Dr. Timothy Bortz, DC
3260 Murrell Rd. Suite 101
Rockledge, FL. 32955
(321) 631-1100
www.BrevardChiro.com

PATIENT NAME: _____TODAY'S DATE: __/__/___ DATE OF ACCIDENT: __/__/___

PATIENT INTAKE – AUTO INJURY

PERSONAL INFORMATION

First Name:_____ M.I._____ Last Name:_____ Preferred Name: _____

Address:_____ City:_____ State: _____Zip:_____

Birthdate:_____/_____/_____ Age_____ Gender: ☐ Male ☐ Female ☐ Unspecified SSN:_____/_____/_____

Primary Phone: _____ Cell Phone: _____ Work Phone: _____

Home Email: _____ Work Email:_____

By providing my email address, I authorize my doctor to contact me via the email address(es) provided.

Which email would you like us to use to communicate with you? (check one) ☐ Home ☐Work

Contact Method: (check one) ☐ Primary Phone ☐ Cell Phone ☐ Work Phone ☐ Home Email ☐ Work Email

Occupation: _____ Employer: _____

Drivers License #: _____

Spouse/Parents Name: _____ Spouse/Parents Occupation: _____

Spouse/Parents Employer: _____ Spouse/Parents Social Security #: _____

Spouse/Parents Work #: _____ Spouse/Parents Cell #: _____

Emergency Contact

Name: _____ Relation to You: _____

Home#: _____ Work #: _____ Cell #: _____

How Did You Hear About Us?

Please be as specific as possible so we can track how our patients FIRST heard about us!

☐BrevardChiro.com ☐BrevardDisc.com ☐Google ☐Drive-by ☐Email Blast ☐TV Commercial ☐Radio
☐Facebook ☐Yelp ☐Direct Mailer ☐YouTube ☐School ☐Work ☐Clinic Employee: _____
☐Magazine Ad:_____ ☐Newspaper:_____ ☐Referred by Friend:_____
☐Current Patient of Physician/NP ☐Other: _____

Attorney Information

If you do not have an attorney, leave this section blank.

Attorney's Name: _____ Name of Law Firm: _____

Attorney's Address: _____ City: _____ State: _____ Zip:_____

Attorney's Phone Number: _____ Email: _____

Brevard Chiropractic & INJURY CENTER

Date:	ID #:

INSURANCE OR PRIVATE PAY INFORMATION

Please provide insurance card(s) to receptionist.

Type of Insurance: ☐ Private Ins. ☐ Medicare ☐ Auto Ins. ☐ Worker's Comp ☐ Other________________________________

Primary Insurance Carrier: ____ Phone: ________________________________

Policy#_____________________________ Group #___________________________ Claim#_________________________________

Name of Policy Holder: ____ Relationship to Patient: _________________________

Policy Holder's Birthdate: ______/_____/______ Policy Holder's SSN: ______/____/______ Employer: _______________________

Is patient covered by another insurance? ☐ Yes ☐ No

Type of Insurance: ☐ Private Ins. ☐ Medicare ☐ Auto Ins. ☐ Worker's Comp ☐ Other________________________________

Secondary Insurance Carrier: ____ Phone: ________________________________

Policy#_____________________________ Group #___________________________ Claim#_________________________________

Name of Policy Holder: ____ Relationship to Patient: _________________________

Policy Holder's Birthdate: ______/_____/______ Policy Holder's SSN: ______/____/______ Employer: _______________________

Reason for today's visit: ____

Is this condition due to an accident? ☐ Yes ☐ No Date of Accident: ____

Type of Accident ☐ Auto ☐ Work ☐ Home ☐ Other ____

To whom have you made a report of your accident? ☐ Auto Insurance ☐ Employer ☐ Worker Compensation ☐ Other

Do you have an attorney? ☐Yes ☐No If So, Name and Number____

Auto Insurance PIP Information

Name of Insurance Company: ____

Name of Insured: ____

Claim#: ____

Name of Adjuster and Phone Number: ____

ASSIGNMENT/AUTHORIZATION/RELEASE:

I certify that I, and/or my dependents, have insurance with the above named insurance company(s) and assign directly to Brevard Chiropractic & Injury Center all benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. I understand that "co pays" are payable at the time of each visit and that I am financially responsible for all charges whether or not paid by insurance. The above named provider's office may use my health care information and may disclose such information to the above named insurance company(s) and their agents for the purpose of obtaining payment for services and determining benefits payable for related services.

☐ **Private Pay/Cash:** By checking this box, I acknowledge that I do not have insurance and understand that I am financially responsible for all services at the time they are rendered.

