rights and benefits under any policy of insurance, indemnity, agreement, or any other collateral source as defined in Florida statues for any service and or charges provided by Chiropractic Naturally.

In witness whereof the undersigned have hereunto set their hands, the _____ day of _____, 20_____.

_____ _____

Patient's name (please print) Patient's signature

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Medical Reports and Doctor's Lien

I do hereby authorize Dr. Archana Mehta/Chiropractic Naturally to furnish you, my attorney, with a full report of the examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was recently involved.

I hereby authorize and direct you, my attorney, to pay directly to the doctor such sums as may be due and owing her for medical services rendered me both by reason of this accident and by reason of any other bills that are due her office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor. And I hereby further give a lien on my case to said doctor against any and all proceeds of my settlement, judgment or verdict which may be paid to you, my attorney or myself, as the results of the injuries for which I have been treated or injures in connections therewith.

I agree never to rescind this document and that a rescission will not be honored by my attorney. I hereby instruct that in the event another is substituted in this matter, that new attorney honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by him.

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

Please acknowledge this letter by signing below. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but will require me to make payments on a current basis.

_____ _____

Patient's signature Date

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict, as may be necessary to adequately protect said doctor above-named.

_____ _____

Attorney's signature Date

_____ _____

Witness' signature Date

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INFORMED CONSENT FORM

I hereby request and consent to the performances of chiropractic treatments and other chiropractic/medical procedures, including various forms of physical therapy and diagnostic x-rays by _____. This consent is extended to other licensed chiropractic physicians, chiropractic assistants and licensed massage therapists, who nor or in the future are employed by, working with or associated with this office.

I certify that I have had the opportunity to discuss with the doctor of chiropractic and/or other office personnel, the nature and purpose of the care that is being provided. I understand that, as in the practice of any of the healing arts, in the practice of chiropractic, there are some risks to treatment including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I also understand that the doctor, who has explained all of these things to me, is not expected to be able to anticipate and explain all the risks and complications. I will rely on the doctor to exercise appropriate judgment during the course of care based on the facts known at this time and in my best interest.

My signature below certifies that I have read or have had read to me the above consent. I also certify that I have had the opportunity to ask questions and options to care have been explained. By signing this consent form, I agree to the care being provided to me for the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

_____	_____
Patient's name (please print)	Witness' name
_____	_____
Patient's signature	Witness' signature
_____	_____
Date	Date
_____	_____
Patient's representative	Patient's representative
_____	_____
Representative's relationship to patient	Translated by
(If patient is a minor or if physically or mentally impaired)	
_____	_____
Doctor's name	Doctor's signature

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NOTICE OF PRIVACY PRACTICE ACKNOWLEDGMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1998 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.

I acknowledge that I have received your Notice of Privacy Practice containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I authorize disclosure of my protected health information for the named individual(s) listed below:

_____	_____
Name	Relationship:
_____	_____
Name	Relationship:

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

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Patient Name: _____

Health Care Authorization Form

The Patient identified above authorizes Chiropractic Naturally to use and/or disclose protected health information in accordance with the following:

. I give permission to Chiropractic Naturally to use my address, phone number, and clinical records to contact me with birthday cards, holiday related cards, recall cards, testimonials, appointment reminders, telephone calls and information about treatment alternatives or other health related information.

. I give permission to Chiropractic Naturally to treat in an open door room. I am aware that the other persons in the office may over hear some of my protected health information during the course of the care. Should I need to speak with the doctor at any time in private, the doctor will provide a room for these conversations.

. By signing this form you are giving Chiropractic Naturally permission to use and disclose your protected health information in accordance with the directives listed above.

EXPIRATION

The authorization shall expire on the following date: _____

RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this authorization, in writing, at any time. However, your written request to revoke authorization is not effective to the extent that we have provided services or taken action in reliance on your authorization.
You make revoke this authorization by mailing or hand delivering a written notice to the Privacy Official of Chiropractic Naturally. The written notice must contain the following: you name, date of birth, a clear statement of your intent to revoke the authorization, the date of your request and your signature.
This revocation is not effective until it is received by the Privacy Official.
This authorization is requested by Chiropractic Naturally for its own use/disclosure of PHI. (Minimum necessary standards apply.)
You have the right to sign this authorization. If you refuse to sign this authorization, Chiropractic Naturally will not refuse to provide treatment.

_____ _____

Patient Signature Date

AUTHORIZATION FOR RELEASE OF HEALTHCARE RECORDS

PATIENT INFORMATION

Name:	DOB:
Address:	

RECORDS RELEASED FROM:

Name:
Address:
Phone#:
Fax#:

RECORDS RELEASED TO:

Name:	CHIROPRACTIC NATUALLY
Address:	13301 Orange Grove Dr. Ste A Tampa, FL 33618
Phone#: 813-963-3055	Fax#: 813-886-0559

INFORMATION TO BE RELEASED:

- ☐ Daily Notes
- ☐ X-Ray films/Reports
- ☐ Verbal communications
- ☐ Consultations/Reports
- ☐ Lab Reports
- ☐ Coding/Billing
- ☐ OTHER_____

PURPOSE OF RELEASE:

- ☐ Patient care
- ☐ At patient's request
- ☐ OTHER_____

EXPIRATION DATE:

- ☐ None
- ☐ DATE: _____/_____/_____

Notice to Patient: Treatment, payment, enrollment or eligibility may not be conditioned on whether the patient signs this form, unless permitted by law.

