Protect Your Spine

NEW PATIENT INFORMATION

First Name: ________________________ M.I. _____ Last Name: _________________________________ D.O.B. ____________________ Age _____ Sex: M / F

Address: ____ City: ______________________________ State ____________ Zip: ______________

Phone: Home ____ Cell: ____ Work: ______________________________

Email Address: ____ Emergency Contact Name / Number: ____

SSN: ____ Marital Status: ❑ Single ❑Married ❑ Divorced ❑ Separated ❑ Widowed

Primary Care Physician: ____ Phone: _____________________________ Fax: ______________________

Any Previous Chiropractic Care? ❑ Yes ❑ No Last Adjustment Date: _____________________ Is this a Motor Vehicle or Work injury? ❑Yes ❑No

Please list the current health complaints and / or other reasons for consulting our office today in order of priority below.

1. ____

2. ____

3. ____

Sports / Hobbies: ____

Medications you are currently taking: ____

❑ **I am not pregnant at this time; I hereby consent to have the X-ray Procedure if necessary** ❑ **Pregnant** ❑ **Not Sure** **Initial: X** _________________

Insurance Information: ***(Do not complete the section below if you do not have insurance)***

Policy Holder (Name): ____ Relation to Patient _________________________________

Policy Holder's DOB: ____ Policy Holder's SSN: _________________________________

Insurance Company: __________________________________ Policy #: ___________________________ Group #: _________________

Additional Insurance Information (Secondary Insurance):

Policy Holder (Name): ____ Relation to Patient _________________________________

Policy Holder's DOB: ____ Policy Holder's SSN: _________________________________

Insurance Company: __________________________________ Policy #: ___________________________ Group #: _________________

How did you hear about us? ❑ Google ❑ Facebook ❑ Twitter ❑ Instagram ❑ Other ____

I authorize the release of any information concerning my (or my child's) health care and treatment for the purposes of evaluation and administering claims of insurance benefits. I also hereby authorize payment of insurance benefits, otherwise payable to me directly, to Protect Your Spine. We will file a claim with your insurance company for services provided. In the event of non-payment you will be responsible for the charges incurred today.

X ____ Date: _____________________________

(Signature of patient or parent / guardian of minor)

Protect Your Spine

AUTHORIZATION FOR RELEASE OF INFORMATION

I herby authorize *Protect Your Spine* and it's staff members to disclose the following information from the healthcare record of:

Patient Name: ____D.O.B. ________________Phone: _______________________

Address: ____City:_________________________ State__________ Zip:___________

This information is to be disclosed to:

Business Name: ____Contact Name: _______________________________________

Address: ____City:_________________________ State__________ Zip:___________

Phone:______________________________Fax:________________________________Email: ______________________________

Information to be disclosed:

❑ Office Notes ❑ X-Ray Reports ❑ MRI Report or CD ❑ Complete Health Records

❑ Other: ____

Special instructions: ____

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- ✓ **I understand that the authorization is valid for 12 months after the date signed, unless canceled by me in writing.**
- ✓ **I have read and understand the above statement and do expressly and voluntarily consent to disclosure of the above information to those persons or business named above.**
- ✓ **I herby release *Protect Your Spine* and its staff members from all legal responsibility or liability that may arise from the release of these healthcare records.**

X____ Date: ________________________

(Signature of patient or parent / guardian of minor)

Protect Your Spine

TERMS OF ACCEPTANCE

When a person seeks chiropractic care, and when a chiropractor accepts a patient for such care, it is essential that they both are seeking and working towards the same goals. Chiropractic has one goal. It is therefore important that you understand the goal and our means to attain it. In this way there will be No confusion, misunderstanding, or disappointment.

1. You must realize that chiropractic is NOT a substitute for medical treatment of any kind, in any way, for any reason. Also NO statement of the Chiropractor is intended as a medical diagnosis and should not be confused as such. Patients usually want to get rid of whatever ailments, symptoms or conditions are bothering them. This however, is NOT the goal of the Chiropractor. Chiropractic is not intended to be a treatment of the symptoms of a medical condition or to treat the cause or causes of a medical condition.

