All Broward Chiropractic
Dr. Michael Surdis, Jr. PA
7900 NW 33rd Street #104
Hollywood, FL 33024

Personal Injury Intake Form and Chiropractic Care Agreement

Patient Information:

Today's Date _____
Name _____ Home Phone _____
I prefer to be called _____ Work Phone _____
Address _____ Email _____
_____ Social Security # _____
_____ Date of Birth _____
Sex ☐ **Male** ☐ **Female** Height ____' ____" Weight _____ lbs
Occupation _____ Marital Status _____
Employer _____ No of Children _____
Address _____
If minor, name of parent or guardian _____
Who should we contact in case of an emergency? _____
Relation _____ Phone _____
Address _____
Attorney _____ Phone _____
Primary Care Physician _____ Phone _____
How did you hear about our office? _____
Have you ever been to a chiropractor before? ☐ **YES** ☐ **NO** If so, whom? _____

Health Insurance Information:

Insurance Company _____ Policy number _____
Policy Holder's Name _____ Social Security # _____
Address _____ Phone _____

Auto Insurance Information:

Insurance Company _____ Policy number _____
Address _____ Phone _____
Adjustor Name _____ Claim # _____

Accident Information:

Date _____ Time _____ AM PM Was it reported to the police? ☐ **YES** ☐ **NO**
Was a traffic violation issued? ☐ **YES** ☐ **NO** To whom? _____

Location of accident (Street, Town) _____ # of other passengers _____
Were there other witnesses? ☐ **YES** ☐ **NO** Make/model of vehicle you were in _____

Please explain in detail how the accident occurred _____
_____
Please list symptoms felt immediately after the accident _____
_____
In which direction were you headed? ☐ **N** ☐ **S** ☐ **E** ☐ **W** Approx. speed of vehicle ___ MPH

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Did the impact to your vehicle come from the: ☐ **FRONT** ☐ **REAR** ☐ **RIGHT** ☐ **LEFT** ☐ **OTHER**
During impact, were you facing: ☐ **RIGHT** ☐ **LEFT** ☐ **FORWARD**
Were you ☐ **AWARE** or ☐ **SURPRISED** by the impact?
Were you the ☐ **DRIVER** ☐ **FRONT SEAT PASSENGER** ☐ **BACK SEAT PASSENGER**?
Were you wearing a seat belt? ☐ **SHOULDER HARNESS** ☐ **LAP HARNESS**
Was the vehicle equipped with air bags? ☐ **YES** ☐ **NO** Did they inflate? ☐ **YES** ☐ **NO**
In relation to the base of your skull, where was the headrest? ☐ **ABOVE** ☐ **BELOW** ☐ **AT BASE**
What did your vehicle impact? ☐ **ANOTHER VEHICLE** ☐ **OTHER** _____
If another vehicle, what was the make/model? _____ Direction _____ Speed _____ MPH
Did any part of your body strike anything in the vehicle? ☐ **YES** ☐ **NO** Describe _____
Did the accident render you unconscious? ☐ **YES** ☐ **NO** If yes, for how long? _____

Post-Injury Information:

Have you seen any other doctor(s) since the accident? ☐ **YES** ☐ **NO** Name _____
When did you go? ☐ **IMMEDIATELY** ☐ **NEXT DAY** ☐ **2 DAYS PLUS**
How did you get there? ☐ **AMBULANCE** ☐ **PRIVATE TRANSPORTATION**
Name of hospital and/or attending doctor: _____
Was he/she a: ☐ **D.C.** ☐ **M.D.** ☐ **D.O.** ☐ **D.D.S.**
Please describe any treatment you received _____
Were X-Rays done? ☐ **YES** ☐ **NO** An MRI? ☐ **YES** ☐ **NO** CAT scan? ☐ **YES** ☐ **NO**
Was medication prescribed? ☐ **YES** ☐ **NO** If yes, what? _____
Have you missed any work since the accident? ☐ **YES** ☐ **NO** Date(s) _____
Are your work activities restricted as a result of your injury? ☐ **YES** ☐ **NO**
Indicate the symptoms that are a result of this accident:

