INJURY CENTERS OF BREVARD

Melbourne Accident & Injury Center **Cocoa Accident & Injury Center**
Titusville Chiropractic & Injury Center

Patient Registration Form

(Please give your car insurance card and police report to the receptionist if you have it)

Patient Name:____
(Last Name) (First Name) (Middle Initial)
Is this your LEGAL name? Yes / No If NOT, what is your legal name?______________________

Marital Status: Single / Married / Divorced / Separated / Widowed

Date Of Birth: / / Age:______ **Sex: M / F Social Security Number:**______________

Address:______________________________ **City:**__________ **State/ZIP:**__________

Cell Phone:_______________________ **Home Phone:**_____________________

Primary Care Physician:____________________________ **Phone:**____________________

Emergency Contact Name:__________________________ **Phone:** ____________________

CAR INSURANCE
Insurance Company Name:________________________ **Claim Number:**_________________

Policy ID: ________________ **Adjuster Name:**________________ **Adjuster Phone:**____________

HEALTH INSURANCE
Insurance Carrier Name:_____________________ **Member ID:** __________________

DATE OF CURRENT ACCIDENT:______________ **Do you own a Vehicle? Yes / No**
If you do not own a vehicle, do you reside with a blood relative? Yes / No

At the time of the accident you were, DRIVER / PASSENGER / PEDESTRIAN

WHERE DID YOU GO AFTER THE ACCIDENT? HOME / WORK / HOSPITAL
If hospital, which hospital? ________________________

The above information is true to my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize the Injury Centers of Brevard and/or insurance company to release my information required to process my claims.

Patient / Guardian Signature: ______________________________ **Date:** ____________

In your Own words please describe the accident:__________________________________

____

____

Melbourne Accident & Injury Center, Inc.
2351 W. Eau Gallie Blvd Ste 8 Melbourne, FL 32935
Tax ID: 81-1010056

Titusville Chiropractic & Injury Center, Inc.
119 S. Park Ave Titusville, FL 32796
Tax ID: 45-3135721

Cocoa Accident & Injury Center, Inc.
200 Willard Str. Ste 1C Cocoa, FL 32922
Tax ID: 46-2281498
PH : 321-735-9050 FAX: 321-735-9429

Assignment of Benefits

I, the undersigned patient/insured, knowingly, voluntarily and intentionally assign and transfer any and all rights and benefits of my automobile insurance policy (i.e. Personal Injury Protection ("PIP"), Uninsured Motorist and Medical Payments benefits) to the above-stated Health Care Provider. I understand it is the intention of the Health Care Provider to accept this Assignment of Benefits in lieu of demanding payment at the time services are rendered. I understand that this document will allow the Health Care Provider to file suit against the insurer either in my name or the provider's name for payment of the insurance benefits, to obtain an explanation of benefits and to seek attorneys' fees and costs under Fla. Stat. §§627.736(8), 627.428 and 57.041 from the insurer. This Assignment of Benefits includes, but is not limited to, the cost of medical care, transportation, medication, supplies, overdue interest and any potential claim for common law or statutory bad faith/unfair claims handling. If the insurer disputes the validity of this Assignment of Benefits, then the insurer is instructed to notify the Health Care Provider in writing within five (5) days of receipt of this document advising of its basis for such dispute. Failure to inform the Health Care Provider shall result in a waiver by the insurer to contest the validity of this Assignment of Benefits. The undersigned patient/insured directs the insurer to pay the Health Care Provider the maximum amount of the policy benefits directly to the Health Care Provider without any reductions and without including the undersigned patient's/insured's name on the check. It is this Health Care Provider's contention that its charges are reasonable.

This Assignment of Benefits applies to past, present and future medical expenses and is valid even if not dated. A photocopy of this Assignment of Benefits is to be considered as valid as the original. I, the undersigned patient/insured, agree to pay any applicable deductible or co-payments for services rendered, including payment for services after the policy of insurance exhausts and for any other services unrelated to the date of injury.

