Beckerton Chiropractic PLLC
DBA Fernandina Chiropractic Center

Phone: 904-491-1345
E-fax: 1- 904-513-9206
email:fernchiro@gmail.com

463392 East State Rd 200
Yulee, Fl. 32097

Appointment Letter:

- Please arrive 30 minutes prior to your appointment for processing to ensure you are ready for your appointment. **If paperwork is not completed prior to appointment, you will be rescheduled to next available appointment.**
- **DON'T FORGET TO BRING WITH YOU-**
    - Insurance cards
    - Photo I.D.
    - List of medications.
    - Previous imaging disks or reports
    - Discharge summary (if you have been hospitalized recently)
- If auto accident related, in addition to above information-
    - Police Report
    - **YOUR** Automobile insurance card
    - **YOUR** Automobile Policy Jacket
        - **MUST HAVE DECLARATION PAGE THAT EXPLAINS BENEFITS**
    - **YOUR** Automobile Claim Number and Medical Adjustor information
- Co-pays are due at the time services are rendered. We accept cash, check, credit and debit cards.
- Please allow 24 hours notice to cancel or re-schedule your appointment. ($45 non-refundable fee for late cancellation or no show to massage only appointments, $75 non-refundable fee for new patient appointments missed)

We are looking forward to working with you to deliver the highest quality of chiropractic care.

Thank you,

Fernandina Chiropractic Staff

Beckerton Chiropractic PLLC
Thomas P. Beckerton, D.C.
463392 East State Road 200
Yulee, Florida 32097
Voice : (904)491-1345 **Fax** : (904)513-9206
E-Mail : fernchiro@gmail.com

NOTICE OF DOCTOR'S LIEN

Patient's Name:_____ Date of Incident: _____

Attorney's Name and Phone #: _____

I do hereby authorize **Beckerton Chiropractic PLLC/dba Fernandina Chiropractic Center** to furnish my attorney named above with a full report of my examination, diagnosis, treatment, prognosis, etc., with regard to the incident in which I was recently injured.

I further authorize and direct my attorney to pay directly to **Beckerton Chiropractic PLLC/ dba Fernandina Chiropractic Center** such sums as may be due and owing for medical services rendered to me both by reason of this incident and by reason of any other bills that are due and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate said doctors.

I hereby further give a Lien on my case to **Beckerton Chiropractic PLLC/dba Fernandina Chiropractic Center** against any and all proceeds of my settlement, judgment or verdict which may be recovered or paid as the result of the injuries for which I have been treated.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for services rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. I further understand that such payment is not contingent on any recovery made by me. I hereby agree to waive the defense of Statute of Limitations as it pertains to any claim filed against me beyond three years (or other statutory) after services were rendered. I agree to promptly notify said doctor of any change or addition of attorney(s) used by me in connection with this accident, and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted or added attorney(s).

I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest by signing this document, the doctor will not await payment but may declare the entire balance due and payable at the time of service.

_____ _____
Date Patient's Signature

_____
Patient's Printed Name

The undersigned attorney or insurance company agrees:

1. To comply with the above "authorization and assignment";
2. To withhold and pay from my proceeds from settlement, collection of judgment, PIP, med-pay or other insurance proceeds, the amount of the doctor's charges, after contacting the doctor's office for a current balance;
3. Advise within ten days of the doctor's requests, the status of the above referenced claim;
4. To notify the doctor of any changes in the status of the claim which may preclude payment of the doctor's charges;
5. To notify any attorney who may assume the representation of the patient of assignment.

_____ _____
Date Attorney's Signature

_____
Attorney's Printed Name

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To whom it may concern:

I,_____, herby authorize _____ insurance company to release insurance benefit information to Beckerton Chiropractic PLLC / dba Fernandina Chiropractic Center LLC.

please sign below

x_____ Date:_____

x_____ Date:_____

Beckerton Chiropractic PLLC

dba Fernandina Chiropractic Center

Phone: 904-491-1345
Fax: 904-513-9206
Email: FERNCHIRO@GMAIL.COM
Address: 463392 East State Road 200
Yulee, Florida 32097

Medical Record Release Form

Fax to: _____ Location: _____

Phone: _____ Fax Number: _____

Date:_____

Patient:_____

Date of Birth_____

Date of Testing:_____

At the request above patient, please fax medical records in regards to the following:

_____

_____

_____

Patient or Guardian: _____(PRINT)

Patient or Guardian: _____(SIGNATURE)

VEHICLE ACCIDENT INFORMATION

PATIENT INFORMATION

Date_____

Patient Name_____

Date of Accident_____ Time of Accident_____ ☐ a.m. ☐ p.m.

