INJURYAND SPINE MEDICAL GROUP, LLC

7824 Lake Underhill Rd, Suite I
Orlando, FL 32822

1405 S. Hiawassee, Rd, Ste D
Orlando, FL 32835

Phone: (407) 601-1210 **Fax: (407) 601-2504**

Patient Information

TODAY'S DATE: / / GENDER: ☐ MALE / ☐ FEMALE AGE:

LAST NAME: FIRST NAME:

DOB: / / SOCIAL SECURITY#: / /

MARITAL STATUS: ☐ SINGLE / ☐ MARRIED / ☐ DIVORCED / ☐ WIDOWED

HOME ADDRESS: CITY: STATE: ZIP:

HOME PHONE:( ) CELL PHONE:( )

EMAIL: @ .COM

EMPLOYER: OCCUPATION: PHONE#:( )

EMERGENCY CONTACT: PHONE:( ) RELATION:

Insurance Information

TYPE OF ACCIDENT: WORK COMP ☐ AUTO ☐ SLIP & FALL ☐ OTHER ☐

ACCIDENT/INJURY DATE: INSURANCE CARRIER::

POLICY#: CLAIM#:

ADJUSTER NAME: PHONE :( ) EXT.

ARE YOU BEING REPRESENTED BY AN ATTORNEY? ☐ **Y** / ☐ **N**

ATTORNEY'S NAME: PHONE:( )

ADDRESS: CITY: STATE: ZIP:

INSURANCE MEDICAL RELEASE/ASSIGNMENT:
I hereby authorize release of Medical Information necessary to process my insurance claim to my insurance company and/or Attorney representing me. I also authorize payment of benefits to provide service. I understand that I am financially responsible for changes not covered by my insurance.

PATIENT SIGNATURE _____ **DATE:**

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1. The services or treatment set forth below were **actually rendered.** This means that those services have **already been provided.**

☐ **99201 Intial Eval-Low**	☐ **97010 Hot/Cold Packs**	☐ **97110 Therapeutic Exercises**
☐ **99202 Intial Eval-Mod**	☐ **97035 Ultrasound**	☐ **97140 Manual Therapy Techniques**
☐ **99203 Initial Eval_Comp**	☐ **97012 Mechanical Traction**	☐ **98940 Chiropractic Treatment 1-2 Regions**
☐ **99204 Initial Eval-High**	☐ **G0283 EMS**	☐ **98941 Chiropractic Treatments 3-4 Regions**
☐ **A4556 Reuseable Electrodes**	☐ **99070 Supplies Biofreeze/Hot/Cold Pack**	

☐ **Other:**

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) Signature Date

The undersigned licensed medical professional or medical director, if applicable, affirms the statement numbered I 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 armed, unbundled,** or constitutes an invalid **or not medically necessary diagnostic test** *as* defined by Section 627.732 (15) and (16), Florida Statutes or Section 6Z7.736*(5)(b) 6, Florida Statutes.*

Licensed Medical Professional Rendering Treatment/ Services or Medical Director, if applicable (Signature by his/her ***own hand****):*

Name (Print) 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.

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ASSIGNMENT OF BENEFITS & CAUSE OF ACTION

I hereby authorize and direct you, my insurance company and/or my attorney, to pay directly to **INJURY AND SPINE MEDICAL GROUP, LLC** ("Assignee "), such sums as may be due and owing Assignee for the services rendered to me, both by reason of accident or illness, and by reason of any other bills that are due Assignee and to withhold such sums from any disability benefits, medical payment benefits, No-Fault benefits, or any other insurance benefits obligated to reimburse me or from any settlement, judgment or verdict on my behalf as maybe necessary to adequately protect said Assignee. In the event that I do not have insurance coverage, I understand that I remain personally responsible for payment of services rendered. I hereby further give an irrevocable lien to said assignee against 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 payments to me upon charges made by the Assignee for its services refuses to make such payments, upon demand by me or Assignee, I hereby assign and transfer to Assignee any and all causes of action, and proceeds from such causes of action, that I might have or that might exist in my favor against such company and authorize Assignee to prosecute said cause of action either in my name or Assignee's name and further I 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 any future bills for services rendered to me. 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 DEC SHEET REQUEST