The above-stated Health Care Provider is given Power of Attorney to: (1) endorse my, the undersigned patient's/insured's, name on any check for services rendered by the above-stated Health Care Provider, (2) to request and obtain copies of any recorded statements or Examinations Under Oath given by me, the undersigned patient/insured, and (3) to request and obtain copies of any Independent Medical Examination report and/or peer review report pertaining to me, the undersigned patient/insured.

Disputes

The insurer is directed by the Health Care Provider and the undersigned patient/insured not to 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 is a written settlement agreement between the Health Care Provider, specifically the Office Manager, and the insurer as to the amount to be paid by the insurer for the services rendered only to the undersigned patient/insured. The undersigned patient/insured and the Health Care Provider hereby contest and object to any reductions or partial payments made by the insurer. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by the Health Care 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 Health Care Provider to accept a reduced amount as payment in full. The insurer is hereby placed on notice that this Health Care Provider reserves the right to seek payment in full for the bills submitted. If the insurer asserts that it can pay claims at 200% of the Medicare Fee Schedule, then the insurer is instructed and directed to provide this Health Care Provider with a copy of the policy of insurance within ten (10) days. Should the insurer and Office Manager of the above-stated Health Care Provider reach an agreement to settle any of the bills submitted at a reduced amount, this agreement shall be reduced to writing and submitted to the attention of the Office Manager for written approval. See Fla. Stat. §673.3111.

Release of Information

I, the undersigned patient/insured, hereby authorize this Health Care Provider to: furnish an insurer, an insurer's intermediary, my other medical providers and my attorney(s) via mail, facsimile or e-mail, with any and all information that may be contained within my medical records to: obtain insurance coverage information (i.e. declarations page and policy of insurance) in writing and telephonically from the insurer, request from any insurer all Explanation of Benefits/Review forms (EOBs) for all of my medical providers, obtain a non-redacted PIP payout sheet, obtain written and verbal statements that I or anyone else provided to the insurer, obtain copies of the entire claim file and all medical records, including, but not limited to: documents, reports, scans, notes, bills, opinions, x-rays, IMEs, peer reviews and MRIs from any of my medical providers or any insurer. The Health Care Provider is permitted to produce my medical records to its attorney in connection with pursing a legal action. The insurer is directed to keep my, the undersigned patient's/insured's medical records confidential. The insurer is not authorized to provide my, the undersigned patient's/insured's, medical records to anyone without my, the undersigned patient's/insured's and the Health Care Provider's express written permission.

Certification

I, the undersigned patient/insured, certify that: I have read and agree to the above; I have not been solicited or promised anything in exchange for receiving health care from the above-stated Health Care Provider; I have not received any promises or guarantees from anyone as to the results that may be obtained by any treatment or service provided; and I agree that the Health Care Provider's prices for the medical services, treatment and supplies provided are reasonable, usual and customary.

Caution: Please read this document carefully before signing. Please ask to review a copy of the above-stated Health Care Provider's charges. If you do not completely understand this document, please ask the front desk personnel or the medical provider to explain it to you. If you sign below it will be understood that you understand and agree with the contents of this Assignment of Insurance Benefits.

Patient/Insured Name:____________________________________ Patient/Insured Signature:____________________________________
(Please print) (If patient/insured is a minor, signature of parent/guardian)

Date: ______________________________

AUTOMOBILE ACCIDENT DESCRIPTION

PLEASE ANSWER THE QUESTIONS BELOW.

Your Vehicle Type: []Car []Station Wagon []Van []Pickup Truck []Large Truck []Bus
[]Other_____________

Your Position in Vehicle: []Driver []Front Passenger []Left Rear Passenger []Right Rear Passenger
[]Other_____________

What was your vehicle doing at time of accident: []Stopped at intersection []Stopped in traffic []Parking
[]Stopped at light []Proceeding along []Making right hand turn []Making left hand turn [] Slowing down
[] Accelerating []Other___________________

Damage to your vehicle: []Mild []Moderate []Totaled

Visibility at time of accident: []Poor []Fair []Good

Who hit who: []You hit other vehicle []Other vehicle hit you [] You hit...(object)________________________

