ProSpine Orlando

DR MINEAUX SAUNDERS, D.C. DR CLEBERTON BASTOS, D.C.

General Information

Patient Name:_____Date of Birth:_____Age:_____Today's Date:_____

Sex: M ☐ F ☐ Address:_____City/State/Zip:_____

Home Phone:_____Work Phone:_____Cell Phone:_____

Are Text Reminders Ok: ☐Yes ☐ No Social Security #:_____

Email:_____Occupation:_____Employers Name:_____

Work Address:_____City/State/Zip:_____

Martial Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

How were you referred to ProSpine Orlando?_____

Previous Chiropractic Treatment? ☐Yes ☐ No Name of Previous Chiropractor:

Primary Care Physician: ☐Yes ☐ No Name of Primary Care Physician:

Phone Number of Primary Care Physician:_____

What type of care are you interested in? ☐ Pain Relief ☐Wellness ☐ Recovery ☐ Optimizing Your Health

What is Your Long Term Goal from Treatment (ex. play tennis):_____

Is Today's Visit Due to a: ☐Work Related Injury? ☐ Auto Accident ☐ Slip and Fall ☐ N/A

Date of Injury:_____

Insurance Information

Primary Insurance Carrier:_____Phone:_____

Claims Address:_____City:_____State: _____Zip:_____

ID Number: _____Group Number:_____

Insured: _____DOB:_____Relationship:_____

Emergency Contact Information

Name:_____Relationship:_____

Home Phone:_____Work Phone:_____Cell Phone:_____

Address:_____City:_____State: _____Zip:_____

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Present Health History

Major Complaint:_____

When Did Symptoms Begin:_____Have You had this Problem Before? ☐Yes ☐No

Was the onset: ☐ Gradual ☐ Sudden Since its Onset, has it gotten: ☐Worse ☐ Better

What aggravates this condition?_____What makes it better?_____

Have you seen another doctor for this complaint? ☐Yes ☐No Doctor's Name:_____

List all medications you are taking now, **including** over the counter / supplements:_____

Are you allergic to any medications? ☐Yes ☐No Explain:_____

Check the Activities Below That Cause You Difficulty and Pain:

☐Lying on Back	☐Getting In/out of Car	☐Pulling	☐Sitting	☐Prolonged Standing
☐Lying on Side	☐Dressing Self	☐Reaching	☐Forward Bending	☐Sneezing
☐Turning over in Bed	☐Sexual Activity	☐Kneeling	☐Backward Bending	☐Coughing
☐Lying Flat on Stomach	☐Pushing	☐Stooping	☐Walking	☐Other:

Past Health History

Do You or Have You Ever Had Any Problems With the Following Areas?

Eyes	☐Yes ☐No	_____
Ears, Nose, Throat	☐Yes ☐No	_____
Heart	☐Yes ☐No	_____
Lungs/Breathing	☐Yes ☐No	_____
Digestion/Bowels	☐Yes ☐No	_____
Urinary	☐Yes ☐No	_____
Allergies	☐Yes ☐No	_____
Skin	☐Yes ☐No	_____
Internal Organs	☐Yes ☐No	_____
Blood	☐Yes ☐No	_____
Joints/Bones	☐Yes ☐No	_____
Muscle Pain/Weakness	☐Yes ☐No	_____
Nerves	☐Yes ☐No	_____

Have you ever had any major illnesses, injuries, fractures, hospitalizations, or surgeries? ☐Yes ☐No

If yes, explain:_____

Date of occurrence:_____ **Females only** Date of last menstrual cycle:_____Pregnant: ☐Yes ☐No

Have you recently experienced dizziness, unexplained fatigue, weight loss or blood loss? ☐Yes ☐No

Have you ever had a stroke or issues with blood clotting? ☐Yes ☐No

Habits

☐Yes ☐No	Do You Exercise?	_____Times per week.
☐Yes ☐No	Do You Smoke?	_____Packs per day
☐Yes ☐No	Consume Alcohol?	☐Socially ☐Rarely ☐Daily
☐Yes ☐No	Consume Coffee?	_____Cups per day
☐Yes ☐No	Use Recreational Drugs?	If yes, explain:
☐Yes ☐No	Get Adequate Sleep?	If no, explain:
☐Yes ☐No	Stressed?	If yes, explain:
☐Yes ☐No	Do You Have Any Hobbies?	What are they?