☐ **DIZZINESS**	☐ **DIFFICULTY SLEEPING**	☐ **JAW PROBLEMS**	☐ **NAUSEA**
☐ **MEMORY LOSS**	☐ **ARM/SHOULDER PAIN**	☐ **IRRITABILITY**	☐ **BACK PAIN**
☐ **HEADACHE(S)**	☐ **NUMB HANDS/FINGERS**	☐ **FATIGUE**	☐ **LOW BACK PAIN**
☐ **BLURRED VISION**	☐ **TENSION**	☐ **CHEST PAIN**	☐ **BACK STIFFNESS**
☐ **BUZZING IN EAR**	☐ **NECK PAIN**	☐ **SHORT BREATH**	☐ **LEG PAIN**
☐ **EARS RINGING**	☐ **NECK STIFF**	☐ **STOMACH UPSET**	☐ **NUMB FEET/TOES**

☐ **OTHER** _____
Did you ever experience similar symptoms prior to the accident? ☐ **YES** ☐ **NO**
Has your condition ☐ **IMPROVED** ☐ **WORSENED** or ☐ **STAYED SAME** since the accident?
Is your condition affecting your ☐ **WORK** ☐ **SLEEP** or ☐ **DAILY ROUTINE**? Please explain _____

Please indicate your degree of difficulty (on a scale of 1-5, with 1 being comfortable, 3 being uncomfortable, and 5 being painful) in performing the following activities:

___ Lying on Back	___ Lying on Side	___ Lying on stomach	___ Sitting
___ Standing	___ Stretching	___ Lovemaking	___ Walking
___ Running	___ Sports	___ Working	___ Lifting
___ Bending	___ Kneeling	___ Pulling	___ Reaching

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How many hours are in your normal workday? _____

Please indicate your daily job duties and any activities that you are occasionally asked to perform:

☐ STANDING	☐ OPERATING EQUIPMENT	☐ DRIVING	☐ SITTING
☐ TWISTING	☐ WORK W/ARMS ABOVE HEAD	☐ WALKING	☐ CRAWLING
☐ TYPING	☐ LIFTING	☐ BENDING	☐ STOOPING

What positions can you work in with minimum physical effort, and for how long? _____
Do you work with others who can help you with any heavy lifting? ☐ YES ☐ NO
While in recovery, are there any light duty tasks you could request? ☐ YES ☐ NO

Health History

Have you ever had any of the following diseases or conditions?

☐ HEART ATTACK or STROKE	☐ HEART SURGERY or PACEMAKER	☐ HEART MURMUR
☐ CONGENITAL HEART DEFECT	☐ MITRAL VALVE COLLAPSE	☐ ARTIFICIAL VALVES
☐ ALCOHOL/DRUG ABUSE	☐ VENEREAL DISEASE	☐ HEPATITIS
☐ HIV+/AIDS	☐ SHINGLES	☐ CANCER
☐ FREQUENT NECK PAIN	☐ EMPHYSEMA	☐ ANEMIA
☐ HIGH/LOW BLOOD PRESSURE	☐ PSYCHIATRIC PROBLEMS	☐ RHEUMATIC FEVER
☐ SEVERE/FREQ. HEADACHES	☐ KIDNEY PROBLEMS	☐ ULCERS/COLONITIS
☐ FAINTING/SEIZURE/EPILEPSY	☐ SINUS PROBLEMS	☐ ASTHMA
☐ DIABETES	☐ DIFFICULTY BREATHING	☐ TUBERCULOSIS
☐ LOWER BACK PROBLEMS	☐ ARTIFICIAL BONES/JOINTS	☐ ARTHRITIS

Please list **any other** medical conditions that you have or have ever had. _____

Please list any allergies. _____

Please list previous surgeries and dates. _____

Please list any past motor vehicle accidents or traumas and dates. _____

Is there anything else about your health history or family health history that you feel is important to share? _____

Do you exercise? ☐ YES ☐ NO
Are you on a special diet? ☐ YES ☐ NO Since: ___/___/___
Do you smoke? ☐ YES ☐ NO How much? _____ How long? _____
Are you wearing: ☐ ORTHOTICS ☐ HEEL LIFTS ☐ ARCH SUPPORTS

For women: Are you taking birth control? ☐ YES ☐ NO
Are you pregnant? ☐ YES ☐ NO How long? _____ Nursing? ☐ YES ☐ NO

Patient/Legal Guardian Signature _____ **Date** _____

DR. MICHAEL SURDIS, JR., P.A. d/b/a ALL BROWARD CHIROPRACTIC AND REHAB. CENTER
7900 NW 33rd Street #104, Hollywood, FL 33024 954-443-2420

ASSIGNMENT OF INSURANCE BENEFITS, RELEASE, & DEMAND

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

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, any premium reimbursement 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. To the extent the PIP insurer contends there is a material misrepresentation on the application for insurance resulting in the policy of insurance being 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.

