Signature Touch Chiropractic 2700 S. University Drive, STE 203 Miramar, FL 33025 Phone: (954) 367-6716 Fax: (954) 391-8711

PATIENT INFORMATION

Today's Date: ____/____/____ Date of Accident: ____/____/____

Patient Last Name: _____ First Name: _____ MI: _____

Social Security Number _____ Birth Date: ____/____/____ Age: _____ Gender: F M

If patient under 18 yrs, legal parents or guardian: _____

Race: African American ( ) Asian ( ) Caucasian ( ) Hispanic ( ) Other _____ Language: English ( ) ( ) Spanish Other _____ Marital Status: ( ) Married ( ) Single ( ) Divorced ( ) Widowed

CURRENT ADDRESS

Street_____City_____ State _____ Zip _____

Home Phone: _____ **Cell**: _____ Cell carrier: at&t Verizon Sprint

T-Mobile (Other):_____Email address:_____

Emergency Contact: _____ Contact's Phone #: _____

Emergency Contact is my: (specify relationship) _____

If you are covered under another person's insurance.... Please complete

Patient Relationship to the insured Self Spouse Child Other: _____

Name of Insured:_____

Address of insured:_____

Phone of insured: _____Sex : _____Birth date: _____

Auto Accident Insurance: _____ Policy Number: _____

Carrier: _____

Address: _____

City: _____ State: _____ ZIP: _____Phone: _____

Person to Contact… _____ Claim #_____

Health Insurance Info: _____

Carrier: _____ Ins Co phone: _____

Address: _____

Policy # _____Group #_____

How did you hear about us? (Circle One) Newspaper Ad, Mailer/Flyer, Website, Workshop/Event, Medical Referral Friend, Family, Yellow Pages , Insurance Co. Other: _____

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Patient Name: _____

Date of Exam: ___/___/___ Provider: _____
New Patient: [ ] Yes [ ] No Have you ever been in our office before? [ ] Yes [ ] No

Basic Information about the Accident:

Date Accident Occurred: ___/___/___ Time of Day when Accident Occurred or Started: ___:___ AM / PM

Describe how the Accident took place:

_____
_____
_____
_____
_____

Auto-Accident Specific Information:

Were you the: [ ] Driver [ ] Passenger [ ] Pedestrian

Automobile you were in: Year _____ Make _____ Model _____
Damage to your car: [ ] Front [ ] Rear [ ] Driver Side [ ] Passenger Side [ ] Bumper [ ] Fender
Damage: [ ] Minor [ ] Major [ ] Totaled
Other Automobile: Year _____ Make _____ Model _____
Damage to other car: [ ] Front [ ] Rear [ ] Driver Side [ ] Passenger Side [ ] Bumper [ ] Fender
Damage: [ ] Minor [ ] Major [ ] Totaled
Where did the accident happen? Street Names: _____ City/State

_____

Was it a: [ ] Controlled Intersection [ ] Uncontrolled [ ] Not intersection
Was there a traffic light? [ ] None [ ] Green [ ] Red [ ]Turn Arrow [ ] Stop Sign
Were you: [ ] Slowly Moving [ ] Moving [ ] Stopped
Weather Conditions: [ ] Sunny [ ] Rainy [ ] Cloudy
Street surface: [ ] Dry [ ] Wet [ ] Slick [ ] Icy [ ] Pavement [ ] Other _____
Type of Impact: [ ] Rear end [ ] Front [ ] Side Impact [ ] Roll Over
How far did your car move? [ ] Did not move [ ] Moved 1-5 ft [ ] Moved 6-10ft [ ] Moved over 10ft
Where were you seated in the vehicle: _____ Wearing Seat belt? [ ] Yes [ ] No
Shoulder harness: [ ] Yes [ ] No Headrest: [ ] Yes [ ] No Headrest Position: [ ] Up [ ] Down
Is the car equipped with airbags? [ ] Yes [ ] No Did they deploy? [ ] Yes [ ] No
Did you see the impact coming? [ ] Yes [ ] No Did you brace yourself for impact? [ ] Yes [ ] No
On impact, your head was looking: [ ] Ahead [ ] Behind [ ] Up [ ] Down [ ] To the Right [ ] To the Left
On impact were you: [ ] Thrown forward [ ] Thrown backwards [ ] Thrown sideways [ ] Other
Did your body hit anything inside the car? [ ] Yes [ ] No Body Part: _____

