

**PATIENT QUESTIONNAIRE  
Clinic**

**Bauman Chiropractic**

3613 North Highway 231  
Panama City, Fl. 32404

DATE: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_ DOB: \_\_\_\_\_  
SS# \_\_\_\_\_ E-MAIL: \_\_\_\_\_

PHONE: (HOME) \_\_\_\_\_ (WORK) \_\_\_\_\_ (CELL) \_\_\_\_\_  
PHYSICAL ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_  
STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

MARITAL STATUS: M S D W Sep. SPOUSE NAME: \_\_\_\_\_  
(circle one)

IN CASE OF EMERGENCY NOTIFY: \_\_\_\_\_ PHONE: \_\_\_\_\_  
RELATIONSHIP: \_\_\_\_\_ ADDRESS: \_\_\_\_\_

WHO IS RESPONSIBLE FOR YOUR BILL?  SELF  SPOUSE  PARENT/GUARDIAN  
 EMPLOYER  OTHER: \_\_\_\_\_

MEDICAL INSURANCE CARRIER \_\_\_\_\_ ID# \_\_\_\_\_  
NAME OF INSURED \_\_\_\_\_ DOB \_\_\_\_\_ SS# \_\_\_\_\_

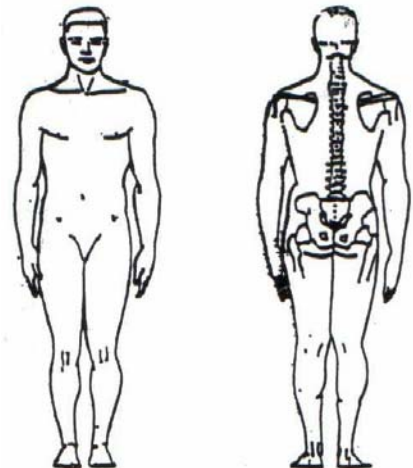
IS THIS INJURY DUE TO AN AUTOMOBILE ACCIDENT?  YES  NO  
DATE OF ACCIDENT \_\_\_\_\_ STATE ACCIDENT OCCURRED \_\_\_\_\_  
WERE YOU AT FAULT? \_\_\_\_\_ NAME OF INSURED \_\_\_\_\_  
AUTOMOBILE INSURANCE CARRIER \_\_\_\_\_  
PHONE # \_\_\_\_\_ CLAIM # \_\_\_\_\_

IS THIS A WORK RELATED INJURY?  YES  NO DATE OF ACCIDENT \_\_\_\_\_  
WORK COMP. INSURANCE CARRIER \_\_\_\_\_  
CLAIM # \_\_\_\_\_ ADJUSTER \_\_\_\_\_  
PHONE # \_\_\_\_\_

DO YOU HAVE A PRESCRIPTION?  CHIROPRACTIC  PHYSICAL THERAPY  
(not required)

PLEASE DESCRIBE YOUR PRIMARY COMPLAINT

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



PLEASE MARK THE EXACT LOCATION OF YOUR PAIN ON THE DIAGRAM.  
ALSO DESCRIBE THE FREQUENCY OF YOUR PAIN AND ANY ACTIVITY  
THAT INCREASES OR AGGRAVATES YOUR PAIN.

**PATIENT QUESTIONNAIRE – PAGE 2  
Clinic**

**Bauman Chiropractic**

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Panama City, FL. 32404**

DATE: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_

Please list the medications that you are currently taking:

