Watts Chiropractic Center 2751 Enterprise Rd, Ste. 103 Orange City, FL 32763
Office: (386) 218 - 4924

PLEASE PRINT CLEARLY

AUTOMOBILE ACCIDENT HISTORY FORM

Full Name _____ Today's Date _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Occupation _____

Sex ☐ M ☐ F Marital Status ☐ S ☐ M ☐ D ☐ W Age _____ DOB ___/___/_____

Race ☐ Caucasian ☐ African American ☐ Hispanic ☐ Asian ☐ Other _____ SSN _____

Referred by: Attorney _____ Insurance _____

Doctor _____ Other _____

HISTORY OF ACCIDENT (check all that apply)

1. Date of Accident _____/_____/_____ Time of Accident _____ Date of Exam _____/_____/_____
2. Description of Accident_____
_____
_____
_____
3. Location of Accident Street _____ City _____ State _____
4. ☐ Driver ☐ Passenger ☐ Pedestrian ☐ Other _____
5. ☐ Traveling ☐ Stopped Facing ☐ N ☐ S ☐ E ☐ W ☐ Unknown Direction
6. **YOUR** Vehicle Type: ☐ Compact ☐ Midsize ☐ Truck ☐ SUV ☐ Van ☐ Semi-truck
7. **OTHER** Vehicle Type: ☐ Compact ☐ Midsize ☐ Truck ☐ SUV ☐ Van ☐ Semi-truck
8. Who was issued the citation? ☐ Nobody, we exchanged insurance info ☐ I was/My Party ☐ Other Party
9. ☐ Stopped and rear-ended ☐ Moving and rear-ended ☐ Slowing down to make stop / turn and rear-ended
   ☐ Head-on collision – other vehicle was traveling other direction ☐ Side swiped **R / L** ☐ Rolled Over
   ☐ Another vehicle ran stop sign / light ☐ lost control of vehicle ☐ Spun around ☐ T-boned **R / L**
10. If rear-ended, did the force of the impact cause your vehicle to collide with another vehicle? Yes No ☐ ☐
11. Road conditions at the time of the accident: ☐ Wet ☐ Dry ☐ Icy ☐ Other _____
12. Approximate speed of **YOUR** vehicle: _____ mph
13. Approximate speed of **OTHER** vehicle: _____ mph
14. Were you wearing a seat belt? Yes ☐ No ☐
15. How far is the top of your headrest or seatback from the top of your head? (measured in inches)
    ☐ 0" ☐ 1" ☐ 2" ☐ 3" ☐ 4" ☐ 5" ☐ 6" ☐ Other _____ ☐ Above ☐ Below
16. Did you strike any objects in the car? ☐ Yes ☐ No
17. If yes, then what? ☐ Steering Column ☐ Rearview mirror ☐ Seat broke ☐ Dashboard
    ☐ Door Frame ☐ Headrest ☐ Jarred or thrown about ☐ Windshield
    ☐ Cannot remember details (dazed) ☐ Other _____

18. What portion of your body did you strike? ☐ Head ☐ Chest ☐ Face ☐ Arms ☐ Hands ☐ Legs ☐ Knees
☐ Shoulder ☐ Hip ☐ Other _____

19. As a result of the accident were you? ☐ Not injured ☐ Cut/bleeding ☐ Bruised ☐ Dizzy ☐ Nausea
☐ Blurred vision ☐ Unconscious ☐ Ringing/buzz in ear ☐ Partially paralyzed ☐ Other _____

20. If cut, bruised and/or partially paralyzed please explain where_____

21. If you experienced immediate pain, please indicate where:

☐ Headache	☐ Left	☐ Right	☐ Neck pain	☐ Left	☐ Right
☐ Upper-back pain	☐ Left	☐ Right	☐ Mid-back pain	☐ Left	☐ Right
☐ Chest Pain	☐ Left	☐ Right	☐ Low-back pain	☐ Left	☐ Right
☐ Arm	☐ Left	☐ Right	☐ Elbow	☐ Left	☐ Right
☐ Knee	☐ Left	☐ Right	☐ Leg	☐ Left	☐ Right

☐ Other _____

22. After the accident, did you? ☐ Go Home ☐ Go to Work ☐ Go about your business ☐ Go to hospital

HOSPITALIZATION

23. If taken to the hospital, how did you get there? ☐ Ambulance ☐ Driven by friend/relative ☐ Drove yourself ☐ Went later

24. If you went later, then when? _____ Name of Hospital _____

25. Were you seen by the emergency room? ☐ Yes ☐ No

26. Were you admitted to the hospital? ☐ Yes ☐ No

27. If admitted how long did you stay? _____

28. Name if the admitting or hospital physician? _____

29. What was done in the emergency room or hospital? ☐ Examination ☐ Stitches ☐ X-rays ☐ Surgery
☐ Physical Therapy ☐ Casting ☐ Cervical collar ☐ Prescription(s) _____
☐ Other _____

