WELCOME

one ABOUT YOU

Today's Date: ____/____/____ File #: ____

Patient Name: ____
LAST FIRST MI

What You Prefer To Be Called: ____ ❑ Male ❑ Female

Birthdate: ____/____/____ Age: ____ SS#: ____

Mailing Address: ____

CITY STATE ZIP

Home Phone #: (____) ____

Work Phone #: (____) ____ Ext: ____

Cell Phone #: (____) ____

E-mail Address: ____

Employer: ____ How Long? ____

Employer's Address: ____

CITY STATE ZIP

Occupation: ____

Status: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Spouse's Name: ____

Do you have children? ❑ Yes ❑ No How many? ____

two INSURANCE INFO

Primary Insurance

Co. Name: ____

Address: ____

CITY STATE ZIP

Phone #: (____) ____

Insured's ID#: ____

Group # (Plan, Local, or Policy #): ____

Insured's Name: ____

Relation: ____ Date of Birth: ____/____/____

Insured's Employer: ____

Secondary Insurance

Co. Name: ____

Address: ____

CITY STATE ZIP

Phone #: (____) ____

Insured's ID#: ____

Group # (Plan, Local, or Policy #): ____

Insured's Name: ____

Relation: ____ Date of Birth: ____/____/____

Insured's Employer: ____

three ACCOUNT INFO

Person ultimately responsible for account

Name: ____

Relation: ____

Billing Address: ____

CITY STATE ZIP

SS #: ____

Drivers License #: ____

Work Phone #: (____) ____

Payment method: ❑ Cash ❑ Check

____ ____/____

❑ Credit Card - Enter card # above (if accepted)

____ Initials I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

four IN EVENT OF EMERGENCY

Whom should we contact? ____

Relation: ____

Home Phone #: (____) ____

Work Phone #: (____) ____

Cell Phone #: (____) ____

Who is your Medical Doctor? ____

Medical Doctor's Phone #: (____) ____

PLEASE CONTINUE ON BACK

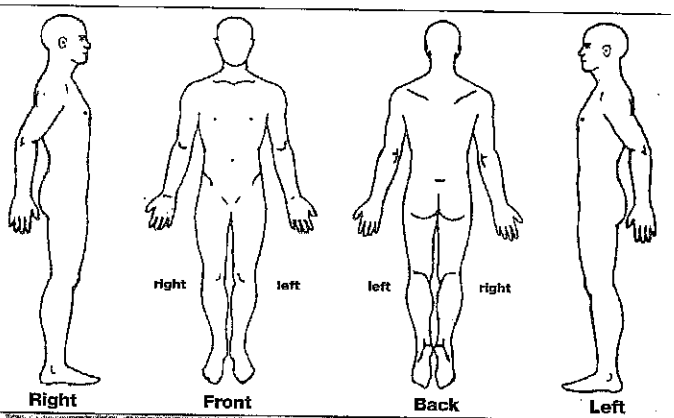
five REASON FOR VISIT

Reason for today's visit: ❑ Emergency ❑ New injury ❑ Old injury ❑ Chronic pain ❑ Wellness
Are you in pain: ❑ Yes ❑ No Rate your pain with the following scale: discomfort 1 2 3 4 5 6 7 8 9 10 intense
Did your injury occur during: ❑ Work ❑ Sports/play ❑ Auto Accident ❑ Routine/Household activity
When did your condition/accident occur? ___/___/___ Where did your injury occur? _____
Please explain what happened: _____
Is your condition getting worse? ❑ Yes ❑ No ❑ Constant ❑ Comes and goes.
Is your condition interfering with your: ❑ Work ❑ Sleep or ❑ Daily routine? If so, how: _____

Has this or something similar happened in the past?
❑ Yes ❑ No Explain: _____

Using the adjacent body charts, please circle all affected areas.
Have you been treated by a Medical Physician for this condition? ❑Yes ❑No If so, where? _____

Have you ever been treated by a Chiropractor? ❑Yes ❑No
Clinic or Dr's name: _____
Clinic phone#: _____



six HEALTH HISTORY

Are you taking any of the following medications? ❑ Nerve pills ❑ Pain killers(including aspirin) ❑ Muscle relaxers
❑ Blood Thinners ❑ Tranquilizers ❑ Insulin ❑ Other(s) _____

Do you have or have you had any of the following diseases, medical conditions or procedures?