What did it hit? _____

Head trauma? [ ] Yes [ ] No Loss of Consciousness? [ ] Yes [ ] No For how long? _____
Do you remember the accident happening? [ ] Yes [ ] No

Did you go to the hospital or Urgent Care? [ ] Yes [ ] No Name of hospital/urgent care: _____
Taken by ambulance? [ ] Yes [ ] No

Diagnostic Studies? [ ] Yes [ ] No If yes: [ ] X-ray [ ] MRI [ ] CT-Scan

Medication Given? [ ] Yes [ ] No RX: _____

Patient's Signature: _____ Date: ___/___/___

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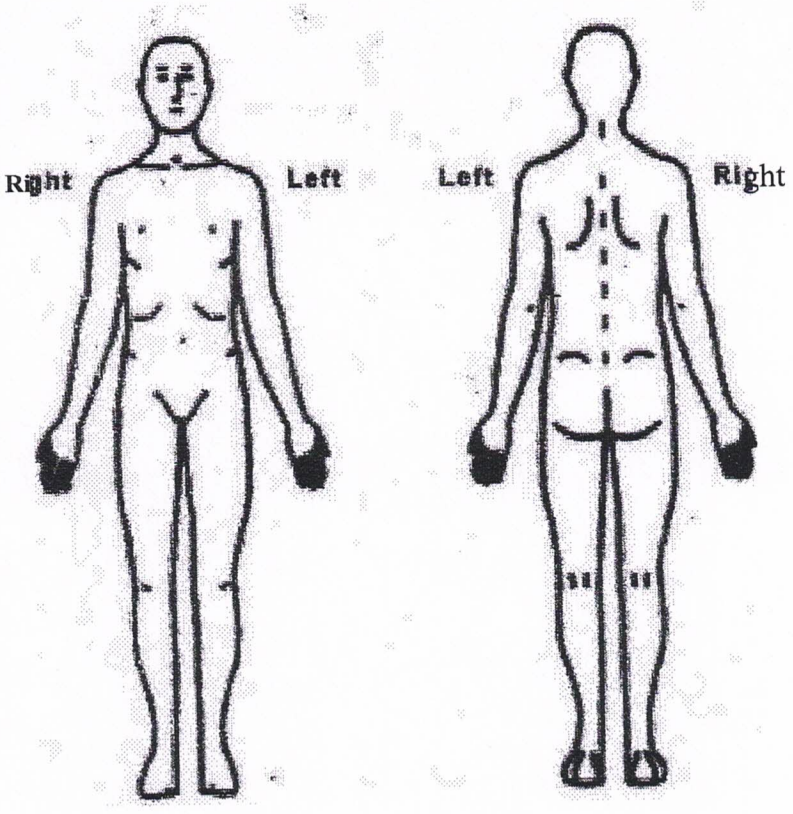
Please check any of the following symptoms you are now experiencing:

On the diagram, circle the area (s) where you feel pain. Put an X on the area that hurts the most

