

Medicus Spine & Joint (Intake Form)

1. Patient Demographic Information

First Name:	Middle Initials:	Last Name:	Date of Birth:
_____	_____	_____	_____
Gender: <input type="radio"/> Female <input type="radio"/> Male	Street Address:	Apt./Unit #:	City:
_____	_____	_____	_____
State:	Zip Code:	Mobile Phone:	Home Phone:
_____	_____	_____	_____
Work Phone:	Email:		
_____	_____		
Occupation	Employer		
_____	_____		
Primary Language	Spouse/Significant Other Name/Number		
_____	_____		
Emergency/HIPPA Contact/Number	Emergency/HIPPA Contact Address		
_____	_____		

2. Incident/Injury Information Is this injury work related?

Yes No

3. Incident/Injury Information Was this injury caused by a motor vehicle crash?

Yes No

4. Incident/Injury Information Date of Auto Crash & or Injury

5. Incident/Injury Information Auto/Workers Compensation Insurance

6. Incident/Injury Information Auto/Workers Compensation Policy Number

7. Incident/Injury Information Auto/Workers Compensation Claim Number

8. Attorney Information Firm Name & Number

9. Attorney/Case Manager Name & Phone Number

10. Crash/Incident/Injury Details Date of Injury

11. Crash/Incident/Injury Details Brief Description of the Crash/Fall/Incident:

12. Crash/Incident/Injury Details If your injury is the result of a motor vehicle crash, were the:

- Driver Passenger

13. Crash/Incident/Injury Details If your injury is the result of a motor vehicle crash, were you wearing a seat belt?

- Yes No

14. Crash/Incident/Injury Details If your injury is the result of a motor vehicle crash, did the airbags deploy?

- Yes No

15. Crash/Incident/Injury Details If your injury is the result of a motor vehicle crash, did you hit your head?

- Yes No

16. Crash/Incident/Injury Details If your injury is the result of a motor vehicle crash, did you lose consciousness?

- Yes No

17. Crash/Incident/Injury Details If your injury is the result of a motor vehicle crash, were you taken to the emergency room? If yes, where?

18. Crash/Incident/Injury Details If your injury is the result of a motor vehicle crash, if you were taken to the emergency room how did you get there?

- Ambulance Drove

19. Crash/Incident/Injury Details If your injury is the result of a motor vehicle crash, when & where was the first time you sought medical treatment?

20. Complaints Please mark the areas where you feel pain and/or discomfort. 1 = mild 10 = severe

- | | | |
|--|--|--|
| <input type="checkbox"/> Headaches/Dizziness | <input type="checkbox"/> Memory/Mood Changes | <input type="checkbox"/> Neck Pain |
| <input type="checkbox"/> Upper/Mid Back Pain | <input type="checkbox"/> Shoulder Pain (Left/Right) | <input type="checkbox"/> Elbow Pain (Left/Right) |
| <input type="checkbox"/> Wrist Pain (Left/Right) | <input type="checkbox"/> Hand Pain (Left/Right) | <input type="checkbox"/> Low Back Pain |
| <input type="checkbox"/> Hip Pain (Left/Right) | <input type="checkbox"/> Knee Pain (Left/Right) | <input type="checkbox"/> Ankle Pain Left/Right |
| <input type="checkbox"/> Foot Pain (Left/Right) | <input type="checkbox"/> Other Pain/Issues since the injury: | |

21. Complaints Please choose the type of pain you are having:

- | | | |
|---|---|---|
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Aching | <input type="checkbox"/> Shooting |
| <input type="checkbox"/> Burning | <input type="checkbox"/> Cramping | <input type="checkbox"/> Throbbing |
| <input type="checkbox"/> Stabbing | <input type="checkbox"/> Itchy | <input type="checkbox"/> Sore |
| <input type="checkbox"/> Dull | <input type="checkbox"/> Tight | <input type="checkbox"/> Stinging |
| <input type="checkbox"/> Mild Stiffness | <input type="checkbox"/> Moderate Stiffness | <input type="checkbox"/> Severe Stiffness |
| <input type="checkbox"/> Other | | |

