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Check One: ____**Auto Accident** ____**Slip & Fall** ____ **Work Injury** **Other:**_____

Name:_____

Age: _____ Date of Birth: _____ Social Security #:_____

Marital Status: S M W D Gender/Sex: _____

Address:_____

City: _____ State: _____ Zip Code: _____

Home Phone #: _____Cell Phone #:_____ Work Phone #:_____

E-mail address: _____

Emergency Contact: _____ Phone #: _____

Occupation: _____ Employer: _____

Accident Date: _____ **Description of the accident:** _____

_____

Were you the: □ Driver □ Passenger Wearing seat belts? □Yes □ No Air bags deploy? □ Yes □ No

Did you go to the hospital? □ No If Yes, any x-rays taken at the hospital? □ Yes □ No

Which hospital did you go to: _____

Any medications prescribed at the hospital? □ No If Yes, list medications: _____

Have you lost time from work? □ No If Yes, list dates missed: _____

Present complaints since the accident: _____

_____

Have you been involved in any previous accidents? □ No If Yes, please explain:

Date: _____ 1. Type: □ Auto □ Work Other: _____

Injuries: □ No If Yes, list injuries: _____

Hospital/ Clinic treated: _____ Doctor's Name: _____

Legal Representation:

Attorney's Name: _____ Case Manager: _____

Telephone Number: _____

Insurance Information:

Insurance Name: _____Adjuster Name _____

Policy #: _____Claim #: _____

Patient's Signature: _____ **Date:** _____

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Consent for Chiropractic Treatment

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures on me or on _____by **Dr. Victor Lasa/Dr. Suanette Torres** or other licensed doctors of Chiropractic who may be employed by or engaged in practice at **Encompass Chiropractic Centers, LLC.**

I have had the opportunity to discuss with the doctor or other clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that the practice of neither chiropractic nor medicine is an exact science and that my care may involve the making of judgments based upon the facts known to the doctor at the time, that it is not reasonable to expect the doctor to be able to anticipate or explain all risks and complications; that an undesirable result does not necessarily indicate an error in judgment; that no guarantee as to results has been made to nor relied upon me, and I wish to rely on the doctor to exercise judgment during the course of the procedure which he/she feels at the time, based upon the fact then known, is in my best interests.

I have also been advised that although the incidence of complications associated with chiropractic services is very low, anyone undergoing adjusting or manipulative procedures should known of possible complications which have been alleged. These include, but are not limited to fractures, disc injuries, strokes, dislocations, sprains, and those which relate to physical aberrations unknown or reasonably undetectable by the doctor.

I have read or have read to me the above consent. I have also had an opportunity to ask any questions about its contents, and by signing below, acknowledge my understanding of its contents.

Patient Name: _____ Date:___/____/___

Patient Signature: _____

If patient/insured is a minor, signature of parent/guardian

Parent/guardian Name: _____

Parent/guardian signature: _____ Date:___/___/___

OFFICE OF INSURANCE REGULATION
Bureau of Property & Casualty Forms and Rates

Standard Disclosure and Acknowledgement Form
Personal Injury Protection - Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

1. The services or treatment set forth below were **actually rendered.** This means that those services have **already been provided.**

_____

_____

2. I have the right and the **duty to confirm** that the services have already been provided.

3. I was **not solicited** by any person to seek any services from the medical provider of the services described above.

4. The medical provider has **explained** the services to me for which payment is being claimed.

5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to $500.

Insured Person (patient receiving treatment or services) or Guardian of Insured Person:

Name *(PRINT or TYPE)*	Signature	Date

The undersigned licensed medical professional or medical director, if applicable, affirms the statement numbered 1 above and also:

A. I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.

B. The treatment or services rendered were explained to the insured person, or his or her guardian, **sufficiently** for that person to sign this form with informed consent.

C. The accompanying statement or bill is **properly completed** in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to **truthfully, accurately**, and in a **substantially complete** manner.

D. The coding of procedures on the accompanying statement or bill is proper. This means that **no service has been upcoded, unbundled**, or constitutes an invalid **or not medically necessary diagnostic test** as defined by Section 627.732(14) and (15), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Licensed Medical Professional Rendering Treatment/Services or Medical Director, if applicable *(Signature by his/ her **own hand**)*:

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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ASSIGNMENT OF INSURANCE BENEFITS, RELEASE & DEMAND

