



AUTO ACCIDENT PATIENT INTAKE FORM

Name:		
Street Address:		
City:	Postal Code:	
Phone: (home)	(Cell)	(Work)
Email Address:	Occupation:	
Social Security Number:		
Would you like to receive South Florida Injury and convenient Care emails regarding appointment Information? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Would you like to receive South Florida Injury and convenient Care texts regarding appointment Information? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Gender(<i>circle</i>): M F	Date of Birth:	
Family Doctor:		
Preferred Pharmacy:	Phone Number:	

Motor Vehicle Accident Patients

(Please fill out this section)

Insurance Company <i>(Branch Office if applicable)</i>	
Address	
Telephone Number	
Fax Number	
Adjuster's Name	
Date of Accident	
Policy Number	
Claim Number	
Name of Policy Holder <i>(If different from claimant)</i>	

CHIEF COMPLAINT:

Describe the Accident:

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

And **worse** by: _____

Does the pain **radiate**? _____

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

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

Other: _____

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

DAILY ACTIVITIES: (Circle one)

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

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

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

PROGRESSION:

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

Much Improved Somewhat Improved Much Worse Somewhat Worse No Change

Please mark all that applies to your daily activities:

- ___ Have difficulty climbing stairs
- ___ Have to hold onto something to sit or stand from chair
- ___ Stay at home most of the time
- ___ Cannot do chores around the house
- ___ Walk slower than usual
- ___ Have to sit most of the day
- ___ Can only stand for short periods of time
- ___ Stays in bed most of the time
- ___ Changes position frequently to try and get comfortable
- ___ Have difficulty Sleeping
- ___ Have difficulty getting dressed
- ___ Have a loss of appetite
- ___ Have more irritable stages

SOCIAL HISTORY:

- ___ Smoker ___ Non-Smoker
- ___ Drink Alcohol How much? _____
- ___ Does not Drink Alcohol ___ Does not take Drugs
- ___ Takes Drugs How Much? ___ How often? _____

MEDICAL HISTORY:

Height: _____ Weight: _____

Do you have any of the following?

Diabetes?	Yes	No
Heart Trouble?	Yes	No
Epilepsy?	Yes	No
High Blood pressure?	Yes	No
Circulation problems?	Yes	No
Osteoporosis?	Yes	No
Bowel/Bladder Problems?	Yes	No
AIDS/HIV positive?	Yes	No
Have you ever had cancer?	Yes	No
Have you ever experienced dizziness or blackouts?	Yes	No
Sudden weight loss?	Yes	No
Breathing problems?	Yes	No
Are you pregnant?	Yes	No
Recent surgery?	Yes	No
Arthritis?	Yes	No

Describe any other health problems:

List of Past Surgeries:

List any allergies:

List all medications you are taking:

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.

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)
reserve the right to charge a \$50 dollar cancellation fee if an appointment is not cancelled at least 24-hours in
advance or there is a no show.

ASSIGNMENT OF INSURANCE BENEFITS, RELEASE, & DEMAND

Insurer and Patient Please Read ttle Following in itsEntirety 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 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/PARAMOUNT MEDICAL BILLING)** 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 MRI's, 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. 7 36 (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 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 d e d u c t i b l e . 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 _____