Application For Personal Injury Treatment

Todays Date:____/____/_____ Date of Accident: ____/____/____ Time of Accident: _____ AM / PM

Personal Information

Patient Name: _____ Preferred Name: _____

Birthdate: _____/_____/_____ Age: _____ □ Male □ Female SSN: _____/_____/_____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Daytime Phone: _____ Mobile Phone: _____ E-mail: _____

Mobile Provider :_____ Status: □ Single □ Married □ Divorced □ Widowed

Employment Information

Employment Status: □ Employed □ Unemployed □ Retired □ Disabled

Employer: _____ Occupation: _____ Work Schedule: _____

Reason for Visit

The reason for this visit is a result of: □ Auto Injury □ Work Injury Other:_____

Explain what happened: _____

_____

Please describe the pain and its location: _____

_____

When did condition begin? _____/_____/_____ Is it getting worse? □ Yes □ No □ Constant □ Comes and Goes

Does it interfere with your □ Work □ Sleep □ Daily Routine Explain: _____

If Auto Accident:

Were you the: □ Driver □ Passenger If Passenger: □ Front Seat □ Back Seat Other:_____ Were you wearing a seatbelt? □ Yes □ No

Area of Impact: □ Front □ Rear □ Driver Side □ Passenger Side # of People in Vehicle:_____ What did the vehicle impact? □ Vehicle □ Other:_____

Make & Model of Vehicle you were occupying: _____ Did the accident render you unconscious? □ Yes □ No If so, how long?_____

Were there any witnesses? □ Yes □ No Was the vehicle equipped with airbags? □ Yes □ No □ Not Sure If yes, did they deploy? □ Yes □ No

In relation to the base of the skull, where was the headrest? □ Above □ Below □ At Base Did your body strike anything in the vehicle? □ Yes □ No

Did you have any cuts or contusions? □ Yes □ No If yes, explain: _____ Fractures? □ Yes □ No If so, Explain:_____

Describe how you felt immediately after the accident: _____

Did the police come? □ Yes □ No If a traffic violation was issued, to whom was it issued?_____ Was a police report filed? □ Yes □ No

Did you go to a hospital or doctor? □ Yes □ No Via: □ Ambulance □ Other: _____ When? □ Immediately □ Next Day □ 2+ days

Was medicine given? □ Yes □ No Name of doctor or hospital that treated you: _____

Describe any treatment you received: _____

Were X-Rays taken? □ Yes □ No If so, what regions? _____

Was an MRI taken? □ Yes □ No Is so, what regions? _____ Was a CT Scan taken? □ Yes □ No If so, what regions?_____

What limitations have you experienced as a result of the injury? □ Standing □ Walking □ Sitting □ Driving □ Typing □ Other:_____

INSURANCE INFORMATION

PRIMARY INSURANCE

Type of Insurance: (Auto, etc.)_____ Insurance Company: _____

Address: _____ Phone Number: _____

Insured's Name: _____Policy Number: _____

Claim Number: _____ Insured's SSN: _____

Insured's Date of Birth: _____ Insured's Employer: _____ Agent's Name: _____

SECONDARY INSURANCE

Type of Insurance: (Health, etc.)_____ Insurance Company: _____

Address: _____ Phone Number: _____

Insured's Name: _____Policy Number: _____

Claim Number: _____ Insured's SSN: _____

Insured's Date of Birth: _____ Insured's Employer: _____ Agent's Name: _____

HEALTH HISTORY

Do you have or ever had any of the following conditions? (Please check all that apply).