Please describe the accident in your own words:_____

_____

_____

_____

Were you the: ☐ Driver ☐ Front Passenger ☐ Rear Passenger ☐ Pedestrian

How many people were in the accident vehicle?_____

ACCIDENT SITE

Road/Street Name_____

City/State_____

Nearest intersection with road/street_____

Driving conditions ☐ Dry ☐ Wet ☐ Icy ☐ Other _____

Which direction were you headed?_____

Speed you were traveling?_____

VEHICLE

Make and model of vehicle you were in:

_____

Were you wearing a seatbelt? ☐ Yes ☐ No

If yes, what type? ☐ Lap ☐ Shoulder

Was vehicle equipped with airbags? ☐ Yes ☐ No

If yes, did it/they inflate properly? ☐ Yes ☐ No

Did your seat have a headrest? ☐ Yes ☐ No

If yes, what was the position of the headrest?

☐ Low ☐ Midposition ☐ High

IMPACT

Did your car impact another vehicle? ☐ Yes ☐ No

Did your car impact a structure? ☐ Yes ☐ No

If yes, explain_____

_____

Did any part of your body strike anything in the vehicle?

☐ Yes ☐ No If yes, explain_____

Was impact from :

☐ Front ☐ Rear ☐ Left ☐ Right ☐ Other_____

At the time of impact were you:

☐ Looking straight ahead ☐ Looking to the right

☐ Looking to the left ☐ Looking down

☐ Looking up

Were both hands on the steering wheel? ☐ Yes ☐ No

If no, which hand was on the wheel? ☐ Right ☐ Left

Was your foot on the brake? ☐ Yes ☐ No

If yes, which foot was on the brake? ☐ Right ☐ Left

Were you: ☐ Surprised by impact ☐ Braced for impact

OTHER VEHICLE

(If applicable)

Make and model of other vehicle_____

Which direction was other vehicle headed?_____

Speed other vehicle was traveling_____

POLICE

Did the police come to the accident site? ☐ Yes ☐ No

Were there any witnesses? ☐ Yes ☐ No

Was a police report filed? ☐ Yes ☐ No

Was a traffic violation issued? ☐ Yes ☐ No

If yes, to whom?_____

PATIENT CONDITION

Were you unconscious immediately after the accident? ☐ Yes ☐ No If yes, for how long?_____

Please describe how you felt immediately after the accident:

_____

_____

TREATMENT

Did you go to the hospital? ☐ Yes ☐ No

When did you go? ☐ Immediately after accident ☐ Next day ☐ 2 days or more after the accident

How did you get to the hospital? ☐ Ambulance ☐ Private transportation

Name of hospital_____ Name of doctor_____

Diagnosis_____

_____

Treatment received_____

X-rays taken_____

SYMPTOMS/INJURIES

Have you been able to work since this injury? ☐ Yes ☐ No How many work days have you missed?_____

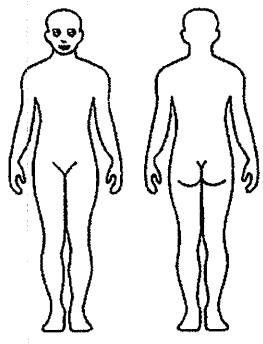
Prior to the injury were you able to work on an equal basis with others your age? ☐ Yes ☐ No

If you have had any of the following symptoms since your injury, please ☑ check:

- ☐ Arm/shoulder pain
- ☐ Back pain
- ☐ Back stiffness
- ☐ Chest pain
- ☐ Dizziness
- ☐ Ear buzzing
- ☐ Ear ringing
- ☐ Fatigue
- ☐ Feet/toe numbness
- ☐ Hand/finger numbness
- ☐ Headaches
- ☐ Irritability
- ☐ Jaw problems
- ☐ Leg pain
- ☐ Memory loss
- ☐ Nausea
- ☐ Neck pain
- ☐ Neck stiff
- ☐ Shortness of breath
- ☐ Sleep difficulty
- ☐ Stomach upset
- ☐ Tension
- ☐ Vision blurred

