WINDMILL HEALTH CENTER

17160 Royal Palm Blvd. Ste. 1 • Weston, Florida • 33326

CONFIDENTIAL PATIENT ENTRANCE INFORMATION
PLEASE PRINT

Date: ____/____/____
Name: _____
SS#: _____ - _____ - _____ Home Phone: _____
Cell Phone: _____ Email: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Birth Date: ___/___/___ Age: _____ Sex: M F Marital Status: M S D W
Occupation: _____ Employed By: _____
Work Phone: _____ Work Address: _____
Spouse's Name: _____ Spouse's Employer: _____
Emergency Contact: _____ Phone: _____
Appt reminders through text messaging? yes ☐ no ☐
List your chief complaints in order of severity and for how long you have been experiencing them:

1. _____ For how long? _____
2. _____ For how long? _____
3. _____ For how long? _____

Have you ever been to a Chiropractor before? Yes No If yes, when?

List doctors consulted for these conditions:

1. _____ Address/Phone: _____
2. _____ Address/Phone: _____

If this is an injury:

1. Work-related? Yes No If yes, have you reported it to your employer?
2. Related to a motor vehicle crash? Yes No
   If this is due to a crash, fill out the appropriate report forms which will be provided to you.

1. ALL FIRST VISIT CHARGES ARE PAYABLE WHEN SERVICES RENDERED.
   NAME OF PARENT OR FINANCIALLY RESPONSIBLE PERSON: _____
2. THE FEE PAID FOR CHIROPRACTIC X-RAYS IS FOR STRUCTURAL ANALYSIS ONLY.
3. METHOD OF PAYMENT YOU PLAN TO TAKE CARE OF TODAY'S CHARGES
   Cash____ Check____ Visa/MC____
4. Do you have any type of insurance? Yes No

FEMALES: Are you pregnant? Yes No Not Sure

Insurance Information

Please provide a copy of your insurance card, driver's license and any secondary insurance information to our front desk.

Insurance Company: _____ Phone #: _____
Member I.D.: _____ Grp. #: _____
Insured's Name: _____ Sex: M F
Insured's Birth Date: ____/____/____ Relationship to Insured: _____
Do you have secondary insurance? □Yes □No

Patient Acknowledgment: I have been given a copy of Windmill Health Center's Notice of Privacy Practice, version effective April 14, 2003. By signing this form, I give my consent to this office's use and disclosure of protected health information about myself for treatment, payment and health care operations, as well as those purposes set forth in the Notice of Privacy.

Signature _____ **Date** _____

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance in my account for any professional services rendered.

Furthermore, I understand that Windmill Health Center will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Windmill Health Center will be credited to my account upon receipt.

However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

I also understand that if I suspend or terminate my care, any fees for professional services rendered me will be immediately due and payable.

I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes in my health insurance status or the above information.

RELEASE & ASSIGNMENT

I authorize release of any information necessary to process my insurance claims and assign and request payment directly to my physician.

Signature: _____ **Date** _____
Print Name: _____
Spouse's Name or Guardian Signature: _____

HEALTH HISTORY

Are you taking any of the following medications?

o Nerve Pills o Pain Killers (including aspirin) o Muscle Relaxers o Stimulants o Blood Thinners o Insulin o Other(s)_____

Do you have or have you ever had any of the following diseases or conditions?

oHeart Attack/Stroke	oHeart Surgery/Pacemaker	oHeart Murmur
oCongenital Heart Defect	oMitral Valve Prolapse	oArtificial Valves
oAlcohol/Drug Abuse	oVenereal Disease	oHepatitis
oHIV/Aids	oShingles	oCancer
oFrequent Neck Pain	oEmphysema/Glaucoma	oAnemia
oHigh/Low Blood Pressure	oPsychiatric Problems	oRheumatic Fever
oSevere/Frequent Headaches	oKidney Problems	oUlcers/Colitis
oFainting/Seizures/Epilepsy	oSinus Problems	oAsthma
oDiabetes/Tuberculosis	oDifficulty Breathing	oChemotherapy
oLower Back Problems	oArtificial Bones/Joints	oArthritis
oDigestive Problems	oRinging in Ears	oNose Bleeds

Please list any other serious medical condition(s) you have or ever had:_____

_____

Please list anything that you may be allergic to: _____

List previous surgeries/treatments with dates: _____

_____

List any PAST serious accidents with dates:_____

_____

Family Health History: _____

_____

Do you: Take supplements or vitamins? Y N Exercise? Y N If yes, describe:

_____

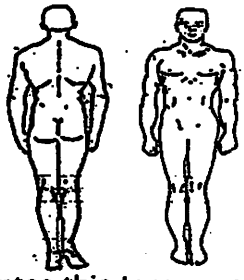
Do you smoke? Y N If yes, how much? _____ How long? _____

Are you wearing: oHeel lifts oSole lifts oInner Soles oArch Supports oOrthotics

Current Weight: _____ **Height:** _____

Women: Are you taking Birth Control? Y N Are you pregnant? Y N If yes, how far along? _____ Are you nursing? Y N

All Patients: Please Mark Problem Area(s):



Is the Pain:

oSharp/Stabbing oAching

oPins & Needles oBurning

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 to the information I have provided.

