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 ID to the receptionist if you have it)

Please PRINT Patient LEGAL Name:_____
(Last Name) (First Name) (Middle Initial)

DATE OF CURRENT ACCIDENT: _____ HEIGHT:_____ WEIGHT:_____

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

Date Of Birth: / / **Age:**_____ **Sex:** M / F **Social Security #:**_____

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: _____

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**

WAS THERE ANYONE ELSE IN THE CAR WITH YOU? Yes / No

WHERE DID YOU GO AFTER THE ACCIDENT? HOME / WORK / HOSPITAL ***If hospital, which hospital?*** _____
How did you get there? [ ] Drove self [ ]Someone else [ ]Police [ ]Ambulance
Where X-rays or CT Scans taken? [ ]Yes [ ]No

In your own words please describe the accident:_____

_____

_____

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:** _____

We have 3 great locations that are able to help you, open Monday- Friday 8:45am-6pm. If you need to reschedule any appointment please give us a call and we can gladly reschedule you.

OFFICE OF INSURANCE REGULATION
Bureau of Property & Casualty Forms and Rates

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:

_____ _____ _____
Patient's 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 up-coded, 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**):*

_____ _____ _____
Doctor's 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.

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.
840 N Cocoa Blvd Suite A 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(s) with which I have treated. I understand it is the intention of the Health Care Providers 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 Providers to file suit against the insurer either in my name or the providers' names 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 Providers in writing within five (5) days of receipt of this document advising of its basis for such dispute. Failure to inform the Health Care Providers 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 Providers the maximum amount of the policy benefits directly to the Health Care Providers without any reductions and without including the undersigned patient's/insured's name on the check. It is the Health Care Providers' contention that the 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 Providers are given Powers 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 Providers 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 Providers, 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 Providers 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 Providers 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 Providers to accept a reduced amount as payment in full. The insurer is hereby placed on notice that the Health Care Providers reserve 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 the Health Care Providers with a copy of the policy of insurance within ten (10) days. Should the insurer and Office Manager of the above-stated Health Care Providers 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 the Health Care Providers 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 Providers are 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 Providers' 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 Provides; 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 Providers' 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 Providers' 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 Name:_____ Patient Signature:_____
(Please print) (If patient/insured is a minor, signature of parent/guardian)

Date: _____

PLEASE ANSWER THE QUESTIONS BELOW.

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_____

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 **Did you brace for the impact?** [ ]Yes [ ]No

Did you have a seat belt on? [ ]Yes [ ]No **Did airbags deploy?** [ ]Yes [ ]No

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

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

Did you lose consciousness during accident? [ ]Yes [ ]No **Was an accident report filled out by police?** [ ]Yes [ ]No

Check off any and all symptoms immediately & days following accident: [ ]Neck stiffness [ ]Mid back pain [ ]Neck pain [ ]Low back pain [ ]Headache [ ]Ringing in ears [ ]Loss of taste /smell [ ]Dizziness [ ] Fainting [ ]Diarrhea [ ]Fatigue [ ]Nausea [ ]Chest Pain [ ]Irritability [ ]Shortness of breath [ ]Confusion [ ]Tension [ ]Anxious /Nervousness [ ]Toe numbness [ ]Pain in eyes [ ]Depression [ ]Constipation [ ]Sleeping problems [ ]Shoulder pain R / L [ ]Knee pain R / L [ ]Wrist pain R / L [ ]Ankle pain R/ L [ ]Hip pain R / L [ ] Elbow pain R / L
[ ]Other_____

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

_____ DOB:_____ Date: _____
Patient / Guardian Signature

_____
Witness **Date**

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_____

INJURY CENTERS OF BREVARD
ADL

Patient Name:_____ DOB:_____

Please complete the following regarding how you feel since the accident:

Rate each activity that you have difficulty preforming.
Scale from 1-5, 5 Being the worst pain possible and you need help completing the activity, 1 being little to no pain completing activity

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

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

Yard Work
_____ Mowing lawn
_____ Raking leaves
_____ Gardening
_____ Other_____

General Movements
_____ Walking
_____ Running
_____ Sitting
_____ Lifting Child
_____ Exercising
_____ Swimming
_____ Climbing Stairs
_____ Sleeping
_____ Reading
_____Sports: Please list_____

_____ Standing
_____ Using computer
_____ Kneeling
_____ Sexual Intercourse
_____ Lying in bed
_____ Bending
_____ Using telephone
_____ Chewing
_____ Squatting

Travel
_____ Driving
_____Riding as Passenger
_____ Getting in / out of car
_____ Plain travel
_____ Other_____

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

Range of Pain over the last week? No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

Are you currently taking any medication for pain, Prescribed or over the counter? [ ]Yes [ ] No

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: _____ DOB:_____ 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

Patient Name:_____ Date:_____

PERSONS AUTHORIZED TO DISCLOSE INFORMATION
Information listed below will be disclosed by: _____

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

Patient 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..