□ Heart Attack	□ Congestive Heart Failure	□ Heart Murmur	□ Congenital Heart Defect
□ Mitral Valve Prolapse	□ Artificial Valves	□ Alcohol/Drug Abuse	□ Venereal Disease
□ Hepatitis	□ HIV+/AIDS	□ Shingles	□ Cancer
□ Frequent Neck Pain	□ Emphysema/Glaucoma	□ Anemia	□ High/Low Blood Pressure
□ Psychiatric Problems	□ Rheumatic Fever	□ Kidney Problems	□ Severe/Frequent Headaches
□ Ulcers/Colitis	□ Fainting/Seizures/Epilepsy	□ Sinus Problems	□ Asthma
□ Diabetes	□ Difficulty Breathing	□ Chemotherapy	□ Lower Back Problems
□ Artificial Bones/Joints	□ Arthritis	□ Tuberculosis	□ Other: _____

Please list any other serious medical conditions you have **or** ever had: _____

_____

Previous surgeries/treatments with dates: _____

Any past serious accidents with dates: _____

Have you ever been diagnosed with cancer? □ Yes □ No If so, what type: _____

Are you in remission? □ Yes □ No If so, how long have you been in remission?_____

Do you have any metal implants? □ Yes □ No If so, where are they? _____

Family health history: _____

_____

Do you take supplements/vitamins? □ Yes □ No If so, explain: _____

Are you taking any medications? □ Yes □ No If so, explain: _____

_____

Do you Exercise? □ Yes □ No Are you on a special diet? □ Yes □ No Since: _____/_____/_____

Do you smoke? □ Yes □ No If so, How Often? _____ How Many Years: _____ Do you drink? □ Yes □ No If so, how often:_____

Do you wear: □ Heel Lifts □ Sole Lifts □ Inner Soles □ Arch Supports Are you: □ Left Handed □ Right Handed

What is the age of your mattress?: _____ Is it comfortable? □ Yes □ No

Are you pregnant? □ Yes □ No How far along? _____ **Do you have a pacemaker? □ Yes □ No**

We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient. I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization, to release any information required to process insurance claims. I understand the above information and guarantee this form was completed correctl to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature: _____ Date: _____

FLORIDA SPINE & INJURY INSTITUTE

INFORMED CONSENT FOR TREATMENT

I hereby request consent to the performance of the chiropractic adjustments and other chiropractic procedures, to include, but not limited to, various modes of physical therapy and diagnostic x-rays, on me (or on the patient below, for whom I am legally responsible) by the doctor of chiropractic name below and/or other licensed doctors of chiropractic now or in the future treat me while employed by, working, or associated with, or serving as backup for the chiropractor name below, including those working at the clinic or office listed below or any other office or clinic associated with ***Florida Spine & Injury Institute***

I have had an opportunity to discuss with the doctor of chiropractic name below the nature and purpose of chiropractic adjustments at other procedures. I understand that results are not guaranteed.

I understand and am informed that as in the practice of medicine, the practice of chiropractic there are some risks to treatment including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain, all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels that time, based upon the facts then known, is in my best interests. Alternative treatments may include: medication, surgery, or physical therapy procedures. As with any of these alternative procedures there are risks. If no treatment is sought, your condition could get worse, remained the same, or improve.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about this 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. A new condition or other than what I had been treated for will be explained to me and a new consent will be signed.

Patient's signature:_____ Date:_____

To be completed by patient's representative if patient is a minor or is physically or mentally incapacitated

Name of Patient:_____

Doctors signature:_____ D.C Date:_____

FLORIDA SPINE & INJURY INSTITUTE

MOHAMMAD M. HAMTAEE D.C.

1048 South Florida Avenue
Lakeland, Florida 33803

PHONE: (863) 688-2200
FAX: (863) 688-2210

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT NAME: _____ Social Security #_____

DATE OF BIRTH:_____ Medical record #_____

I hereby authorize the use or disclosure of the Protected Health Information described below to be provided to or obtained by the following:

Name and Address of Individual/Facility/Company to Receive PHI

Florida Spine & Injury Institute
1048 South Florida Avenue
Lakeland, FL 33803

Name and Address of Individual/Facility to Disclose PHI

_____
_____
_____

Information authorized for use or disclosure, or to be obtained:

☐History & Physical ☐Discharge Summary ☐Operative Report ☐ER Record ☐Consultation ☐Lab reports

☐Progress Notes ☐X-ray reports ☐Other _____

☐Medical information between _____ to _____

The information will be obtained, used, or disclosed for the **following purpose** only:

☐Insurance ☐Continued treatment ☐Legal ☐At the request of the patient or patient's representative

☐Other (specify) _____

I understand:

