Accident and Injury Clinic
PATIENT REGISTRATION FORM
(Please give your insurance information and accident report to the receptionist)

TODAYS DATE: ______________ DATE OF ACCIDENT: ______________

PATIENTS LAST NAME: FIRST: MIDDLE: Mr./Mrs./Miss/Ms.

____

MARITAL STATUS (CIRCLE ONE): SINGLE MAR DIV SEP WID

IS THIS YOUR LEGAL NAME? YES / NO
IF NOT, WHAT IS YOUR LEGAL NAME? ______________

DATE OF BIRTH: ____/____/____ AGE: _____ SEX: M / F SSN:____-____-____

STREET ADDRESS: ______________ CITY: ______________ STATE/ZIP: ______________

CELL PHONE #: (____)-______-______ HOME PHONE #: (____)-______-______

WORK PHONE #: (____)-______-______ E-MAIL: ______________

OCCUPATION: ______________ EMPLOYER: ______________

PRIMARY CARE PHYSICIAN: ______________ PHONE #: (____)-______-______

IN CASE OF AN EMERGENCY

Name of local friend or relative: Relationship: Phone Number:

____

THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE. I AUTHORIZE MY INSURANCE BENEFITS BE PAID DIRECTLY TO THE PHYSICIAN. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE. I ALSO AUTHORIZE ACCIDENT & INJURY CLINIC, INC., OR INSURANCE COMPANY TO RELEASE ANY INFORMATION REQUIRED TO PROCESS MY CLAIMS.

PATIENT NAME: PATIENT/GUARDIAN SIGNITURE:

____

PATIENT INSURANCE INFORMATION

INSURED PARTYS INFORMATION:

LAST NAME: FIRST NAME: MI:

ADDRESS: CITY: STATE/ZIP:

HOME PHONE #: CELL PHONE #:

INSURANCE INFORMATION

INSURANCE COMPANY: ______

POLICY NUMBER: ______

CLAIM NUMBER: ______

I WAS NOT IN AN AUTOMOBILE ACCIDENT, MY INJURY OCCURRED DUE TO:

- ☐ SLIP & FALL
- ☐ PHYSICAL ASSAULT
- ☐ OTHER: ______

YOUR DESCRIPTION OF THE ACCIDENT:

______

______

______

AUTOMOBILE ACCIDENT DESCRIPTION

YOUR VEHICLE TYPE (circle one):

Car/ SUV/ Van/ Truck/ Motorcycle/ Bicycle

YOUR POSITION IN VEHICLE (circle one):

Driver/ Front Passenger/

LT Rear Passenger/ RT Passenger

WHAT WAS YOUR VEHICLE DOING AT THE TIME OF THE ACCIDENT? (please circle)

Parked/ Stopped in traffic/

Proceeding along/ Making a turn

ROAD CONDITIONS AT THE TIME OF THE ACCIDENT? (please circle)

ICY/ WET/ SANDY/ DARK

DURING THE ACCIDENT: (please circle)

BODY POSITION, ETC:

Did you see the accident coming? YES/ NO

Were you braced for the impact? YES/ NO

Did you have a seatbelt on? YES/ NO

WHERE DID YOU GO AFTER THE ACCIDENT? (please circle)

Home/ Work/ Private Doctor/ Urgent Care

HOW DID YOU GET THERE? (please circle)

Drove Self/ Ambulance/ Somebody else/ Police

WAS THERE X-RAYS, MRIS, OR CAT SCANS PROVIDED? (please circle)

-YES

-NO

-I DID NOT GO TO THE HOSPITAL, PRIVATE DOCTOR, OR URGENTCARE.

WHAT BODY PARTS WERE EXAMINED AT THE HOSPITAL/ PRIVATE DOCTOR/ URGENTCARE?

______

______

______

WERE YOU PRESCRIBED ANY TYPES OF MEDICATION?

______

______

______

PATIENT NAME: ______ PATIENT SIGNITURE: ______ DATE: ______

PERSONAL HEALTH HISTORY

Patient's Name ______________________ **DOB** ____________ **Date** ____________

All information will be kept strictly confidential. Your responses will help determine if chiropractic treatment will benefit you. Unless we sincerely feel that your condition will respond satisfactorily, we will not recommend treatment. Please check the degree of all conditions you currently have or have had. To be responsible for your case, we need your complete health history.

