Auto Accident Patient Intake Form

You are completing the following intake forms designed for wellness adult patients.
Please take a moment to fill out our Online intake form before your visit.
All information is kept completely confidential.

PATIENT DEMOGRAPHICS

First Name _____

Last Name _____

Preferred Name (if different) _____

Prefix / Title

Email Address _____

Mobile Phone _____ Home Phone _____

**Your mobile number can be used to look up your Account and receive text message appointment reminders

Street Address _____

Suite Number _____

City _____

State _____

Postal / Zip _____

Date of Birth _____

Gender (Refers to current gender which may be different than what is indicated on your insurance policies).

Sex _____ (Field may be used for submitting claims to insurance provider. Please ensure the sex you provide here matches what your insurance provider has on file).

Emergency Contact _____ Emergency Contact Phone _____

Emergency Contact Relationship _____

Family Doctor _____ Family Doctor Phone (if known) _____

Family Doctor Email (if known) _____

Occupation _____

How did you hear about us? Name of referring person? _____

Patient Health and Accident Information

What is the primary reason for visit? _____

Date of Accident? _____

Retained an Attorney? _____ (YES/NO)
If Yes, name and phone number: _____

Please briefly describe the accident in your own words (1-2 sentences)

Were you the:

ACCIDENT SITE

Road/Street Name: _____

City/State: _____

Direction Traveling: _____

Speed Traveling: _____

VEHICLE

Year, Make and Model:

Wearing a seatbelt?

Did the airbags deploy?

What was the position of the headrest?

IMPACT

Did your car impact another vehicle? No

Was impact from:

Did your body strike the inside of the vehicle? At the time of impact w Yes If yes, which part(s) of your body?

Were both hands on the steering wheel? If no, which hand was on the wheel?

Were you: Braced by im

POLICE

Did the police come to the accident site?

Was a police report filed?

AFTER IMPACT

Did the accident leave you unconscious?D

If so, how long?

you go to a hospital or urgent care center?

If yes, when did you go?

How did you get there?

Name of Hospital and/or attending doctor: _____

What treatment did you receive? _____

Were x-rays taken?

Was medication prescribed?

Have you been able to work since injury?

Is your condition getting worse?

SYMPTOMS (Check Boxes)

- ☐ Headache
- ☐ Head feels too heavy
- ☐ Arm Numbness
- ☐ Mid Back Pain
- ☐ Painful Breathing Buttock
- ☐ Pain
- ☐ Swelling
- ☐ Tension
- ☐ Eye Strain
- ☐ Double vision
- ☐ Shortness of breath
- ☐ Diarrhea
- ☐ Skull Pain
- ☐ Shoulder Pain
- ☐ Cold Hands
- ☐ Mid Back Stiffness Low
- ☐ back Pain
- ☐ Leg Pain
- ☐ Cold Feet
- ☐ Irritability
- ☐ Difficulty Focusing
- ☐ Buzzing/Ringing in ears
- ☐ Digestive problems
- ☐ Constipation
- ☐ Facial Pain Shoulder
- ☐ Stiffness Upper Back
- ☐ Pain Chest Pain
- ☐ Low back Stiffness
- ☐ Leg Numbness
- ☐ Depression
- ☐ Nervousness
- ☐ Pain behind the eyes
- ☐ Loss of balance
- ☐ Nausea
- ☐ Fever
- ☐ Neck Stiffness Arm
- ☐ Pain
- ☐ Upper Back Stiffness
- ☐ Rib Pain
- ☐ Hip Pain
- ☐ Pins/Needles in legs
- ☐ Anxiety
- ☐ Loss of memory Eyes
- ☐ sensitive to light
- ☐ Palpitations Vomiting

Rate your primary pain or discomfort on a scale from 0 to 10 0

0 - Being in no pain or discomfort
1, 2 - Mild pain or discomfort
3, 4, 5 - Moderate pain or discomfort
6, 7, 8 - Severe pain or discomfort
9, 10 - Highest level of pain or discomfort experienced

