AUTO ACCIDENT PATIENT INTAKE FORM

Name/**Nombre:**		
Street Address/**Dirección:**		
City/**Ciudad**:	Postal Code/**Código Postal:**	
Phone/**Telefono:** (home/**casa**)	(Cell/**Celular**)	(Work/**Trabajo**)
Email Address/Correo Electronico:		
Would you like to receive South Florida Injury and convenient Care emails regarding appointment Information? **¿Le gustaría recibir correos electrónicos de South Florida Injury and Convenient Care en referencia a su cita médica?** Yes/**Si** ☐ No/**No** ☐		
Would you like to receive South Florida Injury and convenient Care texts regarding appointment Information? **¿Le gustaría recibir correos mensajes de texto de South Florida Injury and Convenient Care en referencia a su cita médica?** Yes/**Si** ☐ No/**No** ☐		
Gender/**Sexo** *(circle)*: M F	Date of Birth/**Fecha de Nacimiento:**	
Family Doctor/**Medico Familiar:**		
Preferred Pharmacy/**Farmacia Preferida:**	Phone Number/**Telefono:**	
How did you discover this clinic? *(please circle)* **¿Como descubrio nuestra Clinica?** ***(Circule uno)***	Family Doctor | Specialist | Friend/Family | Website | Facebook | Attorney: _____ | Other *(please specify)*: Doctor Familiar | Radio | Amigo/Familia | Web | Facebook | Abogado: _____ | Otro *(especifiqué)*:	

Motor Vehicle Accident Patients/Pacientes de Accidente de Auto

(*Please fill out this section/Por favor completar*)

Insurance Company/**Aseguranza** *(Branch Office if applicable)* ***(Sucursal, si corresponde)***	
Address/**direccion**	
Telephone Number/**Telefono**	
Fax Number/**Fax**	
Adjuster's Name/**Nombre de Ajustadora**	
Date of Accident/**Fecha de Accidente**	
Policy Number/**Numero de Poliza**	
Claim Number/**Numero de Reclamo**	
Name of Policy Holder/**Nombre de Poliza** *(If different from claimant)*	

Have you Retained an Attorney? Yes No if yes, please provide the following Information:
A Contratado a un Abogado? Si No en caso afirmativo, por favor proveer la siguiente información:

Attorney's name: _____

Nombre de Abogado: _____

CHIEF COMPLAINT/MOTIVO DE CONSULTA:

_____

_____

Describe Accident/**Describa el Accidente:**

_____

_____

_____

Have x-rays/MRI been taken? YES NO Where? _____
Le han hecho Radiografias/MRI? Si No Donde? _____

Right or Left Handed? R L
Derecho(a) o Zurdo(a)? D Z

ACCIDENT SPECIFICS/DETALLES DEL ACCIDENTE: (Circle One/ **Circule uno**)

Were you the: Driver Passenger

Usted era el: Conductor Pasajero

Were you wearing your seatbelt: Yes No Did the Airbag Deploy? Yes No

Tenia Puesto el Cinturon? Si No Se desplego la bolsa de Aire? Si No

Accident Type: Rear-Ended Head-on Broadside Other: _____

Typo de Accidente: Por detrás De frente De Lado Otro: _____

Did your head: Strike Object Not Strike Object Break Glass Other: _____

Su Cabeza: golpeo objeto No golpeo objeto Quebro el vidrio Otro: _____

Did you experience: Shock Loss of Consciousness Whiplash Other _____

Usted experimento: Shock Perdio el conocimiento whiplash Otro: _____

State your emotions and physical state immediately following the accident/**Describa su estado emocional y fisico inmediatamente despues del Accidente:**

_____

State your emotions and physical state after the first few days/**Describa su estado emocional y fisico unos dias despues del accidente:**

_____

IMMEDIATELY FOLLOWING THE ACCIDENT/INMEDIATAMENTE DESPUES DEL ACCIDENTE:

Were you treated for your injuries? Yes No

Ha sido tratado por sus lesiones? Si No

If yes what treatment/evaluation did you receive?

En caso afirmativo, que clase de tratamiento/evaluación a recibido?