Road Conditions: []Icy []Wet []Dry & Clean []Sandy []Dark []Other____________________

Point of Impact: []Head-on []Rear-end []Left front []Left rear []Right front []Right rear []Other__________

Did you see the accident coming? []Yes []No **Where you braced for the impact?** []Yes []No

Did you have a seat belt on? []Yes []No **Did you have a shoulder harness on?** []Yes []No

Direction of head at impact: []Facing forward []Turned to the right []Turned to the left

Does your vehicle have a head rest? [] Yes []No

What was the position of the head rest? []Even with top of head []Even with bottom of head []Middle of neck

Did airbags deploy? []Driver side []Passenger side []Side airbags []No

Did your body strike the inside of the vehicle? []Yes []No Describe_________________________________

Did you lose consciousness during injury? []Yes []No How long:______________________________

Was an accident report filled out? []Yes []No **Did police show up at scene?** []Yes []No

Check off your symptoms night after & days following accident: []Headache []Neck pain []Neck stiffness
[]Fainting []Ringing in the ears []Loss of smell []Pain behind the eyes []Dizziness []Confusion []Fatigue
[]Nausea []Tension [] Irritability []Shortness of breath []Mid back pain []Low back pain []Nervousness
[]Loss of taste []Cold hands [] Cold feet [] Toe numbness [] Constipation []Anxious []Diarrhea []Chest Pain
[]Sleeping problems []Depression []Other____

Where did you go after the accident? []Home []Work []Private Doctor []Hospital ER _____________________
How did you get there? [] Drove self []Someone else []Police []Ambulance
Where X-rays taken? []Yes []No Where CT Scans taken? []Yes []No

PERSONAL HEALTH HISTORY

Patient Name:__________________________ **DOB:**__________ **Date:**_____________

All information will be kept strictly confidential. Your responses will help determine if chiropractic treatment will benefit you. Please check all the conditions that you currently have or have had in the past.

GENERAL
[ ] Allergy
[ ] Chills
[ ] Convulsions
[ ] Fainting
[ ] Fatigue
[ ] Fever
[ ] Loss of sleep
[ ] Loss of weight
[ ] Nervousness, depression
[ ] Neuralgia
[ ] Sweats
[ ] Tremors

CARDIOVASCULAR
[ ] Hardening of arteries
[ ] High blood pressure
[ ] Low Blood pressure
[ ] Pain over heart
[ ] Poor blood circulation
[ ] Rapid heartbeat
[ ] Slow heartbeat
[ ] Swelling of ankles

GENITOURINARY
[ ] Bed wetting
[ ] Blood in urine
[ ] Frequent urination
[ ] Lack of bladder control
[ ] Kidney infection
[ ] Prostrate problems
[ ] Pus in urine

RESPITRATORY
[ ] Chest pain
[ ] Chronic pain

[ ] Difficult breathing
[ ] Spitting up blood
[ ] Spitting up phlegm
[ ] Wheezing

EYE, EAR, NOSE & THROAT
[ ] Asthma
[ ] Cold / flu
[ ] Tonalities
[ ] Deafness
[ ] Dental decay
[ ] Earache
[ ] Ear discharge
[ ] Enlarged glands
[ ] Enlarged thyroid
[ ] Eye pain
[ ] Failing vision
[ ] Far sightedness
[ ] Gum trouble
[ ] Hay fever
[ ] Sore Throat
[ ] Nasal obstruction
[ ] Near sightedness
[ ] Nose bleeds
[ ] Sinus infection

GASTROINTESTINAL
[ ] Excessive Gas
[ ] Colitis
[ ] Colon trouble
[ ] Constipation
[ ] Diarrhea
[ ] Difficult digestion
[ ] Bloated abdominal
[ ] Excessive hunger
[ ] Gallbladder trouble
[ ] Hemorrhoids
[ ] Vomiting blood

[ ] Jaundice
[ ] Liver trouble
[ ] Nausea
[ ] Pain stomach
[ ] Poor appetite
[ ] Vomiting

SKIN
[ ] Boils
[ ] Bruise easily
[ ] Dryness
[ ] Hives / rash
[ ] Itching
[ ] Skin rash
[ ] Veracious veins