Y N Heart Attack / Stroke	Y N Heart Surg./Pacemaker	Y N Heart Murmur	Y N Congenital Heart Defect	Y N Mitral Valve Prolapse
Y N Artificial Valves	Y N Alcohol / Drug Abuse	Y N Venereal Disease	Y N Hepatitis	Y N HIV+ / AIDS / ARC
Y N Shingles	Y N Cancer	Y N Frequent Neck Pain	Y N Glaucoma	Y N Anemia / Diabetes
Y N High/Low Blood Pressure	Y N Psychiatric Problems	Y N Rheumatic Fever	Y N Severe / Frequent Headaches	Y N Kidney Problems
Y N Ulcers / Colitis	Y N Fainting/Seizures/Epilepsy	Y N Sinus Problems	Y N Emphysema / Asthma	Y N Tuberculosis
Y N Difficulty Breathing	Y N Chemotherapy	Y N Lower Back Problems	Y N Artificial Bones/Joints/Implants	Y N Arthritis

Please list any surgeries with dates and/or any other serious medical condition(s) not listed above: _____
List any past serious accidents with dates: _____
Please list anything that you may be allergic to: _____
Family Health History: _____
Do you take Supplements or Vitamins? ❑ Yes ❑ No Do you exercise? ❑ No ❑ Yes ____ hours per week
Do you smoke? ❑ No ❑ Yes How much? _____ How long? _____
Are you wearing: ❑ Shoe lifts ❑ Inner soles ❑ Arch supports Are you dieting: ❑No ❑Yes Since: ___/___/___
For woman: Are you taking Birth Control? ❑ Yes ❑ No
Are you Nursing? ❑ Yes ❑ No Are you Pregnant? ❑ No ❑ Yes If so, how many weeks? _____

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ Date ___/___/___
❑ Adult Patient ❑ Parent or Guardian ❑ Spouse

UPDATE (OFFICE USE)	
Initials	Date ___/___/___
Comments	
Initials	Date ___/___/___
Comments	
Initials	Date ___/___/___
Comments	

PLEASE RECYCLE SO THAT WE MAY PRESERVE THE HEALTH OF OUR PLANET

AUTO / WORK RELATED ACCIDENT

one

ABOUT YOU

Today's Date: ___/___/___ File #: _____

Name: _____

two a

AUTO RELATED ACCIDENT

Date & Time of Accident: _____ ❑ a.m. ❑ p.m.

Were you the: ❑ Driver ❑ Front Passenger ❑ Rear Passenger

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

_____

Number of people in accident vehicle? _____

Did the police come to the accident site? . . ❑ Yes ❑ No

Was a police report filed? . . . . . ❑ Yes ❑ No

Were there any witnesses? . . . . . ❑ Yes ❑ No

Were you wearing your seat belt? . . . . . ❑ Yes ❑ No

Was this vehicle equipped with airbags? . . ❑ Yes ❑ No

If yes, did it/they inflate? . . . . . ❑ Yes ❑ No

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

What did your vehicle impact? ❑ Another vehicle ❑ Other

If other, explain: _____

Did any part of your body strike anything in the vehicle? ❑ Yes ❑ No

If yes, please describe: _____

_____

Make & model of the vehicle you were occupying?

_____

Name of the location/street on which you were traveling?

_____

In which direction were you headed? ❑N ❑S ❑E ❑W

What was the approx. speed of your vehicle? _____

Did the impact to your vehicle come from the:

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

During impact, were you facing: ❑ Right ❑ Left ❑ Forward

Were you ❑ aware or ❑ surprised by the impact?

If accident vehicle made impact with another vehicle...

Make and model of that other vehicle? _____

_____

Direction other vehicle was headed? ❑N ❑S ❑E ❑W

Speed of the other vehicle? _____

In your words, please describe the accident: _____

_____

_____

_____

two b

WORK RELATED ACCIDENT

Date & Time of Accident: _____ ❑ a.m. ❑ p.m.