____ ____

Name of Person Responsible For This Account Relationship to Patient

X ____ ____

Responsible Party Signature Date

Motor Vehicle Collision Form

Report of Accident

Brevard Chiropractic & Injury Center
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Name: _____ DOB: _____ Today's Date: _____

Date of Accident: _____ Time of Accident: _____❑ A.M. ❑ P.M. City of Accident: _____

Street of Accident that your car was on: _____ Cross Street (intersection): _____

Road conditions at the time of incident: ❑ Wet ❑ Dry ❑Other **Visibility at time of crash:** ❑ Poor ❑ Fair ❑ Good ❑ Other

Weather conditions: ❑ Clear ❑ Rainy ❑ Other **Light conditions:** ❑ Sunny/Bright ❑ Overcast/Cloudy ❑ Twilight ❑ Dark

Road Type: ❑ Concrete ❑Asphalt ❑ Gravel ❑ Dirt ❑ Other **Were there any witnesses?** ❑ Yes ❑ No

Type of accident: ❑ Head-on ❑ Broadside ❑ Front impact ❑ Rear-ended car in front ❑ Rear impact ❑ Non collision

Were you wearing your seat belt? ❑ Yes ❑ No **Were shoulder harnesses worn?** ❑ Yes ❑ No

Did the police come to the scene of the accident? ❑ Yes ❑ No **Was an accident report filed?** ❑ Yes ❑ No

If a traffic violation was issued, to whom was it issued? _____

Please explain the details of the accident to the best of your knowledge: _____

_____

_____

The following questions pertain to you, the patient, and the vehicle you were in:

Number of people in accident vehicle: _____

Where were you seated? ❑ Mid front ❑ Left front ❑ Right front ❑ Left rear ❑ Mid rear ❑ Right rear

Were you: ❑ aware of the approaching collision or ❑ surprised by impact? Did you brace for impact? ❑ Yes ❑ No

Were you rendered unconscious? ❑ Yes ❑ No If yes, for how long? _____

At the time of the crash, recall what parts of your head or body struck what parts inside the car: _____

_____

In relation to the base of your skull, where was the headrest? ❑ Above ❑ Below ❑ At base of skull

Head/Body position at the time of impact: ❑ Head turned left/right ❑ Head looking back ❑ Head straight forward ❑ Body straight in sitting position ❑ Body rotated right/left ❑ Other:_____

Was this vehicle equipped with airbags? ❑ Yes ❑ No If yes, did it/they inflate? ❑ Yes ❑ No If yes, were you struck? ❑ Yes ❑ No

What did your vehicle impact? ❑ Another Vehicle ❑Other

Vehicle Information & velocity pertaining to the vehicle you were in:

Who owns the car you were in? _____

Vehicle Year: _____ Make: _____Model: _____ Transmission type ❑ Manual ❑ Auto

What direction was your vehicle traveling? ❑North ❑South ❑East ❑West

Was your car ❑ Moving or ❑Stopped If your car was moving: How fast were you traveling? Approximately _____MPH

Just before impact, the vehicle you were in was:

❑ Slowing down ❑ Speeding Up ❑ Constant Speed ❑ Stopped

Did the impact to your vehicle come from the:

❑ Front ❑Rear ❑ Right Side❑ Left Side ❑ Other _____

The following questions pertain to the other vehicle involved in the accident:

Other Vehicle Year: _____Make: _____ Model: _____ Transmission type ❑ Manual ❑ Auto

What direction was the other vehicle traveling? ❑North ❑South ❑East ❑West

Was the other car ❑ Moving or ❑Stopped *If the other car was moving*: How fast was it traveling? Approximately _____MPH

Just before impact, the other car was: ❑Slowing down ❑Speeding Up ❑Constant Speed

Motor Vehicle Collision Form

Report of Accident

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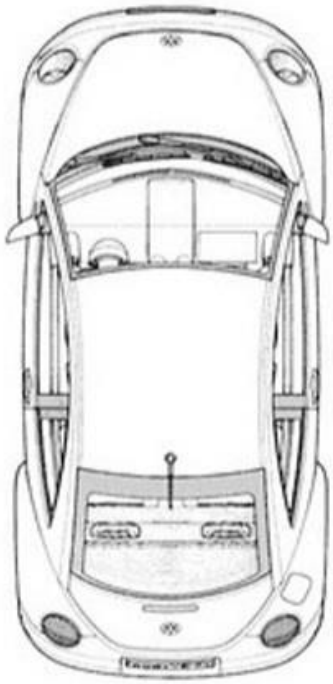
Indicate where the initial impact struck your vehicle by marking an "X" on the diagram below:



I was traveling N S E W (circle one) on _____ (name of road) when: _____

_____

_____

Illustrate below how the accident happened:

Were there bleeding cuts caused by the accident? ❑ Yes ❑ No Where: _____

Where there any bruises caused by the accident? ❑ Yes ❑ No Where: _____

If any part of your body struck anything during the collision please describe what and where: _____

What were the cost of damages to the vehicle you were in? $ _____

Was the trunk of your body pointed straight forward at the time of impact? ❑ Yes ❑ No

If No, which direction was it pointed, and by how much? _____

Were you wearing a hat or glasses? ❑ Yes ❑ No If yes, still on after crash? ❑ Yes ❑ No

