Wellspring
HEALTH & SPORTS PERFORMANCE

Motor Vehicle Accident Intake Form

Name of **First Medical Provider** Seen For This Accident: _____
Provider's Location: _____ Date Seen: _____
Treatment Plan: _____
_____

Contact Information
Name: _____ Nickname: _____
Date of Birth: ___/___/___ Age: ___ Sex: M__ F__ Marital Status: S__ M__ W__ D__
Phone: (H) _____ (W) _____ (Cell) _____ E-Mail: _____
Address: _____ Apt. # _____
City: _____ State _____ Zip _____
Occupation: _____ Position: _____
Spouse: _____ Spouse Date of Birth: __/___/__ Spouse's Employer _____
Children (Name & Ages): _____
Emergency Contact: _____ Phone: _____

Legal Representation: No / Yes
Name: _____ Phone: _____
Address: _____

Your Information:
Insured's Name: _____
Insurance Company Name: _____ Insured's Date of Birth: ___/___/___
Group Number: _____ Member ID _____

Other Vehicle's Information (*if applicable*):
Insured's Name: _____
Insurance Company Name: _____ Insured's Date of Birth: ___/___/___
Group Number: _____ Member ID _____

Claim Number: _____

Date of Accident: _____ Time of Accident: _____ AM / PM
Your Location in Vehicle: Driver / Front Passenger / Back Right Passenger / Back Middle Passenger / Back Left Passenger
Type of vehicle driving: CAR / TRUCK / SUV / VAN Make: _____ Model: _____ Year: _____

By my signature I affirm that the above information is accurate and complete.

Patient's / Guardian's Signature: _____ Date: _____

710 3RD STREET NORTH. JACKSONVILLE BEACH, FL 32250

P: 904-249-1551 ▪ F: 904-249-1530 ▪ WSPHEALTH.COM

Wellspring
HEALTH & SPORTS PERFORMANCE

Location of Accident (Street/ City / State) _____ N/ S/E/W bound

_____

Physical Conditions Before Accident: _____

_____

_____

_____

Brief Description of the Accident: _____

_____

_____

_____

_____

Describe how you felt:

During the Accident _____

_____

_____

Later that day _____

_____

The next day _____

_____

By my signature I affirm that the above information is accurate and complete.

Patient's / Guardian Signature: _____ Date: _____

710 3RD STREET NORTH. JACKSONVILLE BEACH, FL 32250

P: 904-249-1551 ▪ F: 904-249-1530 ▪ WSPHEALTH.COM

Wellspring
HEALTH & SPORTS PERFORMANCE

1. When the Accident Occurred, I (was) ***(check all that apply)***
   ___ Stopped at a : ___ Traffic Light ____ Stop Sign and struck form behind
   ___ Struck "Head On" by another vehicle traveling in the Opposite Direction
   ___ Another vehicle struck my vehicle after running a ____ Red Traffic Signal ____ Stop Sign
   ___ Slowing down to make a stop or turn, when another vehicle struck my vehicle
   ___ Lost control of my vehicle and ___ Spun Around ___ Rolled Over ___ Side Swiped by another vehicle
   ___ Saw accident coming, and braced for impact
   Head facing ___ Right ___ Left ___ Straight and ___ Wearing a Seatbelt ____ Not wearing a seatbelt
2. During the Accident, I struck the following objects inside the vehicle ***(check all that apply)***
   ___ Steering Column ____ Rear view mirror ____ Dash Board ___ Windshield ___ Head Rest
   ___Door Frame ___ Generally Jarred and Thrown About ___ My Seat Broke
   ___ I was Dazed, can not Remember the Details of What I Might Have Struck
3. During the Accident, the Following Parts of My Body Struck the Inside of the Vehicle ***(check all that apply)***
   ___Head ___ Face ___ Chest ___ Stomach ___ Knee ___ Arms ___ Bruises from the Seat Belt
   Other: _____
4. Following the Accident, I Experienced Symptoms Listed, or Pain in the following Area(s): ***(check all that apply)***
   ___ Headache ___ Dizziness ___ Light Headed ___ Neck Pain ___ Mid Back Pain ___ Low Back Pain
   ___ Arm Pain L /R ___ Leg Pain L / R ___ Hip Pain ___ Numbness or Tingling. Where?_____
   ___ Other _____
5. Immediately After the Accident I Did the Following:
   ___ Drove My self-Home ___ Had Someone Drive Me Home ___ Was Taken By Ambulance to the Hospital.
   ___ Was Driven to the Hospital by a Friend ___ Did not Feel Any Immediate Pain, but I felt Worse Later and Went to the Hospital ___ Went to Primary Care Doctor
6. I was seen in the Emergency Room at the Hospital? No / Yes Where? _____

