WELCOME TO ZIVKOVIC CHIROPRACTIC CENTER

DATE:_____ **Please print clearly and fill in completely.**

ABOUT YOU:

Patient Name:_____ Email:_____ □ Male □ Female
What do you prefer to be called:_____ SS# _____
Street Address_____ City_____ State_____ Zip_____
Date of Birth:_____ Age:_____Who referred you to us?_____
Phone #: Home_____Work_____Cell_____
Status: □minor □single □married □ divorced □ separated □ widowed
Employer:_____ How long?_____ Occupation:_____
Spouses name:_____Do you have children? □yes □ no How many?_____

HISTORY:

Reason for seeking chiropractic care:_____
Describe any health problems, including how long you have had them:

_____

_____

Describe the pain and it's location:_____
When did condition begin?___/___/___
Is the condition getting worse? □yes □ no □constant □ comes and goes
Is this condition interfering with your (circle) work, sleep or daily routine.
Explain_____
Have you had the same or similar conditions in the past? □yes □ no
Explain_____
Have you been treated by a medical physician for this condition? □yes □ no Where_____

CHIROPRACTIC HISTORY:

Have you ever been to a chiropractor before?□yes □no If yes, doctor's name_____
Date of last chiropractic visit_____Reason for care_____
Date of last chiropractic x-rays_____How long were you under care?_____
Are other family members under chiropractic care? □yes □ no Who?_____

WELLNESS COMMITMENT:

At this chiropractic office we are dedicated toward achieving the goal of total lasting health for our members. To better help you achieve this, we need to understand your commitment toward being healthy. We do not ask for a financial commitment, but we do ask for your cooperative commitment. Based on a scale of 10% to 100% please circle your personal level of commitment toward obtaining and maintaining wellness.

10%-----20%-----30%-----40%-----50%-----60%-----70%-----80%-----90%-----100%

For Females: Are you taking birth control? □yes □ no
Are you Pregnant? □yes □ no / How far long?_____ Nursing? □yes □ no

IN EVENT OF EMERGENCY:

Contact:_____ Relation:_____
Home phone:_____Work or Cell phone:_____

HEALTH HISTORY:

Current Weight _____lbs. Current Height _____ft. _____in.

Are you taking any of the following medications?

□Nerve pills□ pain killers □muscle relaxers □stimulants □blood thinners □ insulin □tranquilizers □other(s)_____

Do you have or have you had any of the following?

Y N Heart Attack/Stroke	**Y N Heart Surg/Pacemaker**	**Y N Heart Murmur**
Y N Congenital Heart Defect	**Y N Mitral Valve Prolapse**	**Y N Artificial Valves**
Y N Alcohol/ Drug Abuse	**Y N Venereal Disease**	**Y N Hepatitis**
Y N HIV+/Aids	**Y N Shingles**	**Y N Cancer**
Y N Frequent Neck Pain	**Y N Emphysema/ Glaucoma**	**Y N Anemia**
Y N High/Low Blood Pressure	**Y N Psychiatric Problems**	**Y N Rheumatic Fever**
Y N Frequent Headaches	**Y N Kidney Problems**	**Y N Ulcers/ Colitis**
Y N Seizures/Epilepsy	**Y N Sinus Problems**	**Y N Asthma**
Y N Diabetes/ Tuberculosis	**Y N Difficulty Breathing**	**Y N Chemotherapy**
Y N Lower Back Problems	**Y N Artificial Bones/ Joints**	**Y N Arthritis**
Y N Fainting	**Y N Insomnia**	**Y N Digestive Problems**

Please list any other serious medical condition (s) you have or ever had:_____

_____

List anything you may be allergic to:_____

List previous surgeries/ treatments with dates:_____

_____

List any past accidents with dates:_____

_____

List any x-rays you have had in the past 2 years:_____

Family Health History:_____

Do you take supplements or vitamins?□yes □no Exercise □yes □no special diet? □yes □ no