2. The purpose of chiropractic is to restore and maintain the integrity of the spinal cord and its nerve roots. These vital nerve pathways are housed and protected by the bones of the spine. Tiny misalignments of the vertebrae and bones of the spine, which interfere with the function of these nerve pathways, are called subluxations. Subluxations come from many causes and prevent various organs, glands and tissues from functioning properly.

3. By means of a chiropractic adjustment, subluxations are corrected (reduced), thus, the normal nerve function restores itself. The goal of chiropractic is to adjust vertebral subluxations for the purpose of allowing the proper transmission over nerve pathways so that every part of the body may have a proper nerve supply at all times. This allows the innate healing ability of the body to work at maximum efficiency.

4. With proper nerve supply health improves. In some, symptoms clear up quickly. In others, the process is slower, and in some, it is only partial or not at all. Regardless of what the disease is called, the chiropractor does not offer to heal or even treat it, nor does he offer advice regarding the treatment of disease. His only goal is to allow the body to do its job. His only means is the correction of vertebral subluxation. He promises no cure from and offers no treatment of disease.

The information we receive from you is important. We ask only that which is necessary to Protect Your Spine. For this reason, please fill out this form completely and to the best of your ability. If you have any questions or there is any information you feel we should know, please mention it to the doctor.

I **(Print Name)**____, have read the information above, understand it fully, and undertake chiropractic care on this basis.

X____ Date: __________________________

(Signature of patient or parent / guardian of minor)

Protect Your Spine

TO ALL PATIENTS

Since 08/21/96, Health Insurance Portability and Accountability Act (HIPAA) has impacted all areas of the health care industry and was designed to improve the efficiency of health care by standardizing the exchange of administrative and financial data, and to protect the privacy, confidentiality and security of health care information. A major concern in the law was the security and privacy of electronic health records and their transmission between health care entities. The securities consist of more than just firewalls. Organizations must ensure the confidentiality and integrity of their health records, and transmission of data must be authenticated and have the property of nonrepudiation. Additionally, security policies and procedures must be documented and implemented.

Protect Your Spine has a policy requiring all employees to read and sign a confidentiality agreement. This agreement states that the employee understands that we process confidential data, and that the employee agrees not to directly or indirectly disclose any information in an inappropriate manner. *Protect Your Spine* aggressively enforces this and other agreements with entities to which we transmit transactions or from which we receive transactions, such as clearinghouses. *Protect Your Spine* will neither pursue nor knowingly retain a customer relationship with an entity that is either unwilling or unable to concur with reasonable privacy and confidentiality obligations.

Protect Your Spine recognizes that the transfer of medical data must be carried out in a manner that minimizes the risk of inappropriate disclosure and that safeguards the privacy and confidentiality of data that may identify individuals in their rules as patients and consumers. *Protect Your Spine* corporate policy is to observe all existing state and federal laws and regulations relating to the transmission, storage, and access of records and other health care data, and to maintain the security and confidentiality of patient-specific information.

The physicians of this office are contracted with many of the local and national managed care plans. However, there are some plans that we do not currently have contracts with. If you belong to a plan we are not contracted with our insurance / billing office will be glad to file a claim for you with the understanding that full payment is due at the time of service. Your claim will probably be applied to an out-of-network deductible or totally rejected. It is important for you to understand that the patient is ultimately responsible for the fees that are not covered by the provider in this case. If you have any questions concerning the coverage your plan has with *Protect Your Spine* please call the patient relations department of your provider.

Patient Consent for Use and Disclosure of Protected Health Information per the Health Insurance Portability and Accountability Act (HIPAA)

I **(Print Name)**________________________________, hereby certify that the personal medical information submitted is correct and that I seek medical treatment from *Protect Your Spine* and its staff. I hereby authorize such treatment as deemed appropriate and necessary by *Dr. Russell T. Elba* and the *Protect Your Spine* associates / staff.

X____ Date: ___________________________

(Signature of patient or parent / guardian of minor)

NOTICE OF PRIVACY PRACTICES: THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION. We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive in our facilities. This record is necessary to provide you with quality care and to comply with certain legal requirements. Chiropractors, physicians, consultants, specialists, and all others involved in your care may have different policies or notices regarding the use and disclosure of your medical information created and/or maintained at *Protect Your Spine*. Due to the nature of these services, we are required by law to maintain the privacy of certain confidential health care information, known as Protected Health Information (PHI), and to provide you with a notice of our legal duties and privacy practices with respect to your PHI. We are also required to abide by the terms of the version of this Notice currently in effect.