HEALTH HISTORY QUESTIONNAIRE - (please check all that may apply)

- ☐ **General Symptoms**
- ☐ **History of Migraines**
- ☐ **Night Sweats**
- ☐ **Nervousness**
- ☐ **Allergies**
- ☐ **Dizziness**
- ☐ **Blurred Vision**
- ☐ **Numbness or tingling**
- ☐ **Loss of consciousness**
- ☐ **Fever Excess**
- ☐ **Night Pain**
- ☐ **Convulsions**
- ☐ **Loss of Bowel or Bladder Control**
- ☐ **Fainting**
- ☐ **Failing Vision**
- ☐ **Radiating pain**
- ☐ **History of Headaches**
- ☐ **Sweating Generalized**
- ☐ **Pain Loss of Sleep**
- ☐ **Neurological Symptoms**
- ☐ **Problem Speaking**
- ☐ **Nausea**
- ☐ **Eyes/Ears/Nose/Throat Symptoms**

HEALTH HISTORY QUESTIONNAIRE - (Continued)

Vision Problems ☐
Eye Pain ☐
Ringing / Buzzing in ears ☐
Hearing Loss ☐
Other Hearing problems not otherwise listed Respiratory Symptoms ☐
Asthma ☐
Chronic Cough ☐
Difficulty Breathing ☐
Shortness of breath ☐
Bronchitis ☐
Emphysema ☐
Cardiovascular Symptoms ☐
Bleeding Disorder ☐
High Blood Pressure ☐
Low Blood Pressure ☐
Previous Stroke ☐
Cerebral Vascular Aneurysm ☐
Hardening of Arteries ☐
Swelling of Ankles ☐
Poor Circulation ☐
Angina ☐
Chronic Congestive Heart Failure ☐
Previous Heart Attacks ☐
Phlebitis / Varicose veins ☐
Pacemaker or similar device ☐
Other Heart / Blood Disease not discussed Gastrointestinal Symptoms ☐
Jaundice ☐
Irregular or absent bowel movement ☐
Ulcer ☐
Diabetes ☐
Indigestion ☐
Genitourinary Symptoms ☐
Trouble Urinating ☐
Kidney Infection ☐
Prostate Trouble ☐
Genitourinary Symptoms (Female only) ☐
Hot Flashes ☐
Irregular / Absent Cycle ☐
Cramping / Backache ☐

Are you currently pregnant ?

If so, how many weeks into your pregnancy are you, and what is your estimated due date?

_____

Number of Pregnancies

Number of Children

Have you ever had any fractures or surgeries ? If yes, please provide details.

_____

Have you had any X-rays, CT scans, ultrasounds or MRIs in the past 5 years?

If so, please list what type of imaging and which clinic/hospital and the area examined:

_____

Have you ever been diagnosed with cancer ?

If yes, please provide details

_____

Please list your current Medications, Herbs, Supplements.

_____

_____

FAMILY MEDICAL HISTORY

(Please check if any immediate family members suffer from the following)

Headaches or Migraines ☐
Diabetes ☐
Fainting or Dizziness ☐
Circulatory Problems ☐
Neurological disorders ☐
Inflammatory Bowel Disease ☐
Respiratory disorders ☐
Osteoarthritis ☐
Fibromyalgia ☐
Multiple Sclerosis ☐

High or Low blood pressure ☐
Heart Disease ☐
Stroke ☐
Cancer ☐
Kidney disease ☐
Asthma ☐
Rheumatoid arthritis ☐
Osteoporosis ☐
Epilepsy ☐

Please add any additional information that you feel is pertinent:

_____

_____

Premier Chiropractic & Wellness LLC, 160 Cypress Point Parkway Ste A113, Palm Coast, FL 32164

ASSIGNMENT AND LIEN FOR MEDICAL SERVICES RENDERED AGREEMENT/ LETTER OF PROTECTION

Patient authorizes and irrevocably directs his/her present and any future attorneys related to the below referenced date of injury ("Attorneys") to honor this agreement. This irrevocable agreement is made in favor of the above-referenced Medical Provider and shall be termed Letter of Protection." The Letter of Protection shall serve to place a continuing lien on any proceeds I recover in any legal action related to the above referenced date of injury. The Direction to Pay applies to the Patient's Attorneys.

