

**Avarta Wellness**  
**3837 E Colonial Drive**  
**Orlando, FL 32803**

**New Patient Auto Accident Packet**

Date: \_\_\_\_\_ Mr. Mrs. Ms. Dr. Name \_\_\_\_\_ (nickname) \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City \_\_\_\_\_ State: \_\_\_\_\_ Zip Code \_\_\_\_\_ Marital Status: S M D W  
 Home Tel. #: \_\_\_\_\_ Work or Cell Tel. #: \_\_\_\_\_  
 E-mail address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
 Occupation: \_\_\_\_\_ Emergency Contact and Number \_\_\_\_\_  
 Has your Auto Insurance been notified of your personal injuries: YES / NO \_\_\_\_\_ Auto Insurance Carrier \_\_\_\_\_  
 Date Of Accident \_\_\_\_\_ Claim Number \_\_\_\_\_  
 Insured Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Insured DOB: \_\_\_\_\_ Were You referred to this office YES / NO If Yes, By : \_\_\_\_\_

1. I was the Driver Passenger (FRONT: Left Right REAR: Left Mid. Right) PEDESTRIAN
2. My car hit their car The other vehicle hit my car I hit a \_\_\_\_\_
3. Area of impact on your car? front right front left back right back left front end back end left side right side
4. Please describe the damage to your car and any other important additional information: \_\_\_\_\_
5. The Weather Conditions were : Sunny Cloudy Heavy rain Foggy Snowing
6. Time of Day: \_\_\_\_\_ am pm
7. After the accident did you: lose consciousness become dazed and confused go into a state of shock  
 see a flash of light no change in consciousness or awareness
8. Did you strike any objects in the car? Steering wheel Rearview mirror Dashboard Headrest Door frame
9. Where you wearing your seat belt? yes no Did the air bag deploy? yes no
10. Were you aware of impending impact? yes no Was your head turned at time of impact? yes (right left) no
11. Do you have bruises or cuts from the accident? \_\_\_\_\_
12. Did paramedics come? yes no If so, were you treated at the scene? yes no
13. After the accident did you: go home go about your business go to the hospital
14. If you went to the hospital, what was done? X-rays MRI cervical collar  
 medication: \_\_\_\_\_ other: \_\_\_\_\_

☞ Please list your current problem areas with the worst area being 1 and going down:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_
8. \_\_\_\_\_

Have you ever been in any previous accidents of any kind within the last 5 years? yes no

if yes, give dates and details: \_\_\_\_\_  
\_\_\_\_\_

Have you ever been treated for neck or back problems by any other physicians prior to this accident? yes no

if yes, give dates and details: \_\_\_\_\_  
\_\_\_\_\_

Have you had any previous surgery or condition the doctor should know about? yes no

if yes, give dates and details: \_\_\_\_\_  
\_\_\_\_\_

Have you enjoyed good health prior to this accident? yes no

if no, please explain: \_\_\_\_\_  
\_\_\_\_\_

Is there is any other information that the doctor should know about your injuries, accident or medical history that was not covered by this form? If so, please explain below:

\_\_\_\_\_  
\_\_\_\_\_

Review of Systems: Please check any of the following you have had in the last 5 years

<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> dizziness	<input type="checkbox"/> kidney problems
<input type="checkbox"/> allergies	<input type="checkbox"/> ear infections	<input type="checkbox"/> liver / gall bladder problems
<input type="checkbox"/> arthritis	<input type="checkbox"/> fractured bones	<input type="checkbox"/> memory loss
<input type="checkbox"/> asthma	<input type="checkbox"/> frequent colds/flu	<input type="checkbox"/> menopausal problems
<input type="checkbox"/> blurred/double vision	<input type="checkbox"/> gall bladder problems	<input type="checkbox"/> menstrual problems/PMS
<input type="checkbox"/> cancer	<input type="checkbox"/> constipation or diarrhea	<input type="checkbox"/> morning stiffness
<input type="checkbox"/> chest pain	<input type="checkbox"/> frequent colds/flu	<input type="checkbox"/> prostate problems
<input type="checkbox"/> convulsions/epilepsy	<input type="checkbox"/> heart problems	<input type="checkbox"/> sinus problems
<input type="checkbox"/> depression	<input type="checkbox"/> hemorrhoids	<input type="checkbox"/> stroke
<input type="checkbox"/> diabetes	<input type="checkbox"/> high/low blood pressure	<input type="checkbox"/> ulcers
<input type="checkbox"/> digestive problems	<input type="checkbox"/> joint pain or swelling	