Could you move all parts of your body? ❑ Yes ❑ No If no, what parts couldn't you move and why? _____

_____

Were you able to get out of the car and walk unaided? ❑ Yes ❑ No If no, why? _____

Please describe how you felt:

Immediately after the crash: ❑ Dazed ❑ Confused ❑ Shaken ❑ Uncontrolled feelings ❑ Other

Later that day: ❑ Sore ❑ Stiff ❑ Little pain ❑ Moderate pain ❑ Severe pain

The next day: ❑ Better ❑ Same ❑ Worse ❑ Much worse ❑ Intolerable pain

If you have been involved in previous auto accidents, please list the year of each incident: _____

Please list any additional information not covered above that we should know about: _____

_____

Motor Vehicle Collision Form

Report of Accident

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Insurance Information

Name of Insurance Company: _____ Telephone #: _____

Address: _____ City: _____ State: _____ Zip: _____

Insured's Name: _____ Insured's SS #: _____

DOB: _____ Insured's Employer: _____

Policy #: _____ Claim #: _____

Name of Claim Representative: _____ Telephone #: _____

Attorney Information

Name of Attorney/Law Office: _____

Telephone #: _____ Address of Attorney: _____

City: _____ State: _____ Zip: _____

Medical Care

Have you gone to a Hospital or seen any other Doctor? ❑ Yes ❑ No When did you go? ❑ Just after accident ❑ Next Day

Mode of Transportation: ❑ Ambulance ❑ Privately transported Other: _____

Name of Hospital and/or Attending Doctor: _____

Was he/she a: ❑ D.C. ❑ M.D. ❑ D.O. ❑ D.D.S. ❑ P.A.

Were X-Rays taken? ❑ Yes ❑ No If yes, what was X-Rayed: _____

Was medication prescribed? ❑ Yes ❑ No Describe any treatment you received: _____

Work

To evaluate the effect that continuing work will have on your recovery please complete the following: Have you been able to work since the injury? ❑ Yes ❑ No Are your work activities restricted as a result of your injuries sustained? ❑ Yes ❑ No

How many hours are in your normal work day? _____

What can you do for work with minimum physical effort and for how long? _____ ❑ N/A

Prior to the injury were you capable of working on an equal basis with others your age? ❑ Yes ❑ No ❑ N/A

While in recovery, is there any light duty work you could request? ❑ Yes ❑ No ❑ N/A

Please indicate your daily job duties and any activities in which you are occasionally asked to perform:

❑ Standing ❑ Sitting ❑ Walking ❑ Lifting ❑ Driving ❑ Twisting ❑ Crawling ❑ Bending

❑ Operating equipment ❑ Working with arms above head ❑ Typing ❑ Stooping ❑ Other: _____

Complaint(s)/Pain Location(s)

❑ Dizziness	❑ Migraines	❑ Shortness of breath
❑ Memory Loss	❑ Headaches	❑ Upper back → ❑ pain ❑ stiffness
❑ Blurred vision	❑ Neck → ❑ pain ❑ stiffness	❑ Mid back → ❑ pain ❑ stiffness
❑ Chest pain	❑ Jaw problems	❑ Lower pain → ❑ pain ❑ stiffness
❑ Difficulty sleeping	❑ Arm pain ❑ Left ❑ Right ❑ Both	❑ Leg pain → ❑ Left ❑ Right ❑ Both
❑ Fatigue	❑ Shoulder pain → ❑ Left ❑ Right ❑ Both	❑ Numb Feet/Toes → ❑ Left ❑ Right ❑ Both
❑ Irritability	❑ Ringing/Buzzing in ear→ ❑ Left ❑ Right ❑ Both	❑ Other:
❑ Stomach Upset	❑ Shortness of Breath	
❑ Tension	❑ Nausea	

Motor Vehicle Collision Form

Report of Accident

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Patient Current Condition and Pain Form

Name: _____ **Date:** _____

Complaint/Pain Location(s) (example: neck, shoulders, upper back, mid-back, low-back, hips, extremities):

_____

What previous care/treatment have you received for your condition?

☐Physical Therapy ☐Chiropractic ☐Medication ☐Surgery ☐None ☐Other _____

Usual Pain Intensity

No pain 0 1 2 3 4 5 6 7 8 9 10 Severe pain

Today's Pain Intensity

No pain 0 1 2 3 4 5 6 7 8 9 10 Severe pain

Please list any recent falls and/or injuries:

What have you tried to help alleviate your condition?

Please fill out this portion based on your current condition.

Date of Injury/Onset:_____

How would you describe the character of your condition/pain? (please check all that apply)

☐Sharp ☐Dull ☐Tingling ☐Numb
☐Aching ☐Shooting ☐Radiating ☐Burning
☐Throbbing ☐Cramping ☐Stiffness ☐Swelling
☐Other _____

How often do you experience your symptoms?

☐ Constantly (76%-100% of the time)
☐ Frequently (51%-75% of the time)
☐ Occasionally (26%-50% of the time)

When do you experience your symptoms?