Signature _____ **Date** _____

NAME: _____ DATE: _____

AUTO RELATED CRASH

Date & Time of Crash: _____
Were you the: □Driver □Front Passenger
□Rear Passenger
If a traffic violation was issued, to whom was it issued?
_____
Number of people in crash vehicle? _____
Did the police come to the crash site? □Yes □No
Was a police report filed? □Yes □No
Were there any witnesses? □Yes □No
Were you wearing your seat-belt? □Yes □No
Was the vehicle equipped with airbags? □Yes □No
If yes, did it/they inflate? □Yes □No
What did your vehicle impact? □Another vehicle □Other
If other, explain:
_____
Did any part of your body strike anything in the vehicle?
□Yes □No If yes, describe: _____
_____
Make & Model of vehicle you were occupying?
_____
Location/Street of crash site? _____
_____
In which direction were you headed? □N □S □E □W
What was the approximate speed of your vehicle? _____
Did the impact to your vehicle come from the:
□Front □Rear □Right Side □Left Side
During impact, were you facing: □Right □Left □Forward
Were you: □Aware OR □Surprised by the impact?
If crash vehicle made impact with another vehicle, what was the Make and Model of other vehicle:
_____
Direction other vehicle was headed? □N □S □E □W
Speed of other vehicle? _____

In your words, please describe the crash:
_____
_____
_____
_____
_____

AFTER INJURY

Did the accident render you unconscious? □Yes □No
If yes, for how long? _____
Please describe how you felt immediately after the crash? _____
_____
_____
Did your symptoms begin: □Immediately
□Later that day □Other If other, when?
_____
_____

Have you gone to a Hospital or seen any other Doctor due to this crash? □Yes □No
When did you go? □Immediately □Next Day □2 days plus
Did you go by: □Ambulance OR □Private Transportation
Name of Hospital and/or Attending doctor:
_____
_____
Was he/she a: □D.C. □M.D. □D.O. □D.D.S. □Other
Describe treatment received: _____
_____
_____
Were X-ray's taken? □Yes □No
Was medication prescribed? □Yes □No
Have you been able to work since this injury? □Yes □No
Are your work activities restricted? □Yes □No

Indicate symptoms that are a result of this accident?

□Dizziness	□Jaw Problems
□Memory Loss	□Arm/Shoulder Pain
□Headache(s)	□Numb Hands/Fingers
□Blurred Vision	□Chest Pain
□Buzzing in Ear	□Shortness of Breath
□Ears Ringing	□Upset Stomach
□Difficulty Sleeping	□Nausea
□Irritability	□Back Pain
□Fatigue	□Low Back Pain
□Tension	□Back Stiffness
□Neck Pain	□Leg Pain
□Neck Stiffness	□Numb Feet/Toes

Other: _____

Is your condition getting worse? □Yes □No
Is the pain: □Constant OR □Comes & Goes

Indicate your degree of comfort while performing the following activities:

	Comfortable	Uncomfortable	Painful
Lying on Back	□	□	□
Lying on Side	□	□	□
Lying on Stomach	□	□	□
Sitting	□	□	□
Standing	□	□	□
Stretching	□	□	□
Walking	□	□	□
Running	□	□	□
Sports	□	□	□
Working	□	□	□
Lifting	□	□	□
Bending	□	□	□
Kneeling	□	□	□
Pulling	□	□	□
Reaching	□	□	□

Other: _____

Have you retained an attorney: □Yes □No
If yes, whom: _____
Phone #: _____

IN ORDER TO DETERMINE WHICH INSURANCE IS RESPONSIBLE PLEASE FILL OUT THE FOLLOWING FORM:

STOP AFTER YOU ANSWER YES TO ANY QUESTION.

DO YOU HAVE AUTO INSURANCE AND IS IT YOUR POLICY?

DO YOU AUTO INSURANCE AND ARE YOU A LISTED DRIVER ON THE POLICY? IF SO, WHAT IS THE POLICY HOLDERS NAME AND D/O/B. DO YOU LIVE IN THE SAME HOME?

DO YOU OWN AN AUTOMOBILE?

DO YOU LIVE WITH A FAMILY MEMBER THAT HAS AUTO INSURANCE?

WERE YOU IN SOMEONE ELSES CAR WHEN DURING THE ACCIDENT AND THAT PERSON HAS INSURANCE ON THE VEHICLE?

