SMC
SARASOTA MEDICAL CENTER

Patient Information - Please Print

Patient's Name: (LAST)_____ (FIRST)_____ (MIDDLE INTIAL)_____

Local Address:_____

City:_____State:_____Zip Code:_____ Email:_____

Billing Address:_____

City:_____ State:_____ Zip Code:_____

Home Phone: ( )_____ Pref Y / N Cell Phone: ( )_____Pref Y / N

Age:____ Date of Birth: ____/ ____/ ____ Sex □ M □ F Social Security #:_____

Emergency Contact:_____Relationship:_____Phone: (___)_____

Marital Status: □ Single □ Married □ Divorced □ Separated □ Widowed □ Minor

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino □ Unknown □ Declined to Specify

Race: □ American Indian □ Asian □ African American □ White □ Other Race □ Declined to Specify

If Minor, Responsible Parties:_____

If different address than above:_____

City:_____ State:_____ Zip Code:_____

Health Insurance Information:

Primary Insurance Carrier:_____ Policy #:_____

Insurance Policy Holder:_____ Policy Holder DOB:_____

If Auto Accident Case: Date of Accident:_____State:_____

YOUR Auto Insurance Carrier:_____Phone #:_____

YOUR Claim #:_____YOUR Policy #:_____

Adjusters Name:_____ Attorney:_____

Attorney Phone#:_____ Contact/Case Manager:_____

If Worker's Compensation Case:

Employer:_____Date of Injury:_____

Workman's Comp Insurance Co:_____ Phone #:_____

Claims Mailing Address:_____

Claim #:_____Case Manager:_____

I understand that all health or auto insurance policies are an arrangement or agreement between myself and the insurance carrier. I further accept and agree to be personally liable for the timely payment of any balance left unpaid by an insurance carrier. I further understand that if I suspend or terminate my care with Sarasota Medical Center, any fees for professional services rendered to me will be immediately due and payable. Further, if for any reason, any legal action is necessary to collect any unpaid balances incurred by me, for medical treatment with Sarasota Medical Center, I agree to be personally responsible for all court costs and reasonable attorney's fees incurred for the enforcement of this agreement.

Patient/Guardian Signature:_____Date:_____

Medical History

Please fill out to the best of your ability and focus on what is pertinent to today.

Name:_____ Age:_____ Date of Birth:_____ Sex:_____ Date: _____

General Health Status:

Please rate your health: ___ Excellent ___ Good ___ Fair ___ Poor

Exercise: ___ Athlete ___ Heavy ___ Daily ___ Moderate ___ None

Health Habits: Smoking ___No ___ Yes, ___ packs/day ___Years Alcohol ___No ___Yes, ____ drinks per week

Family History:

Please list if your father, mother, sibling, grandparent, or aunt/ uncle has had any of the following conditions.

Arthritis :_____ Cancer:_____

Cholesterol: _____ Diabetes: _____

Heart Disease: _____ Hypertension: _____

Psychological: _____ Seizure/ Epilepsy:_____

Stroke: _____ Other: _____

Allergies: _____

Prescription Medications: _____

_____

_____

Non-Prescription Medications/ Vitamins/ Supplements/ Herbs: _____

_____

Previous Surgeries/ Hospitalizations: _____ Year: _____

_____ Year: _____

_____ Year: _____

_____ Year: _____

Cardiovascular:	**Yes**	**No**
Heart Attack	( )	( )
Chest Pain	( )	( )
Pacemaker/Defibrillator	( )	( )
Leg/Ankle Swelling	( )	( )
Palpitations	( )	( )
Irregular Pulse	( )	( )
Muscle pain/cramps	( )	( )
Heart Murmur/Arrhythmia	( )	( )
Abnormal EKG	( )	( )
High Blood Pressure	( )	( )
Eyes, Ears, Nose, Throat	**Yes**	**No**
Hearing Loss	( )	( )
Uncorrectable Vision Loss	( )	( )
Fever Blisters	( )	( )
Swallowing Difficulty	( )	( )
Blood/ Lymphatic	**Yes**	**No**
Bleeding Disorder	( )	( )
Anemia	( )	( )
Transfusions	( )	( )