This notice will tell you about the ways in which we may use and disclose medical information about you, via any medium (written, oral, or electronic). We also describe your rights and certain obligations we have regarding the use and disclosure of medical information. We are required by law to: Make sure that medical information that identifies you is kept private. Give you this notice of our legal duties and privacy practices with respect to medical information about you. Maintain the privacy of certain confidential health care information, known as Protected Health Information (PHI).

USES AND DISCLOSURES OF PHI: We may use PHI for the purposes of treatment, payment and health care operations, in most cases without your written permission. Examples of our use of your PHI: **For Treatment:** This includes such things as obtaining verbal and written information about your medical condition and treatment from you as well as from others, such as chiropractors, doctors, nurses, and all others who give orders to allow us to provide treatment to you. We may give your PHI to other health care providers involved in your treatment, and may transfer your PHI telephone to the hospital or dispatch center. **For Payment:** This includes any activities we must undertake in order to get reimbursed for the services we provide to you, including such things as submitting bills to insurance companies, making medical necessity determinations and collecting outstanding accounts. **For Health Care Operations:** This includes quality assurance activities, licensing and training programs to ensure that our personnel meet our standards of care and follow established policies and procedures, as well as certain other management functions.

Use and Disclosure of PHI without Your Authorization. We are permitted to use PHI without your written authorization, or opportunity to object, in certain situations, and unless prohibited by a more stringent state law, including: For the treatment, payment or health care operations activities of another health care provider who treats you; For health care and legal compliance activities; To a family member, other relative, or close personal friend or other individual involved in your care if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection, and in certain other circumstances where we are unable to obtain your agreement and believe the disclosure is in your best interests; To a public health authority in certain situations as required by law (such as to report abuse, neglect or domestic violence; For health oversight activities including audits or government investigations, inspections, disciplinary proceedings, and other administrative or judicial actions undertaken by the government (or their contractors) by law to oversee the healthcare system; For judicial and administrative proceedings as required by a court or administrative order, or in some cases in response to a subpoena or other legal process; For law enforcement activities in limited situations, such as when responding to a warrant; To avert a serious threat to the health and safety of a person or the public at large; For workers' compensation purposes, and in compliance with workers' compensation laws; Use or disclose health information about you in a way that does not personally identify you or reveal who you are. Any other use or disclosure of PHI, other than those listed above will only be made with your written authorization. You may revoke your authorization at any time, in writing, except to the extent that we have already used or disclosed medical information in reliance on that authorization.

NOTICE OF INDIVIDUAL RIGHTS: As a patient, you have a number of rights with respect to your PHI, including:

THE RIGHTS, COPY TO INSPECT YOUR PHI: This means you may inspect and copy most of the medical information about you that we maintain. We will normally provide you with access to this information within 30 days of your request. We may also charge you a reasonable fee, as state law permits, to provide a copy of any medical information you have the right to access. In limited circumstances, we may deny you access to your medical information, and you may appeal certain types of denials. We have forms available to request access to your PHI and we will provide a written response if we deny you access and let you know your appeal rights. You also have the right to receive confidential communications of your PHI. If you wish to inspect or obtain a copy of your medical information, you should contact our local privacy representative.

THE RIGHT TO AMMEND PHI: You have the right to ask us to amend written medical information we may have about you. We will generally amend your information within 60 days of your request and will notify you when we have amended the information. We are permitted by law to deny your request to amend your medical information only in certain circumstances, like when we believe the information you have asked us to amend is correct.

THE RIGHT TO REQUEST ACCOUNTING: You may request an accounting from us of certain disclosures of your medical information we have made in the six years prior to the date of your request. However, your requests for an accounting of disclosures cannot precede the implementation date of HIPAA April 14. 2003. We are not required to give you an accounting of information we have used or disclosed for purposes of treatment, payment or health care operations, or when we share our health Information with our business associates, such as our billing company or a medical facility from/to which we have transported you We are also not required to give you an accounting of our uses of PHI for which you have already given us written authorization. If you wish to request an accounting, contact our local privacy representative.