If seen in the Emergency Room
Were You Admitted to the Hospital? No / Yes Where? _____
If yes, How Long Did You Stay in the Hospital? _____
Admitting Physician's Name_____
If Seen by Primary Care Physician
Date of visit: _____ Type of Physician: _____
I received the Following Treatments and/ or Procedures: ***(explain below)***

Examination: _____
Prescription: _____
Imaging (X-ray / CT): _____
Stitches/ Staples: _____
Therapies: _____
Supports/ Braces: _____
Other: _____
If seen by a Physician:
I Received the Following Instructions:
___ Go Home and Rest. If So, How long? : _____
___ Work Instruction ___ Return to Work ___ Disability Given From: ___ To: ___
___ See Another Physician. If a Specific Physician Recommended, Who? _____
___ Home Treatment: ___ Ice ___ Heat ___ Other _____
___ Return to the Hospital for Further Treatment
Other: _____

710 3RD STREET NORTH. JACKSONVILLE BEACH, FL 32250

P: 904-249-1551 ▪ F: 904-249-1530 ▪ WSPHEALTH.COM

Wellspring
HEALTH & SPORTS PERFORMANCE

Present Complaint

1. What is your major complaint? _____
2. What caused this problem? _____
3. When did your major complaint start? _____
4. Where is your pain located? _____
5. Does the pain travel / radiate and where? _____
6. Severity of the pain: Mild____ Moderate____ Severe ____
7. Rate the pain on a scale from 0-10 (10 being the worst): Currently: __/ 10 Worst __/10 Best __/10 Average __/10
8. Describe the pain: Sharp_____ Dull_____ Numbness_____ Tingling_____ Aching_____Itchy____
   Burning_____ Stabbing_____ Other_____
9. How frequent is the condition? Constant_____ Intermittent____ Night Only___ Day Only _____ With Activity ____
10. How long does it last? All Day_____ Few Hours_____ Minutes_____ Seconds _____
11. What makes the problem worse? Standing_____ Sitting_____ Lying_____ Bending_____ Breathing____
    Twisting___ Lifting___ Sleeping____ Other_____
12. Is there anything you can do to relieve the problem? Yes__ No__
    If yes, please describe: _____
13. Is this a recurrence? Yes__ No__ If yes, when did you first notice the problem?_____
14. Have you received any previous treatment for this condition? Yes__ No__ When: _____
    Type of treatment: _____ Provider: _____
15. What have you done, on your own, to treat this condition? Rest __ Ice __ Heat __ TENS __ OTC Pain Pills __
    Other: _____
16. Does the pain feel like it is increasing, decreasing, or remaining the same intensity since its onset? _____
17. Are there any other conditions or symptoms you have that may be related to your major symptom? Yes___ No___
    If yes, describe_____
18. Is this condition affecting your ability to dress, bathe, or groom yourself? Yes __ No __
    If yes, describe_____
19. Is this condition preventing you from doing other activities (working out, etc.) ? Yes __ No __
    If yes, describe_____

ecent Imaging? X-rays_____ MRI_____ CT_____ Dexa _____ PET _____ Other: _____
Date: _____ Results: _____

ccident/Injuries: *(Please include all major injuries and traumas since birth)*

	Describe Injury	Age/ Date
ılls/Injuries?		
ıto Accidents?		
fections?		
ɔspitalizations?		
ther?		