Background. Premier Chiropractic & Wellness LLC Clinic expects to be paid from any proceeds related to the above-referenced date of injury in exchange for providing medical care treatment. Premier Chiropractic & Wellness LLC Clinic also agrees not to place patient in collections until the resolution of Patient's claims related to the below-reference date of injury. Patient expects to receive medical care that is reasonable, related to the below-referenced accident and medically necessary, Patient has sustained injuries as a result of injuries related to the below-referenced date of injury.

Insurance Benefits. ln the event that there are disability benefits, medical payment benefits, No-fault benefits health and accidental benefits, worker's compensation benefits, or any other insurance benefits available to Patient besides Bodily Injury and/or Un-insured Motorist (aka Underinsured Motorist) coverage, then this letter of Protection can be used to cover any co-payments and/or deductibles.

Protection of Medical Bills. If Patient recovers any money related to the below referenced date of injury then Patient's Attorney shall withhold from those funds, sufficient money pays the outstanding balance of any bill(s) owed to Premier Chiropractic & Wellness LLC. It is understood that Attorney's fees/costs are. first-in-line and that this Letter of Protection does not interfere with Attorney's retainer agreement with Patient.

Patient authorizes Premier Chiropractic & Wellness LLC Clinic to provide Attorney with a copy of Patient 's medical records, bills, etc. with regard to the below-referenced date of injury.

Patient's Responsibility for Bills. Patient understands that he/she is directly responsible to Medical Provider for services rendered and that payment is not contingent on any settlement, judgment, or verdict related to the above-referenced date of injury. Regardless of any settlement, judgment, or verdict, Patient is still responsible for paying Premier Chiropractic & Wellness LLC' s outstanding bills as long as they are reasonable and related to the below- referenced date of injury and medically necessary.

Patient's Responsibility Regarding His/Her Attorney (Present and Future). Patient is responsible for informing each and every attorney retained by him/her of the existence of this agreement. Premier Chiropractic & Wellness LLC Clinic has the right to notify Patient' s Attorney(s) about the existence of this Letter of Protection. Upon request, Patient and Patient's Attorney shall provide status updates about any claims related to the below-referenced date of injury as well as the contact information for any new Attorneys.

Direction to Pay. ATTENTION ATTORNEY:, THIS IS AN IRRECOVABLE DIRECTION TO PAY MY MEDICAL PROVIDER. Patient irrevocably directs his/her Attorneys to pay any out standing medical bill s in connection with the above-referenced date of injury.

Effective Date. This agreement becomes effective when the Patient signs the agreement below.

Patient Signature:

Date of Accident: _____ **Today's date:** _____

Attorney Signature: _____ **Date:** _____

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT AND SHARING OF INFORMATION

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.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

Protected health information includes demographic and medical information that concerns the past, present, or future physical or mental health of an individual. Demographic information could include your name, address, telephone number, social security number and any other means of identifying you as a specific person. Protected health information contains specific information that identifies a person or can be used to identify a person.

Protected health information is health information created or received by a health care provider, health plan, employer, or health care clearinghouse. The Department of Health can act as each of the above business types. This medical information is used by the Department of Health in many ways while performing normal business activities.

Your protected health information may be used or disclosed by the Department of Health for purposes of treatment, payment, and health care operations. Health care professionals use medical information in the clinics or hospital to take care of you. Your protected health information may be shared, with or without your consent, with another health care provider for purposes of your treatment. The Department of Health may use or disclose your health information for case management and services. The Department of Health clinic or hospital may send the medical information to insurance companies, Medicaid, or community agencies to pay for the services provided you.

Your information may be used by certain department personnel to improve the department's health care operations. The department also may send you appointment reminders, information about treatment options or other health-related benefits and services.

