7163 University Blvd. Winter Park, FL. 32792
Phone: (321) 441-4944 | **Fax:** (407) 636-8749

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:_____

EMPLOYER:_____OCCUPATION:_____PHONE#:(_____)_____

EMERGENCY CONTACT:_____PHONE:(_____)_____RELATION:_____

Auto Insurance Information

TYPE OF ACCIDENT: WORK COMP_____ AUTO_____ SLIP & FALL_____ OTHER_____

ACCIDENT/INJURY DATE: _____INSURANCE CARRIER:_____

POLICY#: _____CLAIM#: _____

ADJUSTER NAME: _____ PHONE: (_____)_____EXT. _____

Attorney Information

ARE YOU BEING REPRESENTED BY AN ATTORNEY? Y / N

ATTORNEY'S NAME:_____PHONE:(_____)_____

ADDRESS:_____CITY:_____STATE:_____ZIP:_____

PATIENT SIGNATURE_____ **DATE:** _____

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Standard Disclosure and Acknowledgement Form
Personal Injury Protection – Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

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

_____

_____

2. I have the right and the **duty to confirm** that the services have already been provided.
3. I was **not solicited** by any person to seek any services from the medical provider of the services described above.
4. The medical provider has **explained** the services to me for which payment is being claimed.
5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid *by my* motor vehicle insurer. If entitled, my share would be at **least** 20% of the amount of the reduction, up to $500.

Insured Person *(patient receiving treatment or services) or Guardian of Insured Person:*

_____ _____ _____
Name (PRINT) 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 upcoded, 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****):*

_____ _____ _____

Physician Name (PRINT) Physician 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 **UNIVERSITY SPORTS & SPINE, 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 may be 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 insufficient 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:** _____

(PARENT/LEGAL GUARDIAN SIGNATURE)

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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 anytime by sending such written notification to the practice's Privacy Contact at [office address or e-mail address]. I 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 **UNIVERSITY SPORTS & SPINE, 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 **UNIVERSITY SPORTS & SPINE, LLC.** I understand that diagnosis or treatment of me by **UNIVERSITY SPORTS & SPINE, 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. **UNIVERSITY SPORTS & SPINE, LLC,** is not required to agree to the restrictions that I may request. However, if **UNIVERSITY SPORTS & SPINE, LLC agrees to a restriction that I request, the restriction is binding on UNIVERSITY SPORTS & SPINE, LLC.**
I have the right to revoke this consent, in writing, at any time, except to the extent that **UNIVERSITY SPORTS & SPINE, 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 **UNIVERSITY SPORTS & SPINE, LLC** Notice of Privacy Practices prior to signing this document. **UNIVERSITY SPORTS & SPINE, 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 **UNIVERSITY SPORTS & SPINE, LLC.** The Notice of Privacy Practices for **UNIVERSITY SPORTS & SPINE, LLC** is also provided at the reception desk. This Notice of Privacy Practices also describes my rights and **UNIVERSITY SPORTS & SPINE, LLC** duties with respect to my protected health information.

UNIVERSITY SPORTS & SPINE, 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/Legal Guardian** **Date**

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NOTICE OF INITIATION OF MEDICAL TREATMENT PURSUANT TO FLORIDA STATUTE 627.736

PATIENT_____ **DATE OF LOSS** ____/____/____
INSURANCE COMPANY: _____
POLICY NUMBER: _____ **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:

UNIVERSITY SPORTS & SPINE, LLC 7163 University Blvd Winter Park, FL 32792

OFFICIAL CERTIFICATION OF PATIENT AS TO INSURANCE COVERAGE

PATIENT_____ **DATE OF LOSS** ____/____/____
INSURANCE CO_____
POLICY NUMBER: _____ **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.

_____

Siganture of Patient/Legal Guardian **Date**

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PATIENT MEDICAL HISTORY

1. What is your **Weight**(lbs) _____**Height**: _____

2. Medical History: (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 **MEDICATIONS** are you currently taking and what are the **DIRECTIONS**?

