Meyer Medical and Chiropractic

910 N. Pine Hills
Orlando, FL 32808
407-445-4500

34 S. Park Ave
Apopka, FL 32703
407-445-4501

Name: _____ SS# _____

Address: _____

City: _____ State: _____ Zip Code _____

Phone#: _____ Email: _____

Age: _____ Date of Birth _____ Marital Status M S W D

How many children? _____

Occupation _____ Employer _____

Have you lost any time from work as a result of the accident? YES NO

Who lives with you? _____ Occupation _____

Relationship _____ Phone _____

Date of MVA _____ Insurance Company: _____

Has the insurance been notified? YES NO

Claim Number: _____

Adjuster's Name _____ Adjuster's Phone#_____

Do you have an Attorney? YES NO Attorney's Name _____

Do you have additional insurance plans? YES NO Medical _____

Referred By? _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that this healthcare office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this healthcare office will be credited to my account upon receipt. However, I clearly, understand and agree that I am responsible for payment of any services rendered to me.
Initials _____

Patient's Signature _____ Date _____/_____/_____

(WE NEED TO MAKE A COPY OF YOUR INSURANCE CARD, DRIVER LICENSE AND POLICE REPORT IF YOU HAVE IT)

MVA Intake Form

Patient Name: _____ Today's Date _____

Date of injury: ___/____/_____/ Time:_____ AM / PM Where did the collision occur?

City/Town:_____ State:_____

Please describe the collision in your own words.

_____

_____

_____

_____

_____

_____

Allergies: _____ Medications: _____

Surgical History:

_____

_____

_____

Family History:

_____

_____

_____

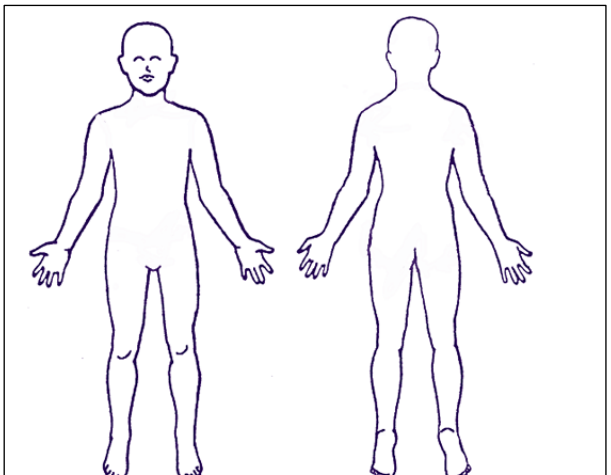
Social History *Please answer the following questions:*

☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Do you have any children? ☐ Yes ☐ No If yes, how many? _____

Do you use: ☐ Tobacco ☐ Alcohol ☐ Coffee

PLEASE MARK BELOW WITH A **"P"** BELOW WHERE YOU HAVE PAIN. MAKE A **"B"** FOR BRUISE



Provider Notes

E= Edema **S=** Spasm **T=** Tenderness

C+G= Comes and Goes **C=** Constant **I=** Immediate

SS= Staying same **W=** Worse

Color in for radiculopathy

LROM= Limited Range of Motion

WK= Weakness **Blank=** WNL

MEYER MEDICAL AND CHIROPRACTIC, LLC

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910 N. Pine Hills Rd.
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Informed Consent to Chiropractic Treatment

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy, and if necessary, diagnostic x-rays on me by the chiropractic physician and/or anyone working in this office authorized by the chiropractic physician.
I further understand that such chiropractic services may be performed by Meyer Heredia Medical and Chiropractic and/or other licensed Physicians of Chiropractic who may treat me now or in the future at this office. I have had an opportunity to discuss with Doctor and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed. I understand and am informed that, as in the practice of medicine and all healthcare, the practice of chiropractic carries some risks to treatment; including, but not limited to: fractures, disc injuries, strokes (CVA), dislocations, and sprains. I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgment during the course of the procedures which the physician feels are in my best interests at the time, based upon the facts then known.
I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my physician. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

Signature _____ Date_____

_____ _____

Patient's Representative Relationship

(If the patient is a minor or if physically or mentally impaired)

CLINICAL PHOTOGRAPHY OF WOUNDS

This consent form is be used to gain consent for taking pictures to enable clinical staff to assess wounds, record a visual image and monitor the healing process.

PATIENT AGREEMENT

I understand the benefits and risks as described to me by the health professional
I understand that if I do not wish to be photographed this is my choice
I understand that recorded information will be used to support my treatment as well as provide proof of injuries sustained during my accident.

☐ I consent to the pictures being taken and stored safely with my health records and that they will be shared with my attorney if applicable.