Some protected health information can be disclosed without your written authorization as allowed by law. Those circumstances include:

- Reporting abuse of children, adults, or disabled persons.
- Investigations related to a missing child.
- Internal investigations and audits by the department's divisions, bureaus, and offices.
- Investigations and audits by the state's Inspector General and Auditor General, and the legislature's Office of Program Policy Analysis and Government Accountability.
- Public health purposes, including vital statistics, disease reporting, public health surveillance, investigations, interventions, and regulation of health professionals.
- District medical examiner investigations;

- Research approved by the department.
- Court orders, warrants, or subpoenas;
- Law enforcement purposes, administrative investigations, and judicial and administrative proceedings.

Other uses and disclosures of your protected health information by the department will require your written authorization. These uses and disclosures may be for marketing and for research purposes, certain uses and disclosure of psychotherapist notes, and the sale of protected health information resulting in remuneration to the Department of Health.
This authorization will have an expiration date that can be revoked by you in writing.

PAGE READ ACKNOWLEDGEMENT
(Patient initials)

_____
(initial)

INDIVIDUAL RIGHTS

You have the right to request the Department of Health to restrict the use and disclosure of your protected health information to carry out treatment, payment, or health care operations. You may also limit disclosures to individuals involved with your care. The department is not required to agree to any restriction.

You have the right to be assured that your information will be kept confidential. The Department of Health will make contact with you in the manner and at the address or phone number you select. You may be asked to put your request in writing. If you are responsible to pay for services, you may provide an address other than your residence where you can receive mail and where we may contact you.

You have the right to inspect and receive a copy of your protected health information that is maintained by the Department of Health within 30 days of the Department's receipt of your request to obtain a copy of your protected health information. You must complete the Department's Authorization to Disclosure Confidential Information form and submit the request to the county health department or Children's Medical Services office. If there are delays in getting you the information, you will be told the reason for the delay and the anticipated date when you will receive your information.

Your inspection of information will be supervised at an appointed time and place. You may be denied access as specified by law.

If you choose to receive a copy of your protected health information, you have the right to receive the information in the form or format you request. If the Department cannot produce it in that form or format, it will give you the information in a readable hard copy form or another form or format that you and the Department agree to.

The Department cannot give you access to psychotherapy notes or certain information being used in a legal proceeding. Records are maintained for specified periods of time in accordance with the law. If your request covers information beyond that time the Department is required to keep the record, the information may no longer be available.

If access is denied, you have the right to request a review by a licensed health care professional who was not involved in the decision to deny access. This licensed health care professional will be designated by the department.

You have the right to correct your protected health information. Your request to correct your protected health information must be in writing and provide a reason to support your requested correction. The Department of Health may deny your request, in whole or part, if it finds the protected health information:

- Was not created by the department.
- Is not protected health information.
- Is by law not available for your inspection.
- Is accurate and complete.

If your correction is accepted, the department will make the correction and tell you and others who need to know about the correction. If your request is denied, you may send a letter detailing the reason you disagree with the decision. The department may respond to your letter in writing. You also may file a complaint, as described below in the section titled Complaints.

You have the right to receive a summary of certain disclosures the Department of Health may have made of your protected health information. This summary does not include:

- Disclosures made to you.
- Disclosures to individuals involved with your care.
- Disclosures authorized by you.
- Disclosures made to carry out treatment, payment, and health care operations.
- Disclosures for public health.
- Disclosures to health professional regulatory purposes.
- Disclosures to report abuse of children, adults, or disabled.
- Disclosures prior to April 14, 2003.

_____

PAGE READ ACKNOWLEDGEMENT
(Patient initials)

This summary does include disclosures made for:

- Purposes of research, other than those you authorized in writing.
- Responses to court orders, subpoenas, or warrants.

You may request a summary for not more than a 6 year period from the date of your request.

If you received this Notice of Privacy Practices electronically, you have the right to a paper copy upon request.

The Department of Health may mail or call you with health care appointment reminders.
You may request a summary for not more than a 6 year period from the date of your request.
If you received this Notice of Privacy Practices electronically, you have the right to a paper copy upon request.