- ☐ Headache
- ☐ **Neck pain**
- ☐ Neck Stiffness
- ☐ Tingling in arms/hands
- ☐ Numbness in arms/hands
- ☐ Pain in arms/hands
- ☐ **Shoulder Pain**
- ☐ **Upper/Mid Back Pain**
- ☐ **Lower Back Pain**
- ☐ Tingling in legs/feet
- ☐ Numbness in legs/feet
- ☐ **Knee Pain**
- ☐ Pain in legs/feet
- ☐ Dizziness
- ☐ Nausea
- ☐ Buzzing in Ears
- ☐ Nervousness
- ☐ Loss of Balance
- ☐ **Chest Pain**
- ☐ Fatigue
- ☐ Rib Pain
- ☐ **Hip Pain**
- ☐ Burning muscle pain
- ☐ Sharp/shooting pain
- ☐ Other: _____



Additional Information Related to the Condition:

Describe your pain: [ ]Burning [ ]Sharp [ ]Dull [ ]Achy [ ]Stiff [ ]Sore [ ]Throbbing [ ]Shooting [ ]Superficial [ ]Deep [ ]Electric [ ]Discomfort [ ]Tearing [ ]Spasm [ ]Stabbing [ ]Cramp-like [ ]Piercing [ ]Other (describe): _____

What aggravates your symptoms?

_____

What relieves your symptoms?

_____

Patient's Signature: _____ Date: ____/____/____

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Medical History:

List any previous accidents (automobile) and date: _____

Illnesses: _____

Previous Surgeries/Hospitalizations: _____

Traumas/Injuries/Accidents: _____

Medication(s): _____

REVIEW OF SYSTEMS

Do you currently have or have had any of the following problems? Please check an answer "Yes" or "No" to every item; do not skip any.

General (constitutional)

Fever	[ ] Yes [ ] No
Chills	[ ] Yes [ ] No
Fatigue	[ ] Yes [ ] No
Unexpected Weight loss	[ ] Yes [ ] No

Eyes

Blurred vision	[ ] Yes [ ] No
Double vision	[ ] Yes [ ] No
Vision loss	[ ] Yes [ ] No
Eye pain	[ ] Yes [ ] No
Sensitivity to light	[ ] Yes [ ] No

Ear/Nose/Mouth/Throat

Earache	[ ] Yes [ ] No
Ringing in ears	[ ] Yes [ ] No
Decreased hearing	[ ] Yes [ ] No
Nosebleeds	[ ] Yes [ ] No
Sore throat	[ ] Yes [ ] No.
Difficulty swallowing	[ ] Yes [ ] No
Wheezing	[ ] Yes [ ] No

Allergic/Immunologic

Hepatitis	[ ] Yes [ ] No
Tuberculosis	[ ] Yes [ ] No
HIV exposure	[ ] Yes [ ] No

Gastrointestinal

Nausea	[ ] Yes [ ] No
Vomiting	[ ] Yes [ ] No
Change in bowel habits	[ ] Yes [ ] No
Abdominal Pain	[ ] Yes [ ] No

Psychiatric

Depression	[ ] Yes [ ] No
Anxiety	[ ] Yes [ ] No
Memory loss	[ ] Yes [ ] No

Genitourinary

Unusual Discharge	[ ] Yes [ ] No
Difficult urination	[ ] Yes [ ] No
Urination blood	[ ] Yes [ ] No
Urination frequency	[ ] Yes [ ] No
Pelvic pain	[ ] Yes [ ] No
STD	[ ] Yes [ ] No

Musculoskeletal

Back pain	[ ] Yes [ ] No
Neck pain	[ ] Yes [ ] No
Shoulder pain	[ ] Yes [ ] No
Wrist/hand pain	[ ] Yes [ ] No
Torticollis/stiff neck	[ ] Yes [ ] No
Hip/knee pain	[ ] Yes [ ] No
Arthritis	[ ] Yes [ ] No

Skin and/or breast

Rash	[ ] Yes [ ] No
Itching	[ ] Yes [ ] No
Suspicious lesions	[ ] Yes [ ] No
Skin infections	[ ] Yes [ ] No

Neurologic

Weakness	[ ] Yes [ ] No
Poor balance	[ ] Yes [ ] No
Difficulty walking	[ ] Yes [ ] No
Difficulty writing	[ ] Yes [ ] No

