BACK TO HEALTH WELLNESS CENTER, INC
PATIENT INFORMATION

Please help me provide you with a thorough evaluation by completing all the forms I have given you. All the information you make available will be absolutely confidential.

YOUR NAME		**Today's Date**	
Age **Birth Date**		**S.S.#**	
Street	**City**	**State**	**Zip**
Home Phone	**Cell Phone**		
Email Address			
Marital Status ❑M ❑D ❑W ❑S	**Number of Children** **Ages**		
Emergency Contact:	**Name**	**Phone#**	

Who Are You Here To See? ❑Chiropractor (Dr. Kuskin) ❑Physical Therapist (Karen Philhower)

How did you hear about us? Referred By:_____ ❑Yellow Pages ❑News Paper Ad ❑Sign ❑Internet ❑Insurance Plan/Book ❑Insurance Plan/Internet ❑Google

Name of Insurance company? ❑ N/A

Describe your primary complaint. _____

_____

_____

Who is your primary care physician? _____

Is this your first experience with chiropractic? ❑Yes ❑No ❑NA *If no, when was your last adjustment*_____

How long have you had this condition?_____

What kinds of treatments have you tried?_____

Have you ever been diagnosed with a herniated disc? ❑Yes ❑No What level?_____Date of most recent MRI_____

Has condition been getting better, worse or the same since it began?_____

Have you ever had similar condition in the past? ❑Yes ❑No How often? _____

Accidents or Injuries *(describe; state when occurred)* _____

_____

_____

General	

Occupation _____ Stress Factors ❑physical ❑psychological ❑chemical

Do you follow a regular exercise program? ❑Yes ❑No

Alcohol per day _____	Tobacco per day _____ # of Years _____	Do you have diabetes? ❑Yes ❑No

Recreational Drugs ❑Yes ❑No	Type _____	Quantity _____

Current Conditions	

Please put a check next to any conditions you have experienced within the last 3 months. ***CONTINUED ON BACKSIDE*

General	❑no complaints ❑weakness ❑fatigued ❑fever ❑chills ❑night sweats ❑fainting ❑flushed face

Head	❑no complaints ❑Injuries ❑headaches ❑poor memory ❑dizziness ❑lumps/bumps
Eyes	❑no complaints ❑corrective lenses ❑color blindness ❑eye pain ❑cataracts ❑excessive tearing ❑eye dryness *Date of Last Exam*_____
Nose	❑no complaints ❑bleeding ❑loss of smell ❑nasal discharge ❑post nasal drip ❑sinus surgery
Ears	❑no complaints ❑discharges ❑pain ❑loss of hearing ❑ringing
Mouth/Throat	❑no complaints ❑bleeding gums ❑difficulty swallowing ❑loss of taste ❑ulcers ❑sores ❑TMJ ❑bad breath ❑sore throat ❑hoarsness
Skin and Hair	❑no complaints ❑color changes ❑nail changes ❑hair changes ❑moles ❑rashes ❑sores ❑ ❑hives ❑ulcerations ❑bruise easily ❑recent cuts/bruises
Muscles and Bones	❑no complaints ❑stiff neck ❑pain in neck ❑upper back ❑lower back pain ❑sciatica ❑shoulder ❑elbow ❑hands ❑hips ❑knees ❑foot/ankle ❑muscular pains ❑muscle weakness
Lung *Now or in the past*	❑no complaints ❑asthma ❑trouble breathing ❑coughing with phlegm ❑dry cough ❑chest pain ❑tightness in chest ❑wheezing ❑shortness of breath *Other*_____
Heart *Now or in the past*	❑no complaints ❑high blood pressure ❑low blood pressure ❑open heart surgery ❑aneurysm ❑palpitations ❑varicose veins ❑bleed easily ❑chest discomfort ❑ankle swelling
Digestion System *Now or in the past*	❑no complaints ❑vomiting ❑IBS ❑indigestion ❑distention of abdomen after eating ❑problems with fatty or oily foods ❑constipation ❑diarrhea/loose stools ❑gas
Psychological	❑no complaints ❑loss of control/violence potential ❑depression ❑treated for emotional problems in the past ❑ever considered suicide or attempted suicide ❑easily susceptible to stress
Females Only	