Place a check in a box for any symptom you currently have or have had

General
- ☐ Allergy
- ☐ Anxiety
- ☐ Chills
- ☐ Convulsions
- ☐ Fainting
- ☐ Fatigue
- ☐ Fever
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Depression
- ☐ Neuralgia
- ☐ Sweats
- ☐ Tremors

Cardiovascular
- ☐ Hardening of arteries
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Pain over heart
- ☐ Poor circulation
- ☐ Rapid heartbeat
- ☐ Slow heartbeat
- ☐ Swelling of ankles

Genitourinary
- ☐ Bed-wetting
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of kidney control
- ☐ Kidney infection
- ☐ Painful urination
- ☐ Prostate trouble
- ☐ Pus in urine

Respiratory
- ☐ Chest pain
- ☐ Chronic cough
- ☐ Difficult breathing
- ☐ Spitting up blood
- ☐ Spitting up phlegm
- ☐ Wheezing

Eye, Ear, Nose and Throat
- ☐ Asthma
- ☐ Colds
- ☐ Crossed eyes
- ☐ Deafness
- ☐ Dental decay
- ☐ Earache
- ☐ Ear discharge
- ☐ Ear noise
- ☐ Enlarged glands
- ☐ Enlarged thyroid
- ☐ Eye pain
- ☐ Failing vision
- ☐ Far sightedness
- ☐ Gum trouble
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Nasal obstruction
- ☐ Near sightedness
- ☐ Nose bleeds
- ☐ Sinus infection
- ☐ Sore throat
- ☐ Tonsillitis

Gastrointestinal
- ☐ Belching or gas
- ☐ Colitis
- ☐ Colon trouble
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficult digestion
- ☐ Bloated abdomen
- ☐ Excessive hunger
- ☐ Gallbladder trouble
- ☐ Hemorrhoids
- ☐ Intestinal worms
- ☐ Jaundice
- ☐ Liver trouble
- ☐ Nausea
- ☐ Pain over stomach
- ☐ Poor appetite
- ☐ Vomiting
- ☐ Vomiting of blood

Skin
- ☐ Boils
- ☐ Bruise easily
- ☐ Dryness
- ☐ Hives or allergy
- ☐ Itching
- ☐ Skin eruptions (rash)
- ☐ Varicose 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 on birth control?
☐Yes ☐No

Are you pregnant? ☐Yes ☐No

If yes, how many months?____

How many children do you have?___

Check any of the following conditions you currently have or have had:

- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Artificial bones
- ☐ Artificial joints
- ☐ Cancer
- ☐ Chicken pox
- ☐ Cholera
- ☐ Cold sores
- ☐ Diabetes
- ☐ Diphtheria
- ☐ Eczema
- ☐ Edema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fever blisters
- ☐ Goiter
- ☐ Gout
- ☐ Heart Attack
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV/AIDS
- ☐ Influenza
- ☐ Lumbago
- ☐ Malaria
- ☐ Measles
- ☐ Miscarriage
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pleurisy
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Typhoid fever
- ☐ Ulcers
- ☐ Venereal disease
- ☐ Whooping cough

CONSENT TO PARTICIPATE IN TELEMEDICINE CONSULATION

Consultant: Andrew Akerman, M.D. Florida License: ME 93824

Patient's Name: ______________________________ **Medical Record No.:** ______________________

1. I understand that my health care provider, ______________________________, wishes me to engage in a telemedicine consultation with Andrew Akerman, M.D.

2. My health care provider has explained to me how the video conferencing technology will be used to affect such a consultation. I understand that this consultation will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.

3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my health care provider(s) or myself can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.

4. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my health care provider and consulting health care provider in order to operate the video equipment. The above mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine
examination room; and/or (3) terminate the consultation at any time.

5. I have had the alternatives to a telemedicine consultation explained to me, and in choosing to participate in a telemedicine consultation, I understand that some parts of the exam involving physical tests may be conducted by individuals at my location at the direction of the consulting health care provider.

6. In an emergent consultation, I understand that the responsibility of the telemedicine consulting specialist is to advise my local practitioner and that the specialist's responsibility will conclude upon the termination of the video conference connection.

7. I understand that billing will occur from both my practitioner and as a facility fee from the site from which I am presented.

8. I have read this document carefully, and understand the risks and benefits of the teleconferencing consultation and have had my questions regarding the procedure explained and I hereby consent to participate in a telemedicine visit under the terms described herein.

9. I understand that there will be no video taping or recording of any materials, unless additional written consent is given. Recording of the medical examination is typically not required, and no recording will be done for the express purpose of maintaining confidentiality and patient privacy.