I hereby authorize Assignee to release any information requested that is pertinent to my case to my insurance company or attorney involved in this case. Pursuant to §627.4 137 Florida Statutes (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 Assignee. I hereby authorize Assignee to request and receive a copy of my pip log periodically as they deem to be necessary. If any term or provision of this Assignment, Lien and Authorization or the application thereof to any person or circumstances 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

Please be advised that I am hereby placing you on notice that, pursuant to Florida case law, should you deny, reduce or fail to pay either a portion of or an entire bill submitted on my behalf from this healthcare provider, I am requesting that you reserve, or hold aside, that same amount until this dispute is resolved. Should you submit a check to this health care provider which is less than the correct contractual amount, and 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 inefficient funds to pay the amount you reduced, denied or failed to pay, please notify me (the assignor) and the assignee (this health care provider) of this fact. Lastly, should my benefits become exhausted; please notify me (the assignor) and this health care provider (the assignee) .

NAME PRINT: _____

SIGNATURE: _____ **DATE** _____

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Authorization for Use or Disclosure of Protected Health information

I authorize my physician and/ or administrative and clinical staff to (check all that apply):

_____ Use the following protected health information, and /or
_____ Disclose the following protected health information to **Name of entity or class of persons to receive information.**

Specifically and meaningfully describe the protected health information to be used or disclosed such as date of service, type of service, level of detail to be released, origin of information, etc.

This protected health information is being used or disclosed for the following purpose:

_____

_____

List specific purpose here. "At the request of the individual" is acceptable if the request is made by the patient, and the patient does not want to state a specific purpose.

This authorization shall be in force and effect until [specify (1) date or (2) event that relates to the patient or the purpose of the use of disclosure] at which time this authorization to use of disclose this protected health information expires. (" find of the research study" "and" none" is acceptable for authorization for research purposes.)

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice's Privacy Contact at [office address or e-mail address] understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be prosecuted by the federal or state law.

My physician will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

The use or disclosure requested under this authorization will result in direct or indirect remuneration to my physician from a third party. [If applicable because the authorization is obtained for marketing purposes.]

_____ _____

Print Name of Patient **Signature of Patient**

_____

Date

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Consent for Purpose of Treatment, Payment, and Healthcare Operations

I consent to the use or disclosure of my protected health information by **INJURY AND SPINE MEDICAL GROUP, LLC** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of **INJURY AND SPINE MEDICAL GROUP, LLC**. I understand that diagnosis or treatment of me by **INJURY AND SPINE MEDICAL GROUP, LLC** may be conditioned upon my consent as evidence by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. **INJURY AND SPINE MEDICAL GROUP, LLC** is not required to agree to the restrictions that I may request. However, if **INJURY AND SPINE MEDICAL GROUP, LLC** agrees to a restriction that I request, the restriction is binding on **INJURY AND SPINE MEDICAL GROUP, LLC.**

I have the right to revoke this consent, in writing, at any time, except to the extent that **INJURY AND SPINE MEDICAL GROUP, LLC** has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review **INJURY AND SPINE MEDICAL GROUP, LLC** Notice of Privacy Practices prior to signing this document. **INJURY AND SPINE MEDICAL GROUP, LLC** Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of **INJURY AND SPINE MEDICAL GROUP, LLC.** The Notice of Privacy Practices for **INJURY AND SPINE MEDICAL GROUP, LLC** is also provided at the reception desk. This Notice of Privacy Practices also describes my rights and **INJURY AND SPINE MEDICAL GROUP, LLC** duties with respect to my protected health information.

INJURY AND SPINE MEDICAL GROUP, LLC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Print Name of Patient

Signature of Patient

Date

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NOTICE OF INITIATION OF MEDICAL TREATMENT PURSUANT TO FLORIDA STATUTE 627.736

PATIENT _____ **DATE OF LOSS** ____/____/____
INSURANCE CO _____
CLAIM NUMBER _____

Dear Sir/Madam: Please be advised that the above medical provider is hereby giving notice pursuant to F.S. 627.736 of initiation of medical treatment within 21 days after first examination or treatment of the claimant. By giving the aforementioned notice, the medical provider may bill for charges for treatment or services rendered up to, but not more than, 75 days before the postmark date of the billing statement.