710 3RD STREET NORTH. JACKSONVILLE BEACH, FL 32250

P: 904-249-1551 ▪ F: 904-249-1530 ▪ WSPHEALTH.COM

Wellspring
HEALTH & SPORTS PERFORMANCE

Patient's Name: _____ Date: _____

Significant Illness/ Conditions: (Check any which apply/ **explain**)

__Heart trouble
__Cancer
__Mental/Depression
__Tuberculosis
__Seizures/Stroke/TIA
__Thyroid problems
__Drugs/Alcohol
__High blood pressure
__Diabetes
__Arthritis
__Colon/Stomach Problems
__Blood Clots/Embolism
__Asthma/Lung Disease
__ Fractures
__ Herniated/ Bulging Disc
__ Spondylolisthesis
__ Degenerative Disc Disease
__ Sciatica
__ HIV positive
__ Liver/Kidney/Spleen
__Other_____

_____

_____

Surgical Procedures: (Check any which apply. Explain below in detail)

__Appendectomy
__Breast/implants
__Eye/Ear/Nose
__Heart/Lung
__Neck/Back
__Carpal Tunnel
__Prostate
__Stomach/Pancreas
__Brain
__Hysterectomy/D&C/Tubal
__Gallbladder
__Hernia
__Hip/Knee/Ankle/Foot
__Nerve
__Kidney
__Vasectomy
__Vascular/ Artery/ Vein
__Shoulder/Elbow
__ Abdominoplasty
__ Spinal Fusion
__ Laminectomy
__ Bone Fusions
__Pace Maker
__Other_____

_____

_____

PAYMENT IS EXPECTED AT TIME OF VISIT

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this chiropractic office will be credited to my account upon receipt. I also give this office power of attorney to endorse checks made out to me, to be credited to my account. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment.

I assign the payments of benefits due to me under my insurance policy with my carrier, and direct my insurance carrier to pay for all services rendered directly to Dunn Wellness Center.

I give permission to Dunn Wellness Center to release all medical information files in relation to my history and treatments to my insurance carrier in order to facilitate processing of insurance claims.

I have read and understand the information presented above. I affirm that the above information is accurate and complete.

Patient's Signature: _____ Date: _____

710 3RD STREET NORTH. JACKSONVILLE BEACH, FL 32250

P: 904-249-1551 ▪ F: 904-249-1530 ▪ WSPHEALTH.COM

Wellspring
HEALTH & SPORTS PERFORMANCE

Mark all ***current*** symptoms. Write "**N**" for new symptoms that occurred as a result of the accident. Write "**P**" for ***current*** symptom experienced prior to accident. Please **explain** in the blanks provided.

Gastrointestinal System

__ Poor appetite
__ Excessive Hunger
__ Difficulty Chewing
__ Difficulty Swallowing
__ Excessive Thirst
__ Nausea
__ Vomiting food
__ Vomiting Blood
__ Abdominal Pain
__ Diarrhea
__ Constipation
__ Black Stool
__ Bloody Stool
__ Hemorrhoids
__ Liver Trouble
__ Gall Bladder Problems
__ Weight Trouble

Nervous System

__ Numbness
__ Loss of Feeling
__ Paralysis
__ Dizziness
__ Fainting
__ Headache
__ Muscle Jerking
__ Convulsion
__ Forgetfulness
__ Confusion
__ Depression

Musculoskeletal System

__ Low Back Problems
__ Pain between Shoulders
__ Neck problems
__ Arm Problems
__ Leg Problems
__ Swollen Joints
__ Stiff Joints
__ Sore Muscle
__ Weak Muscles
__ Walking problems
__ Ruptures
__ Broken Bones

Female

__ Vaginal Discharge
__ Vaginal Bleeding
__ Vaginal Pain
__ Breast Pain
__ Lumps on Breast

Are you pregnant __ Y __ N

Genitourinary System

__ Bladder Troubles
__ Excessive Urination
__ Scanty Urination
__ Discolored Urine

Cardiovascular Respiratory System

__ Chest Pain
__ Pain over heart
__ Difficulty breathing
__ Persistent Cough
__ Coughing phlegm
__ Coughing Blood
__ Rapid Heartbeat
__ Blood pressure problems
__ Heart Problems
__ Lung problems
__ Varicose Veins

Eye, Ear, Nose, and Throat

__ Eye Strain
__ Eye inflammation
__ Vision Problems
__ Ear Pain
__ Ear Noises
__ Hearing loss
__ Ear Discharge
__ Nose Pain
__ Nose Bleeding
__ Nose Discharge
__ Difficult Breathing through

Nose

__ Sore Gums
__ Dental Problems
__ Sore Mouth
__ Sore Throat
__ Hoarseness
__ Difficult Speech

By my signature I affirm that the above information is accurate and complete.