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain)_____

Type of pain:

☐ Sharp	☐ Dull	☐ Throbbing	☐ Numbness
☐ Aching	☐ Shooting	☐ Burning	☐ Tingling
☐ Cramps	☐ Stiffness	☐ Swelling	☐ Other_____

How often do you have this pain?_____

Is it constant or does it come and go?_____

Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Movements that are painful to perform: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

Beckerton Chiropractic PLLC. dba:
Fernandina Chiropractic Center

Patient Registration & Insurance Information

Please present insurance card and photo ID for us to copy.

Date _____ Physician _____

Person Responsible for Bill

Guarantor Name _____
Address _____
City, State, ZIP _____
Home Phone # _____ Work Phone # _____
Relation to Patient _____

Patient Information

I consent to receive email/text relating to my care from your office?
YES:____
NO:____

Name _____
Address _____
City, State, ZIP _____
Home Phone # _____ Work Phone # _____
Cell Phone # _____ Carrier: _____ Email _____
Date of Birth _____ Sex _____ Marital Status _____
Race: ❑ Unknown ❑ African American ❑ Asian ❑ Caucasian ❑ Chinese ❑ Filipino ❑ Hispanic ❑ Japanese ❑ Native American ❑ Native Hawaiian ❑ Pacific Islander ❑ Other _____
Ethnicity: ❑ Hispanic ❑ Non Hispanic ❑ Unknown ❑ Unrecorded
Primary Language _____ Do you require an Interpreter Yes____ No____
Social Security Number _____
(If a minor): Mother's Name _____ Home Phone # _____
Father's Name _____ Home Phone # _____

Emergency Contact Information

Contact Name _____
Relationship to Patient _____
Address _____
City, State, ZIP _____
Home Phone # _____ Work Phone # _____

Primary Insurance Name

Insurance Company _____
Group # _____ Policy # _____
Subscriber Name _____
Patient Relation to Subscriber _____ Date of Birth _____
Social Security Number _____
Employer _____ Work Phone # _____

Secondary Insurance Name

Insurance Company _____
Group # _____ Policy # _____
Subscriber Name _____
Patient Relation to Subscriber _____ Date of Birth _____
Social Security Number _____
Employer _____ Work Phone # _____

Referred by _____

Beckerton Chiropractic PLLC. dba:
Fernandina Chiropractic Center

Authorizations and Acknowledgments

We are commited to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Please ask us if you have any questions about our fees, financial policy, or your payment responsibility.

All new patients will be asked to provide patient information prior to being seen by the physician. We also may ask to make a copy of any type of picture identification to remain a permanent part of your chart.

Insurance Information

- If you are covered by Medicare, or any of our managed plans, we will file your insurance claim. You are responsible for any co-pay, co-insurance, deductible, or non-covered services at the time of your visit. If we do not participate with your insurance company, you will be responsible for full payment at the time of your visit. **Methods of Payment: Cash, Check, Visa, MasterCard and Discover.**
- All self-pay patients are expected to pay for services in full at the time that services are rendered. **Our Office offers Chiro Health USA to patients that are self pay for discounted rates. Ask us for more information.**
- In the event your insurance company does not pay the full balance within 90 days, we will notify you so that you may contact your insurance carrier. Please remember that ultimately, payment responsibility rests with the patient.
- Please advise the office personnel of any changes in your insurance or mailing address.
- Should it ever become necessary to use the services of a collection agency to collect your account, you would be responsible for any costs incurred for that purpose.

Worker's Compensation

Our Office Does NOT accept Worker's Compensation Cases

Unaccompanied Minors

The parents (or guardians) will be responsible for full payment unless covered by a participating managed plan. Authorization to treat an unaccompanied minor must be on file.

Completion of Forms

Beckerton Chiropractic PLLC., dba Fernandina Chiropratic Center reserves the right to charge a nominal fee for the completion of disability and/or Family Medical Leave forms.