DEPARTMENT OF HEALTH DUTIES

DH8006-SSG-09/2017

The Department of Health is required by law to maintain the privacy of your protected health information. This Notice of Privacy Practices tells you how your protected health information may be used and how the department keeps your information private and confidential. This notice explains the legal duties and practices relating to your protected health information. The department has the responsibility to notify you following a breach of your unsecured protected health information.

As part of the department's legal duties this Notice of Privacy Practices must be given to you. The department is required to follow the terms of the Notice of Privacy Practices currently in effect.

The Department of Health may change the terms of its notice. The change, if made, will be effective for all protected health information that it maintains. New or revised notices of privacy practices will be posted on the Department of Health website at http://www.floridahealth.gov/about-the-department-of-health/about-us/patient-rights-and-safety/hipaa/index.html and will be available by email and at all Department of Health buildings. Also available are additional documents that further explain your rights to inspect and copy and amend your protected health information.

COMPLAINTS

If you believe your privacy health rights have been violated, you may file a complaint with the: Department of Health's Inspector General at 4052 Bald Cypress Way, BIN A03/ Tallahassee, FL 32399-1704/ telephone 850-245-4141 and with the Secretary of the U.S. Department of Health and Human Services at 200 Independence Avenue, S.W./ Washington, D.C. 20201/ telephone 202-619-0257 or toll free 877-696-6775.

The complaint must be in writing, describe the acts or omissions that you believe violate your privacy rights, and be filed within 180 days of when you knew or should have known that the act or omission occurred. The Department of Health will not retaliate against you for filing a complaint.

FOR FURTHER INFORMATION

Requests for further information about the matters covered by this notice may be directed to the person who gave you the notice, to the director or administrator of the Department of Health facility where you received the notice, or to the Department of Health's Inspector General at 4052 Bald Cypress Way, BIN A03/ Tallahassee, FL 32399-1704/ telephone 850-245-4141.

EFFECTIVE DATE

This Notice of Privacy Practices is effective beginning July 1, 2013, and shall be in effect until a new Notice of Privacy Practices is approved and posted.

REFERENCES

"Standards for the Privacy of Individually Identifiable Health Information; Final Rule." 45 CFR Parts 160 through 164. Federal Register 65, no. 250 (December 28, 2000).

PAGE READ ACKNOWLEDGEMENT
(Patient initials)

_____
(initial)

"Standards for the Privacy of Individually Identifiable Health Information; Final Rule" 45 CFR Part 160 through 164. Federal Register, Volume 67 (August 14, 2002).

DH8006-SSG-09/2017

HHS, Modifications to the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules under the Health Information Technology for Economic and Clinical Health Act and the Genetic Information and Nondiscrimination Act; Other Modifications to the HIPAA Rules, 78 Fed. Reg. 5566 (Jan. 25, 2013).

I, the undersigned, do hereby acknowledge that I have received a copy of this office's Notice of Privacy Practices Pursuant to HIPAA and have been advised that a full copy of this office's HIPAA Compliance Manual is available upon request. I authorize the clinic and its associated health professionals to collect my personal and medical information as documented above. In addition, I authorize the clinic and its associated health professionals to communicate with my family doctor and/ or referring doctor as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission. I agree to the above.

_____ _____

Patient Signature (Today's Date)

CONSENT TO TREAT ACKNOWLEDGEMENT

I hereby request and consent to the performance of chiropractic adjustments and other associated procedures on myself or the patient named below for who I am legally responsible. (initial)

I understand, as with any health care procedures, that there are certain complications, which may arise during chiropractic treatments. Those complications include but are not limited to: headaches, dizziness, nausea, muscle spasms, disc injuries, dislocations, and fractures. (initial)

If there is any dispute about my care, I agree to a resolution by binding arbitration according to the American Arbitration Association guidelines. I have read (or have had read to me) the above explanation of the chiropractic treatments. I state that I have been informed and weighed the risks involved in chiropractic treatment at this health care office. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

I have read (or have had read to me) the above explanation of the chiropractic treatments. I state that I have been informed and weighed the risks involved in chiropractic treatment at this health care office. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

Patient Signature Date

EMAIL COMMUNICATION

Transactional Emails

You can opt to receive emails to keep you informed of new bookings, changes to your bookings, and reminders for upcoming appointments.

