

CHAMBERS MEDICAL GROUP

1050 East Brandon Blvd. * Brandon, FL 33511 * (813) 661-6841 * (813) 685-3846 fax

PERSONAL INFORMATION: PLEASE PRINT

MISS/MRS/MS/MR: _____ AGE: _____
FIRST MIDDLE MAIDEN LAST

DATE OF BIRTH: _____ / _____ / _____ MALE/FEMALE SINGLE / MARRIED / DIVORCED
MONTH DAY YEAR PLEASE CIRCLE ONE

MAILING ADDRESS: _____
NUMBER & STREET CITY STATE ZIP

HOME PHONE: () _____ SOCIAL SECURITY# _____

CELL/ALTERNATE: () _____

EMPLOYER INFORMATION: PLEASE PRINT

COMPANY NAME: _____ PHONE: _____
OCCUPATION: _____

ADDRESS NUMBER & STREET CITY STATE ZIP

SPOUSE INFORMATION: PLEASE PRINT

NAME: _____ OCCUPATION: _____
FIRST MIDDLE MAIDEN LAST

IN CASE OF EMERGENCY CONTACT: _____ RELATIONSHIP: _____
PHONE: _____ ALTERNATE: _____

* IN ORDER THAT WE DO NOT HAVE TO REPEAT ANY TESTS THAT HAVE ALREADY BEEN PERFORMED, PLEASE OBTAIN ALL MEDICAL REPORTS, X-RAYS, PHYSICAL THERAPY REPORTS AND REHABILITATION REPORTS. THIS INFORMATION WILL ALSO PROVIDE NECESSARY DATES WHICH ARE NEEDED FOR A COMPLETE EVALUATION OF YOUR INJURIES AND ILLNESS.

RELEASE OF MEDICAL RECORDS: PLEASE PRINT

* I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM AND REQUEST PAYMENT OF ALL MEDICAL BENEFITS TO BE MADE DIRECTLY TO THE PHYSICIAN OR SUPPLIER LISTED ON THIS FORM.

PATIENT SIGNATURE: _____ DATE: _____

* PLEASE CIRCLE ONE OR BOTH - PHYSICIAN / ATTORNEY

PHYSICIAN NAME: _____ PHONE: _____

ATTORNEY NAME: _____ PHONE: _____

* I FURTHER AUTHORIZE INFORMATION TO BE RELEASED TO MY PHYSICIAN / ATTORNEY AS INDICATED ABOVE.

PATIENT SIGNATURE: _____ DATE: _____

CLINIC: BRANDON

ACCIDENT INFORMATION:

PATIENT NAME: _____ DATE OF ACCIDENT: _____

TYPE OF ACCIDENT: CIRCLE ONE AUTO / BUS / RENTAL CAR / WORKERS COMP / FALL / OTHER: _____

DRIVER OR PASSENGER NAME OF CAR OWNER: _____

CIRCLE ONE

RELATIONSHIP: _____

AUTO INSURANCE INFORMATION (PLEASE PRINT)

NAME OF INSURED: _____ RELATIONSHIP TO INSURED: _____

NAME OF INSURANCE COMPANY: _____

ADDRESS: _____ PHONE NUMBER: _____

HAS ACCIDENT BEEN REPORTED: Y OR N CLAIM#: _____

POLICY#: _____

FOR OFFICE USE ONLY

ADJ: _____ DEDUCTIBLE MET: Y OR N
COVERAGE INFO: DEDUCTIBLE: _____ COVERAGE: 80% 100% MEDPAY: Y OR N

HEALTH INSURANCE INFORMATION (PLEASE PRINT)

NAME OF INSURED: _____ PATIENT I. D. # _____

DATE OF BIRTH INSURED: _____ GROUP # _____

RELATIONSHIP TO INSURED: _____ EFFECTIVE DATE: _____

EMPLOYER NAME: _____

NAME OF HEALTH INSURANCE COMPANY: _____

ADDRESS: _____ PHONE: _____

FOR OFFICE USE ONLY:

DED: _____ MET: Y OR N COVERAGE: _____ OUT OF NETWORK BENEFITS: Y OR N

WORKERS COMPENSATION INFORMATION (PLEASE PRINT)

EMPLOYER'S NAME: _____ PHONE: _____

WORKER'S COMP. CARRIER: _____ FAX #: _____

ADDRESS: _____ ADJUSTER: _____

FOR OFFICE USE ONLY

DOCTOR: _____

INFORMATION TAKEN BY: _____

DIAGNOSIS CODES: _____

APPLICATION FOR FLORIDA "NO FAULT" BENEFITS

NAME OF
INSURANCE
COMPANY

DATE	OUR POLICY HOLDER	DATE OF ACCIDENT	FILE NUMBER
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TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE FLORIDA PERSONAL INJURY PROTECTION LAW, PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURANCE COMPANY MAKES A STATEMENT OF CLAIM CONTAINING ANY FALSE INCOMPLETE OR MISLEADING INFORMATION, IS GUILTY OF A FELONY OF THE THIRD DEGREE.