22. Complaints How often do you have this pain?

- | | | |
|--------------------------------------|--------------------------------------|---------------------------------------|
| <input type="radio"/> Constant | <input type="radio"/> Intermittent | <input type="radio"/> Daily |
| <input type="radio"/> Every few days | <input type="radio"/> Weekly or less | <input type="radio"/> Monthly or less |

23. Complaints What makes the pain worse?

- | | | |
|--|--|---|
| <input type="checkbox"/> Activity | <input type="checkbox"/> Bending | <input type="checkbox"/> Running |
| <input type="checkbox"/> Reaching | <input type="checkbox"/> Lying down/sleeping | <input type="checkbox"/> Prolonger Walking |
| <input type="checkbox"/> Prolonged Sitting | <input type="checkbox"/> Prolonged Standing | <input type="checkbox"/> Changing Positions |
| <input type="checkbox"/> Lifting Weight | <input type="checkbox"/> Twisting/Rotation | <input type="checkbox"/> Other |

24. Complaints What makes the pain better?

- | | | |
|-------------------------------------|---|------------------------------------|
| <input type="checkbox"/> Nothing | <input type="checkbox"/> Rest | <input type="checkbox"/> Movement |
| <input type="checkbox"/> Heat | <input type="checkbox"/> Therapy | <input type="checkbox"/> Elevation |
| <input type="checkbox"/> Medication | <input type="checkbox"/> Changing Positions | <input type="checkbox"/> Other |

25. Complaints Are you taking any medications for the pain? If yes, does the medication help? Please list medication, strength/dosing:

- | | |
|---------------------------|--------------------------|
| <input type="radio"/> Yes | <input type="radio"/> No |
|---------------------------|--------------------------|

26. Complaints Have you had any bowel/bladder changes such as wetting your pants or soiling yourself since this injury?

- | | |
|---------------------------|--------------------------|
| <input type="radio"/> Yes | <input type="radio"/> No |
|---------------------------|--------------------------|

27. Complaints Do you have increased pain from coughing or sneezing?

- Yes No

28. Complaints Do you have any radiating pain? (Pain that shoots from one area to another) If yes, please describe:

- Yes No

29. Complaints Do you have any tingling, pins and needles or burning sensations? If yes, please describe:

- Yes No

30. Complaints Do you have any feelings of muscle weakness?

- Yes No

31. Complaints Since the onset of your pain, is it:

- Better Unchanged Worse

32. Treatment Details Are you currently attending or completed therapy? If so, where?

- Yes No

33. Are you allergic to LATEX? If yes, what is your reaction?

- Yes No

34. COMPLAINTS If currently attending or completing therapy which type?

- Chiropractic Physical Therapy Occupational Therapy
 Massage Therapy Acupuncture Modalities (ultrasound, electrical stimulation, hot/cold packs)
 Other

35. COMPLAINTS If so, has the therapy helped?

- Yes No

36. COMPLAINTS If you are not currently having therapy, have you had therapy for this problem before? If so when and where?

- Yes No

37. COMPLAINTS Have you had any type of injections for this problem?

- Yes No

38. COMPLAINTS If so, what type of injections did you have?

- Epidural Injections
- Trigger Point Injections
- Facet Injections
- Other

39. COMPLAINTS If you had injections, did they help?

- Yes
- No

40. MEDICAL INFORMATION (Please check all that apply)

- Hypothyroidism
- Hyperthyroidism
- Diabetes I
- Diabetes II
- High Cholesterol
- Alzheimer's
- Sleep Apnea
- Anxiety
- Insomnia
- Depression
- Epilepsy
- Migraine
- Parkinson's
- Rheumatoid Arthritis
- Osteoporosis
- Other
- NONE

41. SURGICAL HISTORY (Please list surgeries, date of surgery and complications in applicable:

42. PHYSICIAN INFORMATION (Please list primary Care Physician/Specialists/Other):

43. ALLERGIES: None: Please leave blank if no known allergies

44. MEDICATIONS

	Medications	Strength	Pills per day
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45. MEDICATIONS If so, pharmacy name/address:

