Personal Injury Registration Form

Patient Name: _____ DOB: _____ Today's Date: _____
Address: _____
Phone: _____ Email: _____ Occupation: _____
Height: _____ Weight: _____ Referred by _____

Your Ins Company _____ Policy # _____ Agent's Name _____
Driver/Other Vehicle Ins. Co._____ Policy # _____
Do you have an attorney? □ **Yes** □ **No** Attorney's name _____
Were there any witnesses? □ **Yes** □ **No** Name(s) _____
Details of Accident: Date _____ Time of Day _____

- Were you: □ Driver □ Passenger □ Front Seat □ Back Seat **Airbag Deploy**: □ **Yes** □ **No**
- Number of people in your vehicle _____ Did you hit your head or lose consciousness? □ **Yes** □ **No**
- Where was the accident? _____ Direction of travel _____
- Where was the impact? □ Front □ Rear □ Passenger-side □ Driver-side Police notified? □ **Yes** □ **No**
- **Please describe the accident** _____
  _____
- Did you have any physical complaints BEFORE THE ACCIDENT? □ **Yes** □ **No** *If yes, please describe:*
  _____
- How did you feel immediately after the accident? _____
- Current complaints _____
- Do you congenital (from birth) factors which relate to these complaints? □ **Yes** □ **No** *If yes, please list:*
  _____
- Do you have any complications to recovery? (e.g., diabetes) □ **Yes** □ **No** *If yes, please list:*
  _____
- Any prior accidents vehicle or otherwise? □ **Yes** □ **No** *If yes, what happened? When? Treatment? If so, where?*
  _____
- Have you been seen a doctor since this accident? □ **Yes** □ **No** *If yes, where and what treatment was rendered?*
  _____
- Did you go to a hospital? □ **Yes** □ **No** *If yes, hospital name* _____ Ambulance? □ **Yes** □ **No**
- Since the accident is your pain: □ Improving □ Staying the Same □ Worsening
- **Please check all symptoms that apply:**
  □ Headache □ Neck pain □ Back pain □ Chest pain □ Shortness of Breath □ Irritability □ Dizziness
  □ Pain/numbness in arms/hands □ Pain numbness in legs/feet □ Buzzing in ears □ Loss of Balance
  □ Tension □ Depression □ Memory Loss □ Difficulty Concentrating □ Depression □ Sleep Disruption
  □ Upset Stomach □ Constipation □ Light/sound sensitivity □ Loss of appetite □ Diarrhea
  Complaints not listed above _____
- Have you lost work because of the accident? □ **Yes** □ **No** *If yes, last day worked* _____
  Are you being compensated? □ **Yes** □ **No** *If yes, what type of compensation?* _____
  Any work restrictions because of the accident? *If yes, please describe:*
  _____
- Are you presently taking any medications, herbs, or over the counter products? □ **Yes** □ **No** *If yes, please list:*
  _____

Patient Name _____ Signature _____ Date _____

Informed Consent to Care

You are the decision maker for your healthcare. Part of our role is to provide you with information to assist you in making informed decisions. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive care.

We may conduct some diagnostic or examination procedures, if indicated. Any examination or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is know as a "chiropractic adjustment." There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in a joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all healthcare approaches, results are not guaranteed, and there is no promise of cure. As with all types of healthcare interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporarily increase in symptoms, lack of improvement to symptoms, burns and/or scarring from electrical stimulation and from hot/cold therapies, including, but not limited to: hot packs, ice, and ultrasound, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. This occurs in 3-4 of every 100,000 people, whether they are receiving healthcare or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke. As chiropractic can involve manually and/or mechanically adjusting the cervical region, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedure. Likely, you have tried many of these approaches already. These options may include, but are not: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly you have the right to a second opinion to secure other opinions about your circumstances and healthcare as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstances. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name _____ Signature _____ Date _____