_____

	Comfortable	Uncomfortable	Painful
Lying down	☐	☐	☐
Sitting	☐	☐	☐
Standing	☐	☐	☐
Stretching	☐	☐	☐
Walking	☐	☐	☐
Running	☐	☐	☐
Bending	☐	☐	☐
Lifting	☐	☐	☐
Kneeling	☐	☐	☐
Pulling	☐	☐	☐
Reaching	☐	☐	☐
Standing from a seated position	☐	☐	☐

Additional Comments:

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Motor Vehicle Collision Form

Report of Accident

A. Date of last: Spinal Exam: _____ Bone Scan: _____

Spinal X-Ray: _____ MRI: _____

Chest X-Ray: _____ CT Scan: _____

Medical Doctor: _____ Previous Chiropractor: _____

Physical Therapist: _____ Massage Therapist: _____

B. Injuries, Traumas, and Illnesses

Broken Bones/Fractures: _____ Head Injuries: _____

Dislocations: _____ Falls: _____

Please check the box to indicate if you have or have had any of the following:

❑ AIDS/HIV	❑ Cancer	❑ Gout	❑ High Cholesterol	❑ Neuropathy	❑ Prosthesis
❑ Alcoholism	❑ Chemical Dependency	❑ Heart Disease	❑ Kidney Disease	❑ Osteoporosis	❑ Psychiatric Care
❑ Arthritis	❑ Diabetes	❑ Hernia	❑ Liver Disease	❑ Pace Maker	❑ Rheumatoid Arthritis
❑ Asthma	❑ Epilepsy	❑ Herniated Disc	❑ Migraines	❑ Parkinson's Disease	❑ Stroke
❑ Bleeding Disorders	❑ Goiter	❑ High Blood Pressure	❑ Multiple Sclerosis	❑ Pinched Nerve	❑ Thyroid Problems

Please list any other illnesses or injuries: _____

C. Surgeries:

Type of Surgery	Date	Surgeon/Hospital

D. Current Medications: (if certain attributes of your medication(s) are unknown, please write unknown)

Medications or Vitamins/Herbs/Minerals	Dosage (mg)	Frequency	Prescribing Doctor
☐ No Current Medications			