Respiratory	**Yes**	**No**
Recent Infection	( )	( )
Asthma	( )	( )
Pneumonia	( )	( )
Tuberculosis	( )	( )
Chronic Cough	( )	( )
Shortness of Breath	( )	( )
COPD	( )	( )
CPAP Machine	( )	( )
Neurological	**Yes**	**No**
Stroke/ TA	( )	( )
Migraine	( )	( )
Black Out Spells	( )	( )
Dizziness	( )	( )
Weakness/Paralysis	( )	( )
Motion/Car Sickness	( )	( )
Endocrine	**Yes**	**No**
Diabetes	( )	( )
Thyroid Problems	( )	( )
Pituitary Problems	( )	( )

Gastrointestinal	**Yes**	**No**
Hepatitis	( )	( )
Jaundice	( )	( )
Ulcer	( )	( )
Hiatal Hernia	( )	( )
Pancreatitis	( )	( )
Vomiting Blood	( )	( )
Colitis	( )	( )
Blood in Stool	( )	( )
Hemorrhoids	( )	( )
Change in Bowels	( )	( )
Genitourinary	**Yes**	**No**
Bladder Infection	( )	( )
Kidney Infection	( )	( )
UTI	( )	( )
Stones in Urine	( )	( )
Blood in Urine	( )	( )
Incontinence	( )	( )
Blockage of Urine	( )	( )
Prostrate Problem	( )	( )

Musculoskeletal	**Yes**	**No**
Fractures	( )	( )
Dislocations	( )	( )
Joint Pains	( )	( )
Arthritis	( )	( )
Back Pain	( )	( )
Neck Stiffness	( )	( )
Neck Immobility	( )	( )

Last Menstral Period:

_____

Using Other Providers?		
Cardiologist	( )	( )
Chiropractor	( )	( )
Dentist	( )	( )
Family Doctor	( )	( )
Gastroenterology	( )	( )
Neurologist	( )	( )
OB/GYN	( )	( )
Orthopedist	( )	( )
Rheumatologist	( )	( )

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Personal Injury Questionnaire

1. Your vehicle type

☐ Sedan ☐ Sports Car
☐ SUV ☐ Pick-up Truck
☐ Station Wagon

Other_____

2. Your position in vehicle

☐ Driver
☐ Front Passenger
☐ Left Rear Passenger
☐ Right Rear Passenger
Other_____

3. At the time of accident, your vehicle was?

☐ Stopped at intersection ☐ Stopped in traffic
☐ Stopped at light ☐ Accelerating
☐ Crossing an intersection ☐ Slowing down
☐ Making a right turn ☐ Making a left turn
☐ Stopped at Stop sign Other _____

4. Time/Speed/Damage

Date of Accident? _____
Time of accident: _____
A.M. or P.M.
Your vehicle speed:_____mph
Their vehicle speed:_____mph
Damage to your vehicle:
☐ Mild ☐ Moderate ☐ Totaled

What type of vehicle hit you?
☐ Sedan ☐ Sports Car
☐ SUV ☐ Pick-up Truck
☐ Station Wagon

Other_____

5. Details of Accident

Visibility at time of accident:
☐ Poor ☐ Fair ☐ Good

Who hit who/what?
☐ You hit other vehicle
☐ Other vehicle hit you
☐ You hit…… (object)

_____

Point of impact:
☐ Head-on ☐ Rear-end
☐ Left-front ☐ Left-rear
☐ Right-front ☐ Right-rear

6. Road/Weather Conditions

Road conditions at time of accident:
☐ Icy ☐ Wet
☐ Sandy ☐ Clean and Dry
☐ Dark ☐ Well lighted