_____

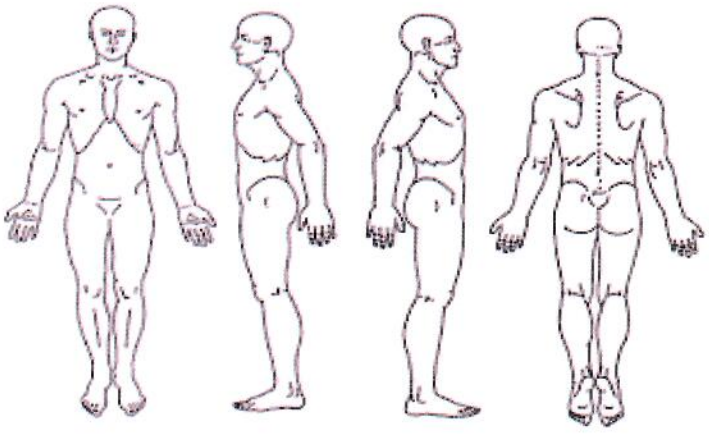
PAIN RATING/CLASIFICACION DE DOLOR:

On a Scale of 0-10, rate your pain: (Please circle the number that best describes your pain)
Del 1-10, califica tu dolor: (Circula el numero que describa mejor su dolor)

No Pain/**No Dolor** Severe Pain/**Dolor Severo**

0 1 2 3 4 5 6 7 8 9 10

INDICATE THE LOCATION OF YOUR PAIN ON THE DIAGRAM/
INDICA LA LOCACION DE SU DOLOR EN EL DIAGRAMA:



The pain is made **better** by: _____

El dolor mejora con: _____

And **worse** by: _____

Y empeora con: _____

Does the pain **radiate?**: _____

El dolor radia? _____

Do you have any **tingling/numbness?**: _____

Tiene hormigueo/entumecimiento? _____

How would you describe your pain? Achy Sharp Stabbing Dull Burning Throbbing

Other: _____

Como describiría su dolor? Dolorido(a) Aguda puñalada Ardor Punzante

Timing (i.e. comes and goes, constant, etc.): _____

Tiempo (biene y se va, constante, etc.): _____

DAILY ACTIVITIES/ACTIVIDAD DIARIA: (Circle one/**Circule uno**)

How much time out of an average day are you in pain? Always Sometimes Never

Cuento tiempo al dia tiene dolor? Siempre Aveces Nunca

What are the worst times of day for the pain? Morning Noon Evening Other _____

Cual es el peor tiempo del dia para su dolor? En la manana Tarde Noche Otro _____

When do you feel the best? Morning Noon Evening other _____

Cuando se siente mejor? En la mañana Tarde Noche Otro _____

PROGRESSION/PROGRESO:

How is your pain compared to when the pain episode first started? (Circle one)

Como se compara el dolor de cuando primero empezó? (Circule uno)

Much Improved Somewhat Improved Much Worse Somewhat Worse No Change

Mejoro mucho Mejoro poco Empeoro Empeoro poco No a cambiado

Please mark all that applies to your daily activities/Por favor marque todos los que aplican:

___ Have difficulty climbing stairs/**Tiene dificultad subiendo escalones.**
___ Have to hold onto something to sit or stand from chair/**Tiene que sostenerse a algo para pararse o sentarse.**
___ Stay at home most of the time/**Se queda en casa la majoria de tiempo.**
___ Cannot do chores around the house/**No puede hacer el quehacer.**
___ Walk slower than usual/**Camina despacio mas de lo normal.**
___ Have to sit most of the day/**Tiene que sentarse la majoria del dia.**
___ Can only stand for short periods of time/**Solo se puede parar por periods corto.**
___ Stays in bed most of the time/**Se queda en la cama la majoria de tiempo.**
___ Changes position frequently to try and get comfortable/**Tiene que cambiar de posición frecuente para estar cómodo(a).**
___ Have difficulty Sleeping/**Tiene dificultad durmiendo.**
___ Have difficulty getting dressed/**Tiene dificulta vistiendose.**
___ Have a loss of appetite/**Tiene Perdida de apetito.**
___ Have more irritable stages/**Esta mas irritable.**

