INJURY CARE CLINIC

JOSEPH W. SLATTERY III, MD • MEDICAL DIRECTOR

Board Certified

630 S. Wickham Road • Suite 101 • W. Melbourne, FL 32904

P 321.952.9993 • F 321.952.9997 • InjuryCareClinic.com

PATIENT INFORMATION

Name: _____ Today's Date: _____

Address: _____ SSN: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work: _____ Cell: _____

Email Address: _____

Sex: __M __F **DOB:**_____ **Status:** __ Married __Widow __Single __Divorced/Separated __Minor

Employer: _____ Occupation _____

Address: _____

Emergency Contact: _____ Phone: _____

Were you referred by another doctor? _____If so, who?_____ Phone: _____

Primary Care Physician: _____ Phone: _____ Fax: _____

AUTO/WORKER'S COMPENSATION/SLIP & FALL INFORMATION – Please Circle One

Insurance Co.: _____ Phone: _____

Claim #: _____ Date of Injury: _____

Address: _____

Are you the Insured? _____Yes _____ No If not, who is the insured and relationship:_____

Adjustor: _____ Phone: _____ Fax: _____

Attorney: _____ Phone: _____ Fax: _____

PRIMARY INSURANCE

Insurance company: _____ Phone: _____

Subscriber ID/Policy: _____ Group#: _____

Address: _____

Insured Name: _____ DOB: _____ Phone: _____

Address (if different from above) _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Injury Care Clinic, or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian Signature Date

Name:_____ Date:_____

History of Current Injury

___Auto/motorcycle injury ___Slip & Fall ___Pedestrian ___Bicyclist

Date of injury:_____ Age:_____ ___right-handed ___left-handed __male __female

If this was not a result of a motor vehicle crash, please explain what happened._____
_____
_____

Motor Vehicle Crash:
Were you the__driver__passenger__front__back(__left__right)? Seatbelt__Y __N.
Your vehicle: Year_____, Make_____, Model_____
Other vehicle: Year_____, Make_____, Model_____
Other vehicle: Year_____, Make_____, Model_____

__Rear end crash.__Head on crash.__Side impact crash.__Hit guard rail, tree or object.__Roll over

Give a brief description of the crash:_____
_____
_____

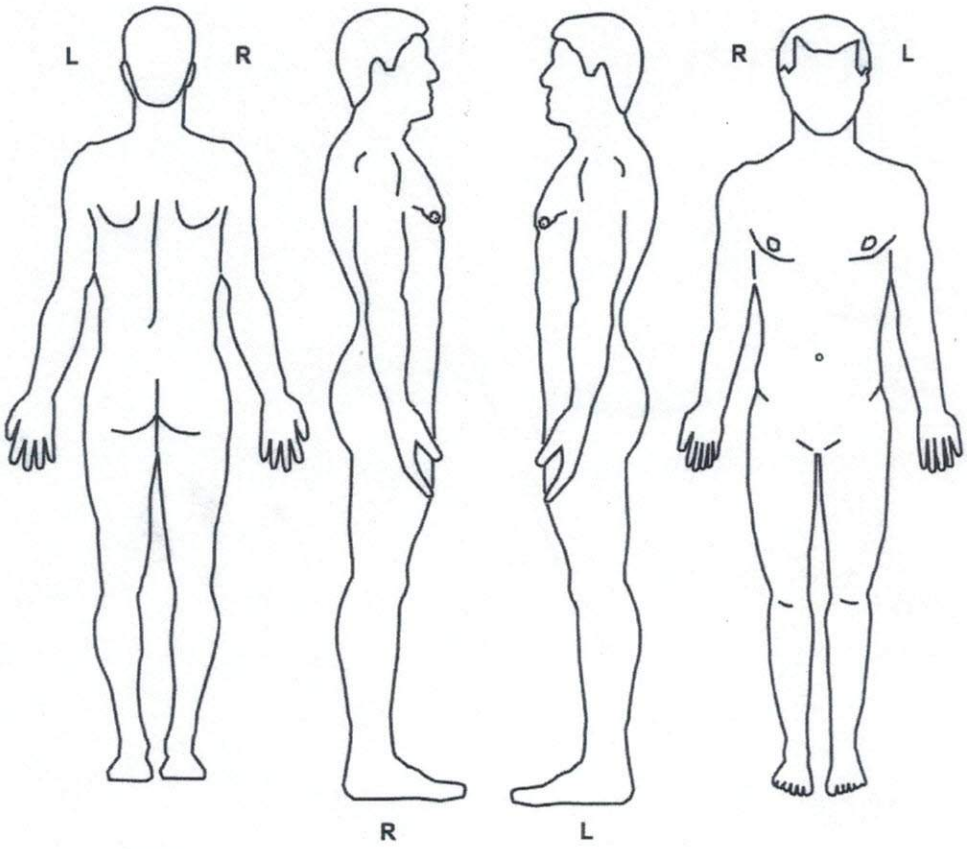
Were you aware that the crash was coming?__Y__N. Did you have time to brace yourself? __Y __N. How did you brace yourself ?_____