Authorization for Payment

I hereby authorize **Beckerton Chiropractic PLLC., dba Fernandina Chiropractic Center,** to bill my insurance company directly for these services. I understand I am financially responsible for charges not covered by my insurance company. I authorized any holder of medical or other information about me to release to the Social Security Administration or intermediaries any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and reques' payment of medical benefits either to myself or to the party who accepts assignment. I certify that the above information is currently correct.

Responsible Party Signature _____ Date _____

Patient's Name (Please Print) _____ Date of Birth _____

Notice of Privacy Practices

I acknowledge receipt of a copy of the **Beckerton Chiropractic PLLC., dba Fernandina Chiropractic Center,** Notice of Privacy Practices (NPP) either at this time or previously. By accepting services at **Beckerton Chiropractic PLLC., dba Fernandina Chiropractic Center,.** I authorize **Beckerton Chiropractic PLLC., dba Fernandina Chiropractic Center,** to use and disclose information from and release copies of my (the patient's) medical records in accordance with **Beckerton Chiropractic PLLC., dba Fernandina Chiropractic Center,** policies and privacy practices, which are summarized in the NPP, including disclosure to my (the patient's) past, present and future healthcare providers.

Patient or Parent (Guardian) _____ Date _____

Beckerton Chiropractic PLLC
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Informed Consent to Care

I herby request and consent to the performance of Chiropractic adjustments and other procedures performed in office, including various modes of physical therapy and diagnostics x-rays by, any Doctor of Chiropractic or therapist, employed by Beckerton Chiropractic PLLC., dba Fernandina Chiropractic Center LLC.

I have had the opportunity to discuss with the Doctor and/or with the other office personnel the purpose and benefits of the Chiropractic adjustments and other treatments outlined below.

Though Chiropractic adjustments and treatments are usually beneficial and seldom cause any problem, I understand and am informed that there are some risks to treatment. Risks include, but are not limited to, fractures, disc injures, strokes, dislocations and sprains.

I understand that I may receive ONE or MORE of the following treatments:

- **Chiropractic Adjustment/Manipulation**
- **Electric Muscle Stimulation**
- **Heat/Cold Pack(s)**
- **Ultrasound**
- **Traction**
- **Massage/Therapeutic exercises and stretches**

I understand that Chiropractic is not an exact science and that, therefore, reputable practitioners cannot fully guarantee the results. I understand, acknowledge and affirm that treatments may involve direct bodily contact and touch. I acknowledge that no guarantee or assurance has been made to anyone regarding the chiropractic treatment that I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

For Treatment of Minors only (Please Initial):

I , as a parent/guardian of a minor receiving treatment from above named provider do and herby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting in failure to do so. I consent to treatment of the minor if I am not in the office _____

Please discuss any questions or concerns with the Doctor or Therapist BEFORE signing this consent.

Signature of patient, parent, guardian, or personal representative: Date:

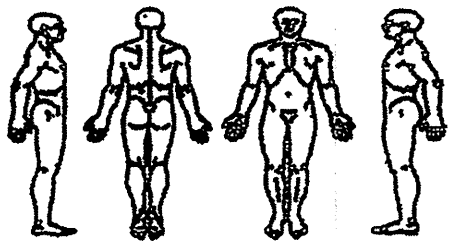
Witness Signature: Date:

Doctor's Signature: Date:

PATIENT INTAKE FORM

Patient Name: _____ Date: _____

Mark The Area Of Pain



Where is your pain/what side? _____

_____

How do you think your problem started? _____

_____

When did your pain start? _____

_____

Have you ever had this problem in the past? ▫Yes ▫No

My pain is located on the ▫Right ▫Middle ▫Left ▫Both Sides

My pain is ▫Getting Worse ▫Staying the Same ▫Getting Better

How would you describe the type of pain?

▫Sharp	▫Numbness	▫Dull	▫Tingling
▫Diffuse	▫Achy	▫Burning	▫Sharp with motion
▫Stiff	▫Shooting	▫Stabbing	▫Electric like
▫sore	▫Other:_____		

Fill in your Pain scale 0-10 (10 being severe pain) _____ (1-3 Mild) (4-7 Moderate) (8-10 Severe)

How often do you experience your symptoms?