Assignment of Benefits

I, the undersigned patient/insured, knowingly, voluntarily and intentionally assign and transfer any and all rights and benefits of my automobile insurance policy (i.e. Personal Injury Protection ("PIP"), Uninsured Motorist and Medical Payments benefits) to the above-stated Health Care Provider. I understand it is the intention of the Health Care Provider to accept this Assignment of Benefits in lieu of demanding payment at the time services are rendered. I understand that this document will allow the Health Care Provider to file suit against the insurer either in my name, or the provider's name, for payment of the insurance rights and/or benefits, to obtain an explanation of benefits and to seek attorneys' fees under Fla. Stat. §627.428 from the insurer. This Assignment of Benefits includes, but is not limited to, the cost of medical care, transportation, medication, supplies, over due interest and any potential claim for common law or statutory bad faith/unfair claims handling. If the insurer disputes the validity of this Assignment of Benefits, then the insurer is instructed to notify the Health Care Provider in writing within five (5) days of receipt of this document advising of its basis for such dispute. Failure to inform the Health Care Provider shall result in a waiver by the insurer to contest the validity of this Assignment of Benefits. The undersigned patient/insured directs the insurer to pay the Health Care Provider the maximum amount of the policy benefits directly to the Health Care Provider without any reductions and without including the patient's/insured's name on the check. It is this Health Care Provider's contention that its charges are reasonable.

Disputes

The insurer is directed by the Health Care Provider and the undersigned patient/insured not to issue any checks or drafts in partial settlement of a claim that contain, or are accompanied by, language releasing the insurer or its insured/patient from liability unless there is a written settlement agreement between the Health Care Provider, specifically the Office Manager, and the insurer as to the amount to be paid by the insurer for the services rendered only to the undersigned patient/insured. The patient/insured and the Health Care Provider hereby contest and object to any reductions or partial payments made by the insurer. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by the Health Care Provider shall be done so under protest, at the risk of the insurer, and the deposit shall not be deemed a waiver, accord, satisfaction, discharge, settlement or agreement by the Health Care Provider to accept a reduced amount as payment in full. The insurer is hereby placed on notice that this Health Care Provider reserves the right to seek the full amount of the bills submitted. If the insurer asserts that it can pay claims at 200% of the Medicare Fee Schedule, then the insurer is instructed and directed to provide this Health Care Provider with a copy of the policy of insurance within ten (10) days. Should the insurer and Office Manager of the above-stated Health Care Provider reach an agreement to settle any of the bills submitted at a reduced amount, this agreement shall be reduced to writing and submitted to the attention of the Office Manager for written approval. See Fla. Stat. §673.3111.

EUOs and IMEs

If the insurer requests an Examination Under Oath (EUO) or Independent Medical Examination (IME) of the patient/insured, the insurer is hereby instructed to promptly send a copy of the request to this Health Care Provider. The Health Care Provider or the Health Care Provider's attorney is expressly authorized to appear at any EUO or IME set by the insurer of this patient/insured. The Health Care Provider is not the agent of the insurer nor the patient for any purpose.

This Assignment of Benefits applies to both past and future medical expenses and is valid even if not dated. A photocopy of this Assignment of Benefits is to be considered as valid as the original. I, the undersigned patient/insured, agree to pay any applicable deductible or co-payments for services rendered after the policy of insurance exhausts and for any other services unrelated to the date of injury. The above-stated Health Care Provider is given Power Of Attorney to: (1) endorse my, the undersigned patient/insured's, name on any check for services rendered by the above-stated Health Care Provider, (2) to request and obtain copies of any recorded statements or Examinations Under Oath given by me, the undersigned patient/insured, and (3) to request and obtain copies of any IME reports and/or peer review reports pertaining to me, the undersigned patient/insured.

Release of Information

I, the undersigned patient/insured, hereby authorize this Health Care Provider to: furnish an insurer, an insurer's intermediary, my other medical providers and my attorney(s) via mail, facsimile or e-mail, with any and all information that may be contained within my medical records to: obtain insurance coverage information (i.e. declarations page and policy of insurance) in writing and telephonically from the insurer, request from any insurer all Explanation Of Benefits/Review forms (EOBs) for all of my medical providers, obtain a non-redacted PIP payout sheet, obtain written and verbal statements that I or anyone else provided to the insurer, obtain copies of the entire claim file and all medical records, including, but not limited to: documents, reports, scans, notes, bills, opinions, x-rays, IMEs, peer reviews and MRIs from any of my medical providers or any insurer. The Health Care Provider is permitted to produce my medical records to its attorney in connection with pursing a legal action. The insurer is directed to keep my, the patient/insured's medical records confidential. The insurer is not authorized to provide my, the patient/insured's, medical records to anyone without my, the patient/insured's and the Health Care Provider's express written permission.