Parent (Guardian) Name _____ Signature _____Date _____

Witness Name _____ Signature _____ Date _____

Parental Consent for the Treatment of a Minor

I, _____, being the parent and/or legal Guardian of the minor age child, _____, DOB_____, hereby give consent for necessary or appropriate treatment and care by the health care providers affiliated with Spinal Science, which may include, without limitation, arranging for and/or authorizing consultation, evaluation, referral, treatment, for the above-named minor. This consent shall remain in effect unless it is revoked in writing. *1 Authority: Sect. 1014.06, Fla. Stat.*

Parent / Legal Guardian _____ Signature_____
Relationship to minor: _____

Witness Name_____ Signature_____ Date_____

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can access this information.
***Protected Health Information (PHI)**

Privacy
Spinal Science is required by state and federal law to maintain the privacy of your protected health information (PHI). PHI includes any identifiable information about your physical or mental health, the healthcare you receive, and the payment for your healthcare. Spinal Science is required by law to provide you with this notice to tell you how it may use and disclose your PHI and to inform you of your privacy rights. Spinal Science must follow the privacy practices as set forth in its most current Notice of Privacy Practices. **This notice refers only to the use/disclosure of PHI. It does not change existing law, regulations, and policies regarding informed consent for treatment.**

Changes to this Notice
Spinal Science may change its privacy practices and the terms of this notice at any time. Changes will apply to PHI that Spinal Science already has as well as PHI that Spinal Science receives in the future. This most current privacy notice will be posted in Spinal Science facilities and programs, and on the Spinal Science website (www.thespinalscience.com), and will be available on request. Every privacy notice will be dated.

How does Spinal Science use and disclose PHI?
Spinal Science use/disclose your PHI for treatment, payment, and healthcare operations without your authorization. Otherwise, yyour written authorization is needed unless an exception listed in this notice applies.

Uses/Disclosures relating to treatment, payment, and healthcare operations
The following examples describe some, but not all, of the uses/disclosures that are made for treatment, payment, and healthcare operations.
For treatment – Consistent with its regulations and policies, Spinal Science may use/disclose PHI to doctors, nurses, service providers, and other personnel (e.g., interpreters), who are involved in delivering your healthcare and related services. Your PHI will be used to help make a determination on your application for Spinal Science services, to assist in developing your treatment and/or service plan to conduct periodic reviews and assessments. PHI may be shared with other healthcare professionals and providers to obtain prescriptions, lab work, consultations, and other items needed for your care. PHI will be shared with Spinal Science service providers for the purposes of referring you for Spinal Science services and then for coordinating and providing the Spinal Science services you receive.
To obtain payment – Consistent with the restrictions set forth in its regulations and policies, Spinal Science may use/disclose your PHI to bill and collect payment for your healthcare services. Spinal Science may release portions of your PHI to the Medicaid or Medicare program or a third-party payor to determine if they will make payment, to get prior approval and to support any claim or bill.
For healthcare operations – Spinal Science may use/disclose PHI to support activities such as programing planning, management, and administrative activities, quality assurance, receiving and responding to complaints, compliance programs (e.g., Medicare), audits, training and credentialing of healthcare professionals, and certification and accreditation (e.g., The Joint Commission).

Appointment Reminders
Spinal Science may use PHI to remind you of an appointment or to provide you with information about treatment alternatives and other health related benefits and services that me be of interest to you.

Uses/Disclosures Requiring Authorization
Spinal Science is required to have a written authorization from you or your personal representative with the legal authority to make healthcare decisions on your behalf for uses/disclosures beyond treatment, payment, and healthcare operations unless an exception listed below applies. You may cancel an authorization at any time if you do so in writing. A cancellation will stop future uses/disclosures except to the extent Spinal Science has already acted based upon your authorization.

Exceptions
- For guardianship or commitment proceedings when Spinal Science is a party.
- For judicial proceedings if certain criteria are met.
- For protection of victims of abuse or neglect.
- For research purposes, following strict internal review.
- If you agree, verbally or otherwise, Spinal Science may disclose a limited amount of PHI for the following purposes:
    - **Clergy -** Your religious affiliation may be shared with clergy.
    - **To Family and Friends –** Spinal Science may share information directly related to their involvement in your care, or payment for your care.
- To correctional institutions, if you are an inmate.