- I may revoke this authorization at any time, in writing, except revocation will not apply to information already retained, used or disclosed in response to this authorization. I may revoke this document by presenting my written revocation as provided in the Notice of Privacy Rights. Unless revoked, the automatic expiration date will be six (6) months from date of signature or upon occurrence of the following event: _____.
- I release the entities listed above, their agents and employees from any liability in connection with the use or disclosure of the protected health information. The entity authorized to disclose the information will not be compensated by the recipient for such disclosure. Normal applicable fees, such as copy fees, may apply.
- Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by federal law. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.
- I have the right to inspect the health information to be released, unless prohibited by law and I may refuse to sign this authorization.
- Unless the purpose of this authorization is to determine payment of a claim for benefits, the requesting entity will not condition the provision of treatment, payment, enrollment in a health plan, or eligibility for benefits on obtaining this authorization.

I understand that my medical information may indicate that I have a communicable or venereal disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and human immunodeficiency viruses also known as Acquired Immune Deficiency Syndrome (AIDS). I further understand that my medical information may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse.

_____ _____
SIGNATURE OF PATIENT DATE

_____ _____
SIGNATURE OF PERSONAL REPRESENTATIVE DATE

_____
DESCRIPTION OF REPRESENTATIVES AUTHORITY TO ACT FOR THE PATIENT

NOTICE OF RIGHTS: Information in your medical records that you have or may have a communicable or venereal disease is made confidential by law and cannot be disclosed without your permission except in limited circumstances including disclosure to persons who have had risk exposures, disclosure pursuant to an order of the court or the Department of Health, disclosure among healthcare providers or for statistical or epidemiological purposes. When such information is disclosed, it cannot contain information from which you could be identified unless disclosure of that identifying information is authorized by you, by an order of the court or the Department of Health or by law

Processed by (Print Name & Dept):_____

Original: Releasing entity Copy: Originator Copy: Patient or representative (Required)

OFFICE OF INSURANCE REGULATION

Bureau of Property & Casualty Forms and Rates

Standard Disclose 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.**

☐99203 Detailed Exam	☐98941 Manipulation/Adjustment 3-4	☐G0283 Electrical Stimulation
☐97012 Mechanical Traction	☐98940 Manipulation/Adjustment 1-2	☐97035 Ultrasound
☐97124 Massage Therapy	☐L0627 Lumbar Support/Belt	☐97010 Cold Packs
☐97110 Therapeutic Exercises	☐97035 Ultrasound (1 unit per 15 min)	☐E0730 Tens Unit
☐A4556 Elec. Stimulation Pads	☐98943 Extraspinal Manipulation	☐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 or TYPE) 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** 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 The 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 up coded, unbundled,** or constitutes an invalid or not medically necessary diagnostic test as defined by Section 627.732 (15) and (16), 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):*

Mohammad M. Hamtaee CH9056 _____ _____
Name (PRINT or TYPE) Signature Date

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of Claim or An application containing any false, incomplete, or misleading information is guilty of a felony of the third degree Per Section 817.234 (1)(b), Florida Statutes

Note: The original of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may not be electronically furnished. Failure to furnish this form may result in non-payment of the claim

APPLICATION FOR FLORIDA "NO FAULT" BENEFITS

DATE: _____ FILE NUMBER: _____

INSURANCE COMPANY: _____

POLICY NUMBER: _____ DATE OF ACCIDENT: _____

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

NAME: _____ ADDRESS: _____

PHONE NUMBER: _____ CITY, STATE, ZIP: _____

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____

HOW LONG HAVE YOU BEEN A RESIDENT OF FLORIDA? _____

DATE OF ACCIDENT: _____ TIME OF ACCIDENT: _____

LOCATION OF ACCIDENT: _____

DESCRIPTION OF ACCIDENT: _____

_____

_____

_____

_____

_____

MAKE AND MODEL OF THE VEHICLE YOU WERE OCCUPYING: _____

AS A RESULT OF THIS ACCIDENT, WERE YOU INJURED? _____

IF YES, COMPLETE THIS FORM. IF NO, SIGN BELOW AND RETURN TO US.