Patient's / Guardian Signature: _____ Date: _____

710 3RD STREET NORTH. JACKSONVILLE BEACH, FL 32250

P: 904-249-1551 ▪ F: 904-249-1530 ▪ WSPHEALTH.COM

Wellspring
HEALTH & SPORTS PERFORMANCE

INFORMED CONSENT

I, _____ ***(Patient's Name),*** herby give permission to Dunn Wellness Center's licensed Chiropractic Physicians, ***Dr. Marcus Kampfe and Dr. Kim Johnston,*** to render Chiropractic care. I give permission to Dunn Wellness Center's licensed massage therapists to perform soft tissue therapies.

(Please initial each below)

___**Chiropractic** focuses on disorders of the neuromusculoskeletal system and its effect on general health. These disorders include, but are not limited to, back pain, neck pain, hip pain, arm pain, leg pain, and headaches. Doctors of Chiropractic utilize a drug-free, hands-on approach to health care that includes patient examination, diagnosis, and treatment. A chiropractic adjustment or manipulation is used to restore joint mobility by manually applying a controlled force into joints that are restricted in their movement. This can cause physical and chemical changes to the body that can cause inflammation, pain, and diminished function. Chiropractic care can affect the joints and tissues to help to restore mobility, thereby alleviating pain, muscle tightness, and allowing tissues to heal.

___**Soft Tissue Therapies** include Functional Specific Microcurrent, Myofascial Release, and Neuromuscular Therapy. These therapies help to decrease muscle spasm, tightness, soreness, and trigger points. Frequency Specific Microcurrent is a physiological electric modality that increases ATP (energy) production in the cells of your body to increase tissue healing by targeting specific frequencies to the targeted tissue.

___ ***I understand*** that Chiropractic is not intended for the treatment or cure of a specific disease or illness, but rather helps maintain optimal efficiency of the body.

___ ***I understand*** that there are risks associated with Chiropractic care. These include but are not limited to sprains, strains, muscle soreness, redness, bruises, fractures, dislocations, seizures, and cerebrovascular accidents.

___ ***I understand*** that there are alternatives to Chiropractic care. These alternatives include neuromuscular therapy, acupuncture, holistic medicine, and allopathic medicine. Patients will be referred to the appropriate health care provider when Chiropractic care is not suitable for the patient's condition, or the condition warrants co-management in conjunction with other members of the health care team.

___ ***I understand*** that my treatment plan may involve Chiropractic adjustments, acupuncture, neuromuscular therapies, soft tissue therapies, physical therapies, functional movement screenings, and therapeutic modalities including the following: instrument assisted soft tissue techniques (Graston Technique ®), ultrasound, electrical stimulation, Frequency Specific Microcurrent, KinesioTape®, stretching, and/ or corrective exercises.

___ ***I understand*** the benefits of Chiropractic care, and how it can positively affect my condition. I have had the opportunity to discuss the nature of my conditions with the doctor and understand why and how Chiropractic care and soft tissue therapies can help me. I will ask questions when applicable.

___ ******(if applicable)*** **CONSENT TO TREAT A MINOR:** I hereby authorize **Dr. Kampfe, Dr. Johnston,** and **their assistants** to administer the medically necessary chiropractic care and therapies, as they deem necessary, and without my presence when necessary to the above named patient, my _____ (*relationship*)

I have read and understand the information presented above. By my signature, I request and give my permission to receive Chiropractic care.

