NEW PATIENT INFORMATION

***NOTE: If this is a Workers' Compensation or Auto Accident Case, please tell Receptionist NOW before you start this form. ***

Date: _____ **Name:** _____
Permanent Address: _____
City: _____ **State:** _____ **Zip:** _____
***If here from out of town*: Local Address:** _____
Phones: Daytime _____ **Cell** _____ **Email** _____
Birth Date: Mo _____ **Day** ____ **Yr** _____ **Sex:** ____ **SS#** _____
Married: _____ **# of Children:** _____ **Spouse Name:** _____
Business/Employer: _____ **Type of Work:** _____
Have you been treated here before? Yes _ No _ If so, when? _____
How did you find out about us? _____
(If referred by someone, please give us their name so we can thank them!)

MAJOR COMPLAINT: _____
Previous Chiropractic Care: _____
(Doctor's Name, Location, Last seen?)
Other Doctors seen for this condition: _____
Medications currently taking: Prescribed _____
Over the counter _____
Vitamins currently taking: Regularly _____
Occasionally: _____

Intake	How much, How often	Intake	How much, How often
Cigarettes		**Coffee**	
Alcohol		**Tea**	
Sugar		**Drugs**	
Water		**Exercise**	

FEMALES ONLY: Are you pregnant? Yes __ No __ Unsure __ Date of last period _____
Any other condition you have or symptom you are being treated for or that the doctor should know about? _____
_____

Medical Insurance Company name: _____
ID No: _____ **Group No:** _____

I hereby represent the above named patient as a MINOR and give authorization for full chiropractic care and treatments. I agree to be responsible for payment.
Signature: _____ **Relationship:** _____ **Date:** _____

I authorize (Office Name) to render chiropractic care and treatments. If applicable, I give them permission to bill my insurance co. & accept payment on my behalf. I agree to be responsible for payment. Signature: _____ **Date:** _____

Please turn page over and fill in the back of the form >

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

PLANTATION SPINE & SPORTS REHAB

I hereby give my consent for Plantation Spine & Sports Rehab (hereinafter referred to as the practice) use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

The practice's Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. The practice reserves the right to revise its notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to

Carrie Norton our privacy Officer, at 8267 West Sunrise Blvd., Plantation, FL 33322.

With this consent, the Practice may call your home or other alternative location and leave a message, voice mail or in person reference to any items that assists the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, the Practice may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards, and patient statements as long as they are marked personal and confidential.

With this consent, the Practice may e-mail to my home or alternative location any time to assist the practice in carrying out TPO, such as appointment reminder card and patient statements. I have the right to request that the practice restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by agreement.

By signing this form, I am consenting to the practice's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, the practice may decline to provide treatment to me.

_____ _____

Signature of Patient or Legal Guardian Date

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

1. MEDICARE (Medicare#) | MEDICAID (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY | SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single | Married | Other; Employed | Full-Time Student | Part-Time Student

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (INCLUDE AREA CODE) ( )

PATIENT AND INSURED INFORMATION

SECOND FOLD

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES | NO

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX M F

b. AUTO ACCIDENT? YES | NO | PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

FIRST FOLD WRAP-AROUND LABEL

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1											
2											
3											
4											
5											
6											

25. FEDERAL TAX I.D. NUMBER SSN | EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES | NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

APPROVED OMB 0938-0008 FORM CMS-1500 (12/90), FORM HHS-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

Plantation Spine and Sports Rehab, Dean Fishman, D.C.
8267 W. Sunrise Blvd Plantation, FL 33322
(954)577-6161 Fax: (954)577-4447

ASSIGNMENT OF INSURANCE BENEFITS, RELEASE, DEMAND, & CERTIFICATION

Insurer and Patient Please Read the Following in its Entirely

I, the undersigned patient/insured knowingly, voluntarily and intentionally assign the rights and benefits of my automobile insurance, also known as Personal Injury Protection (P.I.P.), and Medical Payments policy of insurance to the above health care provider. I understand it is the intention of the provider to accept this assignment of benefits in lieu of demanding payment at the time services are rendered and that this document will allow the provider to file suit against an insurance company for payment of the insurance benefits. This disputes the validity of this assignment of benefits then the insurer is instructed to notify the provider in writing within five (5) days of receipt of this document. Failure to inform the provider shall result in a waiver by the insurer to contest the validity of this document. The undersigned directs the insurer to pay the health care provider directly without including the patient's name on the check.

The insurer is directed by the provider and the undersigned to not issue any checks or drafts in partial settlement of a claim that contain or are accompanied by language releasing the insurer or its insured/patient from liability unless there has been a prior written settlement agreed to by the health provider and the insurer as to the amount payable under the insurance policy or contract. The provider hereby objects to any reductions or partial payments. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by the provider shall be done so under protest, at the risk of the insurer, and the deposit shall not be deemed a waiver, accord, satisfaction, discharge, settlement or agreement by the provider to accept a reduced amount as payment in full. The insurer is hereby placed on notice that this provider reserves the right to seek the full amount of the bills submitted.

In the event the subject medical benefits are disputed by the insurer for any reason the undersigned hereby instructs the insurer to set aside any amount disputed (i.e., to escrow the money) and not pay the disputed amount to anyone, including myself, or any entity until the dispute is resolved. The insurer is instructed to immediately explain in writing to the above provider of any dispute. If the insurer schedules a defense examination or examination under oath (herein after "EUO") the insurer is hereby INSTRUCTED to send a copy of said notification to this provider. The provider or the provider's attorney is expressly authorized to appear at any EUO or IME set by the insurer. The health care provider is not the agent of the insurer or the patient for any purpose.

This assignment applies to both past and future medical expenses and is valid even if undated. A photocopy of this agreement is to be considered as valid as the original.

I agree to pay any applicable deductible, co-payment, for services rendered after the policy of insurance exhausts, and for any other services unrelated to the automobile accident.

The health care provider is given the power of attorney to endorse my name on any check for services rendered by the above provider.

Release of Information: I hereby authorize this provider to: furnish the insurer, an insurer's intermediary and the patient's attorney via mail, fax, or email, with any and all information that may be contained in the medical records; to obtain insurance coverage information in writing (declaration sheet) and telephonically from the insurer request from the insurer all EOB's from all providers and non-redacted PIP payout sheets; obtain copies of all medical records, including but not limited to, documents, records, scans, notes, bills, opinions, X-rays, IME's, and MRI's, from any other medical provider or any insurer. The insurer is directed to keep the patient's medical records from this provider private and confidential and the insurer is not authorized to provide these medical records to anyone without the patient's and the provider's prior express written permission.

Demand: Demand is hereby made for the insurer to pay all bills within 30 days without reductions and to mail the latest non-reacted PIP payout sheet and the insurance coverage declaration sheet to the above provider with 15 days.

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

Caution: Please read before signing. If you do not completely understand this document please ask us to explain it to you. If you sign below we will assume you understand and agree to the above.

Patient's Name _____ Patient's Signature _____
(Please Print) (If patient is a minor, signature of parent/guardian)

Date _____