YOUR NAME	PHONE NO.	HOME	BUSINESS
YOUR ADDRESS (NO, STREET, CITY OR TOWN, STATE AND ZIP CODE)	DATE OF BIRTH	SOCIAL SECURITY NO.	
PERMANENT ADDRESS, IF DIFFERENT	HOW LONG HAVE YOU LIVED IN FLORIDA?		
DATE AND TIME OF ACCIDENT	PLACE OF ACCIDENT (STREET, CITY OR TOWN AND STATE)		

BRIEF DESCRIPTION OF ACCIDENT AND VEHICLES INVOLVED:

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DESCRIBE MOTOR VEHICLE YOU OWN -	DESCRIBE MOTOR VEHICLE OWNED BY ANY MEMBER OF YOUR FAMILY-
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AS A RESULT OF THIS ACCIDENT, WERE YOU INJURED? IF YOUR ANSWER IS YES, COMPLETE THE REST OF THIS FORM. IF NO, SIGN HERE AND RETURN THIS FORM TO US.

SIGNATURE: _____ DATE: _____

DESCRIBE YOUR INJURY

WERE YOU TREATED BY A DOCTOR?	DOCTOR'S NAME AND ADDRESS
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IF YOU WERE TREATED IN A HOSPITAL, WERE YOU AN IN PATIENT ___ OUT PATIENT ___	HOSPITAL'S NAME AND ADDRESS
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AMOUNT OF MEDICAL BILLS TO DATE	WILL YOU HAVE MORE MEDICAL EXPENSE?	AT THE TIME OF YOUR ACCIDENT, WERE YOU IN THE COURSE OF YOUR EMPLOYMENT?
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DID YOU LOSE WAGES OR SALARY AS A RESULT OF YOUR INJURY?	IF YES, AMOUNT OF LOSS TO DATE	WHAT IS YOUR AVERAGE WEEKLY WAGE OR SALARY?
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IF YOU LOST WAGES:	DATE DISABILITY FROM WORK BEGAN	DATE YOU RETURNED TO WORK
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HAVE YOU RECEIVED, OR ARE YOU ELIGIBLE FOR, PAYMENTS UNDER ANY WORKMEN'S COMPENSATION OR EMPLOYMENT LAW?	IF YES, AMOUNT PER WEEK	PER MONTH
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LIST NAMES AND ADDRESSES OF YOUR PRESENT EMPLOYER(S) AND GIVE YOUR OCCUPATION AND DATES OF EMPLOYMENT FOR EACH

EMPLOYER AND ADDRESS	YOUR OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	YOUR OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	YOUR OCCUPATION	FROM	TO

AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES? SIGNATURE: _____ DATE: _____	IF YES, EXPLAIN ON REVERSE SIDE
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IMPORTANT: 1. TO BE ELIGIBLE FOR BENEFITS COMPLETE AND SIGN THIS APPLICATION
2. SIGN AND ATTACH AUTHORIZATION(S)
3. RETURN PROMPTLY WITH ANY MEDICAL BILLS YOU HAVE RECEIVED TO DATE

DO NOT DETACH
AUTHORIZATION FOR MEDICAL INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY HEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY CONDITION WHILE UNDER YOUR OBSERVATION OR TREATMENT, INCLUDING THE HISTORY OBTAINED, X-RAY AND PHYSICAL FINDINGS DIAGNOSIS AND PROGNOSIS. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE FLORIDA "NO FAULT" AUTO INSURANCE LAW (CHAPTER 71-252 F.S.)

SIGNATURE

DATE

DO NOT DETACH

AUTHORIZATION FOR WAGE AND SALARY INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY HEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY WAGES OR SALARY WHILE EMPLOYED BY YOU. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE FLORIDA "NO FAULT" AUTO INSURANCE LAW (CHAPTER 71-252 F.S.)

SIGNATURE

DATE

SOCIAL SECURITY NO.

Designation of Authority for Third-Party Complaints

Please accept the complaint filed with the Office of Insurance on my behalf by Paul Brosky (Vice President of Operations, Chambers Medical Group), Lisabeth Chambers (President, Chambers Medical Group) as having been filed with my consent.

I hereby designate the individuals named above as my authorized representative for the purposes of filing and investigating my complaint.

