

INITIAL PATIENT QUESTIONNAIRE

NAME: _____ DOB: ____/____/____ AGE: ____ SSN: ____/____/____ SEX: M / F

Home Address: _____
Street City State Zip

Phone: (H) _____ (Cell) _____ Email: _____

Marital Status: _____ Occupation: _____ Employer: _____

Emergency Contact & Relation: _____ Phone: _____

PATIENT INFORMED CONSENT

State law requires offices to obtain your informed consent prior to examination and treatment. The purpose of this form is to inform you. What your being asked to sign is simply a confirmation that you have been informed of the following.

EXAMINATIONS

X-RAYS: This office uses highly sensitive x-ray film, intensifying screens and filters that provide high quality x-rays with the lowest possible x-ray exposure. The only risk with taking x-rays deals with pregnancy. If there is any possibility that you are pregnant, inform us prior to any x-ray procedure. If there is no possibility of this condition, the risks are so rare we have no available statistics to qualify their probability.

TREATMENT

Chiropractic adjustment/manipulation: The doctor will use his hands or a mechanical device upon your body in such a way as to move your joints in various directions. This procedure may cause an audible "pop" or "click" to be heard coming from your joints, this is not a cause for alarm. There are some material risks involved in doing these procedures they are as follows:

Pain: Chiropractic treatments may result in a temporary increase in soreness in the area receiving treatment.

Rib Fractures: Fractures caused by chiropractic treatments are rare. They occur most frequently in patients with osteoporosis or weakened bones. Evidence of osteoporosis can be noted on your x-rays, and if detected, the most appropriate and gentle treatments are used, minimizing the possibility of fractures to the ribs.

Disc Injury: Chiropractic treatment is appropriate for the treatment of many kinds of back problems, including some disc problems.* Occasionally, chiropractic may aggravate or cause a problem if the disc is in a severely weakened state. However, this occurs so rarely that statistics to quantify the probability are unavailable, but estimates place risk of serious injury at about 1 serous complication per 100 million low back manipulations.**

Stroke: The overall incidence of stroke in the general population is about 2 per 1000 people.*** Although chiropractic adjustment/manipulation has been implicated as a possible cause of stroke, this possibility is extremely rare. The best available data suggests that stroke secondary to chiropractic adjustment/manipulation may occur in 1 per 100,000 patients **** - a rate well below the overall average risk in the general population. In comparison, the overall average risk of death from taking non-steroidal anti-inflammatory drugs (aspirin, Ibuprofen, Naproxen sodium, etc.) is 4 per 100,000 patients.***** The risk of serious complication or death from spine surgeries of the neck is 11.25 per 1000 patients.***** As you can see, the risk of stroke from chiropractic treatments is much lower than other common medical treatments. Even though the risk is small, we have implemented procedures and test that will likely reduce the potential for stroke even more.

Chiropractic is a system of health care delivery. As with any health delivery system we cannot promise a cure for any symptom, disease, or condition as a result of treatment in this office. We will always give you our best care, and if your results are not acceptable, we will refer you to another health care provider who we feel will assist your situation.

If you have any questions on the above information, please ask the doctor. When you have a clear understanding, please sign and date below.

I HAVE READ OR HAVE HAD READ TO ME THIS CONSENT FORM AND I HAVE BEEN INFORMED OF THE MOST LIKELY COMPLICATIONS, OF THE POSSIBLE UNDESIREED RESULTS OF CHIROPRACTIC EXAMINATION AND TREATMENT IN THIS OFFICE AND UNDERSTAND THEM. I HEREBY AUTHORIZE AND DIRECT DR. COBB AND HIS ASSOCIATES OR ASSISTANTS TO PROVIDE SUCH ADDITIONAL SERVICES AS THEY MAY DEEM REASONABLE AND NECESSARY.

Patient's Signature _____ Date _____

Patient's Printed Name _____ Date _____

Parent's/Guardian's Signature _____ Date _____
If patient is less than 18 years of age.

Parent's/Guardian's Printed Name _____ Date _____

References

- * Troyanovich SJ, Harrison DE. Low Back pain and the lumbar intervertebral disc: Clinical considerations for the doctor of chiropractic.
- ** Shekelle PG, Spine update: Spinal Manipulation, Spine 1994; 19: 858-86
- *** Clayman CB. The American Medical Association Home Encyclopedia. New York: Random House: 947-948
- **** Dabbs V, Lauretti WJ. Risk Assessment of Cervical Manipulation vs. NSAIDS for the treatment of neck pain. J Manipulative Physiol Ther 1995; 18:530-536.
- ***** Harwitz EI, Aker PD, Adams AH, Meeker WC, Shekelle PG. Manipulation and mobilization of the cervical Spine: A systematic review of the literature, Spine 1996; 21: 1746-1760.

HISTORY OF ACCIDENT

Date of Accident: ___/___/___

Time of Accident: _____ AM/ PM

Where were you seated: _____

Make/ Model of vehicle you were occupying: _____

Location where the accident occurred: _____

Approximately how fast were you traveling when the accident occurred? _____ MPH.