SOCIAL HISTORY/HISTORIAL SOCIAL:

___ Smoker/**Fuma** ___ Non-Smoker/**No Fuma**
___ Drink Alcohol/**Toma Alcohol** How much/**Cuanto**? _____
___ Does not Drink Alcohol/**No toma alcohol** ___ Does not take Drugs/No usa drogas
__ Takes Drugs/**Usa drogas** How Much/**Cuanto**? ____How often/**Que tan sequido**? _____

MEDICAL HISTORY/HISTORIAL MEDICO:

Height/**Estatura**: _____ Weight/**Peso**: _____

Do you have any of the following?

Diabetes? /Diabetis?	Y/Si	N/No
Heart Trouble?/Problemas del Corazon?	Y/Si	N/No
Epilepsy? /Epilepsia?	Y/Si	N/No
High Blood pressure? /Pression Alta?	Y/Si	N/No
Circulation problems? /Problemas de Circulacion?	Y/Si	N/No
Osteoporosis?/Osteoporosis?	Y/Si	N/No
Bowel/Bladder Problems? /Problemas de Vejiga?	Y/Si	N/No
AIDS/HIV positive?	Y/Si	N/No
Have you ever had cancer? /Ha tenido Concer?	Y/Si	N/No
Have you ever experienced dizziness or blackouts?	Y/SI	N/No
Sudden weight loss? /Pérdida de Peso Repentino?	Y/Si	N/No
Breathing problems? /Problemas Respiratorios?	Y/SI	N/No
Are you pregnant?Esta Embarazada?	Y/SI	N/No
Recent surgery? /Cirujia Reciente?	Y/Si	N/No
Arthritis? /Artritis?	Y/Si	N/No

Describe any other health problems/Describa algun otro problema de Salud:

_____

_____

List of Past Surgeries/Lista de Cirujias Pasadas:

_____

List any allergies/Alergias:

_____

List all medications you are taking/Lista de Medicamentos que este tomando:

_____

PATIENT CONSENT / ASSIGNMENT OF BENEFITS / AUTHORIZATION AND FINANCIAL RESPONSIBILITY DISCLOSURE STATEMENT

Consent to Use Protected Health Information for Purposes of Treatment, Payment, and Healthcare Operations – I consent to the use and/or disclosure of my protected health information (PHI) by South Florida Convenient Care, LLC (South Florida Injury Convenient Care) for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct healthcare operations of South Florida Injury Convenient Care. I understand that diagnosis or treatment of me by South Florida Injury Convenient Care may be conditioned upon my consent as evidenced by my signature on this document.

Assignment of Benefits – I hereby assign any and all medical benefits to which I am entitled through my current insurance plan/plans to South Florida Injury and Convenient Care, 2601 Manatee Ave. W., Suite E, Bradenton, FL 34205. This assignment shall stay in effect until revoked by me in writing. A copy of this assignment is considered as valid as the original.

Financial Responsibility – I understand that I am responsible for all charges, whether or not I have insurance. I understand that I am responsible for the full amount due to South Florida Injury and Convenient Care billed unless a payment arrangement is negotiated with the South Florida Injury Convenient Care billing department.

Consent for Use and Disclosure of PHI – I understand that by signing this consent form, I am giving my consent to South Florida Injury and Convenient Care to use and disclose my protected health information to carry out treatment, payment activities, and health care operations. I have had full opportunity to read the South Florida Injury Convenient Care Notice of Privacy Practices. This PHI is being used or disclosed for the purpose of expediting communication of my treatment and care and shall remain in full force and effect for twelve months from the date recorded below. I understand that I have the right to revoke this authorization in writing at any time by sending such written notice to the practice's Privacy contact at 2601 Manatee Ave. W., Suite E, Bradenton, FL 34205. I understand that such revocation will not affect any previous claims submission or payments from my insurance provider for dates of service prior to my written notice.

Cancellation / Now Show Policy – South Florida Injury and Convenient Care understands that there are times when you must miss an appointment. Please understand that we (South Florida Injury and Convenient Care) reserves the right to charge a $25 dollar cancellation fee if an appointment is not cancelled at least 24-hours in advance.

