Goodman Chiropractic
2206 Curlew Road, Palm Harbor, FL. 34683
Phone (727) 772-7788
Fax (727) 772-0400

Patient Name_____Birthdate_____

Address_____City_____ State _____ Zip_____

Sex: M / F Marital Status: S M D W Height: ___' ____" Weight: _____ lbs SS #: _____

Cell / Home Phone: _____ (may we leave messages on your email/voice mail? Y / N)

Email _____Employer_____Work Phone_____

Insured's Name_____Insured's Relationship to patient: spouse / child / other

Insured's SS# _____ Insured's Birthdate _____

Insured Address _____City _____ State _____ Zip _____

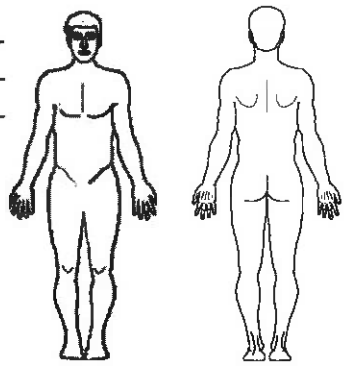
MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.

Date Symptoms Began: _____

Describe Your Symptoms and How They Began: _____

_____

_____



Are Your Symptoms ☐ **Work Related** ☐ **Auto Related** ☐ **Other** ☐ **None**

Current complaint (how you feeltoday):

0 1 2 3 4 5 6 7 8 9 10

No Pain Unbearable Pain

How often are your symptoms present?

(Occasional) ☐ 0 – 25% ☐ 26 – 50% ☐ 51 – 75% ☐ 76 – 100% (Constant)

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN FOR YOUR AREA(S) OF COMPLAINT? ☐ No ☐ Yes

Date(s) taken_____**What areas were taken?** _____

Please check all of the following that apply toyou:

- ☐ Alcohol/Drug Dependence
- ☐ Recent Fever
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Stroke (Date)_____
- ☐ Corticosteroid Use (Cortisone, Prednisone, etc.)
- ☐ Taking Birth Control Pills
- ☐ Dizziness/Fainting
- ☐ Numbness in Groin/Buttocks
- ☐ Cancer/Tumor (Explain)_____
- ☐ Tobacco Use / Type_____
- ☐ Frequency of Use_____
- ☐ Other Health Problems (Explain)_____

_____

- ☐ Prostate Problems
- ☐ Menstrual Problems
- ☐ Urinary Problems
- ☐ Currently Pregnant, #Weeks_____
- ☐ Abnormal Weight ☐ Gain ☐ Loss
- ☐ Epilepsy/Seizures
- ☐ Osteoporosis
- ☐ Visual Disturbances
- ☐ Surgeries_____
- ☐ **Medication (list)**_____

_____

_____

- ☐ **Allergy's (list)**_____

_____

Family History ☐ Cancer ☐ Diabetes ☐ High Blood Pressure
☐ Heart Problems/Stroke ☐ Rheumatoid Arthritis

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this practitioner, I understand that I am liable for all charges for services rendered and I agree to notify this practitioner immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor may need to contact my physician if my condition needs to be co-managed. Therefore I give authorization to my chiropractor to contact my physician, if necessary.