30. After being released, what did you do? ☐ Return home to bed ☐ Return to work ☐ Return to emergency room
☐ Other _____

31. When did you first consult the physician? ☐ Same day ☐ Following day ☐ Within a few days
☐ Did not consult one ☐ Other _____

(If patient consulted this office, skip to PAST HISTORY)

32. Who did you consult? Dr. _____ ☐ Family physician ☐ Chiropractor ☐ Orthopedist
☐ Osteopath ☐ Neurologist ☐ Other _____

33. What did the doctor do? ☐ Chiropractic Manipulation ☐ Exam ☐ X-rays ☐ Injections ☐ Traction
☐ Physiotherapy ☐ Prescriptions ☐ Other _____

34. How long were you under this doctor's care? _____

35. Are you still under this doctor's care? ☐ Yes ☐ No

36. Frequency or number of visits now? _____

37. Did the doctor refer you to or have you been to any other physician? ☐ Yes ☐ No

38. Were you sent for an independent medical examination? ☐ Yes ☐ No If yes who? _____

39. Other pertinent information? _____

_____

_____

PAST HISTORY

40. Have you ever been in any other accident of any kind? ☐ Yes ☐ No

If yes give dates and details? _____

_____

_____

41. Were you rendered permanently impaired? ☐ Yes what % _____ ☐ No

42. Has any other physician prior to this accident ever treated you for neck or back problems? ☐ Yes ☐ No

If yes please explain _____

_____

_____

43. Have you ever had previous surgeries or any conditions that I should know about? ☐ Yes ☐ No

If yes please explain _____

_____

_____

44. Were you symptom free and in good health before this accident? ☐ Yes ☐ No

If no please explain _____

_____

_____

PRESENT COMPLAINTS

45. Please list your current problem areas (prioritize with worst being #1)

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

7. _____ 8. _____ 9. _____

46. Have you lost any time from work since the accident? ☐ Yes ☐ No

47. If yes, how many days? _____ Are you still off work? ☐ Yes ☐ No

48. Date returned? _____/_____/_____ Job description _____

49. In what way have your injuries affected your ability to work? _____

_____

50. Have your injuries affected your hobbies and/or recreational activities? ☐ Yes ☐ No

51. If yes, please explain. _____

_____

_____

_____

52. **If you have an attorney representing you, please give name, address, and telephone number.**

Name _____ Firm _____

Address _____ City _____

State _____ Zip _____ Phone _____

Fax _____

53. **Have you filed this with your insurance company?** ☐ Yes ☐ No

Claim Adjuster name: _____

Claim Adjuster's number: ___(_____)_____-_____

Claim Adjuster's Fax _____(_____)_____-_____

Claim Number for your case: _____

Watts Chiropractic L.L.C.
2751 Enterprise Rd, Ste. 103 Orange City, FL 32763
Office: (386) 218 - 4924 * Fax (386) 218 – 4924

To _____

_____

_____

RE: HEALTH RECORDS AND PROVIDER'S LEAN

I do hereby authorize the above provider, Watts Chiropractic L.L.C., to furnish you my attorney, with a full report of this examination, diagnosis, prognosis, etc.; of myself in regard to the injury in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to Watts Chiropractic L.L.C. such sums as may be due and owing them for medical/chiropractic services rendered me both by reason of this injury and by reason of any other bills that are due their office and to withhold sums from and settlement, judgment or verdict which may be paid to me as a result of the injuries for which I have been treated or injuries in connection herewith.

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

I forbid you, my attorney, from paying my provider any sums less than the full amounts owed to said provider, without its written consent.

Dated: ____/____/_____ Patient's Signature: _____

Dated: ____/____/_____ Printed Name: _____

The undersigned being attorney of record for this above patient does hereby agree to observe all of 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 provider above named.

Dated: ____/____/_____ Attorney's Signature: _____

Dated: ____/____/_____ Printed Name: _____

Watts Chiropractic L.L.C.
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ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO PROVIDER

I _____ hereby instruct and direct my insurance company pursuant to Florida Statue F.S.627.422 to pay by check or draft made out to and mailed directly to the above named provider for professional or medical services, and any reimbursements otherwise payable to me under my current insurance policy as payment toward the total charges for professional services me under my current insurance policy as payment toward the total charges for professional services rendered by them. The payment is not exceed my indebtedness to the above name provider.

I hereby assign all rights and benefits that I have under any Group Health, HMO plan, Individual Health, PIP, Disability or any other health or medical plan or policy or reimbursement plan that may pay patient benefits for services and treatment that I have received or will receive from the above named provider.