E. Females – Pregnancy:

Are you currently pregnant? ☐No ☐Yes Due Date : _____

Patient/Guardian Signature: _____ Date: _____

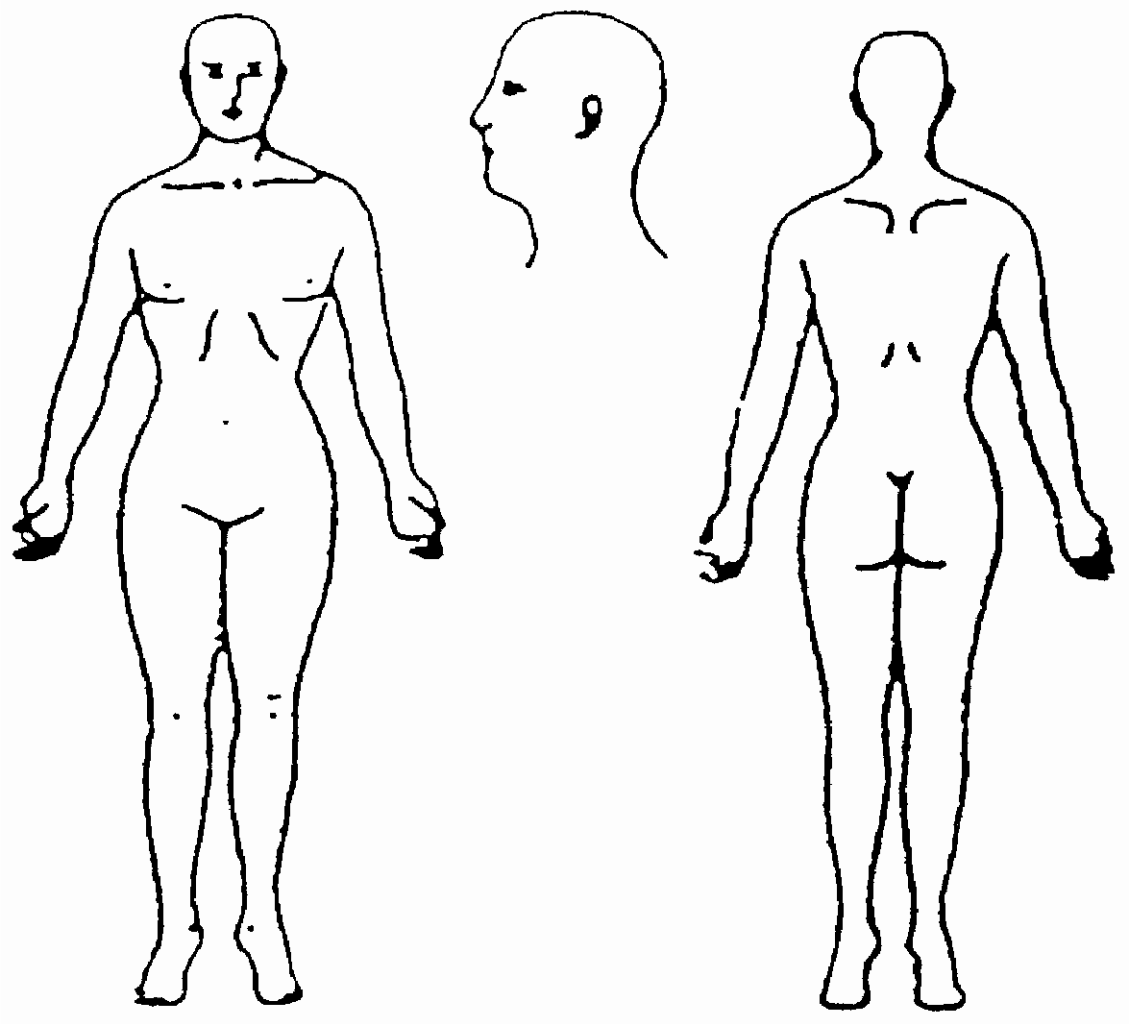
Patient/Guardian Printed Name: _____

SYMPTOM DIAGRAM

Name _____ Number _____ Date _____

Please be sure to fill this form out extremely accurately. Mark the area(s) on your body where you feel the described sensation(s). Use the appropriate symbol(s). Mark areas of radiating pain, and include all affected areas. You may draw on the face as well.

Aches ΛΛΛΛ Numbness oooo Pins/Needles ●●●● Burning xxxx Stabbing ////



Reference: Randsford. Spine, Vol. 1, No 2, June 1976

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Directions: *This questionnaire has been designed to give the doctor information as to how your pain has affected your ability to manage in everyday life. Please check one item in each section that most closely applies to you.*

INJURY HISTORY

Section 1. Pain Intensity

□ I can tolerate the pain I have without using painkillers.
□ The pain is bad but I manage without taking painkiller
□ Painkillers give no relief from pain and I do not use them.
□ Painkillers give complete relief from pain.
□ Painkillers give moderate relief from pain.
□ Painkillers give very little relief from pain.

Section 2. Personal care (washing, dressing, etc.)

□ I can look after myself normally without causing extra pain.
□ I can look after myself normally but it causes extra pain.
□ It is painful to look after myself and I am slow and careful.
□ I need some help but manage most of my personal care.
□ I need help every day in most aspects of self-care.
□ I do not get dressed, wash with difficulty, and stay in bed.

Section 3. Lifting

□ I can lift heavy weights without extra pain.
□ I can lift heavy weights but it causes extra pain, but I can manage if they are conveniently positioned (on a table).
□ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
□ I can only lift very light weights.
□ I cannot lift or carry anything at all.

Section 4. Walking

□ Pain does not prevent me from walking any distance.
□ Pain prevents me from walking more than one mile.
□ Pain prevents me from walking more than ½ mile.
□ Pain prevents me from walking more than ¼ mile.
□ I can only walk using a cane or crutches.
□ I am in bed most of the time and have to crawl to the toilet.

Section 5. Sitting

□ I can sit in any chair as long as I like.
□ I can only sit in my favorite chair as long as I like.
□ Pain prevents me from sitting for more than one hour.
□ Pain prevents me from sitting for more than 30 minutes.
□ Pain prevents me from sitting for more than 10 minutes.
□ Pain prevents me from sitting at all.

Section 6. Standing

□ I can stand as long as I like without extra pain.
□ I can stand as long as I want but it causes extra pain.
□ Pain prevents me from standing for more than one hour.
□ Pain prevents me from standing for more than 30 minutes.
□ Pain prevents me from standing for more than 10 minutes.
□ Pain prevents me from standing at all.

Section 7. Sleeping

□ Pain does not prevent me from sleeping well.
□ I can sleep well only by using tablets.
□ Even when I take tablets I have less than 6 hours sleep.
□ Even when I take tablets I have less than 4 hours sleep.
□ Even when I take tablets I have less than 2 hours sleep.
□ Pain prevents me from sleeping at all.

Section 8. Sex Life

□ My sex life is normal and causes no extra pain.
□ My sex life is normal and causes some extra pain.
□ My sex life is nearly normal but is very painful.
□ My sex life is severely restricted by pain.
□ My sex life is nearly absent because of pain.
□ Pain prevents any sex life at all.

Section 9. Social Life

□ My social life is normal and gives me no extra pain.
□ My social life is normal but increase the degree of pain.
□ Pain has no significant effect on my social life apart from limiting my more energetic interests.
□ Pain has restricted my social life and I do not go out as often.
□ Pain has restricted my social life to my home.
□ I have no social life because of pain.