Patient Signature_____**Date**_____

VEHICLE ACCIDENT REPORT

1) Date of Accident: _____ 2) Time of Accident _____: _____-(AM / PM)
3) Were you: A) Driver B) Passenger (Front) C) Passenger (Rear) D) Pedestrian
4) Were you wearing seatbelts? Y / N 4a) Make/Model of car: _____
5) Type of Vehicle: A) Car B) Truck C) Van D) Motorcycle E) Motorhome F) Bicycle
6) How'd accident occur: A) Struck by another vehicle B) Struck another vehicle C) Struck a stationary object D) Other
7) Where was your vehicle hit? A) Front B) Rear C) Rt. Side D) Lt. Side E) Rt. Front F) Lt. Front G) Rt. Rear H) Lt. Rear
8) Where was other vehicle hit? A) Front B) Rear C) Rt. Side D) Lt. Side E) Rt. Front F) Lt. Front G) Rt. Rear H) Lit Rear
9) Your approximate speed _____ MPH I) Other vehicle approximate speed _____MPH 2) What occurred at the moment of impact? (Circle as many as apply)
A) Tensed body for impact B) Neck whipped forward & back C) Spine torqued and twisted D) Thrown over seat
E) Thrown from vehicle F) Pinned in vehicle G) Thrown from side to side H) Cut and bruised
12) Did you strike your. (Circle as many as apply)
A) Head:
Against the: I) Dashboard 2) Windshield 3) Steering Wheel 4) Rt. Door 5) Lt Door 6) Seat Frame 7) Unknown Object
B) Shoulder: Right / Left
Against the: I) Dashboard 2) Windshield 3) Steering Wheel 4) Rt. Door 5) Lt Door 6) Seat Frame 7) Unknown Object
C) Arm: Right / Left
Against the: I) Dashboard 2) Windshield 3) Steering Wheel 4) Rt. Door 5) Lt Door 6) Seat Frame 7) Unknown Object
D) Elbow: Right / Left
Against the: I) Dashboard 2) Windshield 3) Steering Wheel 4) Rt. Door 5) Lt Door 6) Seat Frame 7) Unknown Object
E) Wrist: Right / Left
Against the: I) Dashboard 2) Windshield 3) Steering Wheel 4) Rt. Door 5) Lt Door 6) Seat Frame 7) Unknown Object
F) Hip: Right / Left
Against the: I) Dashboard 2) Windshield 3) Steering Wheel 4) Rt. Door 5) Lt Door 6) Seat Frame 7) Unknown Object
G) Knee: Right / Left
Against the: I) Dashboard 2) Windshield 3) Steering Wheel 4) Rt. Door 5) Lt Door 6) Seat Frame 7) Unknown Object
H) Ankle: Right / Left
Against the: I) Dashboard 2) Windshield 3) Steering Wheel 4) Rt. Door 5) Lt Door 6) Seat Frame 7) Unknown Object
13) Were you rendered unconscious? Y / N 14) Did you receive medical attention at the scene of the accident? Y / N
15) Where did you go immediately following the accident? A) Hospital B) Home C) Personal Doctor D) To this office E) Resumed activities
16) Were you: (Circle as many as apply) A) Shaken B) Disoriented
17) Weather condition at time of accident: _____

In your own words, please describe the accident AND where it occurred: _____

_____

_____

Did you have any physical complaints before the accident? Y / N If "YES" please describe: _____

_____

_____

How did you feel immediately after the accident? _____

_____

_____

Important: This form may be used in the determination of insurance benefits and / or litigation for compensation. It is imperative that this form be filled out completely to protect your rights of compensation.