Demand

Demand is hereby made for the insurer to pay all submitted bills within thirty (30) days of receipt without restriction and to mail an up-to-date, non-redacted PIP payout sheet and a declarations page to the above-stated Health Care Provider within fifteen (15) days. The insurer is directed to pay the bills received related to the date of injury in the order in which they were received. However, if a bill from this Health Care Provider and a claim from any other person or entity is received by the insurer on the same day, the insurer is directed not to apply this Health Care Provider's bill to the deductible. If a bill from this Health Care Provider and a claim from any other person or entity is received by the insurer on the same day, the insurer is directed to pay this Health Care Provider first before the policy is exhausted. In the event the Health Care Provider's medical bills are disputed or reduced by the insurer for any reason or by any amount, the insurer is to: set aside the entire disputed or reduced amount, escrow the full amount at issue and do not pay the disputed amount to anyone or any entity, including myself, until the dispute is resolved by a Court. The insurer is instructed to inform the Health Care Provider, in writing, of any dispute related to the above-stated Health Care Provider's bills. Additionally, should the remaining amount of my benefits approach an amount where there would be insufficient funds/benefits to pay the full amount of the above-stated Health Care Provider's bill, I hereby instruct the insurer to notify the undersigned patient/insured and the above-stated Health Care Provider of this fact. Should my benefits exhaust, I instruct the insurer to notify me and the Health Care Provider promptly of such exhaustion.

Letter of Protection

I hereby authorize and direct that my attorney, if I am represented by counsel, withhold sums from any disability benefits, Medical Payment benefits, PIP benefits or any other insurance benefits obligated to be reimbursed to me, or, from any settlement, judgment or verdict in my favor, as may be necessary to reimburse the above-stated Health Care Provider for services rendered to me. I, the undersigned patient/insured, hereby further give an IRREVOCABLE LIEN to the above-stated Health Care Provider against any and all insurance benefits named herein and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness sustained, wherein the above-stated Health Care Provider rendered treatment. In the event that I do not have insurance coverage, I understand that I remain personally responsible for payment of services rendered.

Certification

I, the undersigned patient/insured, certify that: I have read and agree to the above; I have not been solicited nor promised anything in exchange for receiving health care from the above-stated Health Care Provider; I have not received any promises nor guarantees from anyone as to the results that may be obtained by any treatment or service provided; and I agree that the Health Care Provider's prices for the medical services, treatment and supplies provided are reasonable, usual and customary.

Caution: Please read carefully before signing. Please ask to review a copy of the above-stated Health Care Provider's charges. If you do not completely understand this document, please ask us to explain it to you. If you sign below we will assume that you understand and agree with the contents of this Assignment of Insurance Benefits, Release & Demand.

Patient's/Insured's Name: _____
(Please print)

Patient's/Insured's Signature: _____
(If patient/insured is a minor, signature of parent/guardian)

Date: _____

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OFFICE POLICIES

1. It is our office policy that any patient and/or insurance company that pays up-front or in advance is entitle to and administrative discount.

2. The fee paid for treatment x-rays is for analysis only. The film itself is the property of this office. Once films are taken, they cannot be released, but may be copied. There may be a fee for copying of the x-rays.

3. If you have any out of pocket responsibility what will be you method of payment? (Please circle)

   Cash Check Credit Card/Debit Card Attorney/Letter of Protection

I understand and agree that health and accident insurance policies are an agreement between the insurance carrier and myself. Furthermore, I understand Encompass Chiropractic Center will prepare any necessary reports, and forms to assist in making collection from my insurance company and that any amount authorize to be paid directly to Encompass chiropractic Center will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me, are charge directly to me and that I am personally responsible for payment.

I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional service rendered to me will be immediately due and payable; I agree that I will be responsible for all attorney and legal action become necessary to collect this amount.

Patient's Name (Print): _____

Date: _____

Patients/ Guardian Signature authorizing care: _____

Date: _____

In case of emergency notify: _____

Relationship: _____

Address: _____

City _____ State _____

Phone Number: _____

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PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

By signing this form I acknowledge that Encompass Chiropractic Center has given me the opportunity to review or obtain the Notice of Privacy Practices.

Print Name: _____
(If you are a legal representative please print the patient's name and sign your name)

Signature: _____

Date: _____

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Authorization for Release of Records

Patient Name: _____ **Date:** _____

Date of Birth: _____

I authorized the release of my medical records to the following individual:

_____ _____

(Name of person authorized to have access) Relationship

_____ _____

(Name of person authorized to have access) Relationship

I understand that my records are confidential and cannot be disclosed without my written authorization. I understand that by signing this consent I am giving authorization for the person listed above to have access to my medical records.