Do you use birth control? ❑Yes ❑No	What type?_____	How long?_____
Painful or tender breasts? ❑Yes ❑No	Do you have breast implants? ❑Yes ❑No	
❑Irregular ❑light ❑heavy menstrual flow? ❑No	Painful Menses? ❑Yes ❑No	
❑Premature Births ❑Miscarriages ❑Abortions? ❑No		
Age menstrual cycle started_____	Age menstrual cycle stopped_____	

Cancer	Have you ever been diagnosed with cancer? ❑Yes ❑No (include skin cancer) When _____	Type and Location	Current Status

Please List Surgeries _____

_____

Family Health

Describe mother's health briefly _____

Describe father's health briefly _____

I declare that the information provided on this form is accurate and complete to the best of my recollection. I will inform the doctor if any other facts about my condition come to mind during the time I am in active care at this office.

Signed Date

❑Parent or ❑Guardian

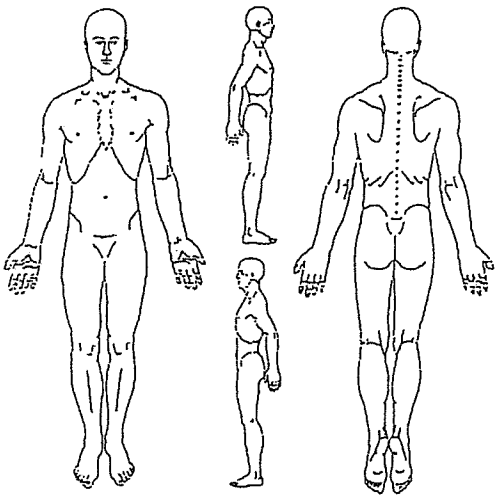
Witness _____

BACK TO HEALTH WELLNESS CENTER

HISTORY OF INJURY FROM MOTOR VEHICLE CRASH

YOUR NAME _____ Date _____ Injury Date _____

☐Driver ☐Passenger (☐Front seat ☐Rear seat ☐R ☐L) Anyone else in your vehicle with you ☐Y ☐N
What area of your car was struck: ☐Rear ☐Front ☐Driver Side ☐Passenger Side
☐Front Right Oblique ☐Front Left Oblique ☐Rear Right Oblique ☐Rear Left Oblique
Road conditions at time of crash ☐Dry ☐Wet ☐Ice ☐Sandy
What was the size, make, model and year of the vehicle that struck your vehicle_____
_____
What is the make, model and year of your vehicle_____
What approximate speed was the other vehicle traveling when it hit you
At time of impact was your vehicle moving (at what speed_____) ☐straight ☐turning ☐right ☐left
☐stopped - did you have your foot on the break ☐Y ☐N
Were your tires in the ☐straight ahead position or ☐turned to the ☐right or ☐left and to what degree_____
After the impact was your vehicle pushed ☐forward ☐backward ☐straight ☐spun to the ☐right ☐left
Did your car strike anything else_____Did your vehicle need to be towed? ☐Y ☐N
Car equipped with ☐shoulder/lap belt harness ☐lap harness only ☐shoulder harness only
and was ☐on ☐off; ☐did or ☐failed to restrain you.
Car equipped with headrests that were positioned ☐correctly ☐incorrectly _____
Headrest was ☐inches above and away from the top of your head _____
☐inches below and away from the top of your head _____
Your seat ☐was ☐was not in the full upright position ☐Seat back broke upon impact
Angle of the back of your seat was more than 90 degrees or slanting back position ☐Y ☐N
☐ Vehicle equipped with airbag ☐Y ☐N
Air bag ☐ did ☐ didn't deploy causing injury to_____
Patient's head was ☐ Straight ahead ☐Up degrees _____☐ Down degrees_____
☐ Right degrees_____☐ Left degrees_____ ☐Combination _____
Your body was out of position (explain)_____
You ☐did ☐did not see accident coming ☐did ☐did not have time to brace for impact
You ☐cannot remember ☐did not ☐did strike body part ☐head ☐face ☐shoulder (☐R ☐L) ☐knee (☐R ☐L) ☐chest ☐hip (☐R ☐L) ☐ankle (☐R ☐L) ☐foot (☐R ☐L) ☐wrist (☐R ☐L) ☐hand (☐R ☐L) ☐elbow (☐R ☐L)
With ☐steering wheel ☐door ☐dashboard ☐windshield ☐airbag ☐rearview mirror ☐other
You ☐did ☐did not lose consciousness_____
You ☐were ☐were not cut or bleeding _____
☐did ☐did not have broken bones _____