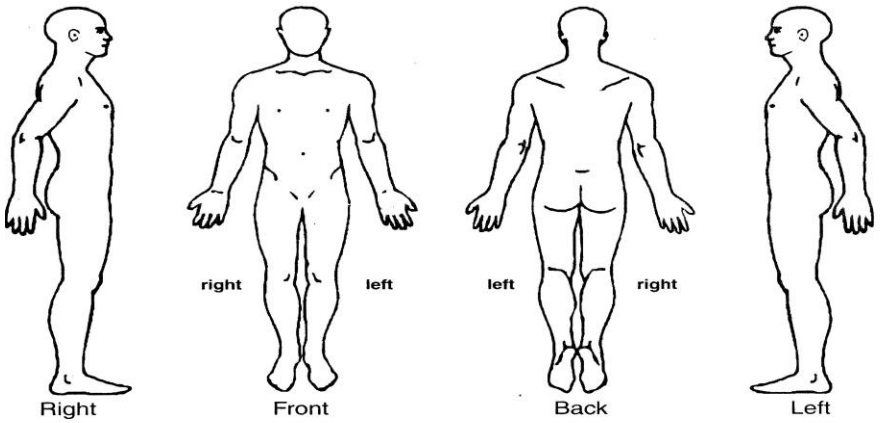
Do you smoke □yes □no How much?____ How long?____ How old is your mattress?_____

Is it comfortable?□yes □no Do you wear □Heel Lifts □Sole Lifts □Inner soles □Arch supports

SHOW US WHERE IT HURTS:

Mark areas of injury or discomfort with the appropriate symbols and indicate the degree of pain using a scale from 1 (discomfort) to 10 (extreme pain).

Description-	**Numbness**	**Pins & Needles**	**Burning**	**Aching**	**Stabbing**
Symbol-	**NNNN**	**PPPP**	**BBBB**	**AAAA**	**SSSS**



<u>INSURANCE INFORMATION</u>: Insurance Company name:____________________________
Address________________________________Phone#___________________________________
InsuredSS#____________________ID#__________________________Group#______________
Insured's Name:_____________________________________ Relation:_____________________
Insured's Date of Birth: ___/___/____ Insured's Employer_______________________________

<u>ACCOUNT INFORMATION:</u> Person ultimately responsible for account
Name:_____________________________ Relation:__________________________
Billing Address:____
SS#:________________________________ D.L. # __________________________
Work Phone# ____________________ Cell Phone#__________________________

Payment Method: ☐CASH ☐ CHECK ☐CREDIT CARD

______ (initials) I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.

- **We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between the provider and the patient.**
- **Our office policy requires payment in full for all services rendered at the time of visit, unless prior arrangements have been made with the office manager. If account is not paid within 90 days from the date of service and no arrangements have been made, I understand I am responsible for legal fees, collection agency fees and any other expenses incurred in collecting my account .**
- **I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release information required to process insurance claims.**
- **I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information that I have provided.**

Signature____ Date ____/____/____

****

If patient is under the age of 18 this portion needs to be filled out

<u>CONSENT TO TREATMENT OF MINOR CHILD</u>

I hereby authorize Dr. Zivkovic and whomever he/she may designate as assistant to administer treatment as he/she so deems necessary to my <u>son/ daughter</u>, ___________________________
Date:_____________________

Parent/ Guardian- Print & Sign:____

Witness/ Office staff:____
****

ZIVKOVIC CHIROPRACTIC CENTER
DR. ANNETTE ZIVKOVIC DR. ROBERT ZIVKOVIC
We're Working Together For Your Health.

Informed Consent for Chiropractic Care

Chiropractic care, like all forms of health care, while offering considerable benefit, may also provide some level of risk. This level of risk is most often very minimal, yet in extremely rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain strain injuries, irritation of a disc condition, and, rarely, fractures. One of the rarest complications associated with chiropractic care—occurring at a rate between one instance per one million to one instance per two million-is the instance of cervical spine (neck) adjustments being applied to a pre-existing vertebral artery injury that could result in stroke.
Prior to receiving chiropractic care in this office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

I understand and accept that there are risks associated with chiropractic care and give my consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments, as reported following my assessments.

_____ _____

Patient Name (Printed) **Date**

_____ _____

Patient or Legal Guardian Signature **Relationship to Patient**

_____ _____

Witness Signature (Office Staff) Date

*****FINANCIAL POLICY*****

OUR OFFICE POLICY IS THAT FEES ARE DUE WHEN SERVICES ARE RENDERED

PLEASE INITIAL LINES 1-5 AND SIGN THE BOTTOM AFTER YOU HAVE READ AND UNDERSTAND THEM ALL.