☐ I do not consent to the pictures being taken

Signature _____ Date _____

Full name of Legal Guardian if a child _____

A witness should sign below if the patient is unable to sign and the health care professional providing clinical care deem taking photographs will be in the patients' best interest.

Witness Signature_____ Date_____

Name (PRINT) _____ Relationship_____

Authorization to Use or Disclose My Health Information

Patient name: _____ Date of birth: _____ SSN: _____

I. My Authorization I _____ Authorize _____

You may use or disclose the following health care information (check all that applies):

☐ All my health information maintained by the above-named practice

☐ My health information relating to the following treatment or condition: _____

☐ My health information for the date(s):_____

☐ *Other:* _____

You may disclose this health information to:

Meyer Medical & Chiropractic

☐ 910 N. Pine Hill Rd.
Orlando, FL 32808
(407) 445-4500 Tel. (407) 770-5514 Fax.

☐ 34 S. Park Ave
Apopka, FL 32703
(407) 445-4501 Tel. (407) 814-9914 Fax.

II. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

- To take part in a research study.

Or

- To receive health care when the purpose is to create health information for a third party.

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by the above-name practice based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

- Fill out a revocation form. The form is available from the office.

or

- Write a letter to the office.

Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

_____ _____ _____
Patient or legally authorized individual signature **Date** Time

_____ _____
Printed Name if signed on behalf of the patient Relationship (parent, legal guardian, personal representative, etc.)

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ASSIGNMENT OF INSURANCE BENEFITS, RELEASE & DEMAND

Assignment of Benefits

I, the undersigned patient/insured, knowingly, voluntarily and intentionally assign and transfer any and all rights and benefits of my automobile insurance policy (i.e. Personal Injury Protection ("PIP"), Uninsured Motorist and Medical Payments benefits) to the above-stated Health Care Provider. I understand it is the intention of the Health Care Provider to accept this Assignment of Benefits in lieu of demanding payment at the time services are rendered. I understand that this document will allow the Health Care Provider to file suit against the insurer either in my name, or the provider's name, for payment of the insurance rights and/or benefits, to obtain an explanation of benefits and to seek attorneys' fees under Fla. Stat. §627.428 from the insurer. This Assignment of Benefits includes, but is not limited to, the cost of medical care, transportation, medication, supplies, over due 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 Health Care Provider in writing within five (5) days of receipt of this document advising of its basis for such dispute. Failure to inform the Health Care Provider shall result in a waiver by the insurer to contest the validity of this Assignment of Benefits. The undersigned patient/insured directs the insurer to pay the Health Care Provider the maximum amount of the policy benefits directly to the Health Care Provider without any reductions and without including the patient's/insured's name on the check. It is this Health Care Provider's contention that its charges are reasonable.

Disputes

The insurer is directed by the Health Care Provider and the undersigned patient/insured not to 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 is a written settlement agreement between the Health Care Provider, specifically the Office Manager, and the insurer as to the amount to be paid by the insurer for the services rendered only to the undersigned patient/insured. The patient/insured and the Health Care Provider hereby contest and object to any reductions or partial payments made by the insurer. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by the Health Care 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 Health Care Provider to accept a reduced amount as payment in full. The insurer is hereby placed on notice that this Health Care Provider reserves the right to seek the full amount of the bills submitted. If the insurer asserts that it can pay claims at 200% of the Medicare Fee Schedule, then the insurer is instructed and directed to provide this Health Care Provider with a copy of the policy of insurance within ten (10) days. Should the insurer and Office Manager of the above-stated Health Care Provider reach an agreement to settle any of the bills submitted at a reduced amount, this agreement shall be reduced to writing and submitted to the attention of the Office Manager for written approval. See Fla. Stat. §673.3111.

EUOs and IMEs

If the insurer requests an Examination Under Oath (EUO) or Independent Medical Examination (IME) of the patient/insured, the insurer is hereby instructed to promptly send a copy of the request to this Health Care Provider. The Health Care Provider or the Health Care Provider's attorney is expressly authorized to appear at any EUO or IME set by the insurer of this patient/insured. The Health Care Provider is not the agent of the insurer nor the patient for any purpose.

This Assignment of Benefits applies to both past and future medical expenses and is valid even if not dated. A photocopy of this Assignment of Benefits is to be considered as valid as the original. I, the undersigned patient/insured, agree to pay any applicable deductible or co-payments for services rendered after the policy of insurance exhausts and for any other services unrelated to the date of injury. The above-stated Health Care Provider is given Power Of Attorney to: (1) endorse my, the undersigned patient/insured's, name on any check for services rendered by the above-stated Health Care Provider, (2) to request and obtain copies of any recorded statements or Examinations Under Oath given by me, the undersigned patient/insured, and (3) to request and obtain copies of any IME reports and/or peer review reports pertaining to me, the undersigned patient/insured.

