Patient Information

Date: _____

How did you hear about us? ☐ Patient ☐ Physician ☐ Attorney ☐ Google ☐ Other_____

Last Name: _____ **First** Name: _____ Middle: _____

Address: _____ Apt/Lot# _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____

Birth Date: _____ Social Security# **XXX - XX -** _____

Email Address: _____

Employer: _____ Employer # _____

>>> Spouse's Name & #: _____

>>> -or- Emergency Contact Name & #: _____

Emergency Contact's relationship: Significant Other Parent Child Friend Other _____

Main Complaint: _____

_____

Date of Accident: _____ -or- Date of Symptom Onset: _____

Description of Accident: _____

_____

_____

_____

Have you consulted anyone else for this condition?

☐ YES ☐ NO

Physicians Name: _____

Location: _____

Allergies? _____

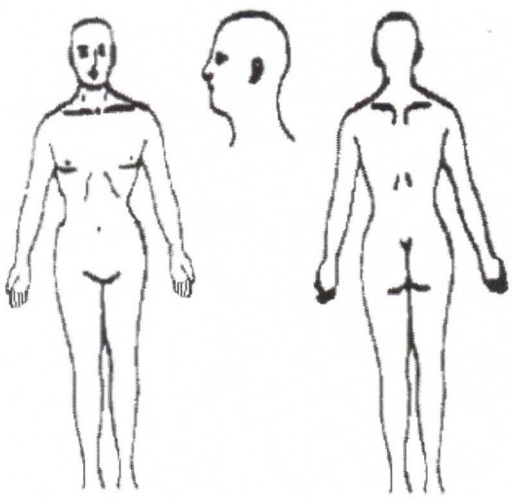
Please Mark Pain Scale with an X

NO Pain Severe Pain

0 I I I 5 I I I 10

Method of Payment: ☐Cash-Check-Card ☐ Insurance

Mark Areas: Pain = X Numbness = O



GULFVIEW CHIROPRACTIC

LIEN

On _____, 20____ I was injured as a result of an auto accident that occurred in the state of _____. I, _____, do hereby authorize Gulfview Chiropractic and its staff to furnish my attorney, _____, and/or their staff, with a full report of examination, diagnosis, treatment, prognosis, etc., in regard to the aforementioned accident. I do hereby hold Gulfview Chiropractic free from any all liability whatsoever that may arise from the release of such information to said attorney or any person designated by the said attorney. I understand that my attorney will work with Gulfview Chiropractic to procure a settlement and to cover most or all of my medical bills incurred here. I hereby authorize and irrevocably direct my above-named attorney to pay directly to Gulfview Chiropractic any and all sums as may be due and owing for medical and medico-legal services (including reports, conferences, appearances, etc.), interest, and service charges rendered to me both by reason of this accident and by reason of any other bills that are due Gulfview Chiropractic for which I am responsible and to withhold such sums from any settlement or judgment effected or entered into on my behalf and to pay the same as heretofore directed. I do hereby assign, transfer, and set over to the extent I am indebted to Gulfview Chiropractic any and all proceeds of any settlement or judgment effected or entered into on my behalf resulting from any litigation arising out of the aforementioned injuries. By this assignment, I do hereby give Gulfview Chiropractic a lien on the proceeds thereof.

However, irregardless of the outcome of my lawsuit and in the event and/or occurrence of insurance medical benefits no longer being available to pay for the services rendered by Gulfview Chiropractic, I acknowledge and agree that payment for services rendered by Gulfview Chiropractic is my sole responsibility. In the event Gulfview Chiropractic agrees to delay receipt of payment for the services rendered to me until such time that my liability claim is resolved, in consideration therefore, I agree to pay, without unreasonable delay, the full sum of any outstanding balance due to Gulfview Chiropractic. I understand and agree that Gulfview Chiropractic is not obligated to provide me services with delayed payment until my liability case is resolved. The decision to extend the delayed payment courtesy rests solely with Gulfview Chiropractic.

In the event there are insufficient monies, funds, settlement or judgment from my case to pay my outstanding balance in full with Gulfview Chiropractic as a result of my liability accident which caused my injuries, I understand that I remain solely responsible for any and all outstanding balance owed to Gulfview Chiropractic. I acknowledge and agree that should my outstanding balance remain unpaid for more than sixty (60) days following my last date of treatment and services and is therefore delinquent, my outstanding balance shall accrue interest at the rate of 1-1/2% per month until paid in full. I further acknowledge and agree that should Gulfview Chiropractic be required to initiate collection and or legal action to secure payment from me for my outstanding balance, I will be responsible for and agree to pay all reasonable collection fees, legal and attorney fees and costs.