☐ I would like email notifications of new, canceled, and rescheduled appointments

☑ Text Message (SMS) 2 hours before appointment _____

☐ Email 24 hours before appointment

News and Special Promotions

☑ Yes, I would like to receive news and special promotions by email _____

ACCURACY OF INFORMATION PROVIDED

_____I certify that the above medical information is correct to my knowledge. Required
(initial)

CANCELATION POLICY

Your appointment time is reserved just for you. A late cancellation or missed visit leaves a hole in the therapists' day that could have been filled by another patient. As such, we require 1 hour notice for any cancellations or changes to your appointment. Patients who provide less than 1 hour notice, or miss their appointment, will be charged a cancellation fee.

I am aware of the Cancellation Policy. _____
(initial)

PHOTO CONSENT

We are PROUD of our patients and the progress they make while under our care! There's nothing we enjoy more than CELEBRATING our patients' successes along with them. And when something good is happening in our lives, we feel inclined to share it with others, right? If the moment arises, we would love to share your photo, story, or progress on our Social Media page(s) or website in the interest of showing others that "real people" visit our office and are smiling while they're here – and most importantly, getting results! Please check the box that applies to you:

☐ **Sure! You can use my picture on Premier Chiropractic & Wellness Website and its Social Media (i.e. Facebook, Instagram, etc.) pages, as long as you think I look good in it!**

☐ **No thanks! I'll pass for now.**

_____ _____

Patient Signature (Today's Date)

Covid-19 Visitor Screening Tool

At Premier Chiropractic & Wellness, we strive to provide the safest environment for our patients and staff. We have implemented a rigorous sanitary protocol and have installed a UV light system in the air filtration system in order to help prevent the propagation of germs, bacteria and viruses. This being said, as the recent pandemic has showed, nothing is unfortunately a 100% effective. We therefore ask our patients to help us keep our environment safe for everyone.

Please read below carefully. Thank you.

I, _____name) , undersigned patient of Premier Chiropractic & Wellness, acknowledge that I do not have any of the following at the time of my visit(s) and will advise Premier Chiropractic & Wellness should any changes in my health condition occur and cancel my appointment(s) should this change until my health situation has been cleared by a medical professional:
I have no Fever greater than 100F,

- I have no Cough/Shortness of Breath,
- I have do not have Pneumonia/flu,
- I have not traveled out of the country in the last 14 days to China, Japan, Italy, Iran or S. Korea,
- I have not had contact with anyone who has lab confirmed Coronavirus within 14 days of symptom onset

(Thank you for your understanding and cooperation in helping us keep our residents, staff and community safe)

_____ (signature), I agree that if I have any of the above symptoms or exposures, I will not visit Premier Chiropractic & Wellness and will advise Premier Chiropractic & Wellness of the changes in my health status.

_____

ASSIGNMENT OF BENEFITS, AUTHORIZATION TO SETTLE CLAIM AND DIRECTION TO PAY MEDICAL PROVIDER DIRECTLY

By my signature below, for good and valuable consideration (including but not limited to the extension of credit to me), I hereby assign, transfer and convey to **Premier Chiropractic & Wellness** (hereinafter "the Provider") all of my rights, title and interest in and to medical expense reimbursement in whatever form, including but not limited to any automobile liability medical expense payments or other health benefits indemnification and/or agreement otherwise payable to me. This payment shall not exceed my indebtedness to the above-named assignee, and I acknowledge that I will timely pay any indebtedness owed by me to the assignee that is not otherwise satisfied by the above-mentioned assigned proceeds. I also acknowledge that any medical expenses not covered under my insurance policy will be my responsibility.