Was your accident directly related to your work? ❑ Yes ❑ No

Briefly describe the events that occurred just before and during your accident: _____

_____

_____

Give the address where accident occurred: (if other than employer's address) _____

_____

Was anyone else present during your accident? ❑ Yes ❑ No

Did you report your accident to your employer? ❑ Yes ❑ No

What recommendations did your employer make just after your accident? _____

_____

Has this type of accident happened to you before? ❑ Yes ❑ No

To the best of your knowledge, has this accident occurred in your workplace before? . . . . . ❑ Yes ❑ No

In general:

Is your job physically stressful? . . . . . ❑ Yes ❑ No

Is your job mentally stressful? . . . . . ❑ Yes ❑ No

Is your workplace noisy? . . . . . ❑ Yes ❑ No

Have you changed jobs in the last year? ❑ Yes ❑ No

PLEASE CONTINUE ON BACK

three

AFTER INJURY

Did accident render you unconscious? . . . . . ❑ Yes ❑ No

If yes, for how long?_____

Please describe how you felt immediately after the accident:

_____

_____

Have you gone to a Hospital or seen any other Doctor? ❑ Yes ❑ No
When did you go? ❑ Just after accident ❑ The next day ❑ 2 days plus
How did you get there? ❑ Ambulance or ❑ Private transportation

Name of Hospital and/or Attending doctor: _____

_____

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

Describe any treatment you received: _____

_____

Were X-rays taken? . . . . . ❑ Yes ❑ No
Was medication prescribed? . . . . . ❑ Yes ❑ No
Have you been able to work since this injury? ❑ Yes ❑ No
Are your work activities restricted as a result of this injury? ❑ Yes ❑ No

Indicate ☑ the symptoms that are a result of this accident:

❑ Dizziness	❑ Difficulty sleeping	❑ Jaw problems	❑ Nausea
❑ Memory loss	❑ Irritability	❑ Arms/Shoulder pain	❑ Back pain
❑ Headache(s)	❑ Fatigue	❑ Numb Hands/Fingers	❑ Lower back pain
❑ Blurred vision	❑ Tension	❑ Chest pain	❑ Back stiffness
❑ Buzzing in ear	❑ Neck pain	❑ Shortness of breath	❑ Leg pain
❑ Ears ringing	❑ Neck stiff	❑ Stomach upset	❑ Numb Feet/Toes

❑ Other _____

Is your condition getting worse?
❑ Yes ❑ No ❑ Constant ❑ Comes & goes

Indicate your degree of comfort while performing the following activities:

	Comfortable	Uncomfortable (even if only sometimes)	Painful
Lying on back	❑	❑	❑
Lying on side	❑	❑	❑
Lying on stomach	❑	❑	❑
Sitting	❑	❑	❑
Standing	❑	❑	❑
Stretching	❑	❑	❑
Lovemaking	❑	❑	❑
Walking	❑	❑	❑
Running	❑	❑	❑
Sports	❑	❑	❑
Working	❑	❑	❑
Lifting	❑	❑	❑
Bending	❑	❑	❑
Kneeling	❑	❑	❑
Pulling	❑	❑	❑
Reaching	❑	❑	❑

Have you retained an attorney: ❑ Yes ❑ No

If yes, whom: _____

His/Her Phone #: _____

four

RECOVERY

To evaluate the effect that continuing work will have on your recovery please complete the following:

How many hours are in your normal work day? _____

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

❑ Standing	❑ Driving	❑ Operating equipment
❑ Sitting	❑ Twisting	❑ Work with arms above head
❑ Walking	❑ Crawling	❑ Typing
❑ Lifting	❑ Bending	❑ Stooping

❑ Other _____

What positions can you work in 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

Do you work with others who can help you with any heavy lifting? . . . . . ❑ Yes ❑ No ❑ N/A

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

five

ADDITIONAL INSURANCE

2nd Insurance Source or Auto Insurance

Type of Insurance: _____

Co. Name: _____

Address: _____

Phone #: _____

Insured's Name: _____

Policy #: _____ Claim #: _____

Insured's SS #: _____ D.O.B. ___/___/___

Insured's Employer: _____

Agent's Name: _____

If any of your medical or account information has changed, please inform our front desk personnel.
Please remember you are ultimately responsible for your account.