WINDMILL CHIROPRACTIC, PA
DBA WINDMILL HEALTH CENTER
17160 ROYAL PALM BLVD. STE 1
WESTON, FL 33326
954-217-4881

ASSIGNMENT OF INSURANCE BENEFITS, RELEASE, & DEMAND

Insurer and Patient Please Read the Following in its Entirety Carefully!

I, the undersigned patient/insured knowingly, voluntarily and intentionally assign the rights and benefits of my automobile Insurance, a/k/a Personal Injury Protection (hereinafter PIP), Uninsured Motorist, and Medical Payments policy of insurance to the above health care provider. I understand it is the intention of the provider to accept this assignment of benefits in lieu of demanding payment at the time services are rendered. I understand this document will allow the provider to file suit against an insurer for payment of the insurance benefits or an explanation of benefits and to seek §627.428 damages from the insurer. If the provider's bills are applied to a deductible, I agree this will serve as a benefit to me. This assignment of benefits includes the cost of transportation, medications, supplies, over due 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 provider in writing within five days of receipt of this document. Failure to inform the provider shall result in a waiver by the insurer to contest the validity of this document. The undersigned directs the insurer to pay the health care provider the maximum amount directly without any reductions & without including the patient's name on the check. The patient agrees, before the services are provided, that the amount the provider charges for services are reasonable, usual and customary. This assignment applies to both past and future medical expenses and is valid even if undated. A photocopy of this assignment is to be considered as valid as the original.

Disputes: The insurer is directed by the provider and the undersigned to not 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 has been a prior written settlement agreed to by the health provider (specifically the office manager) and the insurer as to the amount payable under the insurance policy. The insured and the provider hereby contests and objects to any reductions or partial payments. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by the provider 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 provider to accept a reduced amount as payment in full. The insurer is hereby placed on notice that this provider reserves the right to seek the full amount of the bills submitted. If the PIP insurer states it can pay claims at 200% of Medicare then the insurer is instructed & directed to provide this provider with a copy of the policy of insurance within 10 days. **Any effort by the insurer to pay a disputed debt as full satisfaction must be mailed to the address above, after speaking with the office manager, and mailed to the specific attention of the Office Manager. See Fla. Stat. §673.3111.**

To the extent the PIP insurer contends there is a material misrepresentation on the application for insurance resulting in the policy of insurance is declared voided, rescinded, or canceled, I, as the named insured under said policy of insurance, hereby assign the right to receive the premiums paid for my PIP insurance to this provider and to file suit for recovery of the premiums. The insurer is directed to issue such a refund check payable to this provider only. Should the medical bills not exceed the premium refunded, then the provider is directed to mail the patient/named insured a check which represents the difference between the medical bills and the premiums paid.

EUOs and IMEs: If the insurer schedules a defense physical examination (hereinafter an IME) or examination under oath (hereinafter "EUO") the insurer is hereby INSTRUCTED to send a copy of said notification to this provider. The provider or the provider's attorney is expressly authorized to appear at any EUO or IME set by the insurer. The health care provider is not the agent of the insurer or the patient for any purpose. The provider is authorized and entitled to copy of the IME report and the EUO.

Payment agreement: I agree to pay: for all services; any applicable deductible or co-payment; for services rendered after the policy of insurance exhausts; and for any other services unrelated to the automobile accident in a timely fashion.

Express Consent and Release of information: For the next seven years, I authorize this provider to: furnish an insurer, an insurer's intermediary, the patient's other medical providers, the patient's attorney and hired experts via mail, fax, or email, with any and all information that may be contained in the medical records; to obtain insurance coverage information (declaration sheet & policy of insurance) in writing and telephonically from the insurer; request from any insurer all explanation of benefits (EOBs) for all providers and non-redacted PIP payout sheets; obtain any written and verbal statements the patient or anyone else provided to the insurer; obtain copies of the entire claim file, the property damage file, and all medical records, including but not limited to, documents, reports, scans, notes, bills, opinions, X-rays, IMEs, and MRIs, from any other medical provider or any insurer.

For the next seven years, the provider is permitted to produce my medical records to its attorney and experts in connection with any pending lawsuits. The patient's other medical providers are authorized to sign affidavits and testify justifying the patient's care and treatment. The insurer is directed to keep the patient's medical records from this provider private and confidential. The insurer is not authorized to provide the patient's medical records to anyone without the patient's and the provider's prior express written permission.

The health care provider is given the power of attorney to endorse my name on any check for services rendered by the above provider and to request a copy of any medical records, statements or examinations under oath given by the patient.