- For federal and state oversight activities such as fraud investigations, usual incident reporting, and protection and advocacy activities.
- If required by law, or for law enforcement or national security.
- To avoid a serious and imminent threat to public health or safety.
- For public health activities such as tracking diseases and reporting vital statistics.
- Upon death, to funeral directors and certain organ procurement organizations.

Your Rights

You, or a personal representative with legal authority to make healthcare decisions on your behalf, have the right to:

- Request that Spinal Science use a specific address or telephone number to contact you. Spinal Science is not required to comply with your request.
- Obtain, upon request, a paper copy of this notice or any revision of this notice, even if you agreed to receive it electronically.
- * Inspect any copy PHI that may be used to make decisions about your care. Access to your records may be restricted in limited circumstance. If you are denied access, in certain circumstances, you may request that the denial be reviewed. Fees may be charged for copying and mailing.
- * Request additions or corrections to your PHI. Spinal Science is not required to comply with a request. If it does not comply with your request, you have certain rights.
- * Receive a list of individuals who received your PHI from Spinal Science (excluding disclosures that you authorized or approved, disclosures made for treatment, payment, healthcare operations, and some required disclosures).
- * Ask that Spinal Science restrict how it uses or discloses your PHI. Spinal Science is not required to agree to a restriction.
- *** These requests must be made in writing.**

Record Retention

Your individual records relating to Spinal Science provided care and services will be retained at a minimum for 10 years from the date you are discharged from inpatient care and/or from the applicable community services. After that time, your records may be destroyed.

To contact Spinal Science or file a complaint

If you want to obtain further information about Spinal Science's privacy practices, or if you want to exercise your rights, or you feel your privacy rights have been violated, or you want to file a complaint, you may contact: Spinal Science phone: (904) 661-1125, Fax: (904) 738-7721 , E-mail: TheSpinalScience@gmail.com . A complaint must be made in writing. You also may contact a Spinal Science facility's medical records office (for that facility's records), a Spinal Science program director (for that program's records), your site office (for case management records), or the human rights officer at your facility or program, for more information or assistance.

Patient _____ Patient Signature _____ Date _____

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process, except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. Further, the parties will not have the right to participate as a member of any class of claimants, and there shall be no authority for any dispute to be decided on a class action basis. An arbitration can only decide a dispute between the parties and my not consolidate or join the claims of other persons who have similar claims.

Article 2: All claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, as to whether this agreement is unconscionable, and any procedural disputes, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider, including any heirs or past, present, or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers, preceptors, or interns who now or in the future treat the patient while employed by, working, or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents, and estate, must be arbitrated including, without limitation, claims for loss or consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days, and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgement for future damages conformed to periodic payment, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction, or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof s received, the claim, is asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and, if not revoked, will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment), patient should initial here _____. Effective as of the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRAIL. SEE ARTICLE 1 OF THIS CONTRACT.

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date:_____

SPINAL SOLUTIONS JAX INC. DBA SPINAL SCIENCE

2511 Saint Johns Bluff Rd, Suite 103, Jacksonville, Fl 32246 (P) 904.661.1125 (F) 904.738.7721

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, a/k/a 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 and I authorize and request such litigation. This assignment of benefits includes the cost of 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. 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. It is this provider contention its charges are reasonable based on what other doctors in the community charge and what PIP insurers have allowed for these services. 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 the 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 the 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 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; 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 MRls, 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 and 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 PI P 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 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; and I agree the provider's prices for medical services, treatment and supplies are reasonable, usual and customary.

Caution: Please read before signing. Please ask to view a copy of our charges. 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 _____

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

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

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

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

_____

_____

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

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

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

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

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

Name *(PRINT or TYPE)*	Signature	Date

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

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

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

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

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

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

Name *(PRINT or TYPE)*	Signature	Date

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of Claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234(1)(b), Florida Statutes.

Note: The **original** of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may **not** be electronically furnished. Failure to furnish this form may result in non-payment of the claim.