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 signed 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 the optional permissive fee schedule 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 attention of **Office Manager** per §673.3111.

EUOs and CMEs: If the insurer schedules a compulsory medical examination or examination under oath (hereinafter "EUO") the insurer is hereby INSTRUCTED to send a copy of said notification to this provider in advance of the notice being sent to the insured/patient. The provider or the provider's attorney is expressly authorized to appear at any EUO or CME set by the insurer. It is hereby demanded that at least 10 days prior to any CME that the insurer provide this healthcare provider with a list of exactly what exams and tests the CME doctor will perform. See Schagrin v. Nacht, 683 So.2d 1173 (Fla. 4th DCA 1996).

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. I agree to pay any applicable deductible, co-payments, or services rendered after the policy of insurance exhausts and for any other services unrelated to the automobile accident. 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 and obtain a copy of any statements, examinations under oath given by patient, or to obtain medical records from other health care providers treating me for injuries connected with or related to the event which gave rise to my need for medical treatment with the above provider.

Release of information: I authorize this provider to: furnish an insurer, an insurer's intermediary, the patient's other medical providers, and the patient's attorney 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. The provider is permitted to produce my medical records to its attorney in connection with any pending lawsuits. The insurer is directed to keep the patient's medical records from this provider private and confidential. The insurer is not authorized to provide these medical records to anyone without the patient's and the provider's prior express written permission. This medical records authorization is intended to comply with HIPAA and shall remain in effect for the duration of any lawsuits which may be filed to collect PIP benefits.

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, the insurance coverage declaration sheet and the policy of insurance 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.

Certification: I certify that: I have read and agree to the above and have asked questions regarding any provisions I did not understand; 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 that I shall review all medical records to insure that all treatments reflected on said records were provided and I also agree that the provider's prices are reasonable, usual and customary.

Patient's Name _____ Patient's Signature _____
(Please Print) (If patient is a minor, signature of parent/guardian)

Date _____

Dr. Michael Surdis, Jr.
7900 NW 33RD Street Suite 104
Hollywood, FL 33024
(954) 443-2420 (954) 443-8422 Fax

PREGNANCY WAIVER

ON THIS DAY, IT HAS BEEN EXPLAINED TO ME THAT X-RAYS CAN BE DANGEROUS TO A PREGNANT WOMAN. TO THE BEST OF MY KNOWLEDGE, I DECREE THAT I AM NOT PREGNANT AT THIS TIME AND THAT DIAGNOSTIC X-RAYS CAN BE TAKEN AT THIS TIME.

DATE: _____
PATIENT'S SIGNATURE_____
WITNESS:_____

Dr. Michael Surdis, Jr.
7900 N.W. 33rd Street Suite 104
Hollywood, Fl 33024
(954) 443-2420 (954)443-8422 Fax

Consent to Treat

I,_____authorize the performance upon myself of the following procedures(s): Ultrasound, electric muscle stimulation, traction, massage and stretching to be performed by or under the direction of All Broward Chiropractic/Dr. Michael Surdis, Jr.

I also consent to the performance of other diagnostic and therapeutic procedures in addition to or different from those stated above, whether or not arising from present or unforeseen conditions, that the above-named doctor, physical therapist, associates or assistants, may consider necessary or advisable in the course of my healthcare.

The above-named doctor and/or his associates/assistants have explained the nature and have explained the nature and purpose of the procedures, possible alternatives, the risks involved, and the possibility of complications to me. I acknowledge that no guarantee or assurance have been given as to the results that may be obtained from the procedures given by the above-named doctor and/or physical therapist and/or his associates or assistants. I accept the risks and benefits and consent to treatment.