Weather conditions:
☐ Clear ☐ Cloudy ☐ Raining
☐ Foggy ☐ Drizzling

7. Body Position, etc.

Did you see the accident coming?
☐ Yes ☐ No
Were you braced for the impact?
☐ Yes ☐ No
Did you have a seat belt on?
☐ Yes ☐ No

Does your vehicle have headrests? ☐ Yes ☐ No

What was the position of your headrest at time of impact?
☐ Even with top of head ☐ Even with bottom of head ☐ Middle of neck

What was the direction of your head to time of impact?
☐ Facing straight forward ☐ Turned to the right ☐ Turned to the left

Did driver side air bags deploy? ☐Yes ☐ No Did passenger side air bags deploy? ☐Yes ☐ No
Did side air bags deploy? ☐ Yes ☐ No

8. In your own words, please describe where and how the accident happened.

9. During the accident:

Did your body strike the inside of your vehicle?
☐ Yes ☐ No
If yes, describe
_____
Did you lose consciousness during the injury?
☐ Yes ☐ No
If yes, for how long?
_____
Your vehicle's estimated damage? $_____
Damage to their vehicle: ☐ Mild ☐ Moderate ☐ Totaled
Did police show up at the scene? ☐ Yes ☐ No
Was an accident report filled out? ☐ Yes ☐ No

10. After the accident:

Check your symptoms right after/and few days following:
☐Face pain ☐Fatigue ☐Diarrhea
☐Cold Hands ☐Cold feet ☐Tension
☐Nausea ☐Nervousness ☐Chest pain
☐Fainting ☐Fatigue ☐Anxiety
☐Loss of taste ☐Depression
☐Loss of smell ☐ Pain behind eyes
☐Constipation ☐Blurred Vision
☐Ringing in ears
☐Shortness of breath
Other _____

11. Emergency Room?

Where did you go after the accident? ☐ Home ☐ Work ☐ Hospital ER ☐ Private Doctor
If you went to the hospital:
Hospital Name:_____Doctor Seen:_____
When did you go? ☐ Day of Accident ☐ Next Day ☐ Other time_____
How did you get there?☐ Drove self ☐ Somebody else ☐ Ambulance ☐ Police
Were you admitted? ☐ Yes ☐ No
Were X-rays done? ☐ Yes ☐ No Body parts X-rayed? _____
The X-rays revealed _____
Were MRI's done? ☐ Yes ☐ No Body parts MRI? _____
The MRI's revealed _____
Was lab work done? ☐ Yes ☐ No What lab work? _____
Treatments: ☐ Cervical Collar ☐ Ice ☐ Stitches Other_____
Medications Prescribed: _____
_____
Follow-up instructions: _____
_____
_____

12. Treatment History:

Have you ever been in a previous auto/motorcycle/bicycle accident? ☐ Yes ☐ No If Yes, when_____
If Yes, what were your injuries?_____
_____
Fill in any other doctor(s) seen prior to your first visit to this office.
1. Dr. _____ First visit date: _____
Specialty:_____ X-rays done? ☐ Yes ☐ No
Types of treatments received: _____
How many treatments received? _____ Currently treating? ☐ Yes ☐ No
Did treatments benefit you? ☐ Yes ☐ No Last visit date: _____
2 Dr. _____ First visit date: _____
Specialty:_____ X-rays done? ☐ Yes ☐ No
Types of treatments received: _____
How many treatments received? _____ Currently treating? ☐ Yes ☐ No
Did treatments benefit you? ☐ Yes ☐ No Last visit date: _____