Make/ Model of other vehicle(s) involved: _____

In your own words, briefly describe the accident: _____

At the time of the accident, which way were you facing? Forward? Turned? _____

Were you surprised by the accident? **Y / N** Were you wearing a seatbelt? **Y / N**

Did the airbags deploy? **Y / N** Were you rendered unconscious? **Y / N**

Were the police notified? **Y / N** Was a report filed? **Y / N** With who? _____

How did you feel immediately following the accident? _____

Is the pain: ___ Getting better ___ No Improvement ___ Getting Worse

Did you go to the hospital? **Y / N** Where: _____ How: _____

Were X-rays/ CT / MRI performed? **Y / N** Which? _____

Were you prescribed medication? **Y / N** Which? _____

Have you seen another doctor for this injury? **Y / N** Who? _____

Have you been able to work since the accident? **Y / N** Why? _____

What could you do before the accident that you are now unable to do? _____

Do you have an attorney? **Y / N** Who? _____

Patient Signature

Date

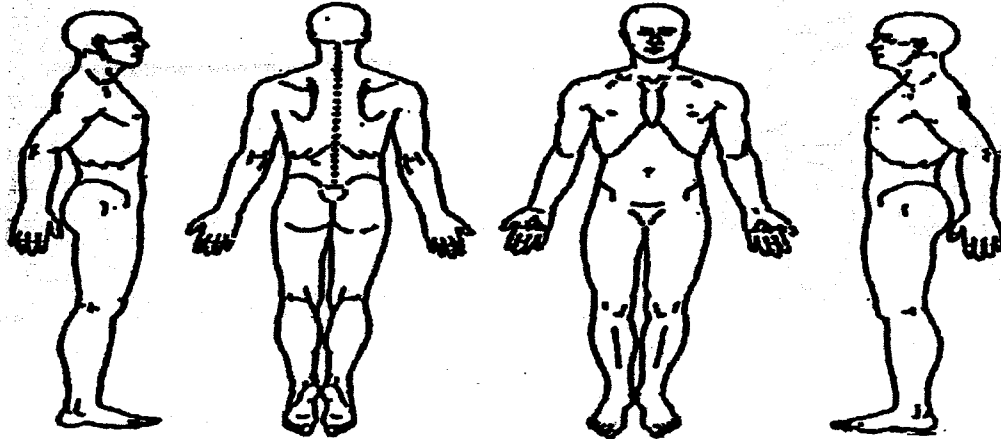
PATIENT INTAKE FORM

Patient Name: _____

Date: _____

1. Is today's problem caused by: Auto Accident Workman's Compensation

2. Indicate on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?

- Constantly (76-100% of the time) Occasionally (26-50% of the time)
 Frequently (51-75% of the time) Intermittently (1-25% of the time)

4. How would you describe the type of pain?

- Sharp Numb
 Dull Tingly
 Diffuse Sharp with motion
 Achy Shooting with motion
 Burning Stabbing with motion
 Shooting Electric like with motion
 Stiff Other: _____

5. How are your symptoms changing with time?

- Getting Worse Staying the Same Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (Please circle)

7. How much has the problem interfered with your work?

- Not at all A little bit Moderately Quite a bit Extremely

8. How much has the problem interfered with your social activities?

- Not at all A little bit Moderately Quite a bit Extremely

9. Who else have you seen for your problem?

- Chiropractor Neurologist Primary Care Physician
 ER physician Orthopedist Other: _____
 Massage Therapist Physical Therapist No one

10. How long have you had this problem? _____

11. How do you think your problem began?

12. Do you consider this problem to be severe?

- Yes Yes, at times No

13. What aggravates your problem?

14. What concerns you the most about your problem; what does it prevent you from doing?

**ASSIGNMENT OF BENEFITS,
LIENS AND DIRECT PAYMENT AUTHORIZATION**

MEDICAL PROVIDER: **Cobb Rehab and Wellness** (formerly Bode Spinal Center)
4209 E. Busch Blvd.
Tampa, FL 33617
(813) 914-8500