We will gladly discuss the cost of your visit and do our best to answer any questions related to payments or insurance. However, you must realize that:

1. **_____ If you have any insurance that you would like us to file, you must provide the benefit information and any forms to the receptionist prior to treatment. Please check with the receptionist to assure that we are contracted providers for your insurance.**
2. **_____ If you choose to use any form of insurance, you will be responsible for any claims that are not paid within 90 days. WE DO NOT FILE SECONDARY INSURANCE. We will be happy to run a receipt of each visit for you to send to your secondary insurance.**
3. **_____ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered.**
4. **_____ I do hereby agree to pay for any treatment at the time of visit and that I will be held responsible for the balance of my account.**
5. **_____ I understand the methods of payment accepted are credit cards, checks and cash. If payment is returned for insufficient funds, a fee of $ 25.00 will be charged.**

Signature:_____ Date:_____

WE MUST EMPHASIZE AS YOUR HEALTH CARE PROVIDER, OUR RELATIONSHIP AND CONCERN IS WITH YOU AND YOUR HEALTH, NOT YOUR INSURANCE COMPANY.

ZIVKOVIC CHIROPRACTIC CENTER

DR. ANNETTE ZIVKOVIC DR. ROBERT ZIVKOVIC

We're Working Together For Your Health

DOCTOR/ PATIENT RELATIONSHIP IN CHIROPRACTIC

CHIROPRACTIC:

It is important to recognize the difference between chiropractic and medicine. Either can be important to your health, but for entirely different reasons. Chiropractors seek to restore health through natural means and without the use of medicine or surgery. Although a medical diagnosis may be of great importance to a patient, such diagnosis does not necessarily assist the chiropractor in his efforts. The chiropractor's purpose is to restore health through the natural flow of energy in the nervous system. This gives the body maximum opportunity to heal itself. The success of the Chiropractic procedures often depends upon underlying causes and conditions. It is important to understand what to expect from chiropractic and medical services in order that you, the patient, can determine whether either or both may be of benefit to you.

ANALYSIS:

A chiropractor conducts a chiropractic analysis for the express purpose of determining whether there is evidence of spinal subluxation. When such subluxations are found, Chiropractic adjustments are given to restore spinal alignment. It is the chiropractor's premise that proper spinal alignments allows free nerve flow throughout the body and gives the body its best chance to restore health. Due to the complexities of nature, no chiropractor can promise you specific results. This depends upon the recuperative powers of the body.

DIAGNOSIS:

Although chiropractors are experts in chiropractic analysis, they are not specialists in the field of diagnosis. Internists are medical specialists who are highly qualified to diagnosis. Every chiropractic patient should be mindful of his own symptoms and should secure medical opinion if he has any concern as to the nature of his illness or injury. Your doctor of chiropractic may express an opinion as to whether or not you should take this step, but you should take the initiative if in doubt.

CHIROPRACTIC ADJUSTMENTS:

The patient, in coming to the chiropractic gives the chiropractor permission and authority to adjust the patient in accordance with the chiropractic analysis. The chiropractic adjustment is usually beneficial and seldom causes any problem. In rare cases underlying physical defects, deformities, or pathology may render the patient susceptible to injury. The chiropractor of course, will not give a chiropractic adjustment if he is aware that such conditions exist. Again, it is the responsibility of the patient to make it known, to learn through medical procedures whether he is suffering from latent pathological defects illness or deformity which otherwise would not come to the attention of the chiropractor. The patient should not look to the Doctor of Chiropractic for indepth diagnosis procedures. The Doctor of Chiropractic provides a specialized health service, does not and should not become involved in the patient's medical regimen. A patient should never ask or accept advice from a chiropractor concerning the taking of prescriptive medicines. The Doctor of Chiropractic is not licensed in medical practices.

RESULT:

The purpose of chiropractic services is to promote natural health through the release of maximum nervous energy. Since there are so many variables, it is difficult to predict the time schedule and efficiency of chiropractic procedures. Sometimes the response is phenomenal, In some cases, there is more gradual, but quite satisfactory response. Occasionally, the results are mediocre or dismal. Two or more similar conditions may respond differently to the same chiropractic care. Many medical failures find quick relief through chiropractic. In turn, we must admit that conditions, which do not respond chiropractic care, may come under control or be better treated through medical science. The fact is, the sciences of chiropractic and medicine may never be so exact as to provide definite answers to many problems. Both have made great strides in alleviating pain and controlling disease.