Demand: Demand is hereby made for the insurer to pay all bills within 30 days without reductions and to mail the latest non-redacted PIP payout sheet and the insurance coverage declaration sheet to the above provider within 15 days. The insurer is directed to pay the bills in the order they are received. However, if a bill from this provider and a claim from anyone else is received by the insurer on the same day the insurer is directed to not apply this provider's bill to the deductible. If a bill from this provider and claim from anyone else is received by the insurer on the same day then the insurer is directed to pay this provider first before the policy is exhausted. In the event the provider's medical bills are disputed or reduced by the insurer for any reason, or amount, the insurer is to: set aside the entire amount disputed or reduced; escrow the full amount at issue; and not pay the disputed amount to anyone or any entity, including myself, until the dispute is resolved by a Court. Do not exhaust the policy. The insurer is instructed to inform, in writing, the provider of any dispute and when the policy is exhausted.

Certification: I certify that: I have read and agree to the above; I have not been solicited or promised anything in exchange for receiving health care; I have not received any promises or guarantees from anyone as to the results that may be obtained by any treatment or service; and I agree the provider's prices for medical services, treatment and supplies are reasonable, usual and customary.

Caution: Please read before signing. If you do not completely understand this document please ask us to explain it to you. If you sign below we will assume you understand and agree to the above.

Patient's Name _____ Patient's Signature _____

(If patient is a minor, signature of parent/guardian)

Date _____

Windmill Chiropractic
17160 Royal Palm, Suite 1
Weston, FL 33326
954-217-4881
954-217-4991fax

CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of the chiropractic named below, and or licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with serving as back-up for the doctor chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

Have had the opportunity to discuss with the doctor of chiropractic named below and/ or with other office of clinic personnel the nature and purpose of chiropractic adjustments and procedure. I understand that results are not guaranteed.

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

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature **Date**

WINDMILL HEALTH CENTER

NOTICE OF PRIVACY PRACTICES – SHORT FORM

Our practice is committed to educating our patients about healthcare issues that affect them. As a result, we are providing you with general information about the Privacy Rule, a federal regulation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) along with a brief overview of our Notice Of Privacy. Our practice is complying with HIPAA's regulations.

What is the HIPAA and how does the Privacy Rule affect you?
When the Health Insurance Portability and Accountability Act (HIPAA) was passed in August of 1996 this gave the federal government the ability to mandate how healthcare plans, providers, and clearinghouses store and send a patient's personal information as it relates to healthcare. The Privacy Rule was created to protect your rights as a patient of our practice and we are required by law to be compliant with this regulation on April 14, 2003. Under the Privacy Rule you are guaranteed access to your medical records, allowed control over how your protected health information is used and disclosed and allowed to take action if your privacy is compromised by following the practice's policy. Our practice is dedicated to maintaining the privacy of your personal information.

What is Individually Identifiable Health Information (IIHI)?
Any health information you provide our practice, including your mailing address. Information that is created and retained by our practice or received by another healthcare provider that relates to treatment, payment and/or that identifies you as an individual.

What is the Notice of Privacy Practice?
Our practice has an official Notice of Privacy Practice posted in our waiting room informing our patients about their rights surrounding the protection of your IHII and our obligations concerning the use and disclosure of your IHII. This notice applies to all records created or retained by our practice. We can update our Notice of Privacy Practices at any time. It will posted in our waiting room and you can ask for a copy of the current notice at any time.

The following categories describe the different ways in which we may use and disclose your IHII:

Treatment	Appointment Reminders	Release of Information to Family/Friends
Payment	Treatment Options	Disclosure Required by Law
Health Care Operations	Health-Related Benefits and Services	

The following categories describe unique situations in which we may use or disclose your identifiable health information:

Public Health Risk	Health Oversight Activities	Lawsuits and Similar Proceedings
Deceased Patients	Organ and Tissue Donation	Serious Threats to Health or Safety
Military	National Security Inmates	Worker's Compensation
Law Enforcement	Research	

What are your rights concerning your individually Identifiable Health Information (IHII)?
You have rights regarding the IIHI that we maintain about you. In our Notice of Privacy you can view the policies and procedures you will need to follow for the areas listed below.

1. Confidential Communications
2. Requesting Restrictions
3. Inspection and Copies
4. Amendment
5. Accounting of Disclosures
6. Right to a Paper Copy of This Notice
7. Right to File a Complaint
8. Right to Provide an Authorization for Other Uses and Disclosures

If you have any questions regarding this notice or our health information privacy policies, please inform us.

Windmill Health Center
17160 Royal Palm Blvd. Ste. 1
Weston, FL 33326
954-217-4881
954-217-4991fax

RECORDS RELEASE REQUEST

I, _____give permission for the release of my records from _____. I hereby request that all written reports and records pertaining to the automobile accident of _____be faxed to Windmill Health Center/Windmill Chiropractic, P.A. at 954-217-4991.

These records can also be emailed to Windmillhealth@att.net.

Patient Info

Name: _____

Date of Birth: _____

SS# _____

Date of Service: _____

_____
Patient or Legal Signature

_____
Witness

Date: _____