At the time of the crash were you (check all that apply):__Looking straight ahead.__Head/torso turned to the left.__Head/torso turned to the right.__Torso/body position and normally against seat back.__Leaning forward.

Were you holding onto the steering wheel at the time of the impact?__Y __N. __left hand __right hand.
Did the air bags deploy? __Y __N. Did the air bag strike you? __Y __N. If so, where?_____
Did you lose consciousness? __Y __N __maybe. If so, how long?_____
Were you dazed and confused after the crash? __Y __N.
Did any part of your body strike (or struck by) an object in the vehicle? __Y __N. Describe: _____
Were there any cuts, scrapes or bruising? __Y __N. Describe:_____
What symptoms developed immediately or shortly after the crash?_____
_____
Did you go to the emergency room (ER)? __Y __N. Date:____ Ambulance? __Y __N.
Name of ER?_____ Were you admitted to the hospital? __Y __N. How long?_____
Check procedures performed at the hospital: __Surgery.__CAT scan.__X-rays.__Stitches/Staples.__ Other____
Were you given prescriptions for any medications? __Y __N. What? _____
Did any other symptoms develop at a later time? __Y __N. If so, what and when?_____
_____
Have you seen any other doctors or received any other treatment since the crash? __Y __N.
If so please describe: _____
_____

Name :_____ Date:_____

Pain Drawing



Mark as follows:
A - Ache B - Burning N - Numbness P - Pins & Needles
S - Stabbing O - Other - Describe _____

Please check only those symptoms that are new or have worsened with the current accident.

__Headache
__Neck pain
__Neck stiffness
__Head feels too heavy
__Pain down arms
__Pins & needles in arms
__Numbness in fingers
__Weakness in arms and hands
__Shoulder pain
__Back pain
__Hip pain
__Pain down legs
__Pins & needles in legs
__Numbness in toes
__Weakness in legs and feet

__Irritability
__Vision changes
__Fatigue
__Depression
__Nervousness
__Memory or concentration changes
__Ringing in ears
__Bowel or bladder changes
__Loss of balance
__Fainting spells
__Dizziness
__Sleeping problems
__Other_____
__Other_____

Name:____ Date__________

Musculoskeletal, Trauma, Injury and MVC History

Please list all previous **motor vehicle crashes** or **work related injuries** you have been involved in (no matter how trivial). Starting from oldest to newest.

Date of crash/injury:____________
Were you injured? __Yes __No If yes, what was injured? ______________________________

Did you see a doctor? __Yes __No. If yes, who? ______________________________

What type of treatment or surgeries did you receive? ______________________________

____

When you recovered, what type of symptoms were you left with? ______________________________

____

Date of crash/injury:____________
Were you injured? __Yes __No If yes, what was injured? ______________________________

Did you see a doctor? __Yes __No. If yes, who? ______________________________

What type of treatment or surgeries did you receive? ______________________________

____

When you recovered, what type of symptoms were you left with? ______________________________

____

Date of crash/injury:____________
Were you injured? __Yes __No If yes, what was injured? ______________________________

Did you see a doctor? __Yes __No. If yes, who? ______________________________

What type of treatment or surgeries did you receive? ______________________________

____

When you recovered, what type of symptoms were you left with? ______________________________

____

Name:_____ Date:_____

Musculoskeletal, Trauma, Injury and MVC History (Cont.)