The patient should discuss any questions or problems with the doctor before signing this statement of policy.

ACKNOWLEDGEMENT:

I HAVE READ THE FOREGOING AND UNDERSTAND IT. Signed this day of _____,_____.

SIGNATURE

COPYING OF X-RAYS

If you have supplied your own x-rays at the time of examination or will receive x-rays at our clinic, please note the following policy and sign below:

" I understand that all records/ x-rays supplied by me and/or taken by the Zivkovic Chiropractic Center will become part of my permanent records and remain in the custody of this clinic. I am entitled to obtain copies at any time of my records as long as I sign an authorization for their release and agree to pay the cost of copying those records. I understand that I must give at least 10 (ten) days notice to the Zivkovic Chiropractic Center to allow ample time for copying of my records."

Patient Name :____

Signature :____

Date :____

****

RECEIPT OF NOTICE OF PRIVACY PRACTICES/ WRITTEN ACKNOWLEDGMENT FORM

I acknowledge that I have reviewed a copy of Zivkovic Chiropractic Center's Privacy Practices.
(If you would like a copy to take home please request it at the front desk)

I allow the following individual(s) to be given information regarding care
____

____

Patient/ Legal Guardian Print:____

Patient or Legal Guardian Signature:____

Date:______________________________

AUTO RELATED ACCIDENT

Today's date:_____ File#_____
Name:_____

Date & time of Accident:_____ □ a.m. □ p.m.
Were you the: □ Driver □ Front Passenger □ Rear Passenger
If a traffic violation was issued, to whom was it issued? _____

Number of people in accident vehicle?_____ Did police come to accident site? □ Yes □ No
Was a police report filed? □ Yes □ No
Were there any witnesses? □ Yes □ No
Were you wearing your seatbelt? □ Yes □ No
Was this vehicle equipped with airbags? □ Yes □ No
If yes, did they inflate? □ Yes □ No
In relation to the base of your skull, where was the headrest? □ Above □ Below □ At base of skull
What did your vehicle impact?□ Another vehicle □ Other, explain_____
Did any part of your body strike anything in the vehicle? □ Yes □ No If es, please describe:_____
_____

Make & model of the vehicle you were occupying?_____
Name of the location/street on which you were traveling?_____
In which direction were you headed? □ N □ S □ E □ W
What was the approximate speed of your vehicle? _____

Did the impact to your vehicle come from the □ Front □ Rear □ Right Side □ Left side □ Other
During impact, were you facing: □ Right □ Left □ Forward
Were you □ aware or □ surprised by the impact?
If accident vehicle made impact with another vehicle, make & model of the other vehicle_____
_____
Direction other vehicle was headed? □ N □ S □ E □ W
Speed of the other vehicle?_____
In your words please describe the accident:_____
_____

Insurance information:
*Your auto insurance company:_____ Adjusters name/ #: _____
Your auto claim #_____ Policy #_____

*The other parties insurance company_____ Adjusters name/ #: _____
Claim # (if given) _____ Their policy #_____Insured's name_____

Your health insurance company_____ ID#_____ Grp#_____
PLEASE GIVE COPIES OF ALL INSURANCE CARDS AND REPORTS TO FRONT DESK

To be completed by doctor
Complete record reviewed by :_____ Date:_____

AFTER INJURY

Did the accident render you unconscious? □ Yes □ No
If yes, for how long?_____

Describe how you felt immediately after the accident?
_____
_____

Have you gone to a hospital or seen any other doctor? □ Yes □ No
When did you go? □ Just after the accident □The next day □ 2 days +
How did you get there? □ Ambulance □ Private transportation

Name of hospital or doctor_____
Was he/she a: □ D.C. □ M.D. □ D.O. □ D.D.S.
Describe any treatment you
received:_____
_____

Were x-rays taken? □ Yes □ No
Was medication prescribed? □ Yes □ No

Have you been able to work since this injury? □ Yes □ No
Are your work activities restricted as a result of this injury □ Yes □ No