▫Constantly ▫Frequently ▫Intermittent (On & Off) ▫Occasionally

Does your pain radiate? ▫Yes ▫No **If so, Where?** _____

The pain is worse during ▫Morning ▫Afternoon ▫Evening ▫During the night ▫Pain does not change

Pain is worse? ▫Sitting ▫Standing ▫Movement ▫Sleeping ▫Walking ▫Other_____

Pain is better during ▫Morning ▫Afternoon ▫Evening ▫During the night ▫Nothing feels better

What makes the pain feel better ▫Rest ▫Medication ▫Cold ▫Heat ▫None ▫Other_____

Do you have Numbness? ▫Yes ▫No **If so, Where?** _____

Headaches ▫Yes ▫No **If so, Where?** _____

This problem interferes with my work? ▫None ▫A little bit ▫Moderately ▫Extremely

Who else have you seen for your problem?

▫Chiropractor ▫Primary Care Physician ▫ER physician ▫Orthopedist ▫Massage Therapist

▫Physical Therapist ▫No one ▫Other _____

What concerns you the most about your problem? What does it prevent you from doing?

What is your occupation?

How would you rate your overall health? ▫Excellent ▫Very Good ▫Good ▫Fair ▫Poor

What type of exercise do you do? ▫Strenuous ▫Moderate ▫Light ▫None

Name: _____ DOB: _____ Date: _____

MEDICATIONS: Please attach medication list if available.

MEDICATION OR VITAMIN NAME	DOSAGE	REASON FOR TAKING

DRUG ALLERGIES	REACTION

Have you been diagnosed with Hypertension (high blood pressure)? Yes or No

Treating Physician: _____

Have you been diagnosed with Diabetes? Yes or No If yes, Type I____ or Type II____

Treating Physician: _____

Primary Care Physician: _____

Name: _____ DOB: _____ Date: _____

PAST MEDICAL HISTORY: Please select if condition applies to your medical history:

- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Anemia
- ☐ Angina (Chest Pain)
- ☐ Arthritis
- ☐ AFib
- ☐ Enlarged Prostate
- ☐ Cancer: _____
- ☐ CVA (Stroke)
- ☐ Congestive heart failure
- ☐ COPD
- ☐ Other _____
- ☐ Coronary artery disease
- ☐ Crohn's disease
- ☐ Degenerative joint disease
- ☐ Depression
- ☐ Diabetes
- ☐ Drug abuse
- ☐ DVT (blood clot)
- ☐ Fibromyalgia
- ☐ Gallbladder disease
- ☐ GERD
- ☐ Gout
- ☐ Hepatitis
- ☐ High Cholesterol
- ☐ Hypertension (high blood pressure)
- ☐ Inflammatory bowel disease
- ☐ Rheumatoid Arthritis
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Lyme disease
- ☐ Migraines
- ☐ Multiple Sclerosis
- ☐ Myocardial Infarction
- ☐ Obesity
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Parkinson's disease
- ☐ Peptic ulcer
- ☐ Psoriasis
- ☐ PVD-vascular disease
- ☐ Renal disease
- ☐ Scoliosis
- ☐ Seizure disorder
- ☐ Sleep apnea
- ☐ SLE - Lupus
- ☐ Spinal stenosis
- ☐ Spondyloarthropathy
- ☐ Thyroid disease
- ☐ Valvular disease

PAST SURGICAL HISTORY:

FAMILY HISTORY:

	Father	Mother	Siblings	Grandparent
Arthritis	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Colitis	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Epilespsy	☐	☐	☐	☐
Heart disease	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐
Psoriasis	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Thyroid disease	☐	☐	☐	☐

SOCIAL HISTORY:

Tobacco Use: ☐ Yes ☐ No ☐ Former packs per day: _____ Years smoked: _____ Year Quit: _____

Alcohol Use: ☐ Yes ☐ No ☐ Former Type: _____ Frequency: _____ Glasses / Day: _____

Caffeine Use: ☐ Yes ☐ No ☐ Former Type: _____ Cups/Day: _____

Activity: ☐ Sedentary ☐ Moderate ☐ Vigorous Frequency: _____ Type of exercise: _____