Have you suffered any broken bones not described above? If so, please describe when, part of body and how it was treated. _____

_____

Have you ever had an orthopedic surgery not described above? If so, please describe. _____

_____

Have you ever had any significant shoulder, knee or other joint injuries not described above? __Yes __No
If yes, please describe. _____

_____

Have you ever had any problems with your neck or back, not described above? __Yes __No.
If yes, please describe. _____

_____

Have ever seen a chiropractor before? __Yes __No. If yes, describe: _____
_____

Patient Name:_____ Date:_____

Medical History:

Who is your primary care physician?_____

Have ever been diagnosed or treated for any of the following conditions or illnesses? Check all that apply.

__Angina
__Heart attack/MI
__Hypertension/high blood pressure
__Heart disease
__High cholesterol
__Pacemaker
__Stroke
__Carotid artery disease
__Peripheral vascular disease
__Asthma
__Chronic bronchitis/emphysema
__Lung disease
__Diabetes
__Rheumatoid arthritis
__Gout
__Kidney disease
__Kidney stones
__AIDS/HIV
__Anemia
__Bleeding or clotting disorder
__Blood clots
__Deep vein thrombosis
__Anorexia
__Bulimia
__Chemical dependency
__Alcoholism
__Depression
__Anxiety
__Suicide attempt
__Psychiatric illness
__Thyroid problems
__Goiter
__Hepatitis
__Crohn's/ulcerative colitis
__Liver disease
__Hernia
__Gastroesophageal reflux
__Ulcers
__Migraine headaches
__Seizures
__Cataracts
__Glaucoma
__Prostate problems
__Urinary problems
__Tuberculosis
__Tumors, growths
__Cancer (type)_____
__Other_____
__Other_____

Surgical History: Have you ever had any of the following surgeries? Check all that apply.

__Cataracts
__Other eye surgery_____
__Nasal surgery
__Tonsillectomy
__Carotid surgery
__Heart surgery
__Pacemaker
__Defibrillator
__Vein stripping
__Cancer surgery_____
__Gallbladder
__Appendectomy
__Bowel surgery
__Hernia repair
__Cosmetic surgery
__Hemorrhoid surgery
__Hysterectomy
__Tubal ligation
__Other female surgery_____
__Prostate surgery
__Other_____
__Other_____

Medications: Pharmacy name, location & phone number:_____

List all medications (including over-the-counter medication) that you were on prior to the accident (include dosage and frequency).

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

List new medications and medications discontinued since the accident.

_____ _____
_____ _____

Do you take any blood thinners such as Coumadin or Warafin? __No__Yes (describe)_____

Are you allergic to any medications? __No __Yes (name) _____

Have your ever had an allergic reaction to IV contrast dye or latex?__No__Yes (describe)_____

Patient Name:_____ Date:_____

Family Medical History:

Please list blood relatives in your immediate family (mother, father, siblings, grandparents, aunts and uncles) that have had the following conditions and list whether they are on mother's (maternal) side or father's (paternal) side of the family.

Cancer (who and what type) _____

Diabetes (who and what type)_____

Heart disease (heart attack, bypass surgery, angioplasty, sudden death) _____

Other diseases that run in the family: _____

Has anyone in your family had an adverse reaction to anesthesia? __Yes __No

Has anyone in your family had a history of alcoholism or drug addiction? __Yes __No

Social History:

Marital Status: __Married __ Widow __Single __Divorced/Separated

Occupation: _____

Do you or have you ever used tobacco? ___Yes ___No ___Quit? When?_____

Average amount used _____ /per day?

Do you drink alcohol? ___Yes ___No How much?_____

Do you use street drugs? ___Yes ___No (these may interact with medication we prescribe so we must know)

Do you have a previous history of alcohol or drug abuse? ___Yes ___No

Name: _____ Date: _____

Please check (√) any problems you currently have **TODAY** on the list below.