Scale 1 to 10 — 10 being the worst pain ever felt

PRIOR TO THIS INJURY

Previous automobile crashes ☐Y ☐N ☐See Attachment
Any other accidents in the past ☐Y ☐N _____
Have you ever had cancer? ☐Y ☐N _____
Does your pain ever wake from a sound sleep? ☐Y ☐N
Are you losing weight now without trying? ☐Y ☐N
Are you coughing up blood or noticing it in your stools or urine? ☐Y ☐N
Have you had any loss of bladder or bowel control? ☐Y ☐N
Have you lost consciousness recently? ☐Y ☐N _____
Concerning your vision, have you had double vision or problems with seeing recently? ☐Y ☐N
Are you having any problem with swallowing? ☐Y ☐N
Are you seeing any other doctor now for any reason? ☐Y ☐N _____
Do you have any other symptoms or health problems? ☐Y ☐N _____
Are you taking any medications or over-the-counter drugs now? ☐Y ☐N _____
Have you been sick or had an infection lately? ☐Y ☐N _____
Is there any chance that you are pregnant now? ☐Y ☐N
Have you recently been injured prior to this injury? ☐Y ☐N _____
Sleep ☐restful ☐restless ☐6-8 hrs ☐8-10 hrs _____
Job description _____
_____
_____
School activities _____
_____
Daily living _____
_____
_____
Drug use: smoker _____ alcohol _____
pain killers _____ muscle relaxants
other _____
Hobbies _____
_____

PRESENT TIME

☐N/A Anyone else in your car injured ☐Y ☐N _____
_____
When did your symptoms first appear _____
Has your symptoms changed since the time of the accident until now *(are the symptoms in a different location, intensity or frequency)* _____
_____
_____
Did you go to the hospital ☐Y ☐N How did you get there _____
How long was the hospital stay _____
What was done at the hospital _____
What were the results _____
How did you leave the hospital _____
Who drove _____
Has there been any visual disturbances ☐Y ☐N _____
Ringing in the ears ☐Y ☐N
Memory loss ☐Y ☐N _____
Emotional changes ☐Y ☐N _____

At the time of the present accident did you feel:
☐Y ☐N Dazed ☐Y ☐N Disoriented ☐Y ☐N Confused

Post-Concussion Syndrome-Symptoms

1.☐Y ☐N Light Headedness	6.☐Y ☐N Phonophobia (affected by sounds)	11.☐Y ☐N Forgetfulness
2.☐Y ☐N Vertigo/dizziness	7.☐Y ☐N Tinnitis (ringing in the ears)	12.☐Y ☐N Impaired logical thought
3.☐Y ☐N Neck Pain	8.☐Y ☐N Impaired memory	13.☐Y ☐N Difficulty with new or abstracted concepts
4.☐Y ☐N Headache	9.☐Y ☐N Easy distractibility	14.☐Y ☐N Insomnia (difficulty in sleeping)
5.☐Y ☐N Photophobia (affected by light)	10.☐Y ☐N Impaired comprehension	15.☐Y ☐N Easy fatigability
16.☐Y ☐N Apathy	17.☐Y ☐N Outbursts of anger	18.☐Y ☐N Mood swings
19.☐Y ☐N Depression	20.☐Y ☐N Loss of libido	21.☐Y ☐N Personality change

Please List All Prescription Medications You Currently Take:

(continue on back if not enough room)

Name	Dosage	Frequency
Ex. Nexium	20mg Capsule	Once per day

Allergies to Medications:_____

OPEN ENVIRONMENT NOTIFICATION

This office has patients treated in an "open environment" – not behind closed doors (except for chiropractic and massage). Please check here to indicate that you understand and accept this policy. If privacy is an issue, you may discuss this with your treating professional.