46. REVIEW OF SYSTEMS Since the accident, have you had problems with the following; If yes, please describe:

- | | | |
|---|--|---|
| <input type="checkbox"/> NONE | <input type="checkbox"/> Ear, Nose, Throat | <input type="checkbox"/> Cardiac, HBP |
| <input type="checkbox"/> Lungs, Asthma, Infection | <input type="checkbox"/> Stomach, Digestion | <input type="checkbox"/> Bladder/Bowel Problems |
| <input type="checkbox"/> Hematologist/Bleeding Problems | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Musculoskeletal | <input type="checkbox"/> Neurological | <input type="checkbox"/> Neurological |
| <input type="checkbox"/> Psychiatric | <input type="checkbox"/> Reproductive/Sexual | <input type="checkbox"/> Fever/Chills |
| <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Night Pain | <input type="checkbox"/> Unexpected Weight Loss |
| <input type="checkbox"/> Skin | | |

47. SOCIAL HISTORY Marital Status:

- | | | |
|-------------------------------|-------------------------------|--------------------------------|
| <input type="radio"/> Single | <input type="radio"/> Married | <input type="radio"/> Divorced |
| <input type="radio"/> Widowed | <input type="radio"/> Other | |

48. SOCIAL HISTORY Work Status:

- | | | |
|---------------------------------|----------------------------------|--------------------------------|
| <input type="radio"/> Full Time | <input type="radio"/> Part Time | <input type="radio"/> Disabled |
| <input type="radio"/> Retired | <input type="radio"/> Unemployed | <input type="radio"/> Other |

49. SOCIAL HISTORY Exercise:

- | | | |
|------------------------------|------------------------------|-------------------------------|
| <input type="radio"/> Daily | <input type="radio"/> Weekly | <input type="radio"/> Monthly |
| <input type="radio"/> Rarely | <input type="radio"/> Never | <input type="radio"/> Other |

50. SOCIAL HISTORY Do you live alone? How many floors in your home?

- | | |
|---------------------------|--------------------------|
| <input type="radio"/> Yes | <input type="radio"/> No |
|---------------------------|--------------------------|

51. SOCIAL HISTORY Do you smoke? Do you use other nicotine products? If so, how many packs per day?

- | | |
|---------------------------|--------------------------|
| <input type="radio"/> Yes | <input type="radio"/> No |
|---------------------------|--------------------------|

52. SOCIAL HISTORY Drink alcohol?

- | | | |
|--------------------------------|--------------------------------|---------------------------------|
| <input type="radio"/> NONE | <input type="radio"/> 1-2 Week | <input type="radio"/> 1-2 Month |
| <input type="radio"/> 1-2 Year | <input type="radio"/> Daily | <input type="radio"/> Never |
| <input type="radio"/> Other | | |

53. FAMILY HISTORY (If Yes, please specify which family member

Arthritis

Diabetes

Mental Health Disorders

Blood Clots/Excessive
Bleeding

Cancer

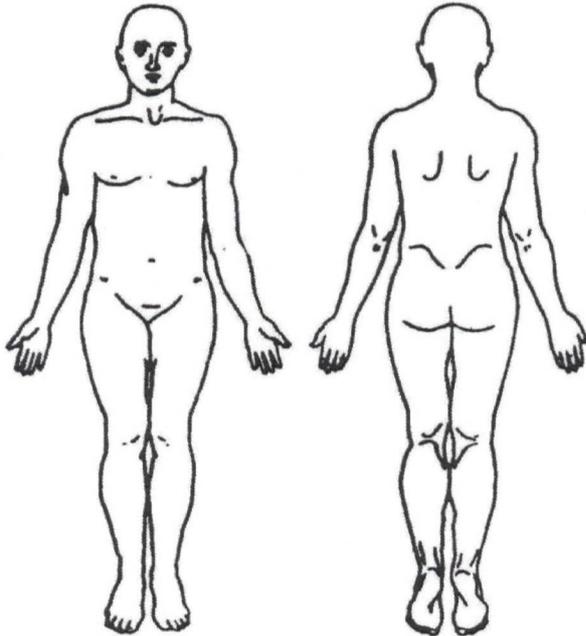
Cardiac Disorders

Hypertension

Adverse Reaction to
Anesthesia

High Cholesterol

54. Please mark the location of your pain: Please describe



NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I have certain rights to privacy regarding my PHI (protected health information). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up amount the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices. I understand that I may request in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