Very truly yours,

Billing Address: *INJURY AND SPINE MEDICAL GROUP, LLC*
P.O. Box 422210, Kissimmee, FL 34742

OFFICIAL CERTIFICATION OF PATIENT AS TO INSURANCE COVERAGE

PATIENT _____ **DATE OF LOSS** ____/____/____
INSURANCE CO _____
CLAIM NUMBER _____

I, as the above captioned patient hereby attest that to the best of my knowledge, that the insurance claims information I have provided above is in fact the correct insurance information under which I am entitled to medical and/or PIP coverage.
I understand that the medical provider is relying on this correct information in order to receive the appropriate coverage and qualify for payment for medical services provided to me.

SIGNATURE _____ **DATE** ____/____/____

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DOCTOR'S LIEN:

Re: Patient records and doctor's lien

I DO HEREBY authorize the above named facility/doctor to furnish you, my attorney, with a full report of its case history, examination, diagnosis, treatment, and prognosis of myself in regard to my accident which occurred on: _____ (DOA)

I DO HEREBY give a lien to said facility/doctor on any settlement, claim, judgment or verdict as a result of said accident, and authorize and direct you, my attorney, to pay directly to said facility/doctor such sums as may be due and owing him or her for services rendered to me, and to withhold such sums from such settlement, claim, judgment or verdict as may be necessary to protect said facility/doctor adequately.

I FULLY understand that I am directly and fully responsible to said facility/doctor for all bills submitted by it for services rendered to me, and that this agreement is made solely for said facility's/doctor's additional protection and in consideration for its awaiting payment.

Dated: _____ PATIENT'S Signature: _____

PRINT NAME: _____

THE UNDERSIGNED, being attorney of record for the above-named patient does hereby acknowledge receipt of the above lien, and does agree to honor the same to protect adequately said above-named facility/doctor.

Dated: _____ Authorized Signature: _____
ATTORNEY

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CONSENT FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____

Birth Date: _____ Social Security No: _____

Release Records To: **INJURY AND SPINE MEDICAL GROUP, LLC**

(Name of Recipient) return via fax (407) 601-2504

Obtain Records From: _____
(Name of Requested)

_____
(Address)

_____
(City, State, Zip Code)

_____
(Phone and Fax Number)

Specific Records Requested:
Office Visits: _____ X-rays: _____ Labs: _____ All: _____

I consent to release information regarding Alcoholism and Drug Abuse. _____
(Initials)

I consent to release information regarding Mental Disorders and Rehabilitation. _____
(Initials)

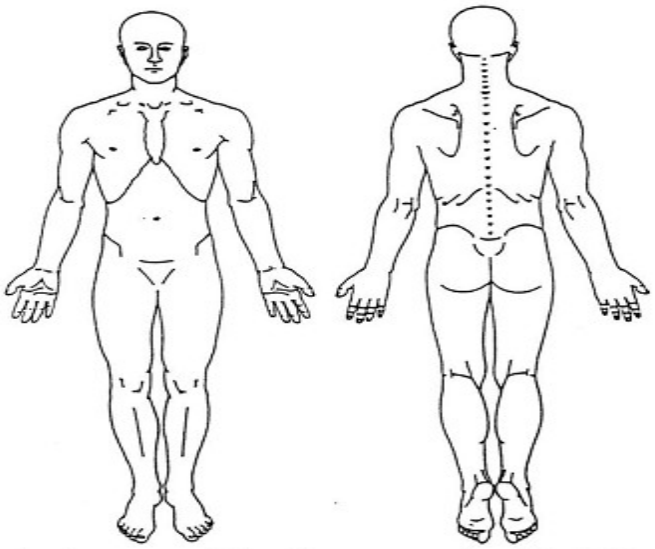
I consent to release information regarding HIV, AIDS, and Sexually Transmitted Diseases. _____
(Initials)

NOTE: Only a Limited Medical Summary will be sent if all of the above consents are not initialed.
Please Do Not Mail Films.