_____ _____

SIGNATURE DATE

DESCRIPTION OF INJURY: _____

_____

WERE YOU TREATED BY A DOCTOR? _____ IF YES, NAME AND ADDRESS: _____

WERE YOU TRESTED AT A HOSPITAL? _____ IF YES, NAME AND ADDRESS: _____

AMOUNT OF MEDICAL EXPENSES TO DATE: $_____ WILL YOU HAVE MORE EXPENSES? _____

AT THE TIME OF THE ACCIDENT, WERE YOU EMPLOYED? _____ IF YES, DID YOU LOSE ANY WAGES? _____

IF YES, AMOUNT LOST: $ _____ YOUR WEEKLY SALARY OR WAGE: $ _____

DATE DISABILITY FROM WORK BEGAN: _____ DATE YOU RETURNED TO WORK: _____

HAVE YOU RECEIVED BENEFITS UNDER WORKER'S COMPENSATION? _____ IF YES, AMOUNT AND FREQUENCY: _____

NAME AND ADDRESS OF EMPLOYER OR PREVIOUS EMPLOYER ALONG WITH OCCUPATION AND DATES OF EMPLOYMENT:

_____

_____

AS A RESULT OF THIS ACCIDENT, HAVE YOU HAD ANY OTHER EXPENSES? ____ IF YES, EXPLAIN BELOW WITH EXPENSE AMOUNTS.

_____

_____ _____

SIGNATURE DATE

ACKNOWLEDGMENT OF LIABILITY
ASSIGNMENT OF BENEFITS

INSURANCE COMPANY:_____

For and in consideration of the above-mentioned provider agreeing to pursue my insurance provider for payment of benefits due me and not requiring prepayment for services, I hereby irrevocably assign to the aforementioned medical provider (the "Provider") any Personal Injury Protection benefits I any have in accordance with Florida Statute 627.736(5). This includes any benefits from my insurance company or any other entity that may be responsible for expenses incurred, and I authorize the "Provider" to prosecute said action and collect legal expenses as they see fit. THIS DOCUMENT CONSTITUTES AN ASSIGNMENT OF BENEFITS. I hereby further give a lien to the "Provider" against any and all insurance benefits named herein, and nay 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 "Provider". This is to act as an irrevocable assignment of my rights and benefits to the extent of the services provided. I agree to cooperate with the "Provider" and any attorney that the "Provider" chooses, and to do all things reasonable to effect payment of the bills by the insurance company to the "Provider" including, but not limited to, disclosing patient's medical condition and treatment. This assignment concerns only the bills for the "Provider" and those costs (including, but not limited to attorney's fees, court cost and interest) necessary in procuring payment from the above-named insurance company, etc. This assignment is not intended to assign any other causes of action that may belong to the undersigned patient. I agree to pay any applicable deductible or co-payment not covered by the PIP insurance coverage. I understand that this is a benefit and convenience to me in that the "Provider" will pursue collection against the insurance company in my behalf. I hereby instruct and direct my insurance company to pay my benefits by check, made payable to and mailed to the "Provider" at the address listed above. If my current policy prohibits direct payment to doctors, then I hereby instruct and direct my insurance company to make the check payable to me and mail it to the "Provider" at the address listed above. If this "Provider" is providing medical care related to an auto accident, "Provider" is charging a reasonable fee for necessary care related to the accident, and these bills should be paid to the full extent of the benefits available under my policy of insurance. If any portion of any charge for these services is either reduced or denied in whole or in part, my insurance company is to place funds equal to the amount of the reduced or denied charges into escrow. My insurance company is to hold the escrowed funds for "Provider", until such time as all escrowed funds are paid to "Provider", or "Provider" instructs my insurance company that "Provider" is no longer making any claim to the escrowed funds. Furthermore, I hereby give the "Provider" limited power of attorney to endorse/sign my name on any and all checks for payment to the "Provider". This agreement is intended to serve as an assignment of the patient's rights and benefits under his/her aforementioned insurance policy in favor of the "Provider". If any language within this agreement has the effect of invalidating this assignment, that language shall be deemed void and the assignment shall remain in full force and effect. A photocopy of this assignment shall be considered as effective and valid as the original.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date

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