CONSENT TO TREAT

I hereby authorize Medicus Spine & Joint, LLC and whomever they may designate to perform examination, physiotherapy, physical therapy and perform non-invasive diagnostic tests and, if any unforeseen condition arises in the course of the procedures calling for judgement, procedures in addition to or different from those non-complicated. I authorize the performance of diagnostic x-ray examination of myself, which the above doctor or his associates may consider necessary or advisable in the course of my examination and treatment. This is to certify that, to the best of my knowledge, I am not pregnant and the above doctor and his associated have my permission to perform diagnostic x-ray examination. I have been advised that x-rays can be hazardous to an unborn child. I further request and authorize this office to perform whatever your practice deems advisable. The nature and purpose of these procedures have risks involved and the possibility of complications has been fully explained to me. I acknowledge that no guarantee has been made to me as the result that may be obtained.

CONSENT TO TREAT A MINOR

I, _____ hereby authorize Medicus Spine & Joint, LLC and whomever they may designate to perform examination, physiotherapy, physical therapy and perform non-invasive diagnostic tests of my child or

ward _____ and, if any unforeseen conditions arises in the course of the procedures calling for judgement, procedures in addition to or different from those non-complicated. I authorize the performance of diagnostic x-ray examination of _____ which the above doctor or his associates may consider necessary or advisable in the course of my child or wards examination and treatment. This is to certify that, to the best of my knowledge, I am not pregnant and the above doctor and his associated have my permission to perform diagnostic x-ray examination. The patient is a minor, _____ years of age. I knowledge that no guarantee has been made to me as the result that may be obtained.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

This authorization or photocopy hereof, will authorize Medicus Spine & Joint, LLC to furnish all information you may have regarding my condition while under your observation of treatment, including the history obtained, x-ray and physical findings diagnosis and prognosis. I authorize the release of a full report of examination findings, diagnosis, treatment program, etc., to any referring or treating dentist or physician. I authorize release of a copy of my patient records or x-ray containing protected health information. This authorization is given pursuant to South Carolina statute and HIPPA regulations. I understand that South Carolina Statute **SECTION 44-115-30** makes clear that any third party to whom records are disclosed is prohibited from further disclosing any information in the medical record without the expressed written consent of the patient or the patient's legal representatives. I additionally authorize the release of any medical information to insurance companies or for legal documentation to process claims. I understand that I am responsible for all charges for the treatment rendered to me regardless of insurance coverage.

Patient Name: _____ Relationship of Patient: (If applicable) _____

Client Signature

Date

Records Release Authorization

Doctor/Hospital _____

Address _____

I, _____ hereby authorize and request the release of any/all of my medical records to Medicus Spine & Joint, LLC. Please fax any records to our office at 843-405-2813. If you have any questions, please feel free to contact our office at 843-885-0898.

Thank you in advance.

Patient's Name (Please Print): _____ Date: _____

Client 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**.

INITIAL EVALUATION

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: _____

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**.

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

Name: _____

Signature: _____

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.

Client Signature

Date

Authorization for Release of Information to Family Members

Patients Name: _____ Date of Birth: _____

Many of our patients allow family members such as their spouse, parents, or others to call and request medical or billing information. Under the requirements of HIPPA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members you must sign this form. Signing this form will only give information to family members indicated below.

I authorize Medicus Spine & Joint, LLC to release my medical and/or billing information to the following individual(s);

_____ Relationship to Patient: _____

_____ Relationship to Patient: _____

_____ Relationship to Patient: _____

Patient Information

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.

I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to re-disclosure by the above recipient.

You have the right to revoke this consent in writing.