Notice to Clinic: Always provide the patient with a copy of this signed form.

Authorizing signature: I authorize release of my healthcare records as stated herein. I understand that I have a right to inspect and receive a copy of the disclosed material. This authorization will remain in effect until the expiration date or this request is revoked through written notice submitted to the entity releasing the records. Any revocation is not effective to the extent that the office/clinic has already released records in reliance on this form.

If this form is singed by a person other that the patient, their relationship to the patient and their authority to sign this authorization must be indicted below.

Signature: _____ Date: _____

Relationship or Authority:_____

OFFICE USE ONLY Date received:____/____/____Date processed: ____/____/____ Processed by: _____

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	Date

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

A. I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.

B. 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.

C. 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.

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 (16), 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):*

- ☐ Dr. Archana Mehta, DC
- ☐ Dr. Gwen Pillow, DC
- ☐ Dr. Ashley Sooklal, DC

Name *(PRINT or TYPE)*	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.

DIAGNOSTIC IMAGING CONSULTANTS

A. Scott Thorpe, DC, DACBR, Rudy N. Heiser, DC, MS, DACBR,
Terry Sandman, DC, MPH, DACBR

CHIROPRACTIC NATURALLY
13301 Orange Grove Dr., Tampa, FL 33618, ste. A
PH: 813-963-3055 FAX: 813-886-0559

ARCHANA MEHTA, D.C.
SUSAN YI, D.C.
EMAIL: CHIRONAT2@GMAIL.COM

Films/Date Exposed _____ Medical History _____

If Digital Images: _____Total # sent

Please print and complete form with patient's signature

Patient Name: Last _____First_____ Date of Birth _____Sex __M__F
Address _____ City/State/Zip _____
Phone _____ SS# _____ Case/Acct# _____

BILL: ____ PIP ____ Health/Other Ins. ____DR***. ____Atty. ____Patient

*****If billing doctor it is not necessary to provide insurance info.*

Primary Insurance: _____ Phone _____
Adjuster_____ ID/Claim#_____
Address_____ Insured _____
City/State/Zip_____ Date of Injury____/____/____

Attorney: _____ Phone_____
Address_____ City/State/Zip_____

****

ASSIGNMENT, LIEN AND AUTHORIZATION/INSURANCE BENEFITS

For and in consideration of receiving services by "Assignee" and for other good and valuable consideration, I hereby agree to the following: I authorize assignee to release any information pertinent to my case to any insurance company, adjuster, or attorney to facilitate collection under this Assignment, Lien, Reservation of Benefits and Authorization.

ASSIGNMENT OF BENEFITS, RESERVATION AND REQUEST TO ESCROW ANY DISPUTED BENEFITS:

I HEREBY ASSIGN MY insurance benefits and any and all causes of action available under my policy of automobile insurance to, DIAGNOSTIC IMAGING CONSULTANTS OF ST. PETERSBURG, PA d/b/a DIAGNOSTIC IMAGING CONSULTANTS hereinafter, collectively referred to as the Assignee. Additionally, both the assignee and the undersigned patient acknowledge they are foregoing or assuming certain rights under this agreement that they would not otherwise have under normal circumstances, and as such, agree the same serves as additional consideration for this assignment of benefits to the provider/assignees. In the event my insurance company, obligated to make payments to me upon charges made by assignee for services, refuses to make or reduces such payments and in order to maximize the benefits available under my policy coverage, I hereby request the insurance company (assuming there is coverage remaining at the time the company receives the Assignees' bill and if the company fails to pay Assignee the full amount of the bill(s) submitted), to avoid exhaustion of coverage while Assignee pursues its rights under this Agreement, both parties to this agreement (the Assignee and I) further authorize, direct, notice and request the Insurance Company to set aside and place in escrow an amount equal to the full amount of any such denial or reduction, and to hold that amount in escrow until the dispute is resolved in the appropriate forum.

IN THE EVENT MY insurance company obligated to make payments to me upon the charges made by Assignee for their services refused to make such payments, upon demand by me or Assignee, I hereby assign and transfer to Assignee any and all causes of action that I might have or that might exist in my favor against such company and authorize Assignee to prosecute said cause of action either in my name or in Assignee name and further I authorize Assignee to compromise, settle or otherwise resolve said claim or cause of action as they see fit.

I AUTHORIZE ASSIGNEE to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under this Assignment, Lien and Authorization. I agree that the above mentioned Assignee be given Special Power of Attorney to endorse/sign my name on any and all checks and claim forms for payment of my bill.

I UNDERSTAND THAT I remain personally responsible for the total amounts due the Assignee for their services as insurance coverage may only pay a certain percentage of the bill; as, I may have an insurance deductible or my insurance benefits may exhaust or otherwise be limited. I further understand and agree that this Assignment, Lien and Authorization does not require Assignee to await payments and they may demand payments from me immediately upon rendering services at their option, although the Assignee agrees to first demand immediate payment from the insurance company as their first means of pursuing payment for services rendered. Also, I understand that if this account is assigned to an attorney for collection and/or suit, the assignee shall be entitled to reasonable attorney fees and costs of collection. I also understand that, if any bad check is written, I agree to pay for those added costs.

Dated this ____ day of _____, 20 __.

Patient Signature_____ Printed Name_____ Witness_____