ASSIGNMENT OF BENEFITS, LIENS AND DIRECT PAYMENT AUTHORIZATION

MEDICAL PROVIDER: Goodman Chiropractic
2206 Curlew Road
Palm Harbor, FL. 34683

INSURANCE COMPANY: _____

For and in consideration of the above-mentioned provider agreeing to pursue my insurance provider for payment of benefits due me and not requiring prepayment for services. I hereby irrevocably assign to the aforementioned medical provider (the 'Provider') any Personal Injury Protection benefits I may have in accordance with Florida Statute 621.736(3). This includes any benefits from my insurance company or any other entity that may be responsible for expenses incurred, and I authorize the 'Provider' to prosecute said action and collect legal expenses as they see fit. THIS DOCUMENT CONSTITUTES AN ASSIGNMENT OF BENEFITS. I hereby further give a lien to the '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 for which I have been treated by the 'Provider'. This is to act as an irrevocable assignment of my rights and benefits to the extent of the services provided. I agree to cooperate with the 'Provider' and any attorney that the 'Provider' chooses, and to do all things reasonable to effect payment of the bills by the insurance company to the 'Provider' including, but not limited to, disclosing patient's medical condition and treatment. This assignment concerns only the bills for the 'Provider' and those costs (including, but not limited to attorney's fees, court costs and interest) necessary in procuring payment from the above-named insurance company, etc. This assignment is not intended to assign any other causes of action that may belong to the undersigned patient. I agree to pay any applicable deductible or co-payment not covered by the PIP insurance coverage. I understand that this is a benefit and convenience to me in that the provider will pursue collection against the insurance company on my behalf I hereby instruct and direct my insurance company to pay my benefits b) check made payable to and mailed to the 'Provider' at the address listed above. If my current policy prohibits direct payment to doctors, then I hereby instruct and direct my insurance company to make the check payable to me and mail it to the 'Provider' at the address listed above. If this 'Provider' is providing medical care related to an auto accident. 'Provider' is charging a reasonable fee for necessary care related to the accident and these bills should be paid to the full extent of the benefits available under my policy of insurance. If any portion of any charge for the services is either reduced or denied in whole or in part. both the provider and the insured request that my insurance company place funds equal to the amount of the reduced or denied charges into escrow. My insurance company is to hold the escrow funds for 'Provider', until such time as all escrowed funds are paid to 'Provider', or 'Provider' instructs my insurance company that 'Provider' is no longer making any claim to the escrowed funds. Furthermore, I hereby give the 'provider' limited power of attorney to endorse / sign my name on any and all checks for payment to the 'Provider'. This agreement is intended to serve as an assignment of the patient's rights and benefits under his / her aforementioned insurance policy in favor of the 'Provider'. If any language within this agreement has the effect of invalidating this assignment, that language shall be deemed void and the assignment shall remain in full force and effect. A photocopy of this assignment shall be considered as effective and valid as the original.

Expiration date: _____

Patient Signature: _____ Date: _____

Print Patient Name / Chart #: _____

Witness Signature: _____ Date: _____

Print Witness Name: _____

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

CARRIER

1. MEDICARE ☐ (Medicare#) MEDICAID ☐ (Medicaid#) TRICARE ☐ (ID#/DoD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (ID#) FECA BLK LUNG ☐ (ID#) OTHER ☐ (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

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.**

   Therapeutic Exercise, Neuromuscular Education, Manual Therapy, Traction, Estim., Heat, Ice

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:

Patient Name *(PRINT or TYPE)*	**Patient** 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 (15) and (16). 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**)*:

Therapist Name *(PRINT or TYPE)*	Provider 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(I)(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.

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.**

   Eval. & Treat, X-Rays, Manual Therapy, Therapeutic Exercise, Massage, Traction, Heat, Ice, Estim.

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:

Patient Name *(PRINT or TYPE)*	**Patient 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 ina **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 (15) and (16). 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**):*

Jamie Goodman D.C.		
Provider Name *(PRINT or TYPE)*	Provider 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.

Goodman Chiropractic
2206 Curlew Road
Palm Harbor, FL. 34683

Patient Authorization for Disclosure of Protected Health Information

HIPPA PRIVACY

PLEASE NOTE THIS FORM ALLOWS GOODMAN CHIROPRACTIC TO SPEAK WITH AND OR GIVE PROTECTED INFORMATION TO THE PERSON (S) LISTED BELOW (i.e. rescheduling appointments, discussing balances, etc...)

Name: _____ **Name:** _____

Relation to patient: _____ **Relation to patient:** _____

Address (if known): _____ **Address (if known):** _____

_____ _____

Phone #: _____ **Phone #:** _____

By signing below, I expressly acknowledge the authorization is voluntary. The authorized person (s) may not be subject to federal / state privacy laws and they may further release my personal health information. I may revoke this authorization at any time by submitting written notice; however revocation will not affect any action previously taken in reliance on this PRIOR to my revocation.

Should revocation not occur I request that this authorization expire on _____.