THE RIGHT TO REQUEST THAT WE RESTRICT THE USES AND DISCLOSURES OF YOUR PHI: You have the right to request that we restrict how we use and disclose your medical information we have about you. We are not required to agree to any restrictions you request, but any restrictions agreed to by us In writing are binding on us.

THE RIGHT TO OBTAIN A PAPER COPY OF THE NOTICE ON REQUEST: If you would like a paper copy of this Notice, you may contact us at the address listed below and we will provide you a paper copy of the Notice upon request.

REVISIONS TO THE NOTICE: We reserve the right to change the terms of this Notice at any time, and the changes will be effective immediately and will apply to all PHI we maintain. Any material changes to the Notice will be promptly posted in our facilities and posted to our web site, if we maintain one you can get a copy of the latest version of this Notice by contacting our office.

YOUR LEGAL RIGHTS AND COMPLAINTS: You also have the right to complain to us, or to the Secretary of the United States Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against in any way for filing a complaint with us or to the government. Should you have any questions, comments or complaints you may direct all inquiries to:

Dr. Russell T. Elba
Protect Your Spine ®
5810 Stirling Road, Hollywood, FL 33021

My signature below constitutes my acknowledgement of the Notice of Privacy Practices.

I **(Print Name)**________________________________, understand that *Protect Your Spine* may share my health information for treatment, billing and healthcare operations. I have been given a copy of the organization's notice of privacy practices that describes how my health information is used and shared. I understand *Protect Your Spine* has the right to change this notice at any time. I may obtain a current copy by contacting The Billing Office or the Facility.

X____ Date: ___________________________

(Signature of patient or parent / guardian of minor)

CONSENT FOR SERVICES: **The undersigned give consent to** *Protect Your Spine*, its authorized representatives, its chiropractors and associates, and/or Independent Contractors to provide appropriate medical services including diagnostic and radiologic procedures, and other treatment and care considered advisable or necessary by the patient's treating providers.

PERSONAL PROPERTY AND VALUABLES: I understand that *Protect Your Spine* is not responsible for any personal property or valuables lost or misplaced at our facility.

FINANCIAL OBLIGATION: In consideration of the services to be provided by *Protect Your Spine* and its physicians, providers, and Independent Physician Contractors, the undersigned jointly and severally, agree to pay all charges, deductibles, co-payments, and/or co-insurance amounts determined not paid or allowable by health insurance payers. Certain routine services and procedures, which are determined as necessary by the treating physician/provider, may not be covered by Medicare, Champus, Blue Cross and Blue Shield, and other third party payers. I/we agree to pay these non-covered services and/or procedures if ordered and performed by the treating physician/provider or *Protect Your Spine*. I agree to make payments according to *Protect Your Spine* credit terms. In the event I should default in payment of any of the above charges then I agree to pay all reasonable costs of collection, including a reasonable attorney's fee as might be allowed by law, whether the account shall be referred to a collection agency or an attorney.

ASSIGNMENT OF BENEFITS: The undersigned assign payment of authorized insurance benefits otherwise payable to the policyholder, including Medicare and Champus benefits, directly to *Protect Your Spine*, or it's authorized representatives who provide services. I certify that all information is correct which has been given to apply to payment under Medicare, Champus, managed care, and Blue Cross and Blue Shield, and other third party programs.

AUTHORIZATION FOR RELEASE OF INFORMATION: The undersigned authorize *Protect Your Spine* and its treating chiropractors / staff, to furnish any medical and billing information about this account, including but not limited to the following: INSURANCE BILLING – information requested by the insurance company, Medicare, Champus or other third party payers to support the claim submitted for payment of charges applicable to this account. MEDICAL NECESSITY AND APPROPRIATENESS OF SERVICES – Information requested by any utilization and/or Peer Review Organization associated with the insurer(s) to evaluate the medical necessity and appropriateness of services of the account or to determine the benefits for related services. This release allows disclosure about the treatment, diagnostic testing, or other medical information including psychiatric, alcohol, HIV, drug abuse, cancer registry treatment and follow-up and/or other confidential information. The recipients are prohibited from any re-disclosure of this information. The undersigned has the right to subsequently revoke this release. The revocation shall not pertain to information previously released. Information requested in good faith by any health care facility or physician for facilitating continuing care and treatment is authorized.