WOMEN ONLY
[] *Congested breasts*
[] *Cramps or backache*
[] *Excess menstrual flow*
[] *Hot flashes*
[] *Irregular cycle*
[] *Lumps in breast*
[] *Menopause*
[] *Painful menstruation*
[] *Vaginal discharge*

Are you pregnant?
[ ]Yes [ ] No
If so, how many months?
____

How many children have you had?______

Check all that apply
[ ] Alcoholism
[ ] Anemia
[ ] Appendicitis
[ ] Arteriosclerosis
[ ] Cancer
[ ] Chicken pox
[ ] Cholera
[ ] Cold Sores
[ ] Diabetes
[ ] Diphtheria
[ ] Eczema
[ ] Edema
[ ] Emphysema
[ ] Epilepsy
[ ] Fever blisters
[ ] Goiter
[ ] Gout
[ ] Heart disease
[ ] Herpes
[ ] Influenza
[ ] Lumbago
[ ] Malaria
[ ] Measles
[ ] Hepatitis
[ ] Multiple sclerosis
[ ] Mumps
[ ] Pacemaker
[ ] Pleurisy
[ ] Pneumonia
[ ] Polio
[ ] Rheumatic fever
[ ] Scarlet fever
[ ] Stroke
[ ] Tuberculosis
[ ] Typhoid fever

[ ] Ulcers
[ ] Venereal disease
[ ] Whooping cough
[ ] HIV/AIDS

[ ] OTHERS____

Standard Disclosure and Acknowledgement Form
Personal Injury Protection - Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

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

____

____

2. I have the right and the **duty to confirm** that the services have already been provided.
3. I was **not solicited** by any person to seek any services from the medical provider of the services described above.
4. The medical provider has **explained** the services to me for which payment is being claimed.
5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to $500.

Insured Person (patient receiving treatment or services) or Guardian of Insured or injured person:

______________________	______________________	____________
Name (PRINT or TYPE)	Signature	Date

The undersigned licensed medical professional or medical director, if applicable, affirms the statement numbered 1 above and also:

A. I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.

B. The treatment or services rendered were explained to the insured person, or his or her guardian, **sufficiently** for that person to sign this form with informed consent.

C. The accompanying statement or bill is **properly completed** in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to **truthfully, accurately**, and in a **substantially complete** manner.

D. The coding of procedures on the accompanying statement or bill is proper. This means that **no service has been upcoded, unbundled**, or constitutes an invalid **or not medically necessary diagnostic test** as defined by Section 627.732
(15) and (16), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Licensed Medical Professional Rendering Treatment/Services or Medical Director, if applicable ***(Signature by his/ her own hand)***:

______________________	______________________	____________
Name *(PRINT or TYPE)*	Signature	Date

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of Claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234(1)(b), Florida Statutes.

Note: The original of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statues and may be electronically furnished. Failure to furnish this form may result in non-payment of the claim.

INJURY CENTERS OF BREVARD
ADL

Patient Name:________________________________ DOB:__________________

Please complete the following regarding how you feel:

What is your pain now?

Current Complaint

____

0 1 2 3 4 5 6 7 8 9 10
No Pain Unbearable Pain

Range of pain level over the last week:

____

0 1 2 3 4 5 6 7 8 9 10
No Pain Unbearable Pain

ADL- Rate each activity that you have difficulty performing on a scale 1-5, 5 being the worst pain possible and need help with the activity, 1 being very little pain and you can perform the activity with no difficulty.