13. Body Symptoms

Neck Problems ☐ Pain ☐ Pain that causes headaches ☐ Spasms ☐ Popping/Clicking sound Pain/numbness/tingling/weakness: ☐Down RIGHT arm ☐Down LEFT arm ☐Down RIGHT Upper Back ☐Down LEFT Upper Back	**Head Problems** ☐ Headaches ☐ Dizziness ☐Balance Problems ☐ Mood Swings ☐ Memory Loss ☐ Irritability ☐ Sleep Difficulties ☐ Flashbacks to accident ☐Disoriented/Confusion ☐ Attention Problems	**Jaw Problems** ☐ Pain ☐ Clicking ☐ Pain while chewing ☐ Pain while talking ☐ Pain while yawning ☐ Pain moving jaw side to side ☐ Other_____
Shoulder Pain ☐ Left ☐ Right ☐ Both ☐ Left ☐ Right ☐ Both ☐ Sharp ☐ Dull ☐ Ache ☐ Stabbing ☐ Other_____	**Upper Arm Pain** ☐ Left ☐ Right ☐ Both ☐ Sharp ☐ Dull ☐ Ache ☐ Stabbing ☐ Other_____	**Elbow Pain** ☐ Left ☐ Right ☐ Both ☐ Sharp ☐ Dull ☐ Ache ☐ Stabbing ☐ Other_____
Forearm Pain ☐ Left ☐ Right ☐ Both ☐ Sharp ☐ Dull ☐ Ache ☐ Stabbing ☐ Other_____	**Wrist Pain** ☐ Left ☐ Right ☐ Both ☐ Sharp ☐ Dull ☐ Ache ☐ Stabbing ☐ Other_____	**Hand Pain** ☐ Left ☐ Right ☐ Both ☐ Sharp ☐ Dull ☐ Ache ☐ Stabbing ☐ Other_____
Chest Pain ☐ Yes ☐ No **Stomach Pain** ☐ Yes ☐ No	**Mid & Upper Back Pain** ☐ Sharp ☐ Dull ☐ Ache ☐ Stabbing ☐ Spasms ☐ Numbness down the RIGHT side Into the shoulder, arm or hand ☐ Numbness down the LEFT side Into the shoulder, arm or hand	**Low Back Pain** ☐ Sharp ☐ Dull ☐ Ache ☐ Stabbing ☐ Spasms ☐ Numbness down the RIGHT side Into the buttock ,leg or foot ☐ Numbness down the LEFT side Into the buttock ,leg or foot
Pelvic or Sacral (Tail Bone) Pain ☐ Sharp ☐ Dull ☐ Ache ☐ Stabbing ☐ Spasms ☐ Numbness down the RIGHT side Into the buttock ,leg or foot ☐ Numbness down the LEFT side Into the buttock ,leg or foot	**Hip Pain** ☐ Left ☐ Right ☐ Both ☐ Sharp ☐ Dull ☐ Ache ☐ Stabbing ☐ Other_____	**Upper Leg Pain** ☐ Left ☐ Right ☐ Both ☐ Sharp ☐ Dull ☐ Ache ☐ Stabbing ☐ Other_____
Knee Pain ☐ Left ☐ Right ☐ Both ☐ Sharp ☐ Dull ☐ Ache ☐ Stabbing ☐ Other_____	**Calf Pain** ☐ Left ☐ Right ☐ Both ☐ Sharp ☐ Dull ☐ Ache ☐ Stabbing ☐ Other_____	**Ankle Pain** ☐ Left ☐ Right ☐ Both ☐ Sharp ☐ Dull ☐ Ache ☐ Stabbing ☐ Other_____
Foot Pain ☐ Left ☐ Right ☐ Both ☐ Sharp ☐ Dull ☐ Ache ☐ Stabbing ☐ Other_____	**Lacerations/Cuts/Bruising** ☐ Head ☐ Face ☐ Neck ☐ Seat Belt Bruising ☐ Cuts/Bruise on Chest ☐ Cuts/Bruise on Arms ☐ Cuts/Bruise on Legs ☐ Other_____	

14. Pain Disability Questionnaire

Please answer every question by making an X along the line to show how much your pain problem has affected you (from having no problems at all to having the most severe problems you can imagine).