Endocrine

Cold intolerance	[ ] Yes [ ] No
Heat intolerance	[ ] Yes [ ] No
Excessive thirst	[ ] Yes [ ] No
Excessive eating	[ ] Yes [ ] No
Excessive urination	[ ] Yes [ ] No

Hematologic/Lymphatic

Abnormal bruising	[ ] Yes [ ] No
Abnormal bleeding	[ ] Yes [ ] No
Enlarged lymph nodes.	[ ] Yes [ ] No

Family/Social History:

Members of my family (parents, brothers/sisters, grandparents, aunts/uncles) suffer with the following:
Check all that apply

- [ ] Stroke
- [ ] Heart Trouble
- [ ] Multiple Sclerosis
- [ ] Diabetes
- [ ] Cancer
- [ ] High blood pressure
- [ ] Arthritis
- [ ] Lung Disease
- [ ] Osteoporosis
- [ ] Migraines
- [ ] Scoliosis
- [ ] Spine Problems
- [ ] Alcohol dependence
- [ ] Aneurysm
- [ ] Mental disorders

Do you smoke? [ ] Yes [ ] No *if yes,* number of packs per day: _____
Do you drink alcohol? [ ] Never [ ] Socially [ ] Occasionally [ ] Frequently [ ] Regularly

Please indicate any other healthcare providers who the Patient has seen for the condition or symptoms:

Name	Type of Licensure	Date of Last Visit
_____	_____	___/___/___
_____	_____	___/___/___

Have you missed work or school due to your injuries? [ ] Yes [ ] No *if so,* How many days? _____

Patient's Signature: _____ Date: ____/____/____

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Medical Records Release Form

I hereby authorize and any of its appointed assistants to obtain the following information from the healthcare record of:

Patient Name _____ Date of Birth_____

Street Address _____ City _____ State _____

Zip code _____ Phone Number _____

This information is to be received by:

Signature Touch Chiropractic
2700 S. University Drive, Suite 203
Miramar, FL 33025
Phone: 954-367-6716 Fax: 954-391-8711

Information to be disclosed:

- ○ Office notes for date(s) of service _____
- ○ X-ray reports of _____ for date(s) of service _____
- ○ MRI reports of _____ for date(s) of service _____
- ○ CD (s) containing images of above marked studies – PLEASE MAIL TO ADDRESS LISTED ABOVE
- ○ Photographs or other images
- ○ Complete healthcare record
- ○ Other (please describe) _____

Special instructions: _____
***PLEASE FAX ALL REPORTS TO

I understand that this authorization is valid for 12 months after the date signed, unless cancelled by me in writing. This authorization must be dated subsequent to the period for which the information is requested.

I have read and understand the above statements and do expressly and voluntarily consent to disclosure of the above information to those persons or agencies named above. I hereby release Palmer Chiropractic care and any of its appointed assistants from all legal responsibility or liability that may arise from the release of these healthcare records.

Signature of patient/guardian Date

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Informed Consent for Chiropractic Care

Patient's Name: _____

Please read carefully before signing.

General. I, the below-signed patient/individuals, have read this document and Care Plan in their entirety and understand the potential benefits and risks of the Care which you are recommending. I understand that there may be other forms of care which I may wish or need to seek provided by other health care practitioners. I also understand that there may be significant risks of not seeking any care for my condition.

I understand that while the Care Plan lists you as the "Rendering Provider,' at any moment, other associates or staff in your office with appropriate scopes of practice and training may need to provide the Recommended Care based on factors which are not necessarily within anyone's ability to predict. You have made it clear that every health care practitioner who is licensed under state law may have different scopes of practice relating to diagnoses and treatment and that the licenses of the primary Rendering Provider are listed below.