Signed: _____Date:_____

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7900 NW 33RD Street Suite 104
Hollywood, FL 33024
(954) 443-2420 (954) 443-8422 Fax

PAYMENT RESPONSIBILITY-PLEASE READ CAREFULLY!!!

Dear Patient:

Please be advised that your Insurance Company, _____, may automatically send payments directly to you home for services rendered by our office. It is your responsibility to forward these payments to our office as soon as possible so that we may properly credit your account.

If your check is made payable to you directly, please copy that check and explanation of benefits, deposit that check into your account and bring in a personal check or money order for the amount you were paid along with the copies of the correspondence and the copy of the check. If we do not receive these payments within fifteen (15) days, your account will be referred to our collections department. Thank you in advance for your cooperation.

Sincerely,

Dr. Michael Surdis, Jr.
All Broward Chiropractic and Pain Rehabilitation Center, Inc.

X_____
Patient Signature

X_____
Print Patient Name

Please sign above to acknowledge that you have read the above statement and that you agree to comply with our request.

All Broward Chiropractic and Rehab. Center
Dr. Michael Surdis, Jr.
7900 NW 33rd Street #104
Hollywood, FL 33024
954-443-2420 954-639-7674-Fax

TO: _____

_____

_____

RE: DOCTOR'S LIEN AND HEALTH REPORTS

I HEREBY AUTHORIZE THE ABOVE DOCTOR TO FURNISH YOU, MY ATTORNEY, WITH A FULL REPORT OF HIS EXAMINATION, DIAGNOSIS, TREATMENT, PROGNOSIS, ETC., OF MYSELF IN REGARD TO THE ACCIDENT IN WHICH I WAS INVOLVED.

I HEREBY AUTHORIZE AND DIRECT YOU, MY ATTORNEY, TO PAY DIRECTLY TO SAID DOCTOR SUCH SUMS AS MAY BE DUE AND OWING HIM FOR PROFESSIONAL SERVICES RENDERED ME BOTH BY REASON OF THIS ACCIDENT AND BY REASON OF ANY OTHER BILLS THAT ARE DUE HIS/HER OFFICE AND TO WITHHOLD SUCH SUMS FROM ANY SETTLEMENT, JUDGEMENT OR VERDICT AS MAY BE NECESSARY ADEQUATELY TO PROTECT SAID DOCTOR. I HEREBY FURTHER GIVE A LIEN ON MY CASE TO SAID DOCTOR AGAINST ANY AND ALL PROCEEDS OF ANY SETTLEMENT, JUDGEMENT OR VERDICT WHICH MAY BE PAID TO YOU, MY ATTORNEY, OR MYSELF (PATIENT) AS THE RESULT OF THE INJURIES FOR WHICH I HAVE TREATED OR INJURIES IN CONNECTION THEREWITH.

I FULLY UNDERSTAND THAT I AM DIRECTLY AND FULLY RESPONSIBLE TO SAID DOCTOR FOR ALL PROFESSIONAL BILLS SUBMITTED BY HIM/HER FOR SERVICE RENDERED ME AND THAT THIS AGREEMENT IS MADE SOLEY FOR SAID DOCTOR (S) ADDITIONAL PROTECTION AND IN CONSIDERATION OF THIS AWAITING PAYMENT. I FURTHER UNDERSTAND THAT SUCH PAYMENT IS NOT CONTINGENT ON ANY SETTLEMENT, JUDGEMENT OR VERDICT BY WHICH I MAY EVENTUALLY RECOVER SAID FEE.

DATE OF ACCIDENT _____

PATIENT'S FULL NAME _____

DATED_____ PATIENT'S SIGNATURE :_____

THE UNDERSIGNED BEING ATTORNEY OF RECORD FOR THE ABOVE PATIENT DOES HEREBY AGREE TO OBSERVE ALL THE TERMS OF THE ABOVE AND AGREES TO WITHHOLD SUCH SUMS FROM ANY SETTLEMENT, JUDGEMENT OR VERDICT AS MAY BE NECESSARY ADEQUATELY TO PROTECT THE SAID DOCTOR (S) NAMED ABOVE.

DATED _____ ATTORNEY'S SIGNATURE :_____

ATTORNEY: PLEASE DATE, SIGN AND FAX TO 954-639-7674.