I ACKNOWLEDGE THAT I HAVE READ THIS FORM AND UNDERSTAND ITS PURPOSES AND CONSENT.

X____ Date: ___________________________

(Signature of patient or parent / guardian of minor)

Protect Your Spine

PERSONAL INJURY QUESTIONAIRE (Page 1 of 2)

First Name: ________________________M.I.______ Last Name: ________________________________D.O.B.____________________Age_____Sex: M / F

Address: ____City:______________________________ State____________ Zip:______________

Phone: Home _______________________________________Cell:______________________________Email:____________________________________

SSN:_____________________________________Employer's Name:____________________________Employer's Phone:_____________________________

Employer's Address: ____

Insurance Name:____________________________________Policy #:___________________________Agent's Name:______________________________

NATURE OF ACCIDENT:

Date of Accident: ____________________Time of Day: _______________ Number of people in your vehicle: _______Were the police notified? ❑ Yes ❑ No

Your seat: ❑ Driver ❑ Passenger ❑ Back Driver ❑ Back Passenger Did you lose consciousness? ❑ Yes ❑ No If yes, how long? ________________

What direction were you headed? ❑ North ❑ East ❑ South ❑ West on (Name of street):____

What direction was the other car headed? ❑ North ❑East ❑ South ❑ West on (Name of street):____

Where were you struck? ❑ Behind ❑ Front ❑ Left Side ❑ Right Side Approximate speed of your car __________mph Other car _____________mph

In your own words, please describe accident: ____

____

____

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____

Did you have any physical complaints BEFORE the accident? ❑ Yes ❑ No If yes, please describe in detail: _____________________________________

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____

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____

What are you present complaints and symptoms? ____

____

____

Protect Your Spine

PERSONAL INJURY QUESTIONAIRE (Page 2 of 2)

Have you ever been involved in an accident before? ❑ Yes ❑ No If yes, please describe including date(s) and type(s) of accidents, as well as injury(ies) received: ______________________________

____

____

Where were you taken after the accident? ______________________________

Have you been treated by another doctor since the accident? ❑ Yes ❑ No If yes, please list doctor's name and address: ______________________________

____

What type of treatment did you receive? ______________________________

____

Since the injury occurred, your symptoms are? ❑ Improving ❑ Getting Worse ❑ The Same

CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

❑ Headache	❑ Irritability	❑ Numbness in Toes	❑ Face Flush	❑ Feet Cold
❑ Neck Pain	❑ Chest Pain	❑ Shortness of Breath	❑ Buzzing in Ears	❑ Hands Cold
❑ Stiff Neck	❑ Dizziness	❑ Fatigue	❑ Loss of Balance	❑ Stomach Upset
❑ Sleeping Problems	❑ Head Seems Too Heavy	❑ Depression	❑ Fainting	❑ Constipation
❑ Back Pain	❑ Pins & Needles in Arms	❑ Lights Bother Eyes	❑ Loss of Smell	❑ Cold Sweats
❑ Nervousness	❑ Pins & Needles in Legs	❑ Loss of Memory	❑ Loss of Taste	❑ Fever
❑ Tension	❑ Numbness in Fingers	❑ Ears Ring	❑ Diarrhea	❑ Other

Symptoms other than listing above: ______________________________

Have you lost time from work as a result of this accident? ❑ Yes ❑ No If yes, please complete this question:

1. Last day worked: ______________________________
2. Type of employment: ______________________________

Did you notice any activity restrictions as a result of this injury? ❑ Yes ❑ No If yes, please describe in detail: ______________________________

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X______________________________ Date: ______________________________

(Signature of patient or parent / guardian of minor)

Protect Your Spine

NOTICE OF DOCTOR'S LIEN

First Name: ______________________________ Last Name: ______________________________ Date of Accident: __________________

I do hereby authorize *Dr. Russell T. Elba* and *Protect Your Spine* to furnish you, my attorney, with a full report of his / her examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was recently involved.

I do hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him for medical services rendered me both by reason of this accident and by reason of any other bills that are due to his office and withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate such doctor against any and all proceeds of my settlement. Judgment or verdict which may be paid you, my attorney, or myself, as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

I agree to promptly notify said doctor of any change or additional of attorney(s) used by me in connection with this accident, and I instruct my attorney to do the same and promptly deliver a copy of this lien to any such subtitled or added attorney(s).