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various methods of physical therapy.

Listed below are some of the therapies performed in our office.

Medical Doctor (MD) Evaluation- our MD evaluated all patients for an Emergency Medical Condition which is required with all auto insurance claims.

Chiropractic Adjustments- important to start adjustments to the injured area before scar tissue starts to form so that the issue doesn't become worse.

Manual Therapy- Important to get range of motion in the injured area, relieve pain, reduce swelling, reduce muscle tension, and improve circulation.

Therapeutic Exercise- Important to restore strength and coordination to the muscles and maintain mobility in the joints. These exercises will help to decrease pain, prevent muscle deterioration, promote joint health, increase stability and range of motion.

Heat / Cold Therapy- depending on your injury, you will receive heat therapy and/or cold pack therapy. Heat therapy is used to deeply penetrate and relax your muscles. Along with relieve pain and soreness in joints. Cold therapy is used to decrease and prevent swelling and reduce the pain.

EMS/ TENS Therapy- Used to prevent muscle spasms and muscle atrophy, increasing local blood circulation by stimulating muscle tissue, and strengthen muscle tissue to promote healing.

Mechanical Traction- Spinal traction uses mechanically created forces to stretch and mobilize the spine. Traction may alleviate pain by stretching tight spinal muscles that result from spasm and widen intervertebral foramen to relive nerve root impingement.

Posture Pump- Used to help relieve stiffness and restore cervical posture. Helps restore the natural curvature of the cervical spine to decompress the discs and relieve pain.

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.

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

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 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.

_____ DOB:_____ Date: _____

Patient / Guardian Signature

_____

Witness **Date**

LETTER OF PROTECTION

INJURY CENTERS OF BREVARD

Cocoa Accident & Injury Center, Inc.
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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:_____

HARDSHIP AGREEMENT

INJURY CENTERS OF BREVARD

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To whom it may concern,

The Clinic Named above has agreed to accept assignment on the undersigned patient. The mentioned office has also conditionally agreed to accept what the insurance pays only as full payment for services rendered to the undersigned patient.

It has been established that this patient is in need of Medical Care and Corrective Chiropractic treatment; However, He / She is unable to pay for these services at this time due to a drastic Financial Hardship.

In the event that the undersigned patient's income increases, a settlement is made, or other financial gain occurs and He /She is able to pay the co-payment or any other part of the outstanding balance, This Agreement will be null and void at that time.

Patient Name:_____

Patient Signature:_____ Date:_____

Witness Signature:_____ Date:_____

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ACKNOWLEDGMENT OF ABUSE INFORMATION

I, _____, have read and received the phone numbers needed to report abuse and complaints.

Signature Date

_____ _____
Witness Date

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement.

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

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 acknowledgment
( ) An emergency situation prevented us from obtaining acknowledgment
( ) Other (Please specify)

_____
_____
_____

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AFFIDAVIT OF INJURY

I hereby affirm that I sustained injuries/ pain as a result of an incident on _____. No one has offered or given me any money, incentive, remuneration, anything of value, or any other form of inducement for the purpose of treating at this clinic.

No one has made any promises or guarantees with regard to my medical treatment or any other aspect of my case and/or claim. I understand that I have a choice regarding where I seek treatment for my injuries, and I have chosen, of my own free will, to seek treatment at this clinic.

_____ _____ _____
Signature of patient and/or responsible parties Date Date of Birth

_____ _____
Signature on behalf of Provider Date

NOTARIZED BEFORE ME

Sworn to and subscribed before me on this _____day of_____, 20_____.

_____ ____personally known to me
____ Provided _____ as identification

Notary Public in and for: Brevard

The State of: Florida

My commission expires:

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

1. MEDICARE ☐ (Medicare#) MEDICAID ☐ (Medicaid#) TRICARE ☐ (ID#/DoD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (ID#) FECA BLK LUNG ☐ (ID#) OTHER ☐ (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☐

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ ***If yes***, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.