Housework
_____ Doing laundry
_____ Making beds
_____ Vacuuming
_____ Washing dishes
_____ Ironing
_____ Carrying groceries
_____ Caring for Pet
_____ Cooking
_____ Other___________________________

Personal Grooming
_____ Combing hair
_____ Shaving
_____ In/Out bathtub
_____ Brushing teeth
_____ Dressing
_____ Other_______________________________

Yard Work
_____ Mowing lawn
_____ Raking Leaves
_____ Gardening
_____ Other_________________________

Travel
_____ Driving
_____ Riding as a passenger
_____ Getting in / out of car
_____ Other_______________________________

General Movements
_____ Walking
_____ Running
_____ Sitting
_____ Lifting Child
_____ Exercising
_____ Swimming
_____ Climbing Stairs
_____ Sleeping
_____ Reading
_____ Standing
_____ Using computer
_____ Kneeling
_____ Sexual Intercourse
_____ Lying in bed
_____ Bending
_____ Using telephone
_____ Chewing
_____ Squatting
_____Sports: Please list____

PRIOR SYMPTOMS HISTORY:
[ ] I have **NOT** had any prior symptoms similar to my current complaints
[ ] My current complaint **DID** exist before, but they have not been bothering me
[ ] My current complaint ALREADY existed and were worsened by this accident

I certify the above information is complete and accurate to the best of my knowledge. I agree to notify the doctor immediately whenever I have changes in my health condition.

Patient Signature: ____ Date: _____________________

MEDICAL RECORDS / X-RAY RELEASE FORM

STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

[ ] Cocoa Accident & Injury Center, Inc.
PH: (321) 735-9050 Fax: (321) 735-9429

[ ] Titusville Chiropractic & Injury Center, Inc.
PH: 321-567-4984 Fax: (321)567-7626

[ ] Melbourne Accident & Injury Center, Inc.
PH: (321) 622-6610 Fax (321) 622-6716

Date:___________________________ Patient Name:____________________________

PERSONS AUTHORIZED TO USE OR DISCLOSE INFORMATION
Information listed above will be used or disclosed by: _____________________________________

PERSONS TO WHOM INFORMATION MAY BE DISCLOSED
Information described above may be disclosed to the above listed offices at the Injury Centers of Brevard

Name:________________________________ Social Security #:_________________________

DOB:__________________________

I hereby request and authorize that the following medical documents/ records to be released and that they be promptly transferred to the above listed offices at the Injury Centers of Brevard.

_______ X- RAY Films
___X___ Complete Medical file
___X___ Medical Records
___X____ Daily Notes
___X___ Other: DOL__________________
___X____ Including HIV/AIDs

Expiration Date of Authorization
This authorization is effective through ____/____/____ unless revoked or terminated by the patient or the patients personal representative.

Right to Terminated or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to the above listed offices at the Injury Centers of Brevard . You should contact the Compliance office to terminate the authorization.

Potential for Re-Disclosure
Information that is disclosed under this Authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under federal privacy regulations.

____ ____________________
Patient Signature Date

____ ____________________
Representative Signature / Print Name Date

INJURY CENTERS OF BREVARD

Titusville Chiropractic & Injury Center, Inc. Cocoa Accident & Injury Center, Inc.
Melbourne Accident & Injury Center, Inc.

Informed Consent

I have been informed it is not uncommon for patients to have some increased discomfort after an adjustment. If that happens, I will apply ice to the area and rest. If I am concerned about this discomfort or develop any new symptoms, I can call the office for attention. If I am out of town or unable to contact the aforementioned number, I can present, myself to the emergency room.

If any tests were performed outside of this office (laboratory or diagnostic procedures), I understand the doctor will notify me of the results at my next appointment or when the reports are available.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various methods of physical therapy and cold laser therapy (Note: Patients who receive cold laser therapy must wear protective eye wear or may run the risk of eye damage. Pregnant patients are not to receive cold laser therapy.) And, if necessary, diagnostic x-rays on me by the doctor of chiropractic in this office or anyone working in this clinic authorized by the doctor of chiropractic.

I further understand and I am informed that, as in all health and chiropractic medicine there are some very slight risks to treatment including, but not limited to, muscle strains and sprains, disc injuries, and strokes. I do not expect the doctor to be able to anticipate and explain all the risks and complications. I wish to rely on the doctor to exercise judgment during the course of procedure which the doctor feels at the time based upon facts then known, is in my best interest.