______________________________ ______________________________
Patient's/parent/guardian signature Date and Time

______________________________ ______________________________
Witness signature Date and Time

Patient Signature

Date

OrthoONE

injuryONE, inc ®

Dr. Victoria Gaus M.D., Dr. Felix Stanziola M.D,
Dr. Edward C. Rivero MPH, PA-C

Orthopedic Surgery, Interventional Medicine
Spinal Epidural-nerve blocks, Physical Medicine & Rehab
Electro-Neurodiagnostic Studies

Independent Medical Examination and Peer Review

Surgical Office Business Office
14750 SW 26 Street, Suite 115 15555 SW 26 Terrace
Miami, Florida 33185 Miami, Florida 33185

Miami, Doral, Tamarac, Sebring & Key West FL
Tel: 305-333-4198, Fax 305-503-8846
Ortho@InjuryOneFlorida.com

I ______________________________ give consent to OrthoONE to review my medical records for Florida PIP EMC determination. I understand that there are no guarantees of an EMC diagnosis.

____
Patient Name

______________________________ ______________ Patient Signature Date

OrthoONE

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Notice of Emergency Medical Condition (EMC) CERTIFICATE

The undersigned licensed medical provider hereby asserts:

1. **The patient below, has in the opinion of this medical provider, suffered an Emergency Medical Condition, as a result of the patient's injuries sustained in an automobile accident that occurred on:___________ (date of accident).**
2. **The basis of the opinion for the finding of an emergency medical condition is that the patient has sustained acute symptoms of sufficient severity, which may include severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following: a) serious jeopardy to the patient's health; b) serious impairment to the bodily functions o c) serious dysfunction of any bodily organ or part. Florida Statutes Section 627.732 "Emergency Medical Condition" is determined following a complete record review. There is no guarantee that an EMC diagnosis will be given.**

I hereby attest that I am a physician license under chapter 458 or chapter 459, a dentist license under chapter 466, a physician assistant licensed under chapter 458 or chapter 459 or an advanced registered nurse practitioner life is under chapter 464, and that the above facts are true and correct.

____ **OrthoONE (print or type)**
OrthoONE Medical Doctor Date

The undersigned injured person or legal guardian of such person asserts:

1. **The symptoms I reported to the medical provider are true and accurate.**
2. **I understand the medical provider has determined I sustained an emergency medical condition as a result of the injuries I suffered in the car accident.**

My physician has explained to my satisfaction the need for future medical attention and the harmful consequences to my health which may occur if I do not receive future treatment.

Injured patient receiving this diagnosis or legal guardian of said injured patient:

____ **Patient Name (print or type) Signature of patient/Guardian Date**

OrthoONE

injuryONE, inc ®

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INITIAL -VAS PAIN SCALE (Please circle your pain level immediately after accident)

^___^___^___^___^___^___^___^___^___^___^ **0 1 2 3 4 5 6 7 8 9 10/10 Zero Pain Moderate Pain Severe Pain**

CURRENT – VAS PAIN SCALE (Please Circle your pain level today)

^___^___^___^___^___^___^___^___^___^___^ **0 1 2 3 4 5 6 7 8 9 10/10 Zero Pain Moderate Pain Severe Pain**

____

Patient Name

INFORMED CONSENT

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

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

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

I further understand and am informed that, as in all health care, in the practice of chiropractic medicine there are some very slight risks to treatment, including, but not limited to, muscle sprains and strains, disc injuries, and strokes. I do not expect the doctor to be able to anticipate and explain all the risks and complications and I wish to rely on the doctor to exercise judgment during the course of the 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 policies will allow you, our patient, to concentrate on the big issue- REGAINING AND MAINTAINING YOUR HEALTH.

Multiple appointments have been given for your convenience, to minimize waiting, and to 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 reschedule 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 has prescribed for best results. Staff is not authorized to change or alter your prescription, only the doctor.

PAYMENT OF BILLS

We will require that you honor the financial agreements you make with our office. If you find that you cannot fulfill the agreement you have made with us, please advise our financial department immediately so that the new arrangements can be made. Our policy is that a patient does not have a cash balance beyond $1000.00. 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 your insurance company and this office.

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

RECEIPT OF NOTICE OF PRIVACY PRACTICE

I have received a copy of the Notice of Privacy Practices from Accident & Injury Clinic and have reviewed carefully.