Constitutional
__ Chills
__ Fatigue
__ Fever
__ Weakness
__ Unexpected weight change
Gain or Loss (circle one)

Ophthalmologic (Eyes)
__ Change in vision

Head/Ears/Nose/Throat/Neck
__ Loss of hearing
__ Ringing in ears
__ Allergies
__ Nose bleeds
__ Mouth sores
__ Teeth pain

Respiratory
__ Cough
__ Trouble breathing
__ Wheezing

Thorax (chest/breast)
__ Breast lump/discharge

Cardiovascular
__ Chest pain/discomfort
__ Abnormal shortness of breath with exertion
__ Palpitations

Gastrointestinal
__ Abdominal pain
__ Blood in stool
__ Diarrhea
__ Nausea
__ Vomiting

Genitourinary
__ Discharge
__ Night time urination
__ Sexual difficulty
__ Urinary incontinence (leaking)
__ Vaginal bleeding

Skin
__ Rash
__ Suspicious moles

Neurological
__ Balance difficulty
__ Dizziness/Light-headedness
__ Headache
__ Memory loss
__ Tingling/Numbness

Psychiatric
__ Anxiety/Stress
__ Depression
__ Insomnia (trouble sleeping at night)

Other (please specify) _____

_____

_____
Patient Signature

I have reviewed this with the patient. Doctor Signature: _____

Health Screening Form
Physical Activity Readiness Questionnaire (PAR-Q)

Common sense is your best guide to answering these few questions. Please read them carefully and check the **YES** or **NO** box next to the question.

YES	NO	
[ ]	[ ]	Has your doctor ever told you that you have heart or lung problems?
[ ]	[ ]	Have you ever had any chest discomfort or pain?
[ ]	[ ]	Do you frequently feel any chest discomfort or pain?
[ ]	[ ]	Do you have episodes of fainting or near fainting?
[ ]	[ ]	Do you currently have a problem with high blood pressure?
[ ]	[ ]	Are you aware of any bone, back or joint disease that may be aggravated by exercise?
[ ]	[ ]	Do you have uncontrolled or poorly controlled lung disease or asthma that affects your ability to exercise?
[ ]	[ ]	Do you ever have episodes of labored breathing or difficult breathing during the night where you have to sit up to breath?
[ ]	[ ]	Have you ever been told by your doctor that you have diabetes?
[ ]	[ ]	Are you over age 65 and not involved in regular exercise?
[ ]	[ ]	Is there a good reason not mentioned here why you should not engage in exercise even if you wanted to? (for example: surgery in the past 6 months)
[ ]	[ ]	Are you pregnant or have you had a baby in the last 2 months?

If you answered YES to any of the questions above, please explain briefly:_____

_____

_____

_____

[ ] [ ] Do you have a regular physician? If so, what is the doctor's name?

_____

I hereby certify that the above information is correct. If patient is under the age of 18, a parent or guardian's signature is also required below.

_____	_____	_____
Patient Name	Signature	Date
_____	_____	_____
Parent or Guardian Name	Signature	Date

Medical Clearance Form

I hereby certify that, to the best of my knowledge, this person examined has no contraindications to participation in a musculoskeletal rehabilitative program unless list below.

Limitations or precautions: _____

_____

_____

Joseph W. Slattery III M.D.	_____	_____
Physician's Printed Name	Signature	Date

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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: _____ Patient's/Insured's Signature: _____ Date: _____

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

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.**

_____

_____

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**):*

Joseph W. Slattery III M.D.	_____	_____
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.

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P 321.952.9993 • F 321.952.9997 • InjuryCareClinic.com

FINANCIAL DISCLOSURE POLICY

As a result of the changes to the 2003 Florida No Fault Statute (PIP statute) it is a third degree felony for any health care provider to agree to waive a deductible or to reduce or waive your co-payment (if applicable) as a routine business practice.

We therefore require payment of all balances due, whether co-payments or deductibles, after all attempts by us (including litigation) to collect from the PIP carrier and the at fault driver's carrier have been exhausted.

Two exceptions are permitted under the law:

1. Reduction of the balance in conjunction with a personal injury settlement.
2. Documented financial hardship.

Please speak with our billing manager if you have any questions or if your visits to our facility are due to the negligence of another party.

_____ _____

Patient's Signature Date

INJURY CARE CLINIC

JOSEPH W. SLATTERY III, MD • MEDICAL DIRECTOR
Board Certified

630 S. Wickham Road • Suite 101 • W. Melbourne, FL 32904
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LETTER OF PROTECTION

Patient Name: _____ Date of Birth: _____

Date of Injury: _____

I authorize and direct my attorney to pay directly to Injury Care Clinic any and all sums due to it for services rendered to me and to withhold such sums owed Injury Care Clinic from any settlement or verdict as may be necessary to adequately protect Injury Care Clinic. I agree that Injury Care Clinic shall have a lien on any settlement or verdict in my favor until such sums owed the Injury Care Clinic are paid in full. Furthermore, I agree that Injury Care Clinic shall not be responsible and shall not pay any attorney fees, expenses or costs for any claim or action I may have or for the collection of any funds due to me from any third parties. I agree to have all my attorneys, whether current or retained in the future, execute this document and agree to be bound by the terms contained herein until Injury Care Clinic has received payment in full.