List any Medications you are taking: none \_\_\_\_\_

Marital Status: single married divorced widowed Number of children: \_\_\_\_\_

Do you exercise? yes no if yes how often? \_\_\_\_\_

Do you drink Alcohol?: yes no if yes how many drinks per week? \_\_\_\_\_

Do you Smoke?: yes no if yes how many packs per day? \_\_\_\_\_

Recreational Drugs?: yes no if yes what type?: \_\_\_\_\_ how often?: \_\_\_\_\_

\_\_\_\_\_  
signature

\_\_\_\_\_  
date

\_\_\_\_\_  
print name

**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 set forth below were **actually rendered**. This means that those services have **already been provided**.

- 
1. I have the right and the **duty to confirm** that the services have already been provided.
  1. I was **not solicited** by any person to seek any services from the medical provider of the services described above. This means that no person has initiated contact with me and/or persuaded me to use the doctor or licensed professional, clinic, or medical institution that provided the services.
  1. The medical provider has **explained** the services to me for which payment is being claimed.
  1. 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.

The undersigned licensed medical professional 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.
- A. I have **explained** the services rendered to the insured person, or his or her guardian, **sufficiently** for that person to sign this form with informed consent.
- A. 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.
- A. 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.

Insured Person (patient receiving treatment) or Guardian of Insured Person:

\_\_\_\_\_  
Name (PRINT or TYPE)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Licensed Medical Professional Rendering Treatment (Signature by his or 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.

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 Note furnish this form may result in non-payment of the claim.

# Avarta Wellness

*“Embrace your body”*

3837 E Colonial Drive • Orlando, Florida • 32803 • 407-228-9599 • Fax: 407-228-1922

## ASSIGNMENT AND AUTHORIZATION OF INSURANCE BENEFITS

I, \_\_\_\_\_, hereby authorize any insurance company that may be obligated to provide insurance benefits to me, or on my behalf, to accept billing and pay directly to John Staub, D.C. (“Assignee”) such sums as may be due and owing Assignee for services rendered to me, both by reason of accident or illness, and by reason of any other bills that are due Assignee; and to withhold such sums from any disability benefits, medical payments benefits, no-fault benefits, or any other insurance benefits obligated to reimburse me or any form of settlement, judgment or verdict on my behalf as may be necessary to adequately protect said Assignee.

I hereby further give lien to said Assignee 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 Assignee. This is to act as an assignment of my rights and benefits to the extent of the Assignee’s services provided.

In the event my insurance company refuses to make such payments, I hereby assign and transfer to Assignee any and all causes of action that I might have or that might exist in my favor against such company. I authorize and direct you, my insurance company to provide fifteen days advance notice to Assignee of any physical examination or examination under oath of myself that is scheduled by any insurance company.

I authorize and direct you, my insurance company and/or my attorney to release a copy of the payment record (PIP Payout Log) without redacting the names of payees and amounts paid and to release a copy of the declarations page of insurance policy and any pertinent information necessary for me to receive treatment and for Assignee to timely process claims. I also authorize Assignee to release any information pertinent to my care to any insurance company, adjustor, or attorney to facilitate collection under this Assignment, Lien, and Authorization. I agree that a photocopy of this document may serve as the original.

I, \_\_\_\_\_, have read and fully understand the above information and agree to receive chiropractic care under these terms.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Sign: \_\_\_\_\_ Date: \_\_\_\_\_

**COMPLETE IF PATIENT IS A MINOR CHILD** \_\_\_\_\_ (Child’s Name)

I, \_\_\_\_\_ being the parent or legal guardian of the above minor child have read and fully understand the above information and agree for my child to receive chiropractic care under these terms.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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## Avarta Wellness Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Avarta Wellness to use and disclose protected health information (PHI) about me to carry out treatment, payment, and health care operations (TPO). With this consent, Avarta Wellness may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my care

With this consent, Avarta Wellness may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With this consent, Avarta Wellness may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Avarta Wellness restrict how it uses or discloses my PHI to carry out TPO.

With this consent, Avarta Wellness may post my picture and testimonial on the bulletin board located in the office.

By signing this form, I am consenting to allow Avarta Wellness to use and disclose my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Avarta Wellness may decline to provide treatment to me.

\_\_\_\_\_

Dated

\_\_\_\_\_

Patient's Name

\_\_\_\_\_

Patient's Signature

\_\_\_\_\_

Print Name of Legal Guardian, if applicable

\_\_\_\_\_

Signature of Legal Guardian, if applicable