This assignment includes but is not limited to all rights to collect benefits directly from my insurance company or HMO for those services and treatments that I have received and all rights to proceed against my insurance company or HMO in any action including legal suit if for any reason my insurance company or HMO fails to make payments of benefits that are due to the above named provider. This assignment also includes the right to recover any attorney's fees and costs for such an action brought by the provider as my assignee.

I also agree that the above mentioned provider be given Power of Attorney to endorse/sign my name on any and all checks for payment of services provided by them.

I also authorize the release of any information pertinent to my case or claim to the above name provider or any attorney involved in this case.

A photocopy of this assignment shall be considered as effective and valid as the original.

I hereby authorize the above name provider to file any formal or informal complaints that are necessary to the Insurance Commissioner's Office or any other agency or court they deem appropriate on my behalf.

Dated: ____/____/_____ (CLAIMANT) Patient's Signature: _____

Dated: ____/____/_____ Printed Name: _____

IF POLICY HOLDER (INSURED) IS SOMEONE OTHER THAN PATIENT

Dated: ____/____/_____ Policy Holder's Signature: _____

Dated: ____/____/_____ Printed Name: _____

Watts Chiropractic L.L.C.
2751 Enterprise Rd, Ste. 103 Orange City, FL 32763
Office: (386) 218 - 4924 * Fax (386) 218 – 4924

NAME: _____ PATIENT # _____

PAYMENT POLICIES

1. All first visit charges are payable when services are rendered.
2. At the completion of your first office visit you will be advised as to a time you may return for your second consultation when the doctor will inform you as to your examination results and whether or not you case has been accepted. You will then be advised concerning treatment options, financial arrangements, and insurance coverage as appropriate.
3. Method of payment you plan to use to take care of today's charges? ☐ Cash ☐ Check ☐ Visa/MasterCard

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the office of Watts Chiropractic L.L.C. will prepare any necessary reports and forms to assist in making collections from the insurance company and that any amount authorized to be paid directly to Watts Chiropractic L.L.C. will be credited to my account upon receipt. **HOWEVER, I CLEARLY INDERSTAND AND AGREE THAT ALL SERVICES RENDERED ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT.**

I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered to me will be immediately due and payable. I agree that I will be responsible for all attorney and legal fees if legal action becomes necessary to collect this account. I authorize the office of Watts Chiropractic L.L.C. to obtain a credit report if deemed necessary.

Patient Signature _____ Date _____/_____/_____

PAYMENT POLICIES

I hereby instruct and direct payment to be made payable to and mailed directly to:

Watts Chiropractic L.L.C.
2751 Enterprise Rd, Ste. 103 Orange City, FL 32763
Office: (386) 218 - 4924 * Fax (386) 218 – 4924

In consideration of the services rendered I authorize and direct the payment to the above named a any sum I now or hereafter owe out of the proceeds of any settlement of my case, and/or by any insurance company obligated to reimburse me for the charges for these services. The payment will not exceed my indebtedness to the above mentioned.

A photocopy of this authorization shall be considered as effective and valid as the original. I authorize use of this form for all insurance claims.

Patient Signature _____ Date _____/_____/_____

X-RAY / MEDICAL RECORDS RELEASE

I authorize the release of any medical information necessary to physicians, employers and/or insurance companies which would expedite the process of my insurance claim(s) and also certify that all insurance information given to this clinic is correct and complete

I authorize the taking of photographs and x-rays to be used for treatment purposes.

I authorize the performance of other diagnostic and therapeutic procedures for treatment purposes.

I have requested the release of records of (patient's name) _____ which are a part of the records at (facility) _____

I hereby request and authorize you, your employees and agents to furnish to the person(s) listed below or anyone designated in writing by them, all insurance information, copies of records and reports, including copies of x-rays, and any other information they may request relating to any examination, treatment or opinion concerning any condition that I may have had in the past, now have, or may have in the future.

Dated: ____/____/_____ Patient's Signature: _____

Dated: ____/____/_____ Guardian's Signature: _____

Sign and date
#12 + #13

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

Fold

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

X SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

X SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. _____ 3. _____

2. _____ 4. _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

Fold

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

Mfd. by Medical Arts Press

Call toll-free: 1-800-328-2179

PLEASE PRINT OR TYPE

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

#14710 - Medical Arts Press

Use with Envelope #14145 (gummed) or #14146 (self-seal)

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**)*:

_____	_____	_____
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.

OIR-B1-1571
Pub. 1/2004

Watts Chiropractic L.L.C.
2751 Enterprise Rd, Ste. 103 Orange City, FL 32763
Office: (386) 218 - 4924 * Fax (386) 218 – 4924

Patient Name: _____ Date:____/_____/_____

Date of Accident: ____/____/_____

Name of Insurance Company: _____

Policy #: _____

Name of Adjuster: _____

Phone #: _____

Claim #: _____

Claim Address: _____

Fax #: _____

E-mail Address: _____