_____ SIGNATURE _____/_____/_____ DATE

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

_____

_____

PLEASE RECYCLE SO THAT WE MAY PRESERVE THE HEALTH OF OUR PLANET

NAME OF INSURANCE COMPANY

DATE	OUR POLICYHOLDER	DATE OF ACCIDENT	FILE NUMBER

TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE FLORIDA PERSONAL INJURY PROTECTIO LAW, PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY

TO: _____
CLAIM DEPARTMENT

YOUR NAME | PHONE NO. HOME | BUSINESS

YOUR ADDRESS (NO., STREET, CITY OR TOWN, STATE AND ZIP CODE) | DATE OF BIRTH / / | SOCIAL SECURITY NO.

PERMANENT ADDRESS, IF DIFFERENT | HOW LONG HAVE YOU LIVED IN FLORIDA?

DATE AND TIME OF ACCIDENT / / A.M. P.M. | PLACE OF ACCIDENT (STREET, CITY OR TOWN AND STATE)

BRIEF DESCRIPTION OF ACCIDENT AND VEHICLES INVOLVED:

DESCRIBE MOTOR VEHICLE YOU OWN — | DESCRIBE MOTOR VEHICLE OWNED BY ANY MEMBER OF YOUR FAMILY —

AS A RESULT OF THIS ACCIDENT WERE YOU INJURED? YES ☐ NO ☐ IF YOUR ANSWER IS YES, COMPLETE THE REST OF THIS FORM. IF NO, SIGN HERE AND RETURN THIS FORM TO US.

SIGNATURE: _____ DATE: _____

DESCRIBE YOUR INJURY

WERE YOU TREATED BY A DOCTOR? YES ☐ NO ☐ | DOCTOR'S NAME AND ADDRESS

IF YOU WERE TREATED IN A HOSPITAL, WERE YOU AN IN-PATIENT? ☐ OUT-PATIENT? ☐ | HOSPITAL'S NAME AND ADDRESS

AMOUNT OF MEDICAL BILLS TO DATE $ | WILL YOU HAVE MORE MEDICAL EXPENSE? YES ☐ NO ☐ | AT THE TIME OF YOUR ACCIDENT WERE YOU IN THE COURSE OF YOUR EMPLOYMENT? YES ☐ NO ☐

DID YOU LOSE WAGES OR SALARY AS A RESULT OF YOUR INJURY? YES ☐ NO ☐ | IF YES, AMOUNT LOST TO DATE $ | WHAT IS YOUR AVERAGE WEEKLY WAGE OR SALARY? $

IF YOU LOST WAGES: DATE DISABILITY FROM WORK BEGAN | DATE YOU RETURNED TO WORK

HAVE YOU RECEIVED, OR ARE YOU ELIGIBLE FOR PAYMENTS UNDER ANY WORKMEN'S COMPENSATION OR UNEMPLOYMENT LAW? YES ☐ NO ☐ IF YES, AMOUNT $ _____ ☐ PER WEEK ☐ PER MONTH

LIST NAMES AND ADDRESSES OF YOUR PRESENT EMPLOYER(S) AND GIVE YOUR OCCUPATION AND DATES OF EMPLOYMENT FOR EACH:

EMPLOYER AND ADDRESS	YOUR OCCUPATION	FROM	TO

AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES? YES ☐ NO ☐ IF YES, EXPLAIN ON REVERSE SIDE.

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 third degree.

I HEREBY AUTHORIZE RELEASE OF MEDICAL INFORMATION INCLUDING, BUT NOT LIMITED TO, MEDICAL BILLS AND REPORTS TO SUCH PERSONS AS THE COMPANY MAY DEEM NECESSARY TO PERFECT ITS RIGHTS OF RECOVERY UNDER THE "NO-FAULT" AUTO INSURANCE LAW.

SIGNATURE: _____ DATE: _____

Request for Direct Pay (and/or) PIP & Med-Pay Log

Patient: _____

Claim#: _____

SS# / ID#: _____

I hereby instruct and direct _____ Insurance Company to pay by check made out and mailed to the following medical provider:

A First Choice Healthcare
5199 S. University Drive
Davie, FL 33328
954-434-7246

If my policy prohibits direct payment to the doctor, then I hereby authorize you to make the check payable to me and mail it to A First Choice Healthcare, at the address listed above.

If requested, pleas supply a PIP pay-out log to this provider.

I authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in the case. This information can include ant personal injury protection along with any medical pay coverage my policy holds. This information can be given to A First Choice Healthcare.

I authorize A First Choice Healthcare to initiate a complaint to the Insurance Commission for any reason on my behalf.

Dated this_____ day of _____, .

Signature of Policyholder: _____

Witness: _____

Yes / NO: Requesting a PIP-Med Pay Out Log to be issued.

A Photocopy or fax Copy of this authorization shall be as effective and valid as the original.

Acknowledgement From Insurance Company

Adjuster or Supervisor:_____ Date: _____

Name_____ _____Da. _____

Release of Records

I, do hereby authorize A First Choice Healthcare Systems, Inc. to release my medical and billing records to any of it's billing companies, attorneys, adjusters, etc. for the sole purpose of getting my bill paid..

_____

patient signature date

Consent to Treat

I, hereby authorize the staff and providers of A First Choice Healthcare Systems to perform medical examination, physical therapy, Chiropractic services, draw blood, perform noninvasive diagnostic testing, or provide me with any treatment deemed medically necessary by the providers. The nature and the purpose of these procedures have risks involved and the possibility of complications have been fully explained to me. I acknowledge that no guarantee has been made to me as to the results that may be obtained.

_____

patient signature date

Assignment of Benefits

I understand that my insurance company may not accept assignment. I understand that my insurance company may pay me directly for the services rendered to me from A First Choice Healthcare Systems . I also understand that I may receive check(s) from the insurance company made payable i my name to me directly. I also understand that it is my responsibility to forward these checks and all explanation of benefits to A First Choice Healthcare Systems immediately upon receipt. I understand that it is illegal for me to cash or deposit the insurance check that I receive for services from these providers, particularly when I have not paid for the services personally. I understand that if I fail to forward the check for these services, it will be my responsibility to pay my balance in full for all services provided to me. I know that I will be given five business days to settle my account before legal proceedings begin. If my account is not settled I will also be responsible for any additional costs, such as court costs and legal fees.. I understand that services provided to me today may be issued on more than one check, and I agree to forward ALL checks regarding today's treatment to A First Choice Healthcare Systems. I willingly sign this agreement.

_____

Patient signature date

Power of Attorney

I expressly authorize and give power of attorney to A First Choice Healthcare Systems, and their billing agents, for the signing and completing of an form in the completion of my claims and endorsing any check made payable to me, in support of processing or making payment of claim for any charges incurred by me at these offices. Further, these offices acknowledge that it is only entitled to receive payment for only those charges which were incurred through their office and any overpayment will be refunded appropriately and timely.

_____

Patient signature date

Doctors Lien

I do hereby authorize A First Choice Healthcare Systems to furnish you, my attorney, with full report of examination, diagnosis, treatments, prognosis, etc. of myself in regard to the accident in which I was involved.

I hereby authorize and direct you, my attorney to pay directly to A First Choice Healthcare Systems such sums as may be due and owing for medical services rendered me by both reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgement, or verdict as may be necessary to adequately protect A First Choice Healthcare Systems. And I hereby further give a lien on my case to A First Choice Healthcare 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 injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to A First Choice Healthcare for all medical bills submitted by them for service rendered to me and that this agreement is made solely for A First Choice Healthcare's additional protection and in consideration of their awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

Patient Signature: _____ date: __/__/____

The undersigned being attorneys of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold sums from any settlement, judgement or verdict as may be necessary to adequately protect A First Choice Healthcare. Attorney shall promptly notify A First Choice Healthcare if and when Attorney ceases to represent patient in the lawsuit described above or when patient retains additional attorney(s) to represent patient in that lawsuit. Attorney shall also promptly deliver a copy of this lien to any additional or substitute attorney(s) retained by patient in connection with that lawsuit.

Attorney's Signature: _____ Date: __/__/____

Attorney's Printed Name: _____ Phone Number: (___)_____

Attorney Address: _____

For Law Enforcement

As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

Family, Friends and Caregivers

We may share your health information with those you tell us will be helping you with your home hygiene, treatment, medications, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want we will use our very best judgment when sharing your health information only when it will be important to those participating in providing your care.

To Coroners, Funeral Directors and Medical Examiners

We may be required by law to provide information to coroners, funeral directors and medical examiners for the purposes of determining a cause of death and preparing for a funeral.