Is your condition getting worse? □ Yes □No □Constant □Comes & goes

Indicate your degree of comfort while performing the following activities:

	Comfortable	Uncomfortable	Painful
Lying on back.	□	□	□
Lying on side	□	□	□
Lying on stomach .	□	□	□
Sitting	□	□	□
Standing	□	□	□
Stretching	□	□	□
Lovemaking	□	□	□
Walking	□	□	□
Running	□	□	□
Sports	□	□	□
Working	□	□	□
Lifting	□	□	□
Bending	□	□	□
Kneeling	□	□	□
Pulling	□	□	□
Reaching	□	□	□

Indicate X for the symptoms that are a result of this accident:

□ Dizziness
□ Difficulty sleeping
□ Jaw problems
□ Nausea
□ Memory loss
□ Irritability
□ Back pain
□ Arm/Shoulder pain
□ Headache(s)
□ Fatigue
□ Lower back pain
□ Numb hands/fingers
□ Blurred vision
□ Tension
□ Chest pain
□ Back stiffness
□ Buzzing in ear
□ Neck pain
□ Leg pain
□ Shortness of breath
□ Ears ringing
□ Neck stiff
□ Stomach upset
□ Numb feet/toes
□ Other_____
_____
_____

****

Have you retained an attorney? □ Yes □ No
if so, who_____

His/her phone#
_____

APPLICATION FOR "NO FAULT" BENEFITS

DATE	OUR POLICY HOLDER	DATE OF ACCIDENT	FILE NUMBER

(Pursuant to Florida Statute 817.234, any person knowing and with intent to injure, defraud or deceive any insurance company filing a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree.)

TO ENABLE TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE PERSONAL INJURY PROTECTION LAW, PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY.

YOUR NAME | PHONE NUMBER HOME . | BUSINESS

FULL ADDRESS PERMANENT ADDRESS, IF DIFFERENT. HOW LONG IN FLA. | DATE OF BIRTH | SOCIAL SECURITY NO.

DATE AND TIME OF ACCIDENT A.M. P.M. | PLACE OF ACCIDENT (STREET, CITY OR TOWN AND STATE)

BRIEF DESCRIPTION OF ACCIDENT

DESCRIBE MOTOR VEHICLE YOU OWN:

OTHER VEHICLES IN YOUR FAMILY:	VEHICLE:	OWNER:	INSURER:
	1._____	1._____	1._____
	2._____	2._____	2._____
	3._____	3._____	3._____

AS A RESULT OF THIS ACCIDENT WERE YOU INJURED? YES NO | 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? YES ☐ NO ☐ | DOCTOR'S NAME AND ADDRESS

IF YOU WERE TREATED IN A HOSPITAL, WERE YOU --------- HOSPITAL'S NAME AND ADDRESS

AN IN-PATIENT? ☐ OUT-PATIENT ☐

AMOUNT OF MEDICAL BILLS TO DATE $ | WILL YOU HAVE MORE MEDICAL EXPENSE? YES ☐ NO ☐ | AT THE TIME OF ACCIDENT, WERE YOU IN THE COURSE OF YOUR EMPLOYMENT? YES ☐ NO ☐

DID YOU LOSE WAGES OR SLARY AS A RESULT OF YOUR INJURY? YES ☐ NO ☐ | IF YES, AMOUNT LOST TO DATE $ | WHAT IS YOUR AVERAGE WEEKLY WAGE OR SALARY?

IF YOU LOST WAGES: DATE DISABILITY FROM WORK BEGAN | DATE YOU RETURNED TO WORK

HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR PAYMENTS UNDER ANY WORKER'S COMPENSATION OR EMPLOYMENT LAW? IF YES:

$_____ per week Name of W/C Insurer:
$_____ per month

Have you received or are you eligible for benefits from the following sources:
Medicaid NO ☐ YES ☐ $ _____ Health Insurer, if any, name
Medicare NO ☐ YES ☐ $ _____
Military Benefits NO ☐ YES ☐ $ _____ $_____

LIST NAMES AND ADDRESSES OF YOUR PRESENT EMPLOYER (s) AND GIVE YOUR OCCUPATION AND DATES OF EMPLOYMENT FOR EACH

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

AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES? YES ☐ NO ☐ IF YES, EXPLAIN ON REVERSE SIDE.