Patient Signature: _____ Date: __/__/__

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Today's Date_____

Request for Financial Assistance

By

_____

Patient's Name

In as much the patient has expressed a strong and willing desire to receive care in this office, and that current circumstances exist which greatly restrict their ability to pay the practice's standard fees for services and/or any co-pay and/or deductible amounts, **Encompass Chiropractic Centers** agrees to temporarily waive the patient's obligation to pay that portion they would otherwise be contractually or legally bound to pay for all services rendered in this clinic.

The reason for financial hardship is _____

_____

If, however, future discussion regarding their financial situation reveals that Mr. /Mrs. _____ circumstances have improved enough to enable them to assume a greater portion of their payment responsibility, the practice will immediately amend this agreement.

Approved by _____ Date _____

I understand that if my financial status or my ability to pay improves for any reasons, the services rendered from that time forward will be based on the practice's 'Standard, Usual, Customary' fees.

Patient's Signature _____ Date _____

Patient Name _____ Date _____

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FINANCIAL DISCLOSURE POLICY

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

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

Two exceptions are permitted under the law:

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

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

_____ _____

Patient's Signature Date

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X-rays Authorization

I, (Patient's Name) _____
give permission to Encompass Chiropractic Centers and its assigned associates to perform x-rays for the sole purpose of diagnosing a potential condition and/or for any possible injuries I may have sustained during my incident/accident.

FOR FEMALES ONLY:
The 10 days following onset of menstrual period are generally considered safe for x-ray examination.

Onset of Menstrual Period:

Date: _____ Today's Date: _____

I am pregnant YES _____ NO _____

I have had a hysterectomy YES _____ NO _____

I am aware that if I am pregnant and received radiation to the abdomen, there is a possibility of injuring to the fetus. However, I understand that the likelihood of such injury is slight and that my physician feels that the information to be gained from this examination is important to my health. I therefore wish to have this examination performed now.

Patient's Name: _____

Patient's Signature: _____

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RECORDS RELEASE AUTHORIZATION

Date: _____

To (Doctor or Hospital)
Name: _____ Phone: _____
Address: _____ Fax: _____
_____

I hereby authorize and request release to:

□ Encompass Integrative
5336 S John Young Parkway
Orlando, FL 32839
Phone: 407-802-3855
Fax: 407-601-7970

□ Encompass Chiropractic Center
4932 West S.R 46 Ste. 1006
Sanford, FL 32771
Phone: 407979-4908
Fax: 407-979-4967

□ Encompass Chiropractic
6479 S. Chickasaw Trail
Orlando, FL 32829
Phone: 407-730-3737
Fax: 407-988-3611

The complete history records in your possession, concerning my illness and/or treatment during the period

From: _____ To: _____

Patient Name: _____

SS#: _____ DOB: _____

Patient's Signature: _____ Date: _____

Witness: _____ Date: _____

THIS FAX IS INTENDED ONLY FOR THE USE OF THE PERSON OR OFFICE TO WHOM IT IS ADDRESSED, AND CONTAINS PRIVILAGED OR CONFIDENTIAL INFORMATION PROTECTED BY LAW. ALL RECIPIENTS ARE HEREBY NOTIFIED THAT DISSMINATION, DISTRIBUTION, OR COPYING OF THIS COMMUNICATION IS PROHIBITED. IF YOU HAVE RECEIVED THIS FAX IN ERROR, PLEASE DESTROY THE ATTACHED DOCUMENT(S) AND NOTIFY THE SENDER OF THE ERROR BY CALLING (407) 802-3855.

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Encompass Chiropractic Centers

- 4932 West S.R. 46 Suite 1006 Sanford, FL 32771
- 5336 S. John Young Parkway Orlando, FL 32839
- 6479 South Chickasaw Trail Orlando, FL 32829

NOTICE OF INITIATION OF TREATMENT

PATIENT NAME: _____

TODAY'S DATE: _____

DATE OF ACCIDENT: _____

AUTO INSURANCE COMPANY NAME: _____

FIRST DATE OF SERVICE: _____

To Whom it may concern:

This document shall serve as our formal Notice of Initiation of Treatment pursuant to Fla. Stat §627.736(5)(c). This notice is being sent, pursuant to Florida Statutes, within 21 days after this facility's first examination or treatment of the above referenced claimant. Because this notice has been timely provided, the law allows statements from this provider to include charges for treatment or services rendered up to, but not more than, 75 days before the postmark date of the statement sent.

OFFICIAL CERTIFICATION OF PATIENT AS TO INSURANCE COVERAGE

I, as the above captioned patient hereby attest that to the best of my knowledge, that the insurance claims information I have provided above is in fact the correct insurance information under which I am entitled to medical and/or PIP coverage.

I understand that the medical provider is relying on this correct information in order to receive the appropriate coverage and quality for payment for medical services provided to me.

SIGANTURE _____ DATE _____