I understand that Florida often is a host for residents of different states and areas to visit and should a dispute arise concerning an outstanding balance on an account, it would be impracticable for Gulfview Chiropractic to pursue delinquent accounts in different locals. Therefore, I agree that should a legal action/lawsuit be filed against me that I consent to the personal jurisdiction of the Courts of the State of Florida and the Courts of Pasco County. Additionally, I agree that the exclusive venue for any legal action/lawsuit against me to recover any outstanding balance owed to Gulfview Chiropractic shall solely be in the Circuit Court or County Court located in Pasco County, Florida.

_____ _____

Patient Name (PRINT) Date

_____ _____

Signature Witness

ACKNOWLEDGEMENT OF RECEIPT FROM ATTORNEY

I acknowledge receipt of this lien signed by our client at _____ (Representing Law Firm) indicating that our client is in expectation of Gulfview Chiropractic, treating physician clinic, working with the aforementioned Firm to procure a settlement to cover most or all of his/her medical bills incurred there.

_____

Attorney Name (PRINT)

_____ _____

Attorney Signature Date

Gulfview Chiropractic & Wellness Center

Dr. Charles Halley

Patient Name_____ Date of Birth _____

General Consent to Treat

I voluntarily consent to medical care of a routine/emergency nature form the authorized professional staff of Gulfview Chiropractic for myself or the above-mentioned minor for whom I am the parent/guardian. I authorize the release of any and all medical records and information obtained through my medical evaluation to those individuals that my doctor feels appropriate for my continued medical care. I understand that I have the right to a full disclosure of the nature of any medical treatment received or proposed to be rendered and the risks, if any, involved and alternative means available. It is understood that I may withdraw this consent at any time by contacting any member of the professional staff in writing.

Financial Agreement

I authorize payment of any medical benefits to Gulfview Chiropractic, which would otherwise be payable to me and which were established by my insurance company. The amount paid to Gulfview Chiropractic shall not exceed the practice's regular charges for the services. I also authorize the release of my medical records to my insurance company/companies or other third party payers or my employer as required for the collection of payments. I understand that I am responsible for the payment of charges that are not paid by my insurance company.

Payment Agreement

I understand this office requests that I read my insurance policy and be fully aware of any limitations of the benefits provided. I understand that my insurance policy is between me and the insurance company. Although they will gladly help, it is my responsibility to know the limitations of my policy. I understand that any charge incurred beyond the reimbursement of said policy will be my financial responsibility.

HIPAA

The undersigned does hereby acknowledge that he/she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersigned does hereby consent to the use of his/her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

I have read the above and understand my financial obligation.

Patient Signature_____Date_____

Spouse/Guarantor Signature/Relationship_____

Witness _____ Date_____

Gulfview Chiropractic and Wellness

In accordance to HIPAA practices, I authorize my medical information to be released to the following person(s):

___ NO other person

☐ Spouse_____

☐ Doctor_____

☐ Doctor_____

☐ Child_____

☐ Child_____

☐ Child_____

☐ Child_____

☐ Other_____

☐ Other_____

☐ Other_____

_____ _____

Signature Print Name

_____

Date

Authorization to Obtain PIP Benefits & Payout Information

Gulfview Chiropractic
8323 US Highway 19, Port Richey, FL 34668
(727) 847-4611 Office (727) 842-3524 Fax

City of Accident: _____

Date of Loss: _____

PIP Claim#: _____

I hereby authorize and direct _____, my auto insurance carrier, to provide Gulfview Chiropractic any requested information, including a ledger of payouts made under all and any claims submitted for payment, for the above-referenced policy and PIP claim relating to the referenced date of loss.

_____ _____
Patient Name (Print) Date

_____
Patient Signature

_____
Gulfview Chiropractic Representative

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.**

   Medical Examination, Electrical Stimulation, Traction Massage, Heat/Ice Pack Therapy,
   Theraputic Exercises, Manual Manipulation

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**):*

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

Gulfview Chiropractic & Wellness Center

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 **Dr. Charles Halley / Gulfview Chiropractic** (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 and,
(3) to institute any necessary litigation and/or complaints against my insurance policy, naming me as plaintiff in such lawsuits and actions if necessary (or me as guardian if the patient is a minor).

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:

_____ _____

Patient's signature Date

8323 US 19, Port Richey FL 34668 Phone: 727-847-4611 Fax: 727-842-3524

Patient Request for Records

I hereby authorize the release copies of my records and x-rays and request that they be sent to:

Dr. Charles Halley

Gulfview Chiropractic & Wellness

8323 US Highway 19
Port Richey, FL 34668

gulfview.chiropractic@gmail.com

Fax (727) 842-3524

Print Name of Patient: _____

Signature of Patient: _____

SSN: XXX-XX-_____ **Date of Birth (DOB):** ____-____-_____

FOR OFFICE USE ONLY

Date: _____-_____-_____

To: _____

(Doctor/Hospital)

Address: _____

City: _____ **St:** _____ **Zip:** _____

Phone: (____)_____-_____ **Fax:** (____)_____-_____