I hereby release medical information including, but not limited to, medical bills and reports, to such parties as the company may deem necessary to perfect its rights to recovery under the NO-Fault Act.

SIGNATURE:_____DATE:_____

IMPORTANT: 1. TO BE ELIGIBLE FOR BENEFITS COMPLETE AND SIGN THIS APPLICATION

zivkovic chiropractic

Dr. Annette Croskey-Zivkovic Dr. R. Robert Zivkovic

In accordance with the new Personal Injury Protection laws, which went into effect in October 2003, the following is being disclosed to you as a patient.

99204-25	E/M Comprehensive Exam (New Patient)	$ 275.00
99213-25	E/M Detailed Exam (Established Patient)	$ 200.00
99211-25	E/M Minimal (Established Patient)	$ 40.00
99070	Supplies (Ice Pack)	$ 15.00
72040	X-Ray Cervical AP and LAT	$ 65.00
72070	X-Ray Thoracic Spine	$ 70.00
72100	X-Ray Lumbosacral	$ 70.00
72050	X-Ray Cervical 4 views	$ 110.00
98942	Adjustment	$ 55.00
98941	Adjustment	$ 45.00
97140	Manual Therapy	$ 65.00
97139	Cold Laser Therapy (Q1000)	$ 65.00
97012	Mechanical Traction Therapy	$ 20.00
98943	Adjustment of Extremity	$ 55.00

Signature:_____ Date:_____

Print Name:_____

4371 U.S. Highway 17 Suite #104 Fleming, Island, FL 32003
www.chiroz.com Office: (904)278-4888 Fax: (904)278-1166

Pain Disability Questionnaire

The Pain Disability Questionnaire is used in Chapter 3 Pain (6th ed, 43-44) and Chapter 17 Spine (6th ed, 599-600). The format provided utilizes a centimeter scale to score, however the size in the *Guides* does not correspond with the same scale. An alternative approach (illustrated below) provides easily administered and scored numerical scales.

Patient Name _____ Date _____

Instructions: These questions ask your views about how your pain now affects how you function in everyday activities. Please answer every question and mark the ONE number on EACH scale that best describes how you feel.

1. Does your pain interfere with your normal work inside and outside the home?
Work normally — Unable to work at all
0 ------- 1 ------- 2 ------- 3 ------- 4 ------- 5 ------- 6 ------- 7 ------- 8 ------- 9 ------- 10

2. Does your pain interfere with personal care (such as washing, dressing, etc)?
Take care of myself completely — Need help with all my personal care
0 ------- 1 ------- 2 ------- 3 ------- 4 ------- 5 ------- 6 ------- 7 ------- 8 ------- 9 ------- 10

3. Does your pain interfere with your traveling?
Travel anywhere I like — Only travel to see doctors
0 ------- 1 ------- 2 ------- 3 ------- 4 ------- 5 ------- 6 ------- 7 ------- 8 ------- 9 ------- 10

4. Does your pain affect your ability to sit or stand?
No problems — Cannot sit /stand at all
0 ------- 1 ------- 2 ------- 3 ------- 4 ------- 5 ------- 6 ------- 7 ------- 8 ------- 9 ------- 10

5. Does your pain affect your ability to lift overhead, grasp objects, or reach for things?
No problems — Cannot do at all
0 ------- 1 ------- 2 ------- 3 ------- 4 ------- 5 ------- 6 ------- 7 ------- 8 ------- 9 ------- 10

6. Does your pain affect your ability to lift objects off the floor, bend, stoop, or squat?
No problems — Cannot do at all
0 ------- 1 ------- 2 ------- 3 ------- 4 ------- 5 ------- 6 ------- 7 ------- 8 ------- 9 ------- 10

7. Does your pain affect your ability to walk or run?
No problems — Cannot walk/run at all
0 ------- 1 ------- 2 ------- 3 ------- 4 ------- 5 ------- 6 ------- 7 ------- 8 ------- 9 ------- 10

8. Has your income declined since your pain began?
No decline — Lost all income
0 ------- 1 ------- 2 ------- 3 ------- 4 ------- 5 ------- 6 ------- 7 ------- 8 ------- 9 ------- 10