\_\_\_\_\_ Nerve Pills: \_\_\_\_\_

\_\_\_\_\_ Pain Killers: \_\_\_\_\_

\_\_\_\_\_ Muscle Relaxers: \_\_\_\_\_

\_\_\_\_\_ "PEP" Pills: \_\_\_\_\_

\_\_\_\_\_ Tranquilizers: \_\_\_\_\_

\_\_\_\_\_ Insulin: \_\_\_\_\_

\_\_\_\_\_ Birth Control Pills: \_\_\_\_\_

\_\_\_\_\_ Diet Pills: \_\_\_\_\_

\_\_\_\_\_ Other: (please list) \_\_\_\_\_

FAMILY PHYSICIAN: \_\_\_\_\_

ADDRESS : \_\_\_\_\_ PHONE: \_\_\_\_\_

DATE LAST SEEN: \_\_\_\_\_

**FINANCIAL ARRANGEMENT:**

**Fees are payable at the time services are rendered, unless prior arrangements have been made.**

**ORIGINAL RADIOGRAPHS (X-RAYS) REMAIN PROPERTY OF THIS CLINIC**

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

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

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

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

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

# Bauman Chiropractic Clinic of Northwest Florida

3613 North Highway 231, Panama City Fl. 32404

Phone: 850-785-8311 Fax: 850-872-9892

## MEDICAL RECORDS REQUEST

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

SOCIAL SECURITY NO: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_ DATE OF LOSS: \_\_\_\_\_

CLAIM NUMBER: \_\_\_\_\_

FROM: \_\_\_\_\_

TO: BAUMAN CHIROPRACTIC CLINIC

3613 Hwy 231 North

PANAMA CITY, FL 32404

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

ف Date Requested \_\_\_\_\_

ف Medical Records     ف Progress Notes     ف Any Radiographs or other reports     ف Other: \_\_\_\_\_

SPECIFIC DESCRIPTION OF INFORMATION TO BE DISCLOSED \_\_\_\_\_

**THIS AUTHORIZATION IS GIVEN PURSUANT TO FLORIDA STATUTE 456.057 AND HIPAA REGULATIONS. I UNDERSTAND THAT FLORIDA STATUTE 456.057(10) MAKES CLEAR THAT ANY THIRD PARTY TO WHOM RECORDS ARE DISCLOSED IS PROHIBITED FROM FURTHER DISCLOSING ANY INFORMATION IN THE MEDICAL RECORD WITHOUT THE EXPRESSED WRITTEN CONSENT OF THE PATIENT OR THE LEGAL REPRESENTATIVES.**

\_\_\_\_\_  
PATIENT OR GUARDIAN SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
WITNESSED BY

I HEREBY AUTHORIZE BAUMAN CHIROPRACTIC CLINIC OF NORTHWEST FLORIDA P.A. TO RECEIVE A COPY OF MY PATIENT RECORDS OR X-RAYS CONTAINING PROTECTED HEALTH INFORMATION.

DATE FAXED: \_\_\_\_\_ (850-872-9892)

WILL PICK UP: \_\_\_\_\_ DATE: \_\_\_\_\_

DATE MAILED: \_\_\_\_\_

I HEREBY ACKNOWLEDGE RECEIPT OF THESE RECORDS AND/OR X-RAYS. IN CONSIDERATION OF THE FOREGOING, I HEREBY RELEASE AND FOREVER DISCHARGE THE AFORESAID DOCTOR OF CHIROPRACTIC FROM ANY AND ALL RESPONSIBILITY OR LIABILITY OF ANY KIND, NATURE, OR CHARACTER WHATSOEVER ARISING FROM SAID TREATMENT.

**BAUMAN CHIROPRACTIC CLINIC**

**Patient Name:** \_\_\_\_\_

**Identification Number:** \_\_\_\_\_

**ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)**

**NOTE:** If Medicare doesn't pay for items checked or listed in the box below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the items listed or checked in the box below.

<b>Listed or Checked Items Only:</b>	Any and All Examinations	Initial Each Item _____	Charges __ UP TO \$250. __
	Any and All X-Rays	_____	__ UP TO \$175. __
	Manipulations / Office Visits	_____	__ UP TO \$35.77 __
	Any and All Therapeutic Services	_____	__ UP TO \$172.80 __
	Any and All Modalities / Physical Therapy	_____	__ UP TO \$134.40 __
	Any and All Supports / Equipment / Supplements	_____	__ UP TO \$320. __
<b>Reason Medicare May Not Pay:</b>	NON COVERED SERVICES UNDER CHIROPRACTIC CARE		
<b>Estimated Cost:</b>	TO BE PAID AT TIME OF SERVICE		\$25.99 UP TO \$320.

**WHAT YOU NEED TO DO NOW:**

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the checked items listed in the first box above.