Hand Dominance: ☐ Right ☐ Left ☐ Ambidextrous

Occupation: Employer: _____ Job Title: _____ Status: P/T F/T Disabled Retired

Review of Symptoms

Please Circle present symptoms and underline prior symptoms

Constitutional	Cardiovascular	Skin/ Integumentary	Metabolic / Endocrine
Chills	Chest Pain	Contact allergy	Cold intolerant
Fatigue	Cyanosis	Itchy skin	Heat intolerant
Fever	Heart Murmur	Rash	Hair loss
Malaise	Irregular Heartbeat	Skin infection	
Night sweats	Leg Swelling	Skin lesion	
Weakness	Syncope (fainting)		
Weight loss			
HEENT	**Gastrointestinal**	**Neurological**	**Psychiatric**
Blurred vision	Abdominal Pain	Difficulty walking	Anxiety
Double vision	Constipation	Dizziness	Depression
Dysphasia	Diarrhea	Poor coordination	Insomnia
Ear Drainage	Heartburn	Memory loss	
Facial Pain	Jaundice	Muscle weakness	
Headache	Loss of appetite	Paresthesia	
Hearing loss	Nausea	Seizures	
Hoarseness	Vomiting	Tremors	
Nasal congestion			
Ringing in ears			
Vertigo			
Vision loss			
Respiratory	**Genitourinary**	**Hematologic**	**Immunological**
Painful breathing	Dysuria	Bleeding	Asthma
Cough	Frequent urination	Bruising	Bee sting allergies
Shortness of breath	Blood in urine		Contact dermatitis
Recent infections	Urge incontinence		Seasonal allergies
Known TB exposure	Urinary incontinence		Food allergies
Wheezing			Environmental allergies

FEMALE ONLY: Are you pregnant? (Please Circle) YES NO If yes, how many weeks?_____

Height:_____ Weight:_____

Office Use only:

BP:_____/_____

Neck Index

Form NI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

Personal Care

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my car as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Headaches

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Neck Index Score _____

Back Index

Form BI-100

rev 3/27/2003

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index Score _____

NECK BOURNEMOUTH QUESTIONNAIRE

Patient Name _____ Date _____

Instructions: The following scales have been designed to find out about your neck pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your neck pain?

No pain Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your neck pain interfered with your daily activities (housework, washing, dressing, lifting, reading, driving)?

No interference Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your neck pain interfered with your ability to take part in recreational, social, and family activities?

No interference Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your neck pain?

Have made it no worse Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your neck pain on your own?

Completely control it No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

OTHER COMMENTS: _____

With Permission from: Bolton JE, Humphreys BK: The Bournemouth Questionnaire: A Short-form Comprehensive Outcome Measure. II. Psychometric Properties in Neck Pain Patients. *JMPT* 2002: 25 (3): 141-148.

BACK BOURNEMOUTH QUESTIONNAIRE

Patient Name _____ Date _____

Instructions: The following scales have been designed to find out about your back pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your back pain?

No pain — Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your back pain interfered with your daily activities (housework, washing, dressing, walking, climbing stairs, getting in/out of bed/chair)?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your back pain interfered with your ability to take part in recreational, social, and family activities?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious — Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed — Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your back pain?

Have made it no worse — Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your back pain on your own?

Completely control it — No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

OTHER COMMENTS: _____

With Permission from: Bolton JE, Breen AC: The Bournemouth Questionnaire: A Short-form Comprehensive Outcome Measure. I. Psychometric Properties in Back Pain Patients. *JMPT* 1999; 22 (9): 503-510.

Beckerton Chiropractic PLLC
DBA Fernandina Chiropractic Center

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E-fax: 1- 904-513-9206
email:fernchiro@gmail.com

463392 East State Road 200
Yulee, Florida 32097

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. THIS NOTICE TAKES EFFECT ON YOUR FIRST DATE OF TREATMENT AND REMAINS IN EFFECT UNTIL WE REPLACE IT.PLEASE REVIEW IT CAREFULLY.

1) **OUR PLEDGE REGAURDING MEDICAL INFORMATION**

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our office. We need this record to provide you with quality care and comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe the rights and certain duties we have regarding the use and disclosure of medical information.

2) **OUR LEGAL DUTY**

LAW REQURES US TO:

I. Keep your medical information private.
II. Give you this notice describing our legal duties, privacy practices, and your right regarding your medical information.
III. Follow the terms of the notice.

WE HAVE THE RIGHT TO:

I. Change our privacy practice and the terms of this notice at any time, provided the changes are all permitted by law.
II. Make the changes in our privacy practice and new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

NOTICE OF CHANGE TO PRIVACY PRACTICES:

I. Before we make any important change in our new privacy practices, we will change this notice and make the new notice available upon request.