Section 10. Traveling

□ I can travel anywhere without extra pain.
□ I can travel anywhere but it gives me extra pain.
□ Pain is bad but I manage journeys over 2 hours.
□ Pain restricts me to journeys of less than one hour.
□ Pain restricts me to short necessary trips under a half hour.
□ Pain restricts me from traveling except to the doctor or hospital.

Informed Consent to Chiropractic Adjustments and Care

I have been informed that it is not uncommon for patients to have some increased discomfort after an adjustment. If that happens, I will apply ice to the area and rest it. If I am concerned about the discomfort or develop any new symptoms, I can call the office and speak to the staff. If I am out of town or unable to contact the doctor, I can present myself to the emergency room.

If any test were performed outside of this office (laboratory or other diagnostic procedures) I understand the doctor will notify me of the results at my next scheduled appointment or when the reports are available.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various methods of physical therapy and if necessary, diagnostic x-rays, on me by the doctor of chiropractic in this office and or anyone working in this clinic authorized by the doctor of chiropractic.

I further understand and have been informed that, as in all health care, in the practice of chiropractic there are some very slight risks to treatment, including, but not limited to muscle strains and sprains. I do not expect the doctor to be able to anticipate and explain all the risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time based upon the facts then known, is in my best interests.

I have read the above consent, and by signing below, I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition for which I seek treatment.

_____ _____

Patient Date

_____ _____

Parent or Guardian Date

_____ _____

Witness Date

X-RAY/MEDICAL RELEASE/INSURANCE INFORMATION:

I hereby authorize that all medical records, x-rays and any other pertinent medical information be released to Brevard Chiropractic & Injury Center. Also to disclose all insurance coverage for treatment provided herein.

_____ _____

Patient Signature Social Security #

Brevard Chiropractic & Injury Center
Timothy Bortz, D.C.
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IRREVOCABLE DOCTORS LIEN

To: Attorney or Insurance Carrier _____

My Patient/Your Client: _____

Date of Accident: _____

I hereby authorize Brevard Chiropractic & Injury Center to furnish you, my attorney/insurance carrier, with a full report of their examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was involved.

I hereby authorize and direct you, my attorney/insurance carrier to pay directly to said doctor such sums as may be due and owing him/her office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor. I hereby further give a lien on my case to said doctor against any and all proceeds of any settlement, judgment or verdict which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated or injuries in connection therewith. In the event that a dispute may arise out of the terms of agreement and requires BCIC to hire an attorney, the patient shall be responsible for payment of all attorneys' fees and all costs that are incurred in enforcing the agreement.

I fully understand that I am directly responsible to said doctor for all professional bills submitted by him/her for services rendered to me and that this agreement is made solely for said doctor's additional protection and in consideration of him/her awaiting payment.

Patient Signature_____ Date _____

ASSIGNMENT OF NO-FAULT INSURANCE BENEFITS

I hereby authorize, direct and demand that my personal injury protection insurance pay directly to my assignee **Brevard Chiropractic & Injury Center 3260 Murrell Road, Suite 101 Rockledge, FL. 32955** such sums as my be due and owing in this office for services rendered to me, both by reason of accident or illness and by reason of any other bills that are due this office, and to withhold such sums from any disability benefits, medical payment benefits, no-fault benefits, health and accident benefits, worker's compensation 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 office. I hereby further give a lien to said office 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 said office. This is to act as an assignment of all my rights, benefiting and privileges under my insurance policy to my assignees for any and all amounts owed.

I hereby assign and transfer to this my assignee/health care provider any and all causes of action that I may have or that might exist in my favor against my insurance company and authorize this office to prosecute said cause of action either in my name or in the office's name, and further I authorize this office to compromise, settle or otherwise resolve said claim or cause of action as they see fit.

I authorize the office to release pursuant to Privacy Rule, 45C.F.R. parts 160 and 164 promulgated pursuant to the HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 ("HIPAA"), Pub. L. No. 104-191, 110 Stat. 1936 (1996), any information including, but not limited to, medical records, insurance information or documents otherwise pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under this assignment.

Patient Signature_____ Date _____

DIRECT PAYMENT AUTHORIZATION WITHOUT ASSIGNMENT OF BENEFITS

By way of original or a copy hereof, I _____, the undersigned patient, hereby direct my applicable personal injury protection and/or medical payments insurance carrier to make payment directly to the undersigned medical provider for services and/or supplies rendered to me by said medical provider which were necessitated by a motor vehicle accident occurring on _____.

Additionally, I hereby authorize and direct my applicable personal injury protection and/or medical payments insurance carrier to make any and all checks or drafts payable to the undersigned medical provider only and to forward same to the undersigned medical provider's place of business.

This authorization for direct payment should not be deemed as assignment of benefits in that I, the patient, retain all rights to enforce my applicable insurance contact. Furthermore, this Direct Payment Authorization without Assignment of Benefits transfers no right, title, or interest in said contract other than the right to receive direct payment as specified hereinabove.

Prior authorizations for payment or assignments for PIP benefits to the undersigned medical provider, if any, are hereby cancelled and replaced by the Direct Payment Authorization without Assignment of Benefits as of the date shown above.