I authorize the Consumer Protection & Education Division of the Florida Office of Insurance to investigate the complaint received on my behalf and to respond directly to:

- My authorized representative (Chambers Medical Group as indicated above)
- Me

Insured's signature: _____

Insured's name: _____
(PLEASE PRINT)

Insured's phone #: (____) _____ - _____

Date: _____

CHAMBERS MEDICAL GROUP
1050 E. Brandon Blvd.
Brandon, FL 33511
(813) 661-6841 Fax# (813) 6853846

AUTHORIZATION FOR RELEASE OF RECORDS

I hereby authorize the use of disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Patient name: _____ SS# Number: _____

Birthdate: _____

I hereby authorize the following Doctor, Office or Institution,

to release a copy of my protected health information to:

CHAMBERS MEDICAL GROUP
1050 E. Brandon Blvd
Brandon, FL 33511
Ph# (813) 661-6841 FAX# (813) 685-3846

Specific description of information requested:

All Medical Records X - ray Reports MRI Reports CT Reports Narrative Reports

X - ray films MRI films Nerve Conduction / EMG Studies

Emergency Room Records Hospital Inpatient Records Physical Therapy Records

Other: _____

Dates: From _____ To _____

1. The provider must complete the following statement:

a. Will the healthcare provider requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above? Yes ___ NO **XXX**

2. The patient must read and initial the following statement:

a. I understand that I may request a copy of this form after I sign it. Pt. initials:

Section C: Must be completed for all authorizations

The patient or the patient's representative must read and initial the following statements:

1. I understand that this authorization will expire on ___ / ___ / ___ (DD/MM/YYYY) Initials:

2. I understand that I may revoke this authorization at any time by notifying the practice in writing, but if I do it won't have any affect on any actions they took place before they received the revocation. Initials:

Signature of patient or patient's representative

Date

Chambers Medical Group

Patient Questionnaire

Patient Name _____ Age _____

1. Accident/Injury Type: Auto, Slip/Fall, On Job Injury, Other (Please specify) _____

2. Date of Accident/Injury: _____ Location: _____

3. Were you wearing a seatbelt Y or N were you the Driver Passenger Front seat Back seat

4. In your own words, please describe the accident/injury. _____

5. Were you struck in the: Front, Rear, Driver's side, Passenger's side?

6. Were you knocked unconscious? Yes, No. If yes for how long? _____

7. Did you feel pain immediately after the accident? Yes No.....If yes please describe _____

8. Were you examined by paramedics after the accident? Yes No

9. Did you go to the hospital? Yes No...If yes how did you get there?

Ambulance Self Driven by _____

10. Which Hospital did you go to? _____

11. Were X-Rays taken? Yes, No. Were you given medication? Yes, No

12. Were you told the diagnosis? Yes, No....If yes please describe _____

13. Have you been treated by another Dr. since the accident? Yes, No.....If yes please list the Dr's name and address: _____

What treatment did you receive? _____

14. Since the injury occurred, are your symptoms: Improving Getting Worse Staying same

15. Have you ever had similar symptoms prior to the accident/injury? Yes No. Please describe _____

16. Have you ever been involved in an accident before? Yes No....If yes please describe, including dates and injuries. _____

17. Have you ever had any surgeries? Yes, No....If yes please describe _____

18. Do you have any health problems we need to know about (including any allergies to medications)?

Yes, No. Please describe _____

19. Have you lost time from work as a result of this accident? Yes, No.....If yes please complete these questions: a) Dates missed ___ / ___ / ___ through ___ / ___ / ___ . b) Type of work _____