I do not expect you to be able to anticipate and explain all risks and complications, or forms of treatment, and I wish to rely on you to exercise judgment within your scope of practice during the course of the Care Plan which you feel at the time based upon the facts known. I understand that in rare cases, underlying physical-defects, deformities or pathologies may render me susceptible to injury. It is my responsibility to make known before and throughout the Care whether I am suffering from any latent, pathological defects, illnesses, or deformities-that would otherwise not come to your attention, as well as any pathological defects, illnesses, or deformities I may be experiencing.

Possible Risks of the Care: Alternatives

Chiropractic manipulation / adjustment, as with any healthcare procedure, I understand that there are certain complications, which may arise during chiropractic manipulation, and that those complications include: fractures, disc injuries, dislocations, muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I understand that fractures are rare occurrences and generally result from some underlying weakness of the bone. I also understand that stroke and other complications are also generally described as "rare."

X-Rays. I have been advised that x-rays can be hazardous to an unborn child. To the best of my knowledge, I am not pregnant.

Other Potential Alternatives. I understand that other treatment options for my condition may include: Self-administered, over-the-counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; hospitalization with traction; and surgery.

Contraindications to Manipulation I Adjustment. I understand that you will not give me an adjustment/ manipulation, x-rays, modalities, or therapies if you feel that such are contraindicated. In the event that the Care does not include such procedures, I have discussed all contraindications with you and fully understand them.

Definitions. "You" and "office" refer to any provider who renders care to me at the Location above. "Care' includes all care outlined in my Care Plan as well as any other care I receive from you in the future, including care related to other conditions.

Patient's Consent. I have thoroughly discussed and reviewed my recommended Cere with you, as well as your examination, diagnoses, and thoughts regarding my condition, and also all of the information in this Informed Consent. I have had ample opportunity to explore other potential forms of care, have asked you all of the questions that have, and have no additional questions. I voluntarily and knowingly elect to receive the recommended Care.

Name of Parent/ Guardian/ Authorized Representative: _____

Signature: _____ Date of Signature: _____/_____/_____

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NOTICE OF OUR PRIVACY PRACTICES

As required by the Privacy Regulations created as a result of the Health Insurance portability and Accountability Act of 1996 (HIPAA)

This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your individually identifiable health information.

PLEASE REVIEW THIS NOTICE CAREFULLY

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (**IIHI**). In conducting our business, we will create records regarding you and your treatment and the services we provide for you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at this time.

We realize that these laws are complicated, but We must provide you with the following important information:

- How we may us and disclose your IIHI
- Your privacy rights in your IIHI
- Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Signature Touch Chiropractic
Mildred Morency DC / Matthew Holmes DC
2700 S. University Drive, Suite 203
Miramar, FL 33025
info@signaturetouchchiropractic.com
Phone: (954)391-8711 Fax: (954)367-6716

C. WE MAY USE AND DISCLOSURE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your IIHI.

1. **Treatment.** Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. Any of the people who work for our practice — including, but not limited to, our doctors and nurses, or indirectly with any provider we refer you to — may use or disclose your IIHI in order to treat you, or to assist others in your treatment. Additionally, we may need to disclose your IIHI to others who may assist in your care, such as your spouse, children, or parents.
2. **Payment.** Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment and health Status to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members or insurance companies. Also, we may use your IIHI to bill you directly for services and items.
3. **Health Care Operations.** Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you receive from us, or to conduct cost-management and business planning activities for our practice.

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4. **Appointment Reminders.** Our practice may use and disclose your IIHI to contact you or a family member who answers the phone (or to leave a recorded message) to remind you of an upcoming appointment.
5. **Treatment Options.** Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.
6. **Health-Related Benefits and Services.** Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.
7. **Release of Information to Family/Friends.** Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to our office for care. In this example, the babysitter may have access to this child's medical information.
8. **Disclosures Required by Law.** Our practice will use and disclose your IIHI when we are required to do so by federal, state, or local law.