_____	_____	_____
Patient / Guardian Print Name	**Signature**	**Date**

710 3RD STREET NORTH. JACKSONVILLE BEACH, FL 32250

P: 904-249-1551 ▪ F: 904-249-1530 ▪ WSPHEALTH.COM

Wellspring

Records Release Authorization

To_____

Date_____ Phone_____ Fax_____

I, _____, do hereby declare that this request is made for the Continuation of Care with this Health Care Facility, staff and physicians. I request that you release any and all of the following medical records from my Confidential Health files:

ER notes; History & Physical Exam notes; Treatment notes; Admission documentation/diagnosis; Plain film/CT/MR reports; Surgical notes; Lab reports; Path reports; Discharge Summary; Electrodiagnostic studies; Physical therapy assessment, daily notes;, discharge summary; or _____; to:

Wellspring Health and Sports Performance
Marcus A. Kampfe, DC
Kim Johnston, DC

710 3rd Street North, Jacksonville Beach, FL 32250
Phone: (904) 249-1551, Fax: (904) 249-1530

This authorization will expire in six months from above date unless otherwise specified here_____/_____ (initials) and I may revoke this authorization at any time in writing.

_____ _____
Signature (Patient or Guardian) Date of Birth

_____ _____
Address Social Security Number

_____ _____
City State Zip Witness

AUTHORIZATION TO RECEIVE INSURANCE INFORMATION AND DOCUMENTATION

The undersigned Patient through this documentation as evidenced by the below signature authorizes their Personal Injury Protection Insurance Company and Health Insurance Company to provide: **Wellspring Health & Sports Performance**, and/or **Dr. Marcus A. Kampfe D.C.**, with any and all documents, reports, materials or information including but not limited to payout ledgers ("PIP logs"), insurance policies, declaration pages, to them when the above medical provider requests them.

The undersigned patient further directs and authorizes their Insurance Company to talk to the medical provider, or anyone acting on the medical provider's behalf, over the telephone and provide them with any information that they request.

_____ _____

Patient Signature Date

_____ _____

Patient Printed Name DOB

_____

Insured's Name

_____

Insurance Company /Claim Number

Jacksonville Chiropractic Associates, Inc d/b/a Wellspring Health & Sports Performance

ASSIGNMENT OF INSURANCE BENEFITS, RELEASE, & DEMAND

Insurer and Patient Please Read the Following in its Entirety

I, the undersigned patient/insured knowingly, voluntarily and intentionally assign the rights and benefits of my automobile Insurance, also known as Personal Injury Protection (P.I.P.), and Medical Payments policy of insurance to the above health care provider, including the right to file a law suit to seek payment of any unpaid PIP benefits, penalty, postage and/or interest. It is the intention of the provider to accept this assignment in lieu of demanding payment at the time services are rendered and that this document will allow the provider to file suit against an insurance company for payment of the insurance benefits. This assignment of benefits includes over due interest payments and any potential claim for common law or statutory bad faith. The undersigned directs the insurer to pay the health care provider directly.

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 settlement agreed to by the health provider and the insurer as to the amount payable under the insurance policy or contract. The provider hereby 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. Please send a copy of any scheduled defense examinations or examination under oath to this provider.

Release of information: I hereby authorize this provider to furnish an insurer, an insurer's intermediary, 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 in writing (declaration sheet) 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 statements the patient provided to the insurer; obtain copies of all medical records, X-rays, IMEs, and MRIs, from any other medical provider or any insurer. The provider may produce my medical records to its attorney in connection with any pending lawsuits. The insurer is directed to keep the patient's medical records private and confidential and is not authorized to provide these medical records to anyone without the patient's and the provider's prior express written permission.

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 and the insurance coverage declaration sheet 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 this provider's medical bills are disputed by the insurer for any reason the undersigned hereby instructs the insurer to set aside any amount disputed (i.e., to escrow the money) and not pay the disputed amount to anyone, including myself, or any entity until the dispute is resolved. The insurer is instructed to immediately explain in writing to the above provider of any dispute.

Certification: I certify that: I have read and agree to the above.

Caution: Please read before signing. If you do not completely understand this document please ask us to explain it to you. If you sign below we will assume you understand and agree to the above.

Date: _____

Patient's Name: _____

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