20. If this was an auto accident how many people were in the car? _____

CHAMBERS

Medical Group

Patient Name: _____ Date of Accident: _____

Patient Injury Identification

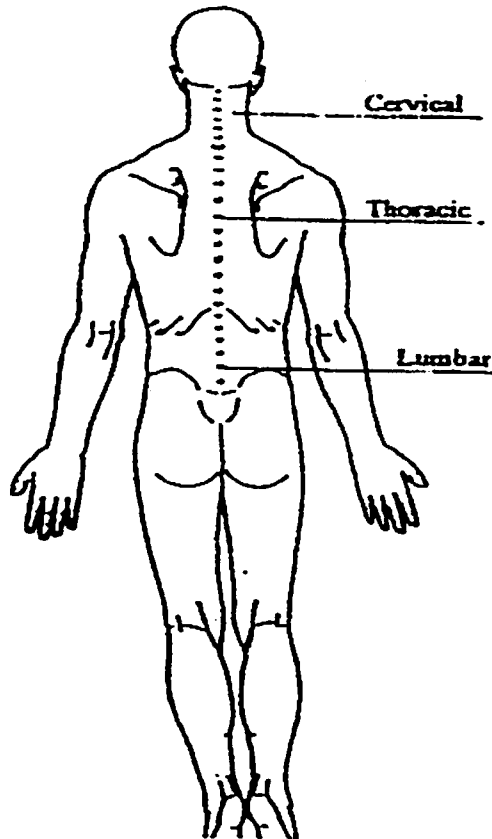
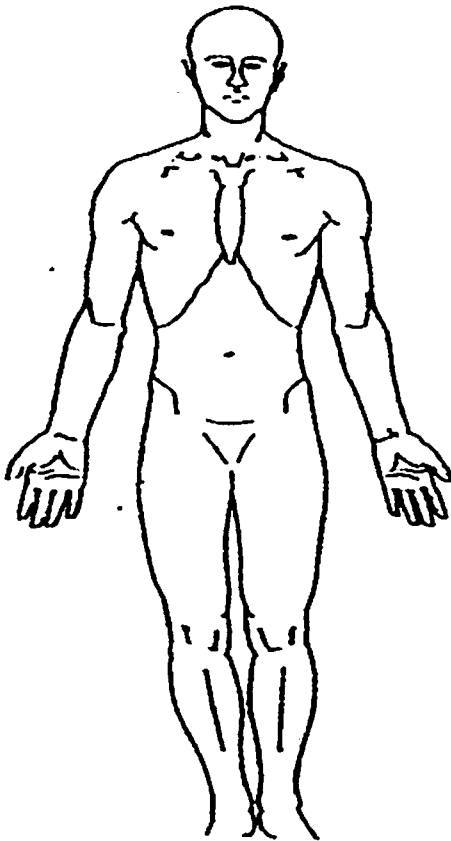
Draw or shade in the location of your body injuries as a result of your most recent accident. Describe, by connecting a line to the area of the body diagram. Note pain, stiffness, weakness, numbness, cuts, black and blue marks, swelling and scars. Carefully scan your entire body pushing on areas to note tenderness. Move arms, legs, back including pain during activities such as lifting, bending and working. This is very important so the physician doesn't overlook any injuries.

RIGHT

LEFT

LEFT

RIGHT



CHECK THE APPROPRIATE BOX FOR ANY SYMPTOMS THAT APPEARED AS A RESULT OF THE ACCIDENT/INJURY:

- Headache
- Neck Pain
- Mid Back Pain
- Low Back Pain
- Shoulder Pain L/R

- Elbow Pain L/R
- Wrist/Hand Pain L/R
- Hip Pain L/R
- Knee Pain L/R
- Ankle/Foot Pain L/R

- Numbness of _____
- Tingling of _____
- Sleep Difficulties
- Jaw Pain L/R
- Other _____

CHAMBERS MEDICAL GROUP
INFORMED CONSENT TO TREATMENT

The purpose of this form is to make you, the patient, aware of the possible risks of the different treatment modalities routinely provided at Chambers Medical Group. If you are referred to one of our specialists (orthopedic surgery, interventional pain management, etc.) they will have an additional form to advise you of the risks of their procedures.

MEDICATION: possible risks include allergic reaction, dependence, liver and kidney function problems, affects on heart, drowsiness, etc. Caution should be used as medication can mask progress, and the danger of side effects and damage to the health of the person taking the medication is well documented. Risk probability is moderate.

THERAPY: possible risks include burns induced by heat (causing temporary pain and possible blistering), temporary pain due to massage or adjunctive therapies. Risk probability is extremely rare.

TRIGGER POINT INJECTIONS: possible pneumothorax, localized reaction to medication, allergic reaction. Risk probability is extremely rare.

NERVE BLOCKADES & EPIDURAL INJECTIONS: possible risks of nerve damage, seizures, adverse bleeding, infection, drug interactions. Risk probability is extremely rare.

CHIROPRACTIC CARE: possible fracture of bone, sprain of ligament, strain of muscle, cerebrovascular injury (stroke) could occur upon severe injury to the arteries of the neck with an extension-rotation-thrust atlas adjustment - that type of adjustment is NOT performed in our offices. Risk probability is extremely rare.

OTHER PROBLEMS: there may be other problems or complications arising from treatment such as massage, traction, etc., other than noted above. These other problems occur so rarely it is not possible to anticipate/explain them in advance. Risk probability is extremely rare.

ALTERNATIVE TREATMENTS

HOSPITALIZATION: proven expensive and exposes the patient to communicable disease and possible doctor/staff mishap. Risk probability is moderate.

SURGERY: risks include reaction to anesthesia, doctor error, and the risks imposed by hospitalization during convalescent period. Risk probability is substantial.

NON TREATMENT: can result in adhesions, pain, and reduction in joint mobility, which can lead to degenerative joint disease. Risk probability is moderate.

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

If you have any question about the above information, please ask your doctor. When you have a full understanding of this consent form, please sign below and date below.

I hereby authorize and direct **CHAMBERS MEDICAL GROUP** to provide such service as they deem reasonable and necessary.

I HEREBY STATE THAT I HAVE READ THIS CONSENT FORM.

Patient

Witness

Date