PRINT NAME: _____ **DATE:** _____

SIGN NAME: _____

GOODMAN
CHIROPRACTIC

NOTICE OF PRIVACY PRACTICES

This notice describes how your health information may be used and disclosed, and how you can access this information **Please review carefully.

At Goodman Chiropractic, we have always kept your health information secure and confidential. The Health Insurance Potability and Accountability Act require us to continue maintaining your privacy to give you this notice and to follow the terms of this notice. The law permits us to use or disclose your health information to those involved in your treatment. For example, reviews or your file by a specialist doctor whom we may involve in your care. We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer. We may use your information to contact you. For example, we want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone. In an emergency, we may disclose your health information to a family member or another person responsible for your care. We may release some or all of your health information when required by law.

Except as described above, this practice will not use or disclose your health information without your prior written authorization. You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.

You have the right to transfer copies of your health to another practice. We will mail your files for you. You have a right to receive a copy of your health information, with a few exceptions. Please provide us with a written request regarding the information you want to have copied, however, we may charge you a reasonable fee for the copies.

You have the right to request and amend your health information. Please provide us with your request to make change in writing. If you wish to include a statement in your file, please provide it to us in writing. We may or may not make the changes that you request, but will be happy to include your statement in your file. If we agree to an amendment *or* change, we will neither move nor alter earlier documents, but will add new information.

You have a right to receive a copy of this notice.

You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, Washington, D.C. 20201. You will not be retaliated against for filling a complaint, however, before filing a complaint, or for more information or assistance regarding your health Information privacy, please contact us at 727.772.7788.

CONSENT FOR TREATMENT:

I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I under- stand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician(s).

Signature _____ Date _____

PATIENT FINANCIAL RESPONSIBILITY DISCLOSURE

Your signature below forms a binding agreement between Goodman Chiropractic (-the provider of medical services) and the Patient who is receiving medical services or the Responsible Party for minor patients (those patients under 18 years old). Responsible Party is the individual who is financially responsible for payment of medical bills.

All charges for services rendered are due and payable at the time of service.

MEDICAL INSURANCE: We have contracts with many insurance companies, and we will bill them as-a service to you. As the responsible party, you are responsible if your insurance company declines to pay for any reason.

The person signing on behalf of the Patient as the Responsible Party must:

- Inform us of the current address and phone number for the patient and the responsible party.
- Present all current insurance cards prior to each office visit.
- Verify at each visit that the information is current by signing our data sheet.
- Pay any required copay at the time of the visit.
- Pay any additional amount owing within 30 days of receiving a statement from our office. (When we receive an explanation of benefits (EOB) from your insurance company, any amounts that you need to pay will be billed to you).

Returned Check Policy

If a payment is made on an account by check, and the check is returned as Non-Sufficient Funds (**NSF**), Account Closed (AC), or Refer to Maker (**RTM**), the patient or the Patient's Responsible Party will be responsible for the original check amount in addition to a **$25.00 Service Charge.** Once notice is received of the returned check, we will send out a letter to notify the Responsible Party of the returned check. If a response is not made within 15 days from the letter date by the Patient or the Responsible Party, the account may be turned over to our collection agency and a collection fee of 50% will be added to the outstanding balance - in addition to the $25.00 Check Service Charge.

Non-Payment on Account

Should collection proceedings or other legal action become necessary to collect an overdue account, the patient or the patient's Responsible Party, understands that we have the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered. The patient, or the patient's Responsible Party, understands that they are responsible for all costs of collection.

By signing below, you agree to accept full financial responsibility as a patient who is receiving medical services or as the responsible party for minor patients. Your signature verifies that you have read the above disclosure statement, understand your responsibilities, and agree to these terms.