_____ _____
Patient Signature Date

PAIN HISTORY

Instructions:
On the body diagram below, please indicate where your pain is located at the present time. Please do not indicate areas of pain that are not related to your present injury or condition,



Indicate on the line below how you would describe your present pain by placing a mark on the line between the two extremes of experiencing no pain at all and experiencing the worst pain you have ever felt.

No Pain ——————————— Worst Pain Possible

For how long have you had this condition? _____

Have you had this condition in the past? ☐ YES / ☐ NO

PROGRESS: WORSE [☐] SAME [☐] CONSTANT [☐] COMES AND GOES [☐]

Is this condition interfering with your daily routines? WORK [☐] SLEEP [☐] SOCIAL ACTIVITIES [☐]
MOBILITY [☐] EXERCISE [☐] CONCENTRATION [☐]

List treatments you have had for this problem and all health professionals that you are currently seeing:

PHYSICIANS	SPECIALTY	TREATMENT DURATION

BRIEFLY DESCRIBE THE ACCIDENT:

_____

_____

Destination after the accident / injury:

When did you go to the hospital? ___/___/___ Hospital Name: _____

Who drove you to the hospital? _____ Where you admitted? _____

Date discharged: ___/___/___ Were X-Rays taken? ☐ YES / ☐ NO Describe _____

PATIENT SIGNATURE _____ **DATE:** _____

PATIENT MEDICAL HISTORY

1. What is your **weight**? _____ **Height**: _____

2. Current **Medical Problems** (please circle all that apply): ____ NONE

   High Blood Pressure, Heart Disease, Emphysema, COPD, Asthma,
   Chest Pain, Heart Murmur, Thyroid Disease, Gallbladder, Kidney/ bladder problems, Cancer/Type,
   Hepatitis, Ulcer, Heartburn, Prostate Disease, Carpel tunnel syndrome, Gastrointestinal problems,
   Diabetes, Glaucoma/Cataracts, Seizures, Depression, Mental illness, Arthritis, Headaches,
   Neck pain, Back pain, Anxiety,
   Other: _____ _____ _____ _____

3. What **medicines** are you currently taking?

Name of Drug	Dosage	Freq	Method
1.			
2.			
3.			
4.			
5.			

Drug Allergies
(Please list reactions)
☐ None
☐ Aspirin (ASA)
☐ Acetaminophen (APAP)
☐ Codeine
☐ Others: _____

4. **Past Surgeries** ____ None

Type	Date
1.	
2.	
3.	

5. Do you require the use of an assistance device? YES / NO
   ____☐____ Cane ____☐____ Walker ____☐____Wheelchair ____☐____ Brace: Type _____

6. Name and Address of your **Primary Care Physician**: _____
   _____

7. Any toxic habits? YES / NO ____☐____ Tobacco ____☐____ Alcohol ____☐____ Illicit Drugs ____☐____ Caffeine
   ____☐____ Others: _____

8. Do you exercise? YES / NO ____☐____ 2-3 days/week ____☐____ More than 3 days/week

Review of Systems: Do you have any of the following (**Circle the ones that apply**):

Constitutional:	fever/chill, weight change, sleep disturbance, appetite change, **NONE.**
Eyes:	visual changes, eye pain, tearing, **NONE**.
ENT:	hearing deficit, ear pain, dizziness, runny nose, hoarseness, sore throat, difficulty swallowing **NONE**.
Cardiovascular:	chest pain, palpitations, edema, dizziness upon change in position, **NONE**.
Respiratory:	cough, wheezing, difficulty breathing, **NONE.**
Gastrointestinal:	abdominal pain, nausea/vomiting, constipation, diarrhea, dark stools, blood in stools, **NONE.**
Genitourinary:	wake up to urinate, blood in urine, pain upon urination, frequency, kidney stones, **NONE.**
Musculoskeletal:	stiffness, back pain, muscle pain, joint pain, cramping, NONE**.**
Neuro:	numbness, tingling, headaches, seizures, falls, gait abnormality, **NONE.**
Psych:	depression, anxiety, confusion, memory difficulty, **NONE.**
Hemat/Lymph:	**easy bruising, nose bleeds, enlarged lymph nodes, NONE.**