_____ _____

Patient Signature Date

_____ _____

Medical Provider Date

Brevard Chiropractic & Injury Center
Timothy Bortz, D.C.
3260 Murrell Road, Suite 101
Rockledge, FL. 32955
(321) 631-1100

HIPAA NOTICE OF PRIVACY PRACTICES - FINANCIAL POLICY – MINOR CONSENT
Brevard Chiropractic & Injury Center

Patient Name: _____ Date: _____

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), commonly known as "HIPAA" is a Federal program that requires all medical records and other individually identifiable health information used or disclosed by us, in any form, whether electrically, on paper or orally, is kept properly confidential. The act gives you, the patient, significant rights and control over your health information. This notice describe certain obligations we have regarding ways in which we may use and disclose health information about you, it also outlines your rights to the health information we keep about you.

We understand that information about you and your health is personal and are committed to your privacy. We create a record of the care and services you receive. We need this record to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of the records of your care generated by this office, whether made by your personal doctor, others working in the office, or associates processing billing and your insurance claims.

We are required by law to:

- Make sure that health information that identifies you is kept private.
- Give you this Notice of our legal duties and privacy practices with respect to health information about you.
- Follow the terms of the Notice that is currently in effect.

A partial list of how we may use and disclose Health Information about you:

- For Treatment, payment, health care and business operations of this office.
- As required by Law, Law enforcement, lawsuits and disputes; protect public safety or assist apprehending criminals.
- Military or Veteran's and Workers Compensation.
- Public Health Risks; Coroners, health examiners and funeral directors.
- To government authorities to prevent child abuse or domestic violence; to avert a serious threat to health and safety
- National security and intelligence activities.
- Security Officials for Inmates:
- To government agencies for audits, investigations and other oversight activities.
- For certain limited research purposes.
- The practice maintains patient sign-in sheets that are visible and accessible to patients, staff and others who may enter this office.

As our patient, your rights regarding Health Information about you:

- Right to Inspect and copy.
- Right to Amend.
- Right to Request Restrictions.
- Right to Request Confidential Communication.
- Right to Accounting Disclosures.
- Right to a Paper copy of this Notice (full Notice is available upon request)

Changes to this Notice: We reserve the right to change this Notice. We will post a copy of a current notice in our facility with the current effective date on the first page.

Complaints: If you believe that your privacy rights have been violates, you may file a complaint with us. All complaints must be in writing. Please contact the administrator at the location where you were treated to file a complaint.

Acknowledgement of Receipt of HIPPA Notice of Privacy Practices:
I acknowledge that I was provided a copy of the Notice of Privacy Practices and have read (or had the opportunity to read if I chose) and understood the Notice. This notice is considered effective dates signed, and shall remain effective for a minimum of 6 years, unless otherwise revoked, in writing, by patient.

Unless you request otherwise, we may use or disclose health information to a family member or other personal representative to the extent necessary to help you with your healthcare or payment for your health care. In addition, we may use your confidential information to remind you of appointments, phone, email, postal service or other method requested by you.

Additional Disclosure Authority: In addition to the allowable disclosures described in the State of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to persons indicated as follows:

Name	Relationship
Name	Relationship

HIPAA NOTICE OF PRIVACY PRACTICES - FINANCIAL POLICY – MINOR CONSENT
Brevard Chiropractic & Injury Center

Patient Name: _____ Date: _____

Financial Policy:

Full payment is expected at the time of service. Payments accepted are cash, check or credit card.

IF you have insurance, we will make a copy of your card and collect any co-pay or co-insurance that is due. As a courtesy, our office will contact your insurance company to obtain a benefit quote. If there is a balance after your insurance processes the claim, we will forward you a statement. Insurance coverage varies greatly, if you have questions, feel free to contact our office and we will do our best to assist you. Please be aware that some insurance plans require pre-certification for care. Care will commence once approval has been obtained.

As a courtesy to our patients we will provide a copy of your medical records at a cost according to Florida Statutes and per written request. Additionally, should you or your insurance company require forms or information, this office reserves the right to charge for time spent in preparation of those forms or requested medical information. It is your responsibility to make sure your insurance company is paying this office. Although this office may bill your insurance carrier for services rendered, all charges for services rendered are the patients' responsibility.

We will notify you as soon as we know of any difficulties we are having collecting monies from your insurance carrier. Should difficulties arise, you may need to contact your insurance company. If our office determines that your insurance carrier will reimburse you directly and not pay our office, you will be required to pay in full for all services at the time they are rendered. Our office makes every attempt to correspond with insurance carriers to assist them in correctly paying your claims.

All patients who have insurance, no matter the type it is, are required to pay co-payments, deductibles and/or percentages required each visit. If our office is a non-participating provider with the insurance company you have, we will gladly file those claims for you but you will be responsible for payment at the time service is rendered. If you are a Medicaid enrollee, your eligibility status must be verified each month. If your eligibility is terminated, you become responsible for services rendered. If you have been injured on the job, you must have authorization for care from the Worker's Compensation Insurance Company before an appointment or treatment can be rendered by our office. Your employer will assist you in securing that information.