Medical Research

Advancing medical knowledge often involves learning from the careful study of the medical histories of prior patients. Formal review and study of health histories as a part of a research study will happen only under the ethical guidance, requirements and approval and of an Institutional Review Board.

Authorization to Use or Disclose Health Information

Other than is stated above or where Federal, State or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

Patient Acknowledgment

Patient Name(s):_____

_____

_____

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions we want to hear from you. If not we would appreciate very much your acknowledging your receipt of our policy by signing and returning this card. We look forward to seeing you again soon!

_____

Patient Signature

Date:_____/_____/_____

Patient Rights

This new law is careful to describe that you have the following rights related to your health information.

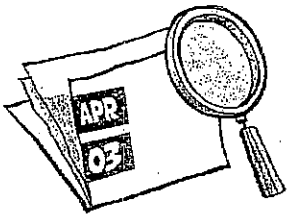
Restrictions

You have the right to request restrictions on certain uses and disclosures of your health information. Our office will make every effort to honor reasonable restriction preferences from our patients.

Confidential Communications

You have the right to request that we communicate with you in a certain way. You may request that we only communicate your health information privately with no other family members present or through mailed communications that are sealed. We will make every effort to honor your reasonable requests for confidential communications.

Inspect and Copy Your Health Information



You have the right to read, review, and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable fee to duplicate and assemble your copy.

Amend Your Health Information

You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe your reason for the change.

Your request may be denied if the health information record in question was not created by our office, is not part of our records or if the records containing your health information are determined to be accurate and complete.

Documentation of Health Information

You have the right to ask us for a description of how and where your health information was used by our office for any reason other than for treatment, payment or health operations. Our documentation procedures will enable us to provide information on health information usage from April 14, 2003 and forward. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. We may need to charge you a reasonable fee for your request.

Request a Paper Copy of this Notice

You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail or email a copy to you.

We are required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practices we will be sure all of our patients receive a copy of the revised Notice.

You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. Please let us know of your concerns or complaints in writing.

QUESTIONAIRE FOR FEMALE PATIENTS

HAVING IMAGING PROCEDURES

Please tell the X-Ray Technician prior to your exam if there is any chance that you may be pregnant. This is very IMPORTANT!! Radiation received during an imaging test can harm an unborn child.

Please check one that applies:

1. I am Pregnant _____.
2. I may be Pregnant. Date of last menstrual period _____.
3. There is NO possibility that I am pregnant_____.

_____ _____

Patient or Legal Guardian Date

_____ _____

Witness Date

5149 S. University Drive. Davie, FL 33328 (954) 434-7246 Fax: (954) 434-8104

NOTICE OF INSURED RIGHTS

BILLING REQUIREMENTS - Florida Statutes provide that with respect to any treatment or services, other then certain hospital and emergency services, the statement of charges furnished to the insurer by the provider may not include, and the insurer and the injury party are not required to pay, charges for treatment of services rendered more than 35 days before the postmark date of the statement, except for past due amounts previously billed on a timely basis, and except that, if the provider submits to the insurer a notice of initiation of treatment within 21 days after its first examination or treatment of the claimant, the statement may include charges for treatment or services rendered up to, but not more than, 75 days before the postmark date of treatment.

RECEIPT AND ACKNOWLEDGEMENT OF NOTICE OF INSURED RIGHTS

The undersigned patient/insured hereby acknowledges receipt of the above Notice of Insured's Rights. The above notice has been provided to me pursuant to Florida Statutes 627.7401
I have read and fully understand the provisions of the above notice.

Received this _____day of _____, 20__

_____
Patient Signature

_____
Patient Printed Name

ASSIGNMENT OF INSURANCE BENEFITS, RELEASE, & DEMAND
INSURER AND PATIENT PLEASE READ THE FOLLOWING IN ITS ENTIRETY CAREFULLY!