☐ **Yes, I understand and accept this policy.**

Patient Signature:_____Date:_____

Print Name:_____

PATIENT PRIVACY

This form states that Back To Health Wellness Center has a patient privacy policy and the patient has been informed that he/she may obtain the complete patient privacy policy at any time.

Patient Signature:_____ Date:_____

Print Name:_____

BACK TO HEALTH WELLNESS CENTER
HIPPA/OSHA POLICY ON ELECTRODES

Please be aware that you may incur a one time $9.00 charge if electrodes are used during therapeutic modalities as prescribed by your healthcare provider. We will house the electrodes for you in the office, but they are yours.

This is not covered by any health insurance program. Please be aware that Back To Health Wellness Center is giving these electrodes to you at cost. We wish to provide you with the best, most sanitary care while conforming to all HIPPA and OSHA requirements.

Sincerely,

Robert I. Kuskin, D .C.
Karen Philhower, P.T.

Please Initial:_____

Back to Health Wellness Center, Inc.

Patient Name:_____Date: _____

Consent for Telephonic or Other Communication

(This consent is intended to satisfy and comply with the requirements of Florida Statute 501.059, if applicable.)

This consent authorizes the following, including, but not be limited to: patient appointment reminders, available appointment openings, urgent notifications regarding changes in office hours (such as inclement weather or illness), or office news. It also includes telephonic sales calls by telephone call, text message, voicemail transmission to deliver or cause to be delivered a telephonic sales call using an automated system for the selection and/or dialing of telephone numbers, the playing of a recorded message when a connection is completed to a number called, or the transmission of a prerecorded voicemail.

By executing this agreement, I hereby authorize Back to Health Wellness Center, Inc. to deliver or cause to be delivered telephonic sales calls to the undersigned at the below telephone number and/or email address using an automated system for the selection and/or dialing of telephone numbers or the playing of a recorded message when a connection is completed to the number called.

Signator is not required to directly or indirectly sign this written agreement or to agree to enter into such an agreement as a condition of purchasing any property, goods, or services.

Signature: _____

Authorized telephone number for calls and texts:_____

Authorized email for communications: _____

OR

I decline to receive phone calls or texts: _____(signature)

I decline to receive emails:_____(signature)

BACK TO HEALTH WELLNESS CENTER
DISCLOSURE & CONSENT FOR
CHIROPRACTIC ADJUSTMENTS AND CARE

TO THE PATIENT: You have a right as a patient to be informed about your condition, the recommended chiropractic treatment, and the potential risks involved with the recommended treatment. This will allow you to make an informed decision whether or not to undergo the treatment. This information is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to treatment.

I request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays. The chiropractic treatment may be performed by Dr. Robert Kuskin and/or other licensed Doctors of Chiropractic working at Back to Health Wellness Center, Inc.. Chiropractic treatment may also be performed by a Doctor of Chiropractic who is serving as a backup for the Doctor of Chiropractic named below.

I have had or will have the opportunity to discuss with the Dr. Kuskin, my diagnosis, the nature and purpose of my chiropractic treatment, the risks and benefits of my chiropractic treatment, alternatives to my chiropractic treatment, and the risks and benefits of alternative treatment, including no treatment at all.
I understand, and I am informed that, there are some risks to chiropractic examination and treatment including, but not limited to:

Increased symptoms and pain	fractures (broken bones)
spinal or disc injuries	no improvement of symptoms or pain
dislocations	stroke
sprains/strains	

I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of treatment as to which risks and complications are significant. I also understand that no guarantees or promises have been made to me concerning the results expected from the treatment.

I have read, or have had read to me, the above consent. I have also had or will have an opportunity to ask questions. All of my questions have or will have been answered to my satisfaction. By signing below, I consent to treatment. 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.