I further authorize the Provider to negotiate, collect and settle any claim with any insurance carrier or other third-party payor with regard to these services, which authorization shall include authority to:
(1) request and receive from any insurer or any other party any and all documentation and records that I am empowered to request regarding this claim, including, without limitation, a statement of coverage, policy declarations page and insurance policy pursuant to Section 627.4137. In addition, the provider has the authority to request and receive any Independent Medical Examination Reports, notices sent to me regarding appointments for Independent Medical Examinations and Examinations Under Oath (including proof of mail), Records Review Reports, coverage denial letters, Explanations of Benefits, and Benefit Payment Sheets or Logs (P.I.P. Payout Sheets), without regard as to whether such documentation has already been provided to me and,
(2) to endorse in my name any check issued for payment where benefits were assigned. By way of this assignment and notice, I further instruct you, the insurer, to furnish to Provider copies of all future notices affecting Provider's interest in this claim, including, without limitation, any notices of requested medical examinations or statements.

The Provider hereby objects to any reductions or partial payments. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by the provider shall be done so under protest, at the risk of the insurer, and the deposit *shall not* be deemed a waiver, *accord, satisfaction*, discharge, settlement, or agreement by the provider to accept a reduced amount as payment in full.

I further direct my insurer to direct all payments for services rendered by the Provider directly to Provider at the billing address contained on Provider's medical bills.

THIS IS A DIRECT AND IRREVOCABLE ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER MY POLICY OF INSURANCE.

A photocopy of this form shall be considered as effective and valid as the original.

I have read the foregoing and understand and agree to each of the above provisions:

_____
Print Name

_____ _____
Patient's signature Date

Premier Chiropractic & Wellness
160 Cypress Point Parkway Suite A113
Palm Coast, FL 32164

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.**

NP/EP	Manipulation	EMS	Heat/Cold	Traction	Manual Therapy
LB Brace	Tens	Pump	Therapeutic Exercise		

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 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(14) and (15), 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
Erika Equizi, DC		

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 Statutes and may **not** be electronically furnished. Failure to furnish this form may result in non-payment of the claim.

Premier Chiropractic & Wellness, LLC

160 Cypress Point Parkway Suite A113, Palm Coast. FL 32164 | Phone: (386) 585-4441

MEDICAL RECORDS REQUEST

Records Requested from: _____

Phone: (_____) _____ Fax:(_____) _____

I authorize the release of ALL my medical records to:

Premier Chiropractic & Wellness, LLC
160 Cypress Point Parkway Suite A113, Palm Coast. FL 32164
Phone: (386) 585-4441
www.PremierChiroPC.com

The above party may disclose this health information and future records of treatment received at Premier Chiropractic & Wellness LLC to the following recipient:

Name: _____
Address: _____
City: _____ State: _____ Zip: _____ Phone: _____

THE PURPOSE OF THIS AUTHORIZATION IS AT MY REQUEST. I UNDERSTAND THAT I HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION, IN WRITING, AT ANY TIME, EXCEPT WHERE USES OR DISCLOSURES HAVE AREADY BEEN MADE BASED UPON MY ORIGINAL PERMISSON. I MAY NOT BE ABLE TO REVOKE THIS AUTHORIZATION IF ITS PURPOSE WAS TO OBTAIN INSURANCE. IN ORDER TO REVOKE THIS AUTHORIAZATION, I MUST DO SO IN WRITING AND SEND IT TO THE APPROPRIATE DISCLOSING PARTY.

I UNDERSTAND THAT USES AND DISCLOSURES MADE BASED UPON MY ORIGINAL PERMISSION CANNOT BE TAKEN BACK.

I UNDERSTAND THAT IT IS POSSIBLE THAT INFORMATION USED OR DISCLOSED WITH MY PERMISSION MAY BE REDISCLOSED BY THE RECIPIENT AND NO LONGER PROTECTED BY THE HIPAA PRIVACY STANDARDS.

BY SIGNING BELOW, I CERTIFY THAT I UNDERSTAND AND AGREE WITH THE ABOVE INFORMATION AND THAT A COPY OF THIS AUTHORIZATION IS AS VALID AS THE ORIGINAL.