D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. **Public Health Risks.** Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of
   - Maintaining vital records, such as births and deaths
   - Reporting child abuse or neglect
   - Preventing or controlling disease, injury or disability
   - Notifying a person regarding potential exposure to a communicable disease
   - Notifying a person regarding a potential risk for spreading or contracting a disease or condition
   - Reporting reactions to drugs or problems with products or devices
   - Notifying individuals if a product or device they may be using has been recalled
   - Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
   - Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. **Health Oversight Activities.** Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. **Lawsuits and Similar Proceedings.** Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the patty has requested. In general, we will require that the party that requests your records provide a records release form, signed by you within the last 3 months.

4. **Law Enforcement.** We may release IIHI if asked to do so by a law enforcement official:
   - Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
   - Concerning a death, we believe has resulted from criminal conduct
   - Regarding criminal conduct at our offices
   - In response to a warrant, summons, court order, subpoena or similar legal process
   - To identify/locate a suspect, material witness, fugitive or missing person
   - In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identify or location of the perpetrator)

5. **Deceased Patients.** Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

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6. **Organs and Tissue Donation.** Our practice may release your IIHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

7. **Research.** Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IIHI for research purposes except when (a) our use or disclosure was approved by an Institutional Review Board or a Privacy Board; (b) we obtain the oral or written agreement of a research that (i) the information being sought is necessary for the research study; (ii) the use or disclosure of your IIHI is being used only for the research and (iii) the researcher will not remove any of your IIHI from our practice; or (c) the IIHI sought by the research only relates to decedents and the researcher agrees either orally or in writing that the use or disclosure is necessary for the research, and if we request it, to provide us with proof of death prior to access to the IIHI of the decedents.

8. **Serious Threats to Health or Safety.** Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

9. **Military.** Our practice may disclose your IIHI if you are a member of the US. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. **National Security.** Our practice may-disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

11. **Inmates.** Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

12. **Workers' Compensation.** Our practice may release your IIHI for worker's compensation and similar programs.

Name of Parent/ Guardian/ Authorized Representative: _____

Signature: _____ Date of Signature: _____/_____/_____

SIGNATURE TOUCH CHIROPRACTIC **Ph.(954) 367-6716**

2700 S. University Drive, Suite 203 Miramar, Florida 33025

ASSIGNMENT OF INSURANCE BENEFITS, RELEASE, & DEMAND

Insurer and Patient Please Read the Following in its Entirety Carefully!

I, the undersigned patient/insured knowingly, voluntarily and intentionally assign the rights and benefits of my automobile Insurance, a/k/a Personal Injury Protection (hereinafter PIP), Uninsured Motorist, and Medical Payments policy of insurance to the above health care provider. I understand it is the intention of the provider to accept this assignment of benefits in lieu of demanding payment at the time services are rendered. I understand this document will allow the provider to file suit against an insurer for payment of the insurance benefits or an explanation of benefits and to seek §627.428 damages from the insurer. If the provider's bills are applied to a deductible, I agree this will serve as a benefit to me. This assignment of benefits includes the cost of transportation, medications, 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 provider in writing within five days of receipt of this document. Failure to inform the provider shall result in a waiver by the insurer to contest the validity of this document. The undersigned directs the insurer to pay the health care provider the maximum amount directly without any reductions & without including the patient's name on the check. The patient agrees, before the services are provided, that the amount the provider charges for services are reasonable, usual and customary. This assignment applies to both past and future medical expenses and is valid even if undated. A photocopy of this assignment is to be considered as valid as the original.