9. Do you have to take pain medication every day to control your pain?
No medication needed — On pain medication throughout the day
0 ------- 1 ------- 2 ------- 3 ------- 4 ------- 5 ------- 6 ------- 7 ------- 8 ------- 9 ------- 10

10. Does your pain force your to see doctors much more often than before your pain began?
Never see doctors — See doctors weekly
0 ------- 1 ------- 2 ------- 3 ------- 4 ------- 5 ------- 6 ------- 7 ------- 8 ------- 9 ------- 10

11. Does your pain interfere with your ability to see the people who are important to you as much as you would like?
No problem — Never see them
0 ------- 1 ------- 2 ------- 3 ------- 4 ------- 5 ------- 6 ------- 7 ------- 8 ------- 9 ------- 10

12. Does your pain interfere with recreational activities and hobbies that are important to you?
No interference — Total interference
0 ------- 1 ------- 2 ------- 3 ------- 4 ------- 5 ------- 6 ------- 7 ------- 8 ------- 9 ------- 10

13. Do you need the help of your family and friends to complete everyday tasks (including both work outside the home and housework) because of your pain?
Never need help — Need help all the time
0 ------- 1 ------- 2 ------- 3 ------- 4 ------- 5 ------- 6 ------- 7 ------- 8 ------- 9 ------- 10

14. Do you now feel more depressed, tense, or anxious than before your pain began?
No depression/tension — Severe depression / tension
0 ------- 1 ------- 2 ------- 3 ------- 4 ------- 5 ------- 6 ------- 7 ------- 8 ------- 9 ------- 10

15. Are there emotional problems caused by your pain that interfere with your family, social and or work activities?
No problems — Severe problems
0 ------- 1 ------- 2 ------- 3 ------- 4 ------- 5 ------- 6 ------- 7 ------- 8 ------- 9 ------- 10

Anagnostis C, Gatchel RJ, Mayer TG. The Pain Disability Questionnaire: A New Psychometrically Sound Measure for Chronic Musculoskeletal Disorders. *Spine* 2004; 29 (20): 2290-2302.

ZIVKOVIC
CHIROPRACTIC CENTER

We're Working Together For Your Health

Dr. Annette Zivkovic
Dr. R. Robert Zivkovic

ASSIGNMENT OF BENEFITS/POLICY RIGHTS

PATIENT: _____

I, the undersigned patient hereby assign the rights and benefits of insurance of the applicable personal injury protections, medical payments, and/or other insurance to the above captioned medical provider of services and/or supplies rendered for treatment of personal injuries sustained in the subject accident to the undersigned patient and covered by Personal Injury Protection (PIP) in accordance with Florida Statute 627.736. The undersigned agrees to pay any applicable deductible or co-payment not covered by PIP or other insurance coverage. I have read the information herein and it is true to the best of my knowledge.

This assignment includes, but is not limited to, all rights to collect benefits directly from the insurance company for services that I have received; and all rights to proceed against the insurance company obligated to provide benefits in any action including legal suit, if for any reason the insurance company fails to make payments of benefits of which I am due. Specifically, this assignment includes the right to collect payment for the reasonable costs connected with copying and mailing records to the insurer at the insurer's request and in accordance with Florida Statute 627.736. Also this assignment includes the right to obtain a payout sheet or payment ledger or log, as well all relevant information in connection with my claim for the subject accident. I agree that upon signing my rights away to the provider above, the provider stands in my shoes and has all the rights and benefits that I would have under the subject policy. This assignment also includes any right to cover attorney's fees and costs for such action brought by the provider as Patient's assignee.

As part of this assignment of rights and benefits, I hereby instruct the insurance carrier that in the event the subject medical benefits are disputed for any reason, including medical reasonableness and or necessity that the amount of benefits at issue be set aside and not disbursed until the dispute is resolved. As part of this assignment of rights and benefits, I further instruct the insurance carrier to notify the provider immediately of any dispute as to payment so that he/she/it may exercise their legal rights. I understand that any person who knowingly files anything containing any false, incomplete or misleading information with the intent of injure, defraud, or deceive any insurance company is guilty of a felony of the third degree. I have read the information herein and it is true and correct to the best of my knowledge and belief.

_____ _____

PATIENT SIGNATURE DATE

_____

PATIENT'S PRINTED NAME