Patient Name: _____

Date of Birth: _____ SSN: _____

Patient Signature: _____ Date: _____

APPLICATION FOR FLORIDA "NO FAULT" BENEFITS

NAME OF INSURANCE COMPANY

DATE	OUR POLICY HOLDER	DATE OF ACCIDENT	FILE NUMBER

TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE FLORIDA PERSONAL INJURY PROTECTION LAW, PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURANCE COMPANY MAKES A STATEMENT OF CLAIM CONTAINING ANY FALSE INCOMPLETE OR MISLEADING INFORMATION, IS GUILTY OF A FELONY OF THE THIRD DEGREE.

YOUR NAME	PHONE NO.	HOME	BUSINESS

YOUR ADDRESS (NO, STREET, CITY OR TOWN, STATE AND ZIP CODE)	DATE OF BIRTH	SOCIAL SECURITY NO.

PERMANENT ADDRESS, IF DIFFERENT	HOW LONG HAVE YOU LIVED IN FLORIDA?

DATE AND TIME OF ACCIDENT	PLACE OF ACCIDENT (STREET, CITY OR TOWN AND STATE)

BRIEF DESCRIPTION OF ACCIDENT AND VEHICLES INVOLVED:

DESCRIBE MOTOR VEHICLE YOU OWN -	DESCRIBE MOTOR VEHICLE OWNED BY ANY MEMBER OF YOUR FAMILY-

AS A RESULT OF THIS ACCIDENT, WERE YOU INJURED? IF YOUR ANSWER IS YES, COMPLETE THE REST OF THIS FORM. IF NO, SIGN HERE AND RETURN THIS FORM TO US.

SIGNATURE: **DATE:**

DESCRIBE YOUR INJURY

WERE YOU TREATED BY A DOCTOR?		DOCTOR'S NAME AND ADDRESS
IF YOU WERE TREATED IN A HOSPITAL, WERE YOU AN IN PATIENT ____ OUT PATIENT _____		HOSPITAL'S NAME AND ADDRESS

AMOUNT OF MEDICAL BILLS TO DATE	WILL YOU HAVE MORE MEDICAL EXPENSE?	AT THE TIME OF YOUR ACCIDENT, WERE YOU IN THE COURSE OF YOUR EMPLOYMENT?

DID YOU LOSE WAGES OR SALARY AS A RESULT OF YOUR INJURY?	IF YES, AMOUNT OF LOSS TO DATE	WHAT IS YOUR AVERAGE WEEKLY WAGE OR SALARY?

IF YOU LOST WAGES:	DATE DISABILITY FROM WORK BEGAN	DATE YOU RETURNED TO WORK

HAVE YOU RECEIVED, OR ARE YOU ELIGIBLE FOR, PAYMENTS UNDER ANY WORKMEN'S COMPENSATION OR EMPLOYMENT LAW?	IF YES, AMOUNT PER WEEK PER MONTH

LIST NAMES AND ADDRESSES OF YOUR PRESENT EMPLOYER(S) AND GIVE YOUR OCCUPATION AND DATES OF EMPLOYMENT FOR EACH

EMPLOYER AND ADDRESS	YOUR OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	YOUR OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	YOUR OCCUPATION	FROM	TO

AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES?	IF YES, EXPLAIN ON REVERSE SIDE
SIGNATURE: DATE:	

IMPORTANT: 1. TO BE ELIGIBLE FOR BENEFITS COMPLETE AND SIGN THIS APPLICATION
2. SIGN AND ATTACH AUTHORIZATION(S)
3. RETURN PROMPTLY WITH ANY MEDICAL BILLS YOU HAVE RECEIVED TO DATE

Premier Chiropractic & Wellness LLC
160 Cypress Point Parkway Ste A113, Palm Coast, FL 32164

HARDSHIP AGREEMENT

The clinic Premier Chiropractic & Wellness LLC 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 the undersigned patient.

It has been established that this patient is in need of Medical Care and or 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 undersigned patient's income inerease.1, 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 become null and void at that time.

☐ I understand and agree to the above.

Today's date:

Patient Signature