3) **USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION**

The following section describes different ways that we use and disclose medical information. Not every use or discloser will be listed. However, we have listed all the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your written authorization. Any specific written authorization you provide may be revoked any time by writing to us at the address provided at the top of this notice.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to Doctors, nurses, technician, medical students, or other people who are taking care of you. We may also share medical information about you to other health care providers to assist them in treating you.

FOR PAYMENT: We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

Beckerton Chiropractic PLLC
DBA Fernandina Chiropractic Center

Phone: 904-491-1345
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email:fernchiro@gmail.com

463392 East State Rd 200
Yulee, Fl. 32097

Statement of Policies

The following policies are in place for mutual convenience and benefit. Please read them carefully and sign at the bottom to indicate your agreement.

1. Deductibles, co-Insurance and co-pays are due at the time of service, payable by cash, check or credit/debit cards. ANY previous balance on your account(s) are expected to be paid at time of service.
2. If you do not have insurance you are responsible for the cost of your visit at the time of service.
3. If you schedule an appointment, and are unable to make it, please call 24 hours in advance. Failure to do so will result in a $45.00 non-refundable charge. A new patient no show fee is a nonrefundable $75.00 fee.
4. Processing disability paperwork, FMLA insurance forms, and any related forms require a $75.00 fee. This fee is to be prepaid and must coincide with an office visit.
5. Request for medical records are subject to a fee of $1.00 per page for the first 25 pages and $0.25 for each additional page after. All requests must be submitted in writing, and please allow 24-48 business hours for these requests. Please plan accordingly.
6. The above named provider is not responsible for loss or damage to personal valuables.

I acknowledge that I have read and understand the Statement of Policies carefully and agree to abide by them.

Name (print) **Signature** **Date**

Witness (print) **Signature** **Date**

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Yulee, Florida 32097

Insurance Assignment and Instruction for Direct Payment

I,_____ hereby instruct and direct my insurance company pursuant to F.S. 627.422 to pay directly to Beckerton Chiropractic PLLC, dba Fernandina Chiropractic Center LLC for professional or medical services by check, draft, or electronic funds transfer (EFT). The payment is not to exceed my indebtedness to the above named provider.

I herby assign all rights and benefits that I have under any Group Health Insurance, Automobile Insurance not to exclude; PIP, UM, or med-pay benefits. To also be included is Medicare and Disability benefits. I direct and assign all related policies or reimbursement plans to pay benefits for services and treatments that I have or continued to receive from the above named provided.

Assignment includes but is not limited to all rights to collect benefits directly from Health or Auto Insurances for those services and treatments that I have received and continue to receive. Including all rights to proceed against my insurance company(s)in any action including legal suit if for any reason my insurance company(s) fails to make payments of benefits that are due to the above named provider. This assignment also includes the right to recover any attorney fees and costs for such action brought by the provider as my assignee.

I agree that the above named provider be given the power of attorney to endorse/sign my name on any and all checks for the payment of services provided by them.

I understand that I am financially responsible for any balance not covered by my insurance company . Ultimately, payment responsibility rests with you the patient.

All self-pay patients are expected to pay for the services in full at the time services are rendered.

I authorize the release of any information pertinent to my case or claim to the above named provider or any attorney involved in this case. A photocopy of the assignment shall be considered as effective and valid as the original.

Signature of patient (Claimant): Date:

Witness: Date:

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DBA Fernandina Chiropractic Center

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Yulee, Florida 32097

Release of Medical Information

I, _____ give permission for my protected heath information to be disclosed for the purposes of communicating results, findings, care decisions and billing inquires to the family members and others listed below.

FAMILY/FRIENDS:

Name :	Relation to Patient:	Release information: YES NO
Name:	Relation to Patient:	Release Information: YES NO
Name:	Relation to Patient:	Release Information: YES NO
Name:	Relation to Patient:	Release Information: YES NO

Primary Care Provider:

Name:	Phone:_____ Fax:_____ Email:_____	Address:_____ _____ _____

*If the requestor/receiver of information is not a healthcare provider, the released information may no longer be protected from discloser.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patients Signature:_____ **Date:**_____