**Note:** If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

<b>Options:</b>	<b>Check only one box. We cannot choose a box for you.</b>
<input type="checkbox"/> <b>OPTION 1.</b> I want the _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but <b>I can appeal to Medicare</b> by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.	
<input type="checkbox"/> <b>OPTION 2.</b> I want the _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. <b>I cannot appeal if Medicare is not billed.</b>	
<input type="checkbox"/> <b>OPTION 3.</b> I don't want the _____ listed above. I understand with this choice I am <b>not responsible for payment</b> , and I cannot appeal to see if Medicare would pay.	

**Additional Information:** BAUMAN CHIROPRACTIC DOES NOT TAKE ASSIGNMENT FROM MEDICARE. THIS MEANS YOU WILL BE RESPONSIBLE TO PAY FOR ITEM(S) OR SERVICE(S) AS THEY ARE RENDERED. BAUMAN CHIROPRACTIC IS NOT A MEDICARE PROVIDER.

**This notice gives our opinion, not an official Medicare decision.** If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

<b>Signature:</b> _____	<b>Date:</b> _____
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According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

# BAUMAN CHIROPRACTIC CLINIC OF NW FL.

3613 N. Hwy 231, Panama City Fl. 32404

Ph: 850-785-8311 Fax: 850-872-9892

## MEDICAL RECORDS RELEASE

### RELEASE OF PROTECTED HEALTH INFORMATION AUTHORIZATION

**I HEREBY AUTHORIZE BAUMAN CHIROPRACTIC CLINIC OF NORTHWEST FLORIDA P.A. TO RELEASE A COPY OF MY PATIENT RECORDS, X-RAYS AND ACCOUNT RECORDS CONTAINING PROTECTED HEALTH INFORMATION TO:** \_\_\_\_\_

THIS AUTHORIZATION IS GIVEN PURSUANT TO FLORIDA STATUTE 456.057 AND HIPAA REGULATIONS. I UNDERSTAND THAT FLORIDA STATUTE 456.057(10) MAKES CLEAR THAT ANY THIRD PARTY TO WHOM RECORDS ARE DISCLOSED IS PROHIBITED FROM FURTHER DISCLOSING ANY INFORMATION IN THE MEDICAL RECORD WITHOUT THE EXPRESSED WRITTEN CONSENT OF THE PATIENT OR THE IR LEGAL REPRESENTATIVES.

I UNDERSTAND THAT THIS INFORMATION MAY INCLUDE INFORMATION RELATING TO: ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS) OR HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTION; TREATMENT FOR DRUG OR ALCOHOL ABUSE, MENTAL OR BEHAVIORAL HEALTH OR PSYCHIATRIC CARE, EXCLUDING PSYCHOTHERAPY NOTES. ANY RELEASE OF SUBSTANCE INFORMATION MUST BE PURSUANT TO 42 CFR. THERE ARE OTHER SPECIAL RESTRICTIONS WHICH APPLY TO THE RELEASE OF INFORMATION REGARDING HIV, ABUSE REPORTS, ETC...

\_\_\_\_\_  
**PATIENT OR GUARDIAN SIGNATURE**

\_\_\_\_\_  
**DATE SIGNED**

\_\_\_\_\_  
**WITNESSED BY**

UNLESS OTHERWISE REVOKED, THE AUTHORIZATION WILL EXPIRE ON THE FOLLOWING DATE, EVENT, OR CONDITION: \_\_\_\_\_

### SPECIFIC DESCRIPTION OF INFORMATION REQUESTED AND DISCLOSED

I HEREBY ACKNOWLEDGE RECEIPT OF THESE RECORDS AND/OR X-RAYS. IN CONSIDERATION OF THE FOREGOING, I HEREBY RELEASE ANK FOREVER DISCHARGE THE AFORESAID DOCTOR OF CHIROPRACTIC FROM ANY AND ALL RESPONSIBILITY OR LIABLITY OF ANY KIND, NATURE OR CHARACTER WHATSOEVER ARISING FROM SAID TREATMENT.

TAX ID 80-000-9303

\_\_\_\_\_  
**SIGNATURE / RECEIPT OF RECORDS**

\_\_\_\_\_  
**DATE**