Family History

	Which Family Member
Heart Disease	_____
Cancer	_____
Diabetes	_____
Stroke	_____
Other_____	_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years,

DO NOT SIGN UNTIL YOU HAVE REVIEWED NOTICE

(see attached HIPPA NOTICE OF PRIVACY PRACTICES)

_____	_____	_____
Patient Print Name	**Patient Signature**	**Date**

INFORMED CONSENT

I Hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various forms of physical therapy and diagnostic images and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as a back-up doctor of chiropractic named below. I understand, and I am informed that, as in the practice of medicine and like all other health modalities, results are not guaranteed and there is no promise of cure. I further understand and am informed that as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor exercise judgment during the course of procedures, which the doctor feels at the time, based upon the facts then known, is in my best interest. I further understand that there are treatment options available for my condition other than chiropractic procedures. I understand, and I have been informed that I have the right to a second opinion. I have read or had read the informed consent to treat, alternative treatment, and treatment results of a chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING. I have made my decision voluntarily and freely.

Patient Print Name	Patient Signature	Date

ASSIGNMENT OF INSURANCE INFORMATION AND BENEFITS

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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 Agreement 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 benefits, to obtain an explanation of benefits and to seek attorneys' fees and costs under Fla. Stat. 627.736, 627.428 and 57.041 from the insurer. This Assignment of Benefits includes, but is not limited to, the cost of medical care, transportation, medication, supplies, overdue interest and any potential claim for common law or statutory bad faith/unfair claims handling. If the 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 maximum amount of the policy benefits directly to the Health Care Provider without any reductions and without including the undersigned patient's/insured's name on the check. It is this Health Care Provider's contention that its charges are reasonable.

This Assignment of Benefits applies to past, present 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, including payment for services 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's/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 Independent Medical Examination report and/or peer review report pertaining to me, the undersigned patient/insured.

Disputes

The insurer is directed by the Health Care Provider and the undersigned patient/insured not to issue and 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 undersigned 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, issues 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 payment in full for the bills submitted. If the insurer asserts that is 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.

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 email, 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, IME's, peer reviews and MRIs from any 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 undersigned patient's/insured's medical records confidential. The insurer is not authorized to provide my, the undersigned patient's/insured's, medical records to anyone without my, the undersigned patient's/insured's and the Health Care Provider's express written permission.

Certification

I, the undersigned patient/insured certify that: I have read and agree to the above: I have not been solicited or promised anything in exchange for receiving health care from the above-stated Health Care Provider; I have not received any promises or guarantees from anyone as to 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 this document 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 the front desk personnel or the medical provider to explain it to you. If you sign below it will be understood that you understand and agree with the contents of this Assignment of Insurance Benefits.**

Patient/Insured Name:_____(If patient/insured is a minor, signature of parent/guardian)
(Please Print)

Patient/Insured Signature:_____Date:_____

Patient Print Name **Patient Signature** **Date**

RECORD RELEASE AUTHORIZATION

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION UNDER HIPAA 164.508

TO:_____
Doctor or Hospital

_____
Address

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE TO:

ProSpine Orlando
F:407-264-6865
Contact@ProsSpineOrlando.com

THE COMPLETE RECORDS AND X-RAYS IN YOUR POSSESSION CONCERNING THE PATIENTS ILLNESS AND/OR TREATMENT DURING THE PERIOD OF_____TO_____.

NAME:_____

DATE OF BIRTH:_____/_____/_____

SOCIAL SECURITY NUMBER:_____-_____-_____

ADDRESS: _____CITY:_____

STATE:_____ZIP:_____

SIGNATURE:_____DATE:_____/_____/_____

Please send the above patient's medical records, x-rays, MRI's, and all other tests as soon as possible, since it is necessary for the doctor to review them prior to the patient's next visit. Thank you.

This authorization will expire one year after the date signed. Your are authorized to accept a copy of this form in lieu of the original. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524.

All information transmitted hereby is intended only for the addressee named above. If the reader of this message is not the intended recipient or the employee or agent responsible for delivering the message to the intended recipient, please note that any distribution or copying of this communication is strictly prohibited. Anyone who received this communication in error should notify us immediately by telephone and return the original message to us at the above address by U.S. mail.

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IF CAREFULLY

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposed that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information : Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health care information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointments.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Disease: Health Oversight Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and Nation Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Departments of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500. Other Permitted and Required Uses and Disclosures will be made only with your consent. Authorization or Opportunity to object unless required by law. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the

authorization. Your Rights: Following is the statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information: Under federal law, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information: This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is n your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically. You may have the right to have your physician amend your protected health information. If we deny your request for an amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. ***We will not retaliate against you for filing a complaint.***

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 (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**):*

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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