PATIENT SIGNATURE _____ **DATE:** _____

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24 Hour Cancellation & "No Show" Fee Policy

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, INJURY AND SPINE MEDICAL GROUP, LLC reserves the right to charge a fee of $25.00 for all missed appointments ("no shows") and appointments which, absent a compelling reason, are not canceled with a 24-hour advance notice.

"No Show" fees will be billed to the patient. This fee is not covered by insurance, and must be paid prior to your next appointment. Multiple "no shows" in any 12 month period may result in termination from our practice.

Thank you for your understanding and cooperation as we strive to best serve the needs of all of our patients.

_____ _____

By signing below, you acknowledge that you have received this notice and understandthis policy.

_____ _____

Print Name of Patient **Signature of Patient**

_____

Date

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APPOINTMENT REMINDER

We have now the ability to text you, reminding you of your appointments. If you would like to receive this feature in the future, please read the consent below and sign.

Consent to Text Message for Appointment reminders and Other Health care Communications: Patients in our practice may be contacted via text messaging to remind you of an appointment, to obtain feedback on your experience with our health care team, and to provide general heal reminders/information.

_____**(Patient initials)** I consent to receive text messages from INJURY AND SPINE MEDICAL GROUP, LLC at my cell phone and any number forwarded or transferred to that number.

The **cell phone number** that I authorize to receive text messages for appointment reminders, feedback and general heal reminders/information is
(_____)_____-_____ Carrier:_____

_____**(Patient initials)** I do not wish to have an appointment reminder and will tappet any charges associated with missed physiotherapy scheduled treatments.

I understand that this request to receive text messages will apply to all future appointment reminders/feedback/health information unless I request to change otherwise.

Patient Name:_____ ***Patient Signature:***_____

Date:_____

Staff Signature:_____ ***Date:***_____

Pain Disability Questionnaire (PDQ)

Name: _____ Date: _____

Please answer every question by making an **X** along the line to show how much your pain problem has affected you (from having no problems at all to having the most severe problems you can imagine).

1. Does your pain interfere with your normal work inside and outside the home?

   Work normally — Unable to work at all

2. Does your pain interfere with personal care (such as washing, dressing, etc.)?

   Take care of myself completely — Need help with all my personal care

3. Does your pain interfere with your traveling?

   Travel anywhere I like — Only travel to see doctors

4. Does your pain affect your ability to sit or stand?

   No problems — Cannot sit/stand at all

5. Does your pain affect your ability to lift overhead, grasp objects, or reach for things?

   No problems — Cannot do at all

6. Does your pain affect your ability to lift objects off the floor, bend, stoop, or squat?

   No problems — Cannot do at all

7. Does your pain affect your ability to walk or run?

   No problems — Cannot walk/run at all

8. Has your income declined since your pain began?

   No decline — Lost all income

9. Do you have to take pain medication every day to control your pain?

   No medication needed — On pain medication throughout the day

10. Does your pain force you to see doctors much more often than before your pain began?

    Never see doctors — See doctors weekly

11. Does your pain interfere with your ability to see the people who are important to you as much as you would like?

    No problem — Never see them

12. Does your pain interfere with recreational activities and hobbies that are important to you?

    Normal activity — No recreation/hobbies at all

13. Do you need the help of your family and friends to complete everyday tasks (including both work outside the home and housework) because of your pain?

    Never need help — Need help all the time

14. Do you now feel more depressed, tense, or anxious than before your pain began?

    No depression/tension — Severe depression/tension

15. Are there emotional problems caused by your pain that interfere with your family, social, or work activities?

    No problems — Severe problems

0	1	2	3	4	5	6	7	8	9	10
No pain				Moderate pain						Excruciating pain