OUR OFFICE POLICY

We believe that a clear definition of our office polices will allow you, our patient and our office, to concentrate on the big issue**- REGAINING AND MAINTANING YOUR HEALTH.**

Multiple appointments have been given to you for your convenience, to minimized waiting, and help incorporate these appointments into your daily routine. If you are unable to keep an appointment for any reason, it is required that you call immediately to re-schedule your visit. If you miss an appointment, it must be rescheduled within the week it is missed. This permits you to stay on the treatment schedule that the doctor prescribed for best results. Staff is not authorized to change or alter your prescription, only the doctor.

Upon final or discharge of care medical record request(s) will only be provided to another doctor or attorney with a signed medical release form. Medical records will not be released directly to the patient.

PAYMENT OF BILL

We will require that you honor financial agreements you make with our office. If you find that you cannot fulfill the agreement you have with us, please advise our financial department immediately so that new arrangements can be made. Our policy is that if a patient does not have cash a personal balance of $100,000. Insurance balances may exceed this. Any insurance checks sent to your home should be brought or sent to our office within three days, along with the stub or statement to indicate which services were paid.

**Our office will submit your insurance claims for you as a courtesy. However, your insurance is an agreement between you and your company, not between our office and your insurance company.

I have read the above consent, and by signing below, I agree to the above name procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition for which I seek treatment.

RECEIPT OF NOTICE PRIVACY PRACTICE
I have received a copy of the Notice of Privacy from the Injury Centers of Brevard and have reviewed it carefully.

________________________________ DOB:___________ Date: ________
Patient/ Guardian Signature

____
Witness **Date**

LETTER OF PROTECTION

INJURY CENTERS OF BREVARD

Cocoa Accident & Injury Center, Inc.
PH: (321) 735-9050 Fax: (321) 735-9429

Titusville Chiropractic & Injury Center, Inc.
PH: 321-567-4984 Fax: (321)567-7626

Melbourne Accident & Injury Center, Inc.
PH: (321) 622-6610 Fax (321) 622-6716

Patient Name:_________________________ Date of Birth:___________________

Date of Accident:_______________

I do hereby authorize **Injury Centers of Brevard** to furnish my attorney with a full report of this examination, diagnosis, treatment, prognosis, etc. Regarding myself for medical conditions related to the accident dated above.

I hereby authorize and direct you, my attorney, to pay directly to the doctor such sums may be due and owing him for reasonable and necessary medical services rendered to me for the evaluation or treatment for the conditions related to this accident. I hereby further give a lien on my case to the doctor against any and all proceeds of my settlement, judgment or the verdict which may be paid to you by my attorney or myself as a result of the injuries of which I have been treated or injuries in connection therewith.

I fully understand that I am responsible to the doctor for all reasonable medical bills submitted by him for necessary services rendered to me and the payments for such bills will be paid solely out of my settlement, judgment or verdict. I further understand that his agreement is made for the doctor's protection in consideration of his awaiting payment. I understand and agree that my directions to you, as my attorney, are irrevocable until either the satisfaction of my financial account with Injury Centers of Brevard occurs or Injury Centers of Brevard releases such Letter of Protection.

I agree to promptly notify the doctor of any change or addition of attorney(s) used by me in connection of the accident and instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted or added attorney.

Please acknowledge this letter by signing below and return it to the doctor's office.

Patients Signature:_____________________________ Date:______________________

I, being the attorney of record for the above patient, do hereby agree to observe all the terms of the above and agree to withhold such sums for any settlement, judgment, or verdict as may be necessary to adequately protect and fully compensate the doctor named above in payment of his fees.

Attorney's Name:_________________________________

Attorney's Signature:________________________________ Date:________________

ACKNOWLEDGE OF ABUSE INFORMATION

INJURY CENTERS OF BREVARD

Cocoa Accident & Injury Center, Inc.
PH: (321) 735-9050 Fax: (321) 735-9429

Titusville Chiropractic & Injury Center, Inc
PH: 321-567-4984 Fax: (321)567-7626

Melbourne Accident & Injury Center, Inc.
PH: (321) 622-6610 Fax (321) 622-6716

I, ____, have read and received the phone numbers needed to report abuse and complaints on this __________ day of _____________, 20____.