1. Does your pain interfere with your normal work inside and outside the home?

|_____|_____|_____|_____|_____|

Work normally — Unable to work at all

2. Does your pain interfere with personal care (such as washing, dressing, etc.)?

|_____|_____|_____|_____|_____|

Take care of myself completely — Need help with all my personal care

3. Does your pain interfere with your traveling?

|_____|_____|_____|_____|_____|

Travel anywhere I like — Only travel to see doctors

4. Does your pain affect your ability to sit or stand?

|_____|_____|_____|_____|_____|

No problems — Cannot sit / stand at all

5. Does your pain affect your ability to lift overhead, grasp objects, or reach for things?

|_____|_____|_____|_____|_____|

No problems — Cannot do at all

6. Does your pain affect your ability to lift objects off the floor, bend, stoop, or squat?

|_____|_____|_____|_____|_____|

No problems — Cannot do at all

7. Does your pain affect your ability to walk or run?

|_____|_____|_____|_____|_____|

No problems — Cannot walk / run at all

8. Has your income declined since your pain began?

|_____|_____|_____|_____|_____|

No decline — Lost all income

9. Do you have to take pain medication every day to control your pain?

|_____|_____|_____|_____|_____|

No medication needed — On pain medication throughout the day

10. Does your pain force you to see doctors much more often than before your pain began?

|_____|_____|_____|_____|_____|

Never see doctors — See doctors weekly

11. Does your pain interfere with your ability to see the people who are important to you as much as you would like?

|_____|_____|_____|_____|_____|

No problem — Never see them

12. Does your pain interfere with recreational activities and hobbies that are important to you?

|_____|_____|_____|_____|_____|

Normal activity — No recreationlhobbies at all

13. Do you need the help of your family and friends to complete everyday tasks (including both work outside the home and housework) because of your pain?

|_____|_____|_____|_____|_____|

Never need help — Need help all the time

14. Do you feel more depressed, tense or anxious than before your pain began?

|_____|_____|_____|_____|_____|

No depression/tension — Severe depression/tension.

15. Are there emotional problems caused by your pain that interfere with your family, social, or work activities?

|_____|_____|_____|_____|_____|

No problems — Severe problems

Rate your overall pain level below:

0	1	2	3	4	5	6	7	8	9	10

No Pain — Excruciating pain

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Doctor's Lien

C. John Mason, MD Joaquin J. Aristimuño, MD Steven O. Gaeta, DC Yishai Sprung, PT

2830 Bee Ridge Road
Sarasota, FL 34239

Patient's Name: _____

Date of Accident: _____

Lien & Agreement

Lien

I, hereby authorize and give a lien, in favor of Good Business LLC dba Sarasota Medical Center and its doctors within, on any settlement, claim, judgement or verdict as a result of said accident.
I authorize and direct you, as my insurance carrier, second party insurance, third party insurance carrier and my attorney, to pay directly to Good Business LLC dba Sarasota Medical Center, such sums as may be due or owed to Good Business LLC dba Sarasota Medical Center for services rendered to me, and to withhold such sums for such settlement, claim, judgment, or verdict as may be necessary to protect Good Business LLC dba Sarasota Medical Center and its doctors within.

Agreement

I fully understand that I am directly and fully responsible to Good Business LLC dba Sarasota Medical Center for all medical and physical therapy bills or charges submitted by Good Business LLC dba Sarasota Medical Center or his office for services rendered to me, and that this agreement solely for Good Business LLC dba Sarasota Medical Center's additional protection and consideration of their awaiting payment. I further understand that such payment is not contingent on any settlement, claim, judgement, or verdict by which I may eventually recover said fee.

Enforcement

The undersigned patient accepts and agrees to be bound by the terms and conditions of this lien and/ or any accompanying agreement.
The undersigned agrees that if he/ she is responsible for violation of the terms and conditions of this agreement, that he/ she will be responsible for all attorney's fees and court costs associated with the collection of any outstanding balances owed to Good Business LLC dba Sarasota Medical Center.