Client Signature

Date

Authorization For Use and Disclosure Of Protected Health Information Under HIPPA Rule 164.508

I _____ (hereafter referred to as "individual") hereby authorize Medicus Spine & Joint (hereafter collectively referred to as "you") to use and disclose in any form or format a copy of records concerning an individual but only as follows to Medicus Spine & Joint, LLC for the purpose(s) of care, treatment, insurance claim submission and bill collection (including litigation). I specifically authorize you to use and disclose the following types of super-confidential information (initial where appropriate);

_____ HIV records (including HIV test results) and sexually transmissible diseases

_____ Alcohol and substance abuse diagnosis and treatment records

_____ Psychotherapy records

_____ Tuberculosis records

_____ All Hospital records

_____ All the above I specifically authorize you to use and disclose the following Protected Health Information

Please initial one or more of the following if applicable

_____ Written Medical Records

_____ X-rays/MRI/CT

_____ Billing records

_____ Prescription records

_____ Other (specify in detail) _____

_____ All of the above

I understand that the information described above may be re-disclosed by the person or group that I hereby give Medicus Spine & Joint, LLC its contract representatives permission to share my information with, and that my information would no longer be protected by the federal privacy regulations. Therefore, I release Medicus Spine & Joint, LLC its workforce members, and its contract representatives from all liability arising from the disclosure of my health information pursuant to this agreement. I understand that I may inspect, or request copies of any information disclosed by this authorization if the Medicus Spine & Joint, LLC or its contract representatives initiated this request for disclosure. I understand that I may revoke this authorization by notifying Medicus Spine & Joint, LLC through its contractor representatives, in writing, knowing that previously disclosed information would not be subject to my revocation request. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment or eligibility for benefits.

Client Signature

Date

Medicus Spine & Joint

LETTER OF PROTECTION

Patient Name: _____

Date: _____

Attorney's Name: _____

Date of Injury: _____

I do hereby authorize and direct you, my attorney, to pay directly to Medicus Spine & Joint, LLC, such sums as may be due and owing them for medical services provided to me by reason of injuries sustained on the above date, as well as monthly service charge on all sums from any settlement, judgement or verdict as may be necessary to adequately protect Medicus Spine & Joint, LLC.

I fully understand that I am directly and fully responsible to Medicus Spine & Joint, LLC for all medical bills and service charges thereon submitted by said group for services provided to me and that this agreement is made solely for Medicus Spine & Joint, LLC additional protection and in consideration of their awaiting payment as set forth above. I further understand that such payment is not contingent on any settlement, judgement or verdict by which I may eventually recover such fees. The undersigned agrees that he/she shall be responsible for attorney's fees and cost incurred to recover any balance due. I also understand that regardless of insurance, Medicus Spine & Joint, LLC does not reduce or adjust any of their usual and customary charges, whether or not they are participating with health insurance.

The undersigned, being the attorney of record for the above patient does hereby agree to observe all the terms above and agree to withhold such sums from any settlement, judgement or verdict REGARDLESS OF THE AMOUNT OF INSURANCE COVERAGE as may be necessary to adequately protect Medicus Spine & Joint, LLC. It is the policy of the practice to not reduce customary and reasonable charges incurred, the attorney agrees that prior to disbursement of any settlement proceeds, he/she will contact Medicus Spine & Joint, LLC to determine the total charges and the outstanding balance owed, and shall provide at least 72 hours' notice prior to disbursement, if the amount recovered is not sufficient to cover the full amount of charges outstanding.

Attorney Signature: _____

Date: _____

PLEASE DATE< SIGN AND RETURN ONE COPY TO Medicus Spine and Joint, LLC. KEEP ONE FOR YOUR RECORDS. A PHOTOCOPY OF THIS FORM SHALL BE CONSIDERED AS VALID AS THE ORIGINAL.

Client Signature

Date

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 **SECTION 38-61-10** 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 Medicare 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 manager and mailed to the attention of the Office Manager.** See SC. Title 36 - Commercial Code.

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.

Express Consent and 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 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.

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 a claim from anyone else 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 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.

Client Signature

Date