Patient Name (Please Print) _____

Patient Signature _____

Responsible Party Name (Please Print) _____

Responsible Party Signature _____ Date _____

DIAGNOSTIC IMAGING CONSULTANTS

A.Scott Thorpe, DC, DACBR, Rudy N. Heiser, DC, MS, DACBR,
Terry Sandman, DC, MPH, DACBR

GOODMAN CHIROPRACTIC
2206 CURLEW RD.
PALM HARBOR, FL 34683
PH: (727) 772-7788 FAX: (727) 772-0400

Jamie Goodman, DC

Films/Date Exposed _____ Medical History_____

**PROVIDER to print and complete form ** Patient only sign **

Patient Name: _____ Date of Birth: _____ Sex: M F

Address: _____ City/State/Zip: _____

Phone _____SS# _____Case/Acct #: _____

BILL: ____PIP ____Health/Other Ins. ____Dr. ____Atty. ____Patient

Primary Insurance: _____ Phone: _____
Adjuster: _____ ID/Claim #: _____
Address: _____Insured:_____
City/State/Zip _____Date of Injury: _____
Attorney's Name, Address & phone #:_____
_____

****

ASSIGNMENT, LIEN AND AUTHORIZATION /INSURANCE BENEFITS

For and in consideration of receiving services by "Assignee" and for other good and valuable consideration, I hereby agree to the following: I authorize assignee to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under this Assignment, Lien, Reservation of Benefits and Authorization.

ASSIGNMENT OF BENEFITS, RESERVATION AND REQUEST TO ESCROW ANY DISPUTED BENEFITS:

I HEREBY ASSIGN MY insurance benefits and any and all causes of action available under my policy of automobile insurance to. DIAGNOSTIC IMAGING CONSULTANTS OF ST. PETERSBURG, PA d/b/a DIAGNOSTIC IMAGING CONSULTANTS hereinafter, collectively referred to as the Assignee. Additionally, both the assignee and the undersigned patient acknowledge they are foregoing or assuming certain rights under this agreement that they would not otherwise have under normal circumstances, and as such, agree the some serves as additional consideration for this assignment of benefits to the provider/assignees. In the event my insurance company, obligated to make payments to me upon charges made by assignee for services. refuses to make or reduces such payments and in order to maximize the benefits available under my policy coverage, I hereby request the insurance company (assuming there is coverage remaining at the time the company receives the Assignees' bill and if the company fails to pay Assignee the full amount of the bill(s) submitted) , to ovoid exhaustion of coverage while Assignee pursues its rights under this Agreement, both parties to this agreement (the Assignee and I) further authorize, direct, notice and request the Insurance Company to set aside and place in escrow an amount equal to the full amount of any such denial or reduction, and to hold that amount in escrow until the dispute is resolved in the appropriate forum.

IN THE EVENT MY insurance company obligated to make payments to me upon the charges made by Assignee for their services refused to make such payments. upon demand by me or Assignee, I hereby assign and transfer to Assignee any and all causes of action that I might have or that might exist in my favor against such company and authorize Assignee to prosecute said cause of action either in my name or in Assignee name and further I authorize Assignee to compromise, settle or otherwise resolve said claim or cause of action as they see fit.

I AUTHORIZE ASSIGNEE to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under this Assignment, Lien and Authorization. I agree that the above mentioned Assignee be given Special Power of Attorney to endorse/sign my name on any and all checks and claim forms for payment of my bill.

I UNDERSTAND THAT I remain personally responsible for the total amounts due the Assignee for their services as insurance coverage may only pay a certain percentage of the bill; as. I may have on insurance deductible or my insurance benefits may exhaust or otherwise be limited. I further understand and agree that this Assignment. Lien and Authorization does not require Assignee to await payments and they may demand payments from me immediately upon rendering services at their option, although the Assignee agrees to first demand immediate payment from the insurance company as their first means of pursuing payment for services rendered. Also, I understand that if this account is assigned to an attorney for collection and/or suit, the assignee shall be entitled to reasonable attorney fees and costs of collection. I also understand that. If any bad check is written, I agree to pay for those added costs.

Dated this _____ day of _____, 20 ____

Patient Signature: _____Printed Name: _____Witness: _____

5136 Central Ave., St. Petersburg, FL. 33707
Phone #: (727) 579-2500 Toll free: (877) 579-8800 Fax: (727) 579-1060