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that of my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but may declare the entire balance due and payable.

X____ Date: __________________________
(Signature of patient or parent / guardian of minor)

The undersigned being my attorney of record the above patient does hereby agree to observe all the terms of the above and agrees to such sums from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate said doctor above named. Attorney further agrees that in the event this lien is litigated that the prevailing party will be awarded fees and costs.

X____ Date: __________________________
(Signature of Attorney)

Protect Your Spine

APPLICATION FOR FLORIDA "NO FAULT" BENEFITS

Date:______________________________ File Number:____

Insurance Name:__________________________________Policy #:_________________________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 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.

First Name: _____________________M.I._____ Last Name: ____________________________D.O.B.__________________Age_____Sex: M / F

Address: ____City:___________________________ State__________ Zip:___________

Phone: Home ____________________________________Cell:____________________________SSN:_______________________________

How long have you been a resident of Florida? ____

Time of Accident:__________________________Make and model of vehicle you were occupying during the accident:________________________

Location of Accident:____

Description of Accident:____

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Were you injured in this accident? ❑ Yes ❑ No If yes, please complete this form. If not, please sign here: **X**______________________________________
(Signature of patient)

IF YOU WERE INJURED DUE TO THIS ACCIDENT PLEASE COMPLETE SECTION BELOW:

Description of Injury:____

____

Were you treated by a doctor? ❑ Yes ❑ No If yes, list doctor's name and address: ____________________________________

Were you treated at a hospital? ❑ Yes ❑ No If yes, list Hospital's name and address: __________________________________

Amount of medical expenses to date: $____________________Will you have more expenses? _______________________________

At the time of accident, were you employed? ❑ Yes ❑ No If yes, did you lose any wages? ❑ Yes ❑ No If yes, amount lost? ___________________

Your weekly salary or wages? __________________Date disability from work began? ______________Date returned to work: ___________________

Have you received benefits under Worker's Compensation? ❑ Yes ❑ No If yes, amount and frequency: $_____________________________

Name and address of employer or previous employment along with occupation and dates of employments: _________________________

____

As a result of this accident, have you had any other expenses? ? ❑ Yes ❑ No If yes, explain below with expenses amounts: ___________________

____

X____ Date: ___________________________
(Signature of patient or parent / guardian of minor)

Protect Your Spine

RETURN RECEIPT REQUESTED

Certified Mail #____________________ Date: ______________________

TO: ____

____

____

NOTICE OF INTIATION OF TREATMENT

Patient: ________________________________

Insured: ________________________________

DOA: ________________________________

Claim #: ________________________________

Policy #: ________________________________

TO WHOM IT MAY CONCERN:

Please be advised that I have been consulted by, and have begun rendering treatment to, the above referenced patient, with the patient's first date of treatment occurring on ____.

Enclosed please find an assignment of benefits signed by the patient directing you to send all payments for services rendered to the undersigned. The patient has also granted us a lien on the benefits.

In accordance with Florida Statue 627.736(5)(6), I will submit the bills in a timely manner and in doing so, request timely payment of this patient's bills, within 30 days of receipt.

Yours Truly,

Dr. Russell T. Elba
Protect Your Spine®

X____ Date: ______________________
(Signature of Office Manager)

Protect Your Spine

NOTICE OF EMERGENCY MEDICAL CONDITION

The undersigned licensed medical provider, hereby asserts:

1. The below patient, 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 accidently that occurred on: ___________________________.
(Date of Accident)

2. The basis of the opinion for finding 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 patient health B) serious impairment to bodily functions or C) serious dysfunction of a bodily organ or part.

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

Print Name:____ X____ Date: _____________
(Signature of medical provider)

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 in the car accident.