Disputes: The insurer is directed by the provider and the undersigned to not 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 has been a prior written settlement agreed to by the health provider (specifically the office manager) and the insurer as to the amount payable under the insurance policy. The insured and the provider hereby contests and 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. The insurer is hereby placed on notice that this provider reserves the right to seek the full amount of the bills submitted. If the PIP insurer states it can pay claims at 200% of Medicare then the insurer is instructed & directed to provide this provider with a copy of the policy of insurance within 10 days. **Any effort by the insurer to pay a disputed debt as full satisfaction must be mailed to the address above, after speaking with the office manager, and mailed to the specific attention of the Office Manager. See Fla. Stat. §673.3111.**

To the extent the PIP insurer contends there is a material misrepresentation on the application for insurance resulting in the policy of insurance is declared voided, rescinded, or canceled, I, as the named insured under said policy of insurance, hereby assign the right to receive the premiums paid for my PIP insurance to this provider and to file suit for recovery of the premiums. The insurer is directed to issue such a refund check payable to this provider only. Should the medical bills not exceed the premium refunded, then the provider is directed to mail the patient/named insured a check which represents the difference between the medical bills and the premiums paid.

EUOs and IMEs: If the insurer schedules a defense physical examination (hereinafter an IME) or examination under oath (hereinafter "EUO") the insurer is hereby INSTRUCTED to send a copy of said notification to this provider. The provider or the provider's attorney is expressly authorized to appear at any EUO or IME set by the insurer. The health care provider is not the agent of the insurer or the patient for any purpose. The provider is authorized and entitled to copy of the IME report and the EUO.

Payment agreement: I agree to pay: for all services; any applicable deductible or co-payment; for services rendered after the policy of insurance exhausts; and for any other services unrelated to the automobile accident in a timely fashion.

Express Consent and Release of information: For the next seven years, I authorize this provider to: furnish an insurer, an insurer's intermediary, the patient's other medical providers, the patient's attorney and hired experts via mail, fax, or email, with any and all information that may be contained in the medical records; to obtain insurance coverage information (declaration sheet & policy of insurance) in writing and telephonically from the insurer; request from any insurer all explanation of benefits (EOBs) for all providers and non-redacted PIP payout sheets; obtain any written and verbal statements the patient or anyone else provided to the insurer; obtain copies of the entire claim file, the property damage file, and all medical records, including but not limited to, documents, reports, scans, notes, bills, opinions, X-rays, IMEs, and MRIs, from any other medical provider or any insurer. The provider is authorized to discuss the patient's care and treatment telephonically with the insurance adjuster for the health/pip insurance company.

For the next seven years, the provider is permitted to produce my medical records to its attorney and experts in connection with any pending lawsuits. The patient's other medical providers are authorized to sign affidavits and testify justifying the patient's care and treatment. The insurer is directed to keep the patient's medical records from this provider private and confidential. The insurer is not authorized to provide the patient's medical records to anyone without the patient's and the provider's prior express written permission.

The health care provider is given the power of attorney to endorse my name on any check for services rendered by the above provider and to request a copy of any medical records, statements or examinations under oath given by the patient.

Demand: Demand is hereby made for the insurer to pay all bills within 30 days without reductions and to mail the latest non-redacted PIP payout sheet and the insurance coverage declaration sheet to the above provider within 15 days. The insurer is directed to pay the bills in the order they are received. However, if a bill from this provider and a claim from anyone else is received by the insurer on the same day the insurer is directed to not apply this provider's bill to the deductible. If a bill from this provider and claim from anyone else is received by the insurer on the same day then the insurer is directed to pay this provider first before the policy is exhausted. In the event the provider's medical bills are disputed or reduced by the insurer for any reason, or amount, the insurer is to: set aside the entire amount disputed or reduced; escrow the full amount at issue; and not pay the disputed amount to anyone or any entity, including myself, until the dispute is resolved by a Court. Do not exhaust the policy. The insurer is instructed to inform, in writing, the provider of any dispute and when the policy is exhausted.

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

Caution: Please read before signing. If you do not completely understand this document please ask us to explain it to you. If you sign below we will assume you understand and agree to the above.

Patient's Name_____ **Patient's Signature**_____ **Date** _____

(Please Print) (If patient is a minor, signature of parent/guardian)