Patient or Guardian	Date	Witness	Date

Accident & Injury Clinic, Inc.
LETTER OF PROTECTION

Patient's Name: ______________________ **Date of Birth** __________________________

Date of Incident: ______________________

I do hereby authorize **Accident & Injury Clinic, Inc.** to furnish my attorney will 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 as may be due and owing him for reasonable and necessary medical services rendered to me for evaluation or treatment for 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 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 Accident & Injury Clinic, Inc. for all reasonable medical bills submitted by Accident & Injury Clinic, Inc. for 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 this 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 Accident & Injury Clinic, Inc. occurs or Accident & Injury Clinic, Inc. 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 I 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.

Patient's 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 Signature: ________________________________ Date: ______________

ASSIGNMENT OF BENEFITS

I hereby authorize and direct you, my insurance company ________________________ and/or my attorney to pay directly to Accident and Injury Clinic ("Assignee") such sums as may be due and owing Assignee for services rendered by reason of accident, illness, and for any other bills due Assignee, and to withhold such sums from any disability benefits, medical payments, No-Fault benefits, or any other insurance benefits obligated as reimbursement from any settlement, judgment or verdict on my behalf as may be necessary to adequately protect said Assignee. In the event I do not have insurance coverage, I understand I remain personally responsible for payment of services rendered. I further give an irrevocable lien to said assignee gains any and all insurance benefits named herein and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by the Assignee. This is to act as an assignment of my rights and benefits to the extent of the Assignee's services provided. In the event my insurance company is obligated to make payment to me upon charges made by the Assignee for its services, refuses to make such payment, upon such cause of action, that I might have or that might exist in my favor against such company, authorize Assignee to prosecute said cause of action either in my name or Assignee's and further authorize Assignee to compromise, settle or otherwise resolve said claim of action as they see fit.

Direction of Payment

I hereby authorize any insurance company or attorney to pay directly to Assignee the amount of this and/or future bills for services rendered. I also agree to pay in a current manner any difference between the total charges and the amount paid by the insurance company directly to Assignee.

PIP Log & Declaration Sheet Request

I hereby authorize Assignee to release requested information, which is pertinent to my case, to my insurance company or the attorney involved in this case. Pursuant to 627.4137 Florida Statues (2001). I hereby request a copy of the pip log and declaration sheet, which reflects the policy limits available at the time of this accident, to be provided to this Assignee. I hereby authorize this Assignee to request and receive a copy of my pip log periodically as they deem necessary. If any term or provision of this Assignment, Lien and Authorization or the application thereof to any person or circumstance shall to any extent be invalid or unenforceable, the remainder of this Assignment, Lien and Authorization, or the application of such term or provision to persons or circumstances other than those as to which it is held invalid or unenforceable, shall not be affected thereby, and each term and provision of this Assignment, Lien and Authorization shall be valid and enforced to the fullest extent of the law.

Reservation of Benefits

Be further advised, I am hereby placing you on notice pursuant to Florida case law that should you (the insurance company/carrier) deny, reduce or fail to pay any part of, or an entire bill which was submitted on my behalf from this health care provide, I (the assignor) as well as the assignee (health care provider) are requesting, in advance, that you reserve, or "act aside," the amount reduced or denied until the dispute is resolved. Should you submit a check to this health care provider which is less than the correct contractual amount, and contains any language referring to payments as "Full and Final Payment," I have instructed this health care provider to return the check to you (the carrier) and consider the bill still due and owing (i.e. a late payment as defined in F.S. 627.736). Additionally, should the remaining amount of my benefits approach an amount where there would be insufficient funds to pay the amount reduced, or failed to pay, please notify me (the assignor) and this health care provider (the assignee).

Print Name: ________________________

Signature: ________________________

Date: ________________________

Health Care Provider

Accident & Injury Clinic
807 Beville Rd.
South Daytona, FL 32119

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 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

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: [illegible] insurer pursuant to Section 627.736(4)(b), Florida Statutes and may not [illegible] form may result in non-payment of the claim.

MEDICAL RECORDS RELEASE FORM

STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Phone Number: 386-492-7931 Fax Number: 386-492-7933

Date: ____________________ Account Number: ____________________

Persons Authorized to Use or Disclose Information:

Information described above may be disclosed to **Accident & Injury Clinic, Inc.**

Name: ____________________________ Social Security Number: ______-____-______

Date of Birth: ______-______-______

I hereby request and authorize that the following medical documents/records to be released and that they be promptly transferred to **Accident & Injury Clinic, Inc.**

_____ X-Ray/ CT/ MRI Reports

_____Complete Medical File

_____Medical Reports

_____Daily Notes

_____Other: ____________________

Expiration Date of Authorization

This authorization is effective through ______/______/______ unless revoked or terminated by the patient or the patient's personal representative.