INSURANCE COMPANY: _____

For and in consideration of the above-mentioned provider agreeing to pursue my insurance provider for payment of benefits due me and not requiring prepayment for services. I hereby irrevocably assign to the aforementioned medical provider (the "Provider") any Personal Injury Protection benefits I may have in accordance with Florida Statute 621.736(3). This includes any benefits from my insurance company or any other entity that may be responsible for expenses incurred, and I authorize the 'Provider' to prosecute said action and collect legal expenses as they see fit. THIS DOCUMENT CONSTITUTES AN ASSIGNMENT OF BENEFITS. I hereby further give a lien to the 'Provider' against any and all insurance benefits named herein, and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by the 'Provider'. This is to act as an irrevocable assignment of my rights and benefits to the extent of the services provided. I agree to cooperate with the 'Provider' and any attorney that the 'Provider' chooses, and to do all things reasonable to effect payment of the bills by the insurance company to the 'Provider' including, but not limited to, disclosing patient's medical condition and treatment. This assignment concerns only the bills for the 'Provider' and those costs (including, but not limited to attorney's fees, court costs and interest) necessary in procuring payment from the above-named insurance company, etc. This assignment is not intended to assign any other causes of action that any belong to the undersigned patient. I agree to pay any applicable deductible or co-payment not covered by the PIP insurance coverage. I understand that this is a benefit and convenience to me in that the provider will pursue collection against the insurance company on my behalf I hereby instruct and direct my insurance company to pay my benefits by check made payable to and mailed to the 'Provider' at the address listed above, if my current policy prohibits direct payment to doctors, then I hereby instruct and direct my insurance company to make the check payable to me and mail it to the 'Provider' at the address listed above, if this 'Provider' is providing medical care related to an auto accident, 'Provider is charging a reasonable fee for necessary care related to the accident and these bills should be paid to the full extent of the benefits available under my policy of insurance. If any portion of any charge for these services is either reduced or denied in whole or in part, both the provider and the insured request that my insurance company place funds equal to the amount of the reduced or denied charges into escrow. My insurance company is to hold the escrowed funds for 'Provider', until such time as all escrowed funds are paid to 'Provider', or 'Provider' instructs my insurance company that 'Provider' is no longer making any claim to the escrowed funds. Furthermore, I hereby give the 'Provider' limited power of attorney to endorse/sign my name on any and all checks for payment to the 'Provider'. This agreement is intended to serve as an assignment of the patient's rights and benefits under his/her aforementioned insurance policy in favor of the 'Provider'. If any language within this agreement has the effect of invalidating this assignment, that language shall be deemed void and the assignment shall remain in full force and effect. A photocopy of this assignment shall be considered as effective and valid as the original.

Expire Date _____

Patient Signature

Date

Witness Signature

Date

LETTER OF PROTECTION

AUTHORIZATION AND MEDICAL ASSIGNMENT

I _____, do hereby authorize and direct my attorneys, _____, to pay Cobb Rehab and Wellness, 4209 East Busch Blvd., Tampa, FL 33617 from the share of my proceeds of any recovery as

A result of the settlement or litigation of the accident on _____ the unpaid balance for the reasonable and customary charges as determined by the insurance company, for professional services rendered by said hospital, physician, or other medical care provider, on my behalf. In the event of a dispute between my insurance carrier and my physician, hospital, or medical care provider shall serve as my authority for my said physician, hospital, or medical care provider to proceed against my insurance carrier in the method and manner as provided in Florida Statute. Said professional services to include those for the medically necessary and reasonable diagnosis treatment and care heretofore and hereafter rendered to me as well as those medical reports, consultations, with my attorney, and court appearances on my behalf. Payment of these balances as herein stated shall be the same as if paid by me.

I understand that this assignment in no way relieves me of my personal responsibility and obligation to pay my physician, hospital, or medical care provider for such charges as herein stated for such services rendered and that such physician's, hospital's, or other medical care provider's fee for such services rendered is not contingent upon the outcome of this litigation.

I further authorize the before said physician, hospital, or medical care provider to furnish my attorney with a full report of the physician's, hospital's, or medical care provider's treatment evaluation of me in regard to the said incident.

In exchange for this letter of protection, it is our understanding that all such related bills will be directed to this office and not to the client/ patient and that client/patient's account will not be turned over to any type of collection agency or credit bureau, nor will any adverse credit information be reported against this client's credit during the pendency of this case and if this account is turned over to a collection agency or credit bureau, or if any adverse information is reported against this client's credit by you, directly or indirectly, this Letter of Protection is null and void and this law has no further obligation to you whatsoever.

Signature (Client/Patient)

Date

Firm Representative

Date

Cobb Rehab and Wellness

4209 E. Busch Blvd.

Tampa, FL 33617

(813) 914-8500

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

Patient Name (please print)

Date

Parent, Guardian or Patient's legal representative

Signature

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.



DR. GREGORY COBB

4209 E. BUSCH BLVD. TAMPA, FL 33617
phone: (813) 914-8500 fax: (813) 914-8511
cobbrehabwellness.com

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ to
release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

This request and authorization applies to:

Healthcare information relating to the following treatment, condition, or dates: _____

All healthcare information

Other: _____

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.

COBB REHAB & WELLNESS

4209 E Busch Blvd
Tampa, FL 33617
(813) 914-8500

HOW DID YOU HEAR ABOUT OUR CLINIC:

PPO-HMO Provider book: _____

Sign / Location: _____

Friend / Relative / Co-worker: _____

Yellow Pages: _____

Attorney: _____

Another Doctor / Clinic: _____

THANK YOU FOR CHOOSING *COBB REHAB & WELLNESS* FOR YOUR HEALTH CARE NEEDS.