Print Name

Signature

Date

_________________________ ________________

Witness Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Injury Centers of Brevard

You may refuse to sign this acknowledgement.

I, ____, have received a copy of this office's Notice of Privacy Practices.

Please Print Name

Signature

Date

For Office Use Only

We attempted to obtain a written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

( ) *Individual refused to sign*
( ) *Communication barriers prohibited obtaining the acknowledgement*
( ) *An emergency situation prevented us from obtaining acknowledgement*
( ) *Other (Please specify)*

____

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. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

OUR OBLIGATIONS

We are required by law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal obligation, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect on May 26, 2015, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practice, we will change this Notice and make the new Notice available to you upon request.

You may request a copy of our Notice at any time. For more information about privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH

We use and disclose health information about you for our treatment, payment and health care operations. For example:

Treatment: We may use or disclose your health information to a physician or other health care provider providing treatment to you.

Payment: We may use or disclose your information to your health insurer to obtain payment for services we provide to you.

Health Care Operations: We may use or disclose your health information in connection with our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation and certification, licensing or credentialing activities. For example, we may use or disclose your health information in order to conduct an internal assessment of the quality care we provide.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification (including identifying or locating) a family member, your personal representative or another person responsible for your care, to the extent necessary to help with your health care or with payment of your health care, if you agree that we may do so. We may also advise these persons of your locations, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information this is directly relevant to the person's involvement in your health care. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Disclosure Permitted or Required by Law: We are permitted and in some cases required, by law to make certain other disclosures of health information without your consent. We may disclose your health information, as appropriate, to the following entities under the following circumstances:

1. to public health agencies to satisfy certain reporting requirements, such as births and deaths, certain communicable diseases, child abuse and other public health issues;
2. to health oversight agencies such as governmental auditors, the Florida Agency for Health Care Administration, the Florida Department of Health and other agencies when required;
3. to any individual when Injury Centers of Brevard. is ordered by court or other legal process to do so;
4. to law enforcement officials when necessary for law enforcement purposes and required by law;

5. to a coroner or medical examiner when necessary to enable them to perform their duties;
6. to organ procurement organizations, to enable them to make suitability determination;
7. in case of an emergency; or
8. to researchers if their research has been approved by an institutional review board and they take certain steps to protect your privacy.

Appointment Reminder: We may use or disclose your health information to provide you with appointment reminders (such as a voicemail message, postcards, or letters of information about treatment alternatives of other health-related benefits and services that may be of interest to you.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Your Authorization: Other uses and disclosures of your health information will be made if you give us written authorization to do so. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

PATIENT RIGHTS

You have certain rights regarding your health information. These rights include:

1. the right to obtain a paper copy of this Notice;
2. the right to inspect and copy your health information (copies are available for a reasonable fee);
3. the right to request amendments to your health information you believe to be inaccurate;
4. the right to obtain an accounting of Injury Centers of Brevard uses and disclosures of your health information, subject to certain expectations;
5. the right to request restrictions on our permitted uses and disclosures of your information (although we are not legally obligated to honor this request); and
6. the right to request that communications regarding your health information be sent by alternative means or at alternative locations.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights or wish to exercise any of your rights described herein, please contact us using the contact information listed at the end of this Notice. You also may submit a written complaint to the US Department of Health and Human Services. We will provide you with the address to file your complaint with the US Department of Health and Human Services upon request. We support your right to the Privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the US Department of Health and Human Services.

ABUSE INFORMATION

Cocoa Accident & Injury Center, Inc.
PH: (321) 735-9050 Fax: (321) 735-9429

Titusville Chiropractic & Injury Center, Inc.
PH: 321-567-4984 Fax: (321)567-7626

Melbourne Accident & Injury Center, Inc.
PH: (321) 622-6610 Fax (321) 622-6716

408.810 On or before the first day of services and provided to client, a licensee must inform the client and his or her immediate family or representative, if appropriate, of the right to report:

- Complaints. The statewide toll-free number to report a complaint regarding the services you receive 1-888-419-3456
- To report abuse, neglect, or exploitation, please call toll free 1-800-96-ABUSE