3. The medical provider 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:

X____ Date: ___________________________
(Signature of patient or parent / guardian of minor)

Protect Your Spine

ASSIGNMENT OF INSURANCE BENEFITS, RELEASE, & DEMAND

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

I **(Print Name)**_________________________________, the undersigned patient/insured, knowingly, voluntarily and intentionally assign the rights and benefits of my automobile insurance, also known as Personal Injury Protection (hereinafter PIP), and Medical Payments policy of Insurance to the above health care provider. I understand it is the intention of the provider to accept this assignment of benefits in lieu of demanding payment at the time services are rendered. I understand this document will allow the provider to file suit against an insurance company for payment of the insurance benefits or an explanation of benefits. If the provider's bills are applied to a deductible, I agree this will serve as a benefit to me and I authorize and request such litigation. This assignment of benefits includes the cost of transportation, medications, supplies, overdue interest and any potential claim for common law or statutory bad faith/unfair claims handling. If the insurer disputes the validity of this assignment of benefits, then the insurer is instructed to notify the provider in writing within five days of receipt of this document. Failure to inform the provider shall result in a waiver by the insurer to contest the validity of this document. The undersigned directs the insurer to pay the health care provider the maximum amount directly without any reductions and without including the patient's name on the check. To the extent the PIP insurer contends there is a material misrepresentation on the application for insurance resulting in the policy of insurance being declared voided, rescinded, or canceled, I, as the named insured under said policy of insurance, hereby assign the right to receive the premiums paid for my PIP insurance to this provider and to file suit for recovery of the premiums. The insurer is directed to issue such a refund check payable to this provider only. Should the medical bills not exceed the premium refunded, then the provider is directed to mail the patient/named insured a check, which represents the difference between the medical bills and the premiums paid. The patient agrees before the services are provided that the provider's charges for services are reasonable, usual and customary.

Disputes: The insurer is directed by the provider and the undersigned to not issue any checks or drafts in partial settlement of a claim that contain or are accompanied by language releasing the insurer or its insured/patient from liability unless there has been a prior written settlement agreed to by the health provider and the insurer as to the amount payable under the insurance policy. The insured and the provider hereby contest and object to any reductions or partial payments. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by the provider shall be done so under protest, at the risk of the insurer, and the deposit shall not be deemed a waiver, accord, satisfaction, discharge, settlement or agreement by the provider to accept a reduced amount as payment in full. The insurer is hereby placed on notice that this provider reserves the right to seek the full amount of the bills submitted. If the PIP insurer states it can pay claims at 200% of Medicare then the insurer is instructed & directed to provide this provider with a copy of the policy of insurance within 10 days. **Any effort by the insurer to pay a dispute debt as full satisfaction must be mailed to the address above, after speaking with the Office Manager, and mailed to the specific attention of the Officer Manager. See Florida Statute §673.3111.**

EUOs and IMEs: If the insurer schedules a defense examination or examination under oath (hereinafter "EUO") the insurer is hereby INSTRUCTED to send a copy of said notification to this provider. The provider or the provider's attorney is expressly authorized to appear at any EUO or IME set by the insurer. The health care provider is not the agent of the insurer or the patient for any purpose. The assignment applies to both past and future medical expenses and is valid even if undated. A photocopy of this assignment is to be considered as valid as the original. I agree to pay any applicable deductible, co- payments, for services rendered after the policy of insurance exhausts and for any other services unrelated to the automobile accident. The health care provider is given the power of attorney to endorse my name on any check for services rendered by the above provider, and to request and obtain a copy of any statements or examinations under oath given by patient.

Express Consent and Release of Information: I hereby authorize this provider to: furnish an insurer, an insurer's intermediary, the patient's other medical providers, and the patient's attorney via mail, fax, or e-mail, with any and all information that may be contained in the medical records; to obtain insurance coverage information (declaration sheet and policy of insurance) in writing and telephonically from the insurer; request from any insurer all explanation of benefits (EOBs) for all providers and non-redacted PIP payout sheets; obtain any written and verbal statements the patient or anyone else provided to the insurer; obtain copies of the entire claim file and all medical records, including but not limited to, documents, reports, scans, notes, bills, opinions, X-rays, IMEs, and MRIs, from any other medical provider or any insurer. The provider is permitted to produce my medical records to its attorney in connection with any pending lawsuits. The insurer is directed to keep the patient's medical records from this provider private and confidential and the insurer is not authorized to provide these medical records to anyone without the patient's and the provider's prior express written permission.

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

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

Caution: **Please read before signing. Please ask to view a copy of our charges. If you do not completely understand this document please ask us to explain it to you. If you sign below, we will assume you understand and agree to the above.**

X____ Date: ___________________________

(Signature of patient or parent / guardian of minor)

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.**

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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: 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.