Release of Information

I, the undersigned patient/insured, hereby authorize this Health Care Provider to: furnish an insurer, an insurer's intermediary, my other medical providers and my attorney(s) via mail, facsimile or e-mail, with any and all information that may be contained within my medical records to: obtain insurance coverage information (i.e. declarations page and policy of insurance) in writing and telephonically from the insurer, request from any insurer all Explanation Of Benefits/Review forms (EOBs) for all of my medical providers, obtain a non-redacted PIP payout sheet, obtain written and verbal statements that I or anyone else provided to the insurer, obtain copies of the entire claim file and all medical records, including, but not limited to: documents, reports, scans, notes, bills, opinions, x-rays, IMEs, peer reviews and MRIs from any of my medical providers or any insurer. The Health Care Provider is permitted to produce my medical records to its attorney in connection with pursing a legal action. The insurer is directed to keep my, the patient/insured's medical records confidential. The insurer is not authorized to provide my, the patient/insured's, medical records to anyone without my, the patient/insured's and the Health Care Provider's express written permission.

Demand

Demand is hereby made for the insurer to pay all submitted bills within thirty (30) days of receipt without restriction and to mail an up-to-date, non-redacted PIP payout sheet and a declarations page to the above-stated Health Care Provider within fifteen (15) days. The insurer is directed to pay the bills received related to the date of injury in the order in which they were received. However, if a bill from this Health Care Provider and a claim from any other person or entity is received by the insurer on the same day, the insurer is directed not to apply this Health Care Provider's bill to the deductible. If a bill from this Health Care Provider and a claim from any other person or entity is received by the insurer on the same day, the insurer is directed to pay this Health Care Provider first before the policy is exhausted. In the event the Health Care Provider's medical bills are disputed or reduced by the insurer for any reason or by any amount, the insurer is to: set aside the entire disputed or reduced amount, escrow the full amount at issue and do not pay the disputed amount to anyone or any entity, including myself, until the dispute is resolved by a Court. The insurer is instructed to inform the Health Care Provider, in writing, of any dispute related to the above-stated Health Care Provider's bills. Additionally, should the remaining amount of my benefits approach an amount where there would be insufficient funds/benefits to pay the full amount of the above-stated Health Care Provider's bill, I hereby instruct the insurer to notify the undersigned patient/insured and the above-stated Health Care Provider of this fact. Should my benefits exhaust, I instruct the insurer to notify me and the Health Care Provider promptly of such exhaustion.

Letter of Protection

I hereby authorize and direct that my attorney, if I am represented by counsel, withhold sums from any disability benefits, Medical Payment benefits, PIP benefits or any other insurance benefits obligated to be reimbursed to me, or, from any settlement, judgment or verdict in my favor, as may be necessary to reimburse the above-stated Health Care Provider for services rendered to me. I, the undersigned patient/insured, hereby further give an IRREVOCABLE LIEN to the above-stated Health Care Provider 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 sustained, wherein the above-stated Health Care Provider rendered treatment. In the event that I do not have insurance coverage, I understand that I remain personally responsible for payment of services rendered.

Certification

I, the undersigned patient/insured, certify that: I have read and agree to the above; I have not been solicited nor promised anything in exchange for receiving health care from the above-stated Health Care Provider; I have not received any promises nor guarantees from anyone as to the results that may be obtained by any treatment or service provided; and I agree that the Health Care Provider's prices for the medical services, treatment and supplies provided are reasonable, usual and customary.

Caution: Please read carefully before signing. Please ask to review a copy of the above-stated Health Care Provider's charges. If you do not completely understand this document, please ask us to explain it to you. If you sign below we will assume that you understand and agree with the contents of this Assignment of Insurance Benefits, Release & Demand.

Patient's/Insured's Name: _____

(Please print)

Patient's/Insured's Signature: _____

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

Date:_____

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NOTICE OF INITIANATION OF TREATMENT

Date: _____

Certified Mail Number: _____

Patient: _____

Insured: _____

Date of Loss: _____

Claim/Policy #: _____

To whom it may concern:

Please be advised that I have been consulted by and have begun rendering medical treatment to the above referenced patient with the first date of treatment occurring on the above date of loss. If this or any future bills are not sufficient as notice of a covered loss or a notice of the claim, then please notify us in writing as to why it is not sufficient and how to make it sufficient.

Sincerely,

I, _____, agree that the above statement is true and factual.