Name of Drug	Drug Allergies
1. _____	(Please list reactions)
2. _____	☐ None
3. _____	☐ Aspirin (ASA)
4. _____	☐ Acetaminophen (APAP)
5. _____	☐ Codeine
	☐ Others: _____

4. Past Surgeries ____ None

Type	Date
1. _____	
2. _____	
3. _____	

5. Family Medical History:

Relationship and Maternal/Paternal side:

Hypertension: _____
Diabetes: _____
Cancer/Type: _____
Thyroid Disease: _____
Mental Illness: _____
Depression: _____
Heart Disease: _____
Other: _____

6. Do you require the use of an assistance device? YES / NO
_____ Cane _____ Walker _____Wheelchair _____ Brace: Type _____

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

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8. Any toxic habits? YES / NO , if yes what habit?
____Tobacco ____Alcohol ____ Illicit Drugs ____ Caffeine ___ Others: _____

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

10. Today's Pain Level (1-10) with ten being the worst _____/10

11. Is this condition interfering with your daily routine:
___ Work ___ Sleep ____ Social Activities___ Mobility ___ Exercise ___ Concentration

12. How is the progress of the condition?
____ WORSE ____ SAME ____ CONSTANT ____ INTERMITTENT

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, 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**

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

PHYSICIANS	SPECIALTY	TREATMENT DURATION

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BRIEFLY DESCRIBE THE ACCIDENT:

Destination after the accident / injury:

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

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

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

Describe Imaging results:

PATIENT SIGNATURE_____ **DATE:** _____

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CONSENT FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____

Birth Date: _____ Social Security No: _____

Release Records To: **UNIVERSITY SPORTS & SPINE, LLC**

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.
(initial)

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

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

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

Patient/Legal Guardian Signature Date

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PATIENT ASSIGNMENT OF BENEFITS

I _____ _____

Patient or Finanically Responsible Party (PLEASE PRINT) Date of Birth (Month/Day/Year)

I hereby assign medical benefits payments to University Sports and Spine for the services rendered by University Sports and Spine. I hereby instruct that medical benefits owed for my medial treatment by University Sports and Spine be made payable to and mailed directly to University Sports and Spine. I hereby irrevocable assign to University Sports and Spine the rights and benefits under policy of insurance for which benefits are available for payment of my medical bills.

FINANCIAL RESPONSIBILITY

Co-Pays, Deductibles and fees for non-covered services are due at the time of service, at the discretion of University Sports and Spine.

DIRECTION TO PAY

I agree to hereby assign to University Sports and Spine an amount sufficient to pay all charges I owe to University Sports and Spine and I hereby direct my attorneys of record to pay University Sports and Spine that sum from any settlement or recovery I may receive for the incident which resulted in my need for services provided to me by University Sports and Spine. This direction to pay may only be revoked upon the written consent of University Sports and Spine. If I decide to obtain a different attorney, I will notify University Sports and Spine of my new attorney information within 10 days of obtaining the new attorney.

MEDICAL RELEASE

I agree that a photocopy of this document shall be sufficient to authorize any person having record of medical treatment, services, or supplies pertaining to me to release true copies of same to University Sports and Spine or any insurer providing coverage to me in connection with processing of any claim for benefits made by me or by the assignee herein. A photocopy of this document shall be binding as an original signature page.

CONSENT TO TREAT

I authorize University Sports and Spine to perform the treatments or procedures approved by my physician. I acknowledge that no guarantees, either expressed or implied, have been made to me regarding the outcome of any treatments and/or procedures. The nature and purpose of the procedure, possible alternative methods of treatment and risk involved and the possibilities of complications have been fully explained to me.

PATIENT

_____

Date (month/day/year)

Patient's Name **(Print)** Patient/Legal Guardian **Signature**

WITNESS

_____

Date (month/day/year)

Witness's Name **(Print)** Witness **Signature**