I, the undersigned patient/insured knowingly, voluntarily and intentionally assign the rights and benefits of my automobile insurance, also known as Personal Injury Protection (hereinafter PIP), 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 insurance benefits. I understand the provider may file lawsuit against my insurer for payment and if the provider's bills are paid or includes the cost of transportation, medications, 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 provider in writing within five 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 reductions & without including the patient's name on the check. To the extent the PIP insurer contends there is a material misrepresentation on the application for insurance resulting in the policy of insurance is declared voided, rescinded, or canceled, I, as the named insured under said policy of insurance, hereby assign the right to receive the premiums paid for my PIP insurance to this provider and to file suit for recovery of the premiums. The insurer is directed to issue such a refund check payable to this provider only. Should the medical bills do not exceed the premium refunded, then the provider is directed to mail the patient/named insured a check which represents the difference between the medical bills and the premiums paid. The insurer is directed by the provider and the undersigned to not issue any check 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. The insured and the provider hereby contests and 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 to agreement by the provider to accept a reduced amount as payment in full. The insurer is hereby placed on notice that this provider reserves to seek the full amount of the bills submitted.

If the insurer schedules a defense examination under oath (hereinafter "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 updated. A photocopy of this assignment is to be considered as valid as the original. I agree to pay any applicable deductible, co-payments, for services rendered after the policy of insurance exhausts and for any other services to the automobile accident. The healthcare provider is given the power of attorney to: endorse my name on any check for services rendered by the above provider; and to request and obtain a copy of any statement or examinations under oath given by patient.

Release of Information: I hereby authorize this provider to :furnish an insurer, an insurer's intermediary, the patient's other medical providers, 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 (declaration sheet & policy of insurance) in writing and telephonically from the insurer; request from any insurer all explanation of benefits (EOBs) for all providers and non-redacted PIP payout sheets; obtain any written and verbal statements the patient 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, and MRIs, from any other medical provider or any insurer.

The provider is permitted to produce my medical records to its attorney in connection with any pending lawsuits. 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 with out 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-redacted PIP payout sheet and the insurance coverage declaration sheet to the above provider within 15 days. The insurer is directed to pay the bills in the order they are received. However, if a bill from this provider and the claim from anyone are received by the insurer on the same day, the insurer is directed to not apply this provider's bill to the deductible. If a bill from this provider and claim from anyone else is received by the insurer on the same day then the insurer is directed to pay this provider first before the policy is exhausted. In the event the provider's medical bills are disputed or reduced by the insurer for the reason, or amount, the insurer is to: set aside the entire amount disputed or reduced; escrow the full amount at issue; and not pay the disputed amount to anyone or any entity, including myself, until the dispute is resolved by a Court. Do not exhaust the policy. The insurer is instructed to inform, in writing, the provider of any dispute.

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

Caution: **Please read before signing. Please ask to view a copy of our charges. 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: _____ Date: _____

ALL PERSONAL INJURY PATIENTS

Dear Patient:

Please be advised that sometime during your treatment your insurance company will be notifying you to attend an appointment with another physician for the purpose of an Independent Medical Examination (IME.)

Don't get mad. This is not a bad thing. When you receive this letter, please bring it into our office so we will be aware of the date of the exam and the doctor you will be seeing. At that time we will give you any necessary records, x-rays and any other medical information you may need for that appointment.

As usual, if you have any questions we may answer please do not hesitate to ask.

Please sign below acknowledging you have read this document

_____
Print Name

_____
Patient Signature

RELEASE OF MEDICAL RECORDS

I, _____ do hereby authorize the release of my medical records and/or health information to below named practice and/or facility.

Release To:

A 1st Choice Healthcare
5149 S. University Dr.
Davie, Fl 33328
P: (954) 434-7246 F: (954) 434-8104

Patient:

Patient Name: _____ **DOB:** _____/_____/_____

Information to Be Disclosed:

___ Discharge Summary ___ Progress Notes

___ History & Physical ___ Operative/Pathology Reports

___ Xrays/Any Diagnostic Testing ___ Entire Medical Records

___Drug/Alcohol/Substance Abuse _____ Psychiatric/Psychological Treatment
___HIV/AIDS Tests/Results/Diagnosis _____ Sexual Abuse _____Court Order

Dates Needed: From: ___/___/___ to ___/___/___

Expiration Date: _____/_____/20____, this authorization shall be valid for up to 6 months or unless otherwise stated or revoked through written notice to the Medical Records Department.
Alternate Date (if not 6 months from signature date): _____/_____/_____.

_____ _____/_____/_____
Patient Signature **Date**