Brevard Chiropractic & Injury Center also accepts Personal Injury Protection claims resulting from motor vehicle accidents and Workers Compensation claims to treat injured workers. Prior approval must be obtained with these cases before care can commence. You will also be required to complete an "Accident Form" in addition to the regular "Intake Forms" Brevard Chiropractic & Injury is also a provider for Medicare. You will be required to read and sign the separate Medicare policy documentation.

By signing below, I agree to the following: "I have read and understand "HIPPA Notice of Privacy Practices" &"Financial Policy" I understand that health and accident insurance policies are an agreement between and insurance carrier and me. I authorize payment from my insurance carrier directly to this office and with the understanding that all monies be credited to my account upon receipt. I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. We will require you to honor the financial agreements you make with our office. If you find that you cannot fulfill the agreement you have made with us, please advise our financial department immediately so new arrangements can be made. Any insurance checks sent to your home should be brought or sent to our office within three (3) days with Explanation of Benefits (stub/statement) to indicate which services were paid.

**Our office will submit your insurance claims for you as a courtesy. However, your insurance is an agreement between you and your carrier, not between your insurance company and this office.

Patients without insurance are expected to pay in full at the time services are rendered, unless other arrangements have been made with our financial department

Patient Signature: _____ Date: _____

Consent to Treatment of Minors:

By my signature below, I consent to any x-ray, examination, and chiropractic or rehabilitative diagnosis or treatment, which is deemed advisable by a licensed chiropractor, be rendered under the general of special supervision of any licensed chiropractor or trained professionals at Brevard Chiropractic & Injury Center.

Patient/Guardian Signature: _____ Date: _____

Patient/Guardian Printed Name: _____

Relation to Minor: _____

AGREEMENT WITH MEDICAL SERVICE PROVIDER

I, _____, HEREBY, authorize my attorney to pay the proceeds of any net recovery all outstanding amounts owed to BREVARD CHIROPRACTIC & INJURY CENTER, for medical care or services. I agree that I am responsible to the above-named health care provider for the payment of all services rendered to me, regardless of the outcome of my case. My attorney is authorized to protect medical bills and expenses accrued. My attorney in no way accepts any direct or personal liability for any medical bills, expenses, or the payment of amounts owed to any health care provider. Any request by my attorney for any information or services are made on my behalf and are owed by me and in no way are the obligation of my attorney other than the withholding of suns from my recovery.

_____ _____
Patient Signature Date

_____
Patient Printed Name

_____
Treating Physician Signature

_____
Treating Physician Printed Name

The undersigned attorney for the above patient agrees with the assignment and authorization. Any outstanding amounts, at the time of recovery, will be protected to the extent of the remaining recovery funds. No additional or excess amounts shall be protected or paid unless a separate written agreement is entered into. This protection agreement is valid only so long as the treating healthcare provider strictly complies with the terms above and withholds any collection efforts and does not report any adverse credit information on the above patient.

_____ _____
Attorney Signature Date

_____
Attorney Printed Name

Brevard Chiropractic & Injury Center
Timothy Bortz, D.C.
3260 Murrell Road, Suite 101
Rockledge, Florida 32955
(321) 631-1100

CONSENT TO PARTICIPATE IN TELEMEDICINE CONSULTATION

Consultant: Andrew Akerman, M.D. Florida License: ME 93824

Patient's Name:_____ Medical Record No: _____

1. I understand that my healthcare provider, ***Timothy Bortz, D.C.,*** wishes me to engage in a telemedicine consultation with Andrew Akerman, M.D.

2. My health care provider has explained to me how the video conferencing technology will be used to affect such a consultation. I understand that this consultation will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.

3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my health care provider(s) or myself can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.

4. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my health care provider and consulting health care provider in order to operate the video equipment. The above mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine examination room; and/or (3) terminate the consultation at any time.

5. I have had the alternatives to a telemedicine consultation explained to me, and in choosing to participate in a telemedicine consultation I understand that some parts of the exam involving physical tests may be conducted by individuals at my location at the direction of the consulting health care provider.

6. In an emergency consultation, I understand that the responsibility of the telemedicine consulting specialist is to advise my local practitioner, and that the specialist's responsibility will conclude upon termination of the video conference connection.

7. I understand that billing will occur from both my practitioner and as a facility fee from the site from which I am presented.

8. I have read this document carefully, and understand the risks and benefits of the teleconferencing consultation and have had my questions regarding the procedure explained and I hereby consent to participate in a telemedicine visit under the terms described herein.

9. I understand that there will be no videotaping or recording of any materials, unless additional written consent is given. Recording of the medical examination is typically not required, and no recording will be done for the express purpose of maintaining confidentiality and patient privacy.

_____ _____

Patient/Parent/Guardian Signature Date and Time

_____ _____

Witness Signature Date and Time