Return Check Policy – A $50.00 fee will be charged for all returned checks.

Indicated below are individuals whom South Florida Injury and convenient Care may speak to regarding my treatment. Please enter the name of the individual in the space provided.

- Spouse: _____
- Family Member: _____
- Other: _____

Do we have your permission to leave a confidential message at the phone number(s) you provided to us?

□ Yes □ No □ Home □ Mobile □ Work □ Other: _____

I understand that I am responsible for knowing the details of my benefits and agree to pay charges for my visit.

_____ _____
Signature of Patient / Guardian / Responsible Party Date

_____ _____
Print Name of Patient/Guardian/Responsible Party Relationship to Patient (if applicable)

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you, or to family and friends you approve.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization : In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. You also have the right to request restrictions on disclosure of PHI (Personal Health Information),or alternative means of communication to ensure privacy.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law or national security activities.

Abuse or Neglect: We may disclose your health information to appropriate authorities when we suspect abuse or neglect.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (Such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information with limited exceptions. If you request copies, we will charge you a reasonable fee to locate and copy your information, and postage if you want the copies mailed to you.

Amendment: You have the right to request that we amend your health information.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us with the U.S. Department of Health and Human Services. A Privacy/Contact Officer has been designated for this office. The Privacy Officer can be contacted by simply contacting the office and asking to speak to the Office Manager who serves as the Privacy Officer.

PATIENT ACKNOWLEDGEMENT OF THE NOTICE OF PRIVACY PRACTICES AND CONSENT FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

Print Patient's Name _____ Date _____

I, _____, acknowledge that I
(Signature of Patient or Parent or Legal Guardian)

Have either received a copy of this office's NOTICE OF PRIVACY PRACTICES or that this office's NOTICE OF PRIVACY PRACTICES was made available to me to receive.

I, _____, consent to the use and disclosure of
(Signature of Patient or Parent or Legal Guardian)

My personal health information by your office for Treatment, Billing / Payment and Health care Operations as outlined in the NOTICE OF PRIVACY PRACTICES.

SOUTH FLORIDA INJURY CONVENIENT CARE
2601 MANATEE AVE. W.
BRADENTON, FL 34205
941-744-0040

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), Uninsured Motorist 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. I understand this document will allow the provider to file suit against an insurer for payment of the insurance benefits or an explanation of benefits and to seek §627.428 damages from the insurer. If the provider's bills are applied to a deductible, I agree this will serve as a benefit to me. This assignment of benefits includes transportation, medications, supplies, overdue 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. 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 the maximum amount directly without any 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 he 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 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 the premiums paid.

Disputes: 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 (specifically the office manager) and the insurer as to the amount payable under the insurance policy. The insured and 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 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. If the PIP insurer states it can pay claims at 200% of the Medicare Fee Schedule or any other fee schedule contained within F.S. 627.736 then the insurer is instructed & directed to provide this provider with a copy of the policy of insurance within 10 days. Any effort by the insurer to pay a disputed debt as full satisfaction must be mailed to the address above, after speaking with the office/billing manager and mailed to the attention of the **Office/Billing Manager (SOUTH FLORIDA INJURY/SUSAN DONAVAN).** See Fla. Stat. §673.3111.

EUOs and IMEs: If the insurer schedules a defense examination or 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 undated. 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 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; and to request and obtain a copy of any statements 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; and for my insurance carrier to **send insurance coverage information (declaration sheet & policy of insurance) in writing and telephonically to the above-named provider**; 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 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, 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. The insurer is not authorized to provide these medical records to anyone without the patient's and the provider's prior express written permission. **PLEASE NOTE: The insurer is not authorized to release protected health information (PHI) to third party vendors that schedule independent medical examinations or independent medical examination physicians.**

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, and the insurance policy to the above provider within 15 days, as well as notify the provider pursuant to F.S. 627.736(6)(f) when benefits have been exhausted. The insurer is directed to pay the bills in the order they are received. However, if a bill from this provider and a claim from anyone else is 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 any 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; 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 _____