To be completed by the patient:

_____
print name

_____
signature of patient

_____
date signed

To be completed by the patient's representative:

_____
print name of patient

_____
print name of patient's representative

_____
signature of patient's representative

as:_____
relationship/authority of patient's representative

_____
date signed

To be completed by doctor or staff:

_____
witness to patient's signature

_____
translated by

_____
date

_____
date

BACK TO HEALTH WELLNESS CENTER
OFFICE FINANCIAL POLICY

Our policy is to extend to you the courtesy of allowing you to assign your insurance benefits directly to us. This policy reduces your out-of-pocket expense and allows you to place your family under care.

1) **If you do not have insurance:** All payments are expected at the time of service or on an authorized payment plan. Your personal balance may not exceed $100 at any time or care may be terminated. We provide multiple payment options to make care an affordable part of your family budget. If you have a problem with payment please let us know, we will work with you.

2) **If you have insurance:** All deductibles and co-payments are expected at the time of service or on an authorized payment plan. Your co-insurance balance may not exceed $100 at any time or care may be terminated. We provide multiple payment options to make care an affordable part of your family budget. If you have a problem with payment please let us know, we will work with you.

   You are considered a cash patient until your insurance is verified and we get our first explanation of benefits from your insurance company. We will accept assignment for most secondary insurance carriers.

   Our fees are considered usual, customary, and reasonable by most companies, and therefore are covered up to the maximum allowance determined by each insurance carrier. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard of care in this area.

   If your carrier has not paid a claim within sixty (60) days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid within ninety (90) days of submission, you accept responsibility for payment in full of any outstanding balance and authorize us to use your credit card to collect full payment.

   If you discontinue care for any reason other than discharge by the doctor, all balances will become due and payable in full by you, regardless of any claim submitted.

Patient's printed name:_____

Signature:_____ Date:_____

ASSIGNMENT OF BENEFITS, AUTHORIZATION TO SETTLE CLAIM AND DIRECTION TO PAY MEDICAL PROVIDER DIRECTLY

By my signature below, for good and valuable consideration (including but not limited to the extension of credit to me), I hereby assign, transfer and convey to Back to Health Wellness Center, Inc. and/or Robert I Kuskin, D.C. (hereinafter "the Provider") All of my rights, title and interest in and to medical expense reimbursement in whatever form, including but not limited to any automobile liability medical expense payments or other health benefits indemnification and/or agreement otherwise payable to me. This payment shall not exceed my indebtedness to the above-named assignee and I acknowledge that I will timely pay any indebtedness owed by me to the assignee that is not otherwise satisfied by the above-mentioned assigned proceeds. I also acknowledge that any medical expenses not covered under my insurance policy will be my responsibility.

I further authorize the provider to negotiate, collect and settle any claim with any insurance carrier or other third-party payer with regard to these services, which authorization shall include authority to: 1) request and receive from any insurer or any other party any and all documentation and records that I am empowered to request regarding this claim, including, without limitation, a statement of coverage, policy declarations page and insurance policy pursuant to Section 627.4137. In addition, the provider has the authority to request and receive any Independent Medical Examination report, notices sent to me regarding appointments for Independent Medical Examinations and Examinations Under Oath (including proof of mail), Records Review Reports, coverage denial letters, Explanation of Benefits, and Benefit Payment Sheets or logs (P.I.P. Payout Sheets), without regard as to whether such documentation has already been provided to me and 2) to endorse in my name any check issued for payment where benefits were assigned. By way of this assignment and notice, I further instruct you, the insurer, to furnish to provider copies of all future notices affecting providers interest in this claim, including, without limitation, any notices of requested medical examinations or statements.

The Provider hereby 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.

I further direct my insurer to direct all payments for services rendered by the Provider directly to Provider at the billing address contained on Provider's medical bills.

THIS IS A DIRECT AND A REVOCABLE ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER MY POLICY OF INSURANCE.

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

I have read the foregoing and understand and agree to each of the above provisions:

_____ _____

Patient's signature Date

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.