Notwithstanding anything to the contrary herein, I understand that I remain directly and fully responsible to Injury Care Clinic for all sums due. I expressly agree and understand that payment to Injury Care Clinic for all sums I owe is not contingent on any settlement or verdict that I may receive.

Should any dispute arise or breaches occur regarding this Letter of Protection all attorney fees and costs shall be paid by me.

Patient Signature: _____ **Date:** _____

The undersigned, being the attorney of the record for the above patient, does hereby agree to observe all the terms of the above agreement and agrees to withhold sums from any settlement or verdict regarding the above patient's claim or action and to notify any other attorney retained by the above patient of the terms or the agreement. Should undersigned representative fail to abide by this agreement, he/she shall be responsible for said payment. The undersigned acknowledges that Injury Care Clinic is not responsible and shall not pay any attorney fees, expenses or costs in connections with the patient's claim or action.

Attorney Signature: _____ **Date:** _____

Print Name: _____

Address: _____

Phone: _____ Fax: _____

Physician Signature: _____ **Date:** _____

PLEASE FAX TO: 321-952-9997

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MEDICAL RECORDS REQUEST

I,_____DOB:_____
give Injury Care Clinic permission to :

Please check one:

YOU NEED TO PROVIDE A FAX AND PHONE NUMBER!!!

_____: Release a copy of my medical records to _____

_____

_____: Request a copy of my medical records from _____

_____

The following medical records (Please check all that apply):

_____Office/Procedure/PT Notes _____Lab Results _____ MRI Reports _____X-ray Reports

_____Other_____

I am requesting a copy for the following purpose (Please check all that apply):

_____ Insurance Company, Auto/Health Insurance (Please circle)

_____ Another Physician, Please give name:_____

_____ My Attorney, Please give name: _____

_____ Personal use: (A Fee May Apply)

I understand that the information in my record may include sensitive information about behavioral or mental health service, treatment for alcohol and/or drug abuse. It may also contain information related to sexually transmitted disease, Acquired Immuno-Deficiency Syndrome (AIDS), and infection with Human Immunodeficiency Virus (HIV). I understand that any disclosure of this information carries with it the potential for re-disclosure and that the information then may not be protected by federal confidentiality rules. I accept full responsibility for the same; with the understanding they are a part of your permanent record. I have been informed that I have the right , and may exercise that right in writing at any time, to revoke this authorization otherwise this authorization will remain in effect until such time until I am no longer under the care of Injury Care Clinic.

_____ _____

Signature of Patient or Legal Representative Date

_____

If Signed by Legal Representative, Relationship to Patient

_____

Witness

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FAX TRANSMITTAL

Adjustor:_____

Fax: _____

I, _____, do hereby authorize

_____Insurance Company to release my auto coverage (benefits and deductible) information to Injury Care Clinic.

Printed Name: _____

Date: _____

Patient Signature: _____

Claim#:_____

DOI: _____

Please fax the requested information to **321-952-9997**
or call **321-952-9993**

Thank You –

Injury Care Clinic

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PRESCRIPTION AND PERSONAL HEALTH INFORMATION RELEASE AUTHORIZATION

I, _____, give permission for the following person to pick up prescriptions and/or any or my personal health information, to include super sensitive information on my behalf. I understand that no prescription will be released other than to the person listed below. This includes insurance and/or financial information about my account.

***Please Note: Person listed will be required to provide their driver's license for verification.**

I understand that the information in my record may include protected health information (PHI) regarding the following:

_____ Behavioral or Mental Health Services

_____ Treatment for alcohol and/or drug abuse

_____ Sexually transmitted diseases

_____ AIDS/HIV

Name: _____

Relationship: _____

Phone Number: _____

I acknowledge receipt of HIPAA and Privacy Practice Laws.

_____ _____

Patient Signature Date