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to Accident & Injury Clinic, Inc. You should contact the Compliance Office to terminate this 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 the federal privacy regulations.

____

Patient Signature Date

____

Representative Signature/ Please Print Name Date

ACCIDENT & INJURY CLINIC
807 Beville Rd.
South Daytona, FL 32119

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA | PICA | CARRIER

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | 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. PATIENT STATUS Single Married Other

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

Employed Full-Time Student Part-Time Student

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

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes, return to and complete item 9 a-d.*

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

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. ___ . ___ 3. ___ . ___

2. ___ . ___ 4. ___ . ___

22. MEDICAID 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	

PHYSICIAN OR SUPPLIER INFORMATION

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. BALANCE DUE $

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.

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

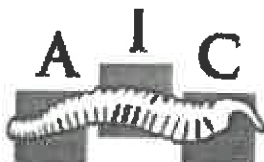
HAVE YOU RECEIVED, OR ARE YOU ELIGIBLE FOR, PAYMENTS UNDER ANY WORKMEN'S COMPENSATION OR EMPLOYMENT LAW?	IF YES, AMOUNT	PER WEEK	PER MONTH

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? SIGNATURE: DATE:	IF YES, EXPLAIN ON REVERSE SIDE

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



Accident & Injury Clinics

DISCLOSURE OF PHYSICIAN OWNERSHIP

NOTICE TO PATIENTS

PLEASE CAREFULLY REVIEW THE INFORMATION CONTAINED IN THIS NOTICE:

1. Harry Vassilakis D.C. is the owner of Accident & Injury Clinics INC., Spine Recovery Clinic LLC, Mid Florida Ortho Daytona LLC, Mid Florida Neuro Daytona LLC and Zion Medical Inc.

2. This Disclosure includes Physicians Advisors LLC.

3. You have the right to choose the provider of your health care services. Therefore, you have the option to use a health care facility other than Accident & Injury Clinics, INC, Spine Recovery Clinic LLC, Mid Florida Ortho Daytona LLC, Mid Florida Neuro Daytona LLC and Zion Medical Inc.

4. You will not be treated differently by your physician if you choose to obtain health care services at a facility other than Accident & Injury Clinics, INC, Spine Recovery Clinic LLC, Mid Florida Ortho Daytona LLC, Mid Florida Neuro Daytona LLC and Zion Medical Inc.

5. If you have any questions concerning this notice, please feel free to ask your physician or any representative of the Accident & Injury Clinics, INC, Spine Recovery Clinic LLC, Mid Florida Ortho Daytona LLC, Mid Florida Neuro Daytona LLC and Zion Medical Inc.

6. By signing this Disclosure of Physician Ownership, you acknowledge that you have read and understand the foregoing notice and hereby understand that your physician has an ownership interest in than Accident & Injury Clinics, INC, Spine Recovery Clinic LLC, Mid Florida Ortho Daytona LLC, Mid Florida Neuro Daytona LLC and Zion Medical Inc.

Patient Name (Please Print): ______________________________

Signature of Patient: ______________________________ Date: ____________

Parent or Guardian Name (Please Print): ____________________

Signature of Parent/Guardian: ______________________ Date: ____________

ACCIDENT & INJURY CLINIC
807 Beville Rd
South Daytona, FL 32119

HARDSHIP AGREEMENT

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 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 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 become null and void at that time.

Patient Signature: ______________________________ Date: ________________

Witness Signature: ______________________________ Date: ________________

Accident & Injury Clinic INC

807 Beville Rd

South Daytona, FL 32119

Phone: 386-492-7931   Fax: 386-492-7933

PRESCRIPTION/PHYSICIAN'S STATEMENT OF MEDICAL NECESSITY

CERVICAL POSTURE PUMP

Patient Name: ______________________________ Date: ____________________

Ordering Physician: Anthony Howe, DC

ICD10: ______ G44.319 Post traumatic headache
______ S13.4XXA Sprain of the ligaments of the cervical spine

Frequency/Duration of Use: Daily, after warmup, begin one minute, gradually increase to fifteen minutes as tolerated.

A Cervical Posture Pump was prescribed for the patient. The Cervical Posture Pump decompresses joints and hydrates discs as it aligns vertebras. Expanding Ellipsoidal Decompression (EED) decreases disc bulging and spinal cord indentations while enhancing that lordotic curves and ranges of motion.

CONSENT FOR CERVICAL POSTURE PUMP

A Cervical Posture Pump has been ordered and given to you. It is customary for us to instruct you on how to properly use the Cervical Posture Pump and provide further instructions for continued home use.

By signing this form below I agree that I have been given instructions on how to use the Cervical Posture Pump and I am comfortable with using it on my own.

If I have any further questions, I will contact the Doctor in person or at the number provided above.

Patient Signature: ______________________________ Date: ____________________

Doctor Signature: ______________________________ Date: ____________________

Accident & Injury Clinic INC

807 Beville Rd

South Daytona, FL 32119

Phone: 386-492-7931   Fax: 386-492-7933

PRESCRIPTION/PHYSICIAN'S STATEMENT OF MEDICAL NECESSITY

LUMBAR SPINAL ORTHOSIS

Patient Name: ______________________________ Date: ______________________

Ordering Physician: ***Anthony Howe, DC***

ICD10: ***S33.5XXA Sprain of the ligaments of the Lumbar spine***

S39.012A Strain of the muscle, fascia, and tendon of the Lumbar Spine

Frequency/Duration of Use: As needed during prolonged standing, sitting, or when lifting and bending.

A Lumbar Spine Orthosis was prescribed for the patient. The Lumbar Spine Orthosis has sagittal control, with a rigid anterior panel, posterior panel extends from L1 to below L5 vertebra, produces intracavitary pressure to reduce load on intervertebral discs which will help with the ability to perform activities of daily living. The Lumbar Spine Orthosis will be used:

_____ To reduce pain by restricting mobility of the trunk; or

_____ To facilitate healing following an injury to the spine or related soft tissues; or

_____ To facilitate healing following a surgical procedure on the spine or related soft tissue; or

_____ Otherwise support weak spinal muscles or deformed spine.

CONSENT FOR LUMBAR SPINAL ORTHOSIS

A Lumbar Spinal Orthosis has been ordered, fitted and given to you. It is customary for us to instruct you on how to properly use the Lumbar Spine Orthosis and provide further instructions for continued home use.

By signing this form below I agree that I have been given instructions on how to use the Lumbar Spinal Orthosis and I am comfortable with using it on my own.

If I have any further questions, I will contact the Doctor in person or at the number provided above.

Patient Signature: ______________________________ Date: ______________

Doctor Signature: ______________________________ Date: ______________

Accident & Injury Clinic INC
807 Beville Rd.
South Daytona, FL 32119
Phone: 386-492-7931 Fax: 386-492-7933

PRESCRIPTION/PHYSICIAN'S STATEMENT OF MEDICAL NECESSITY TRANSCUTANEOUS ELECTRICAL NERVE STIMULATION (TENS) unit

Patient Name:_________________________ Date:_________________________

Ordering Physician: Anthony Howe , DC

Diagnosis/Codes: ____ S13.4XXA - Sprain of the ligaments of the cervical spine, initial encounter.
____S33.5XXA - Sprain of ligaments of lumbar spine, initial encounter.

Frequency/Duration of Use: As needed to reduce pain and discomfort of musculoskeletal injuries. Limit to 20 minutes per session.

A TENS unit was prescribed for the patient. TENS Unit stimulation is a non-invasive based treatment modality that will increase local blood, stimulate soft tissue healing, increase range of motion, aid in muscle reeducation, relax muscle spasms , and provide symptomatic relief of pain. This will allow the return to functional restoration and participation in the activities of daily living. The use of the TENS unit will provide relief of pain by blocking nerve impulses in superficial sensory nerves.

CONSENT FOR TRANSCUTANEOUS ELECTRICAL NERVE STIMULATION (TENS) UNIT

A TENS unit has been ordered and given to you. it is customary for us to instruct you on how to properly use the TENS unit end to provide further instructions for continued home use.
By signing this form, I agree that I have been given instructions on how to use the TENS unit and I am comfortable with using it on my own.
If I have any further questions, I will contact the Doctor in person or at the number provided above.

Patient Signature:_________________________ Date:_________________________

Doctor Signature:_________________________ Date:_________________________

ACKNOWLEDGEMENT 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.

____

Please Print Name

____

Signature

____

Date

For Office Use Only

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

( ) Individual refused to sign

( ) Communication barriers prohibited obtaining the acknowledgement

( ) An emergency situation prevented us from obtaining acknowledgement

( ) Other (Please Specify)

____
____
____
____
____
____