_____ _____
Signature of Patient/ Guardian Date

_____
Printed Patient/ Guardian Name

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Informed Consent to Care

You are the decision maker for your health care, Part of our role is to provide you with information to assist you in making informed choices, 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 the care.

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

Chiropractic care centrally involves what is known 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 the joint, and improving neurological functioning and overall well-being,

It is important that you understand, as with all health care approaches, results are not guaranteed, and there Is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke, The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery, Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care 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.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments, For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 121 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already, These options may include, but are not limited to: 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 and to secure other opinions about your circumstances and health care 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 circumstance. 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 or Guardian: _____ Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date: _____

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SARASOTA MEDICAL CENTER
2830 Bee Ridge Road
Sarasota, FL 34233
P-941-927-1234 F-941-921-0043

AUTHORIZATION FOR RELEASE, USE AND DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____Date of Birth: _____
Address: _____
Phone #: _____ Fax #: _____

I hereby request and authorize the use/ disclosure of health information about me as described below by the following individual/ organization: □ To Disclose Information To □ To Receive Information From

Receiving Information From:

□ Sarasota Memorial Hospital
Fax: 941-917-1106

□ Doctor's Hospital
Fax: 941-371-1029

□ Provider _____
_____
_____

□ Other: _____
_____
_____

Dates of Service: _____
The type of information to be used or disclosed is as follows (please include dates of service):

□ Complete Medical Record □ History & Physical □ Consultation Reports □ X-Ray & Imaging
□ Discharge Summary □ Pathology Reports □ Progress Notes □ Cardiac Cath
□ Operative Reports □ Physician Orders □ Lab Results □ Echo
□ EKG □ Ultrasound Results
□ Abstract of Medical Records (H & P, Discharge Summary, Consultation Reports, Operative & Procedure Reports, EKG's, Labs, X-Ray, & Imaging Reports)

Disclosure Information:

This information is being provided to you from records whose confidentiality may be protected by State and/or Federal Law. Any disclosure is bound by Title 42 of the Code of Federal Regulations governing the confidentiality of alcohol and drug abuse patient records and that redisclosure of this information to a party other that the one designated above is forbidden without additional written authorization on my part.

Purpose of Disclosure: □ Further Medical Care □ Insurance Eligibility/ Benefits □ Inspection/ Copying of My Records
□ Legal Investigation/ Action □ Personal □ Changing Physicians
□ Other _____

I understand I have the right to inspect and obtain a copy of my protected health information in the designated record sets you or your business associates maintain. I understand, however, I am not entitled to inspect or obtain a copy of any psychotherapy notes or any information compiled in anticipation of use of or for any civil, criminal, or administrative action or proceeding, any information not subject to disclosure under the Clinical Laboratory Improvements Amendments of 1988 (42 USC sec. 263.a) and certain other records.

I understand that the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected under the terms of this authorization.

I have read the above and authorize the disclosure of or reception of protected health information as stated.

Patient Signature: _____ Date: _____

If signed by person other than the patient, state relationship and authority to do so.
□ Minor □ Incompetent □ Disabled □ Deceased □ Custodial Parent □ Legal Guardian
□ Power of Attorney for Health Care □ Executor of Estate of Deceased □ Authorized Legal Personal Representative

Signature of Witness: _____ Date: _____

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ASSIGNMENT OF INSURANCE BENEFITS, RELEASE, & DEMAND
Insurer Attorney and Patient Please Carefully Read the Following in its Entirety!

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 F.S.§627.428 damages from the insurer. If the provider's bills are applied to a deductible, I agree this will serve as a benefit to me. This assignment of benefits includes transportation, medications, supplies, overdue interest and any potential claim for common law or statutory bad faith/unfair claims handling. If the insurer disputes the validity of this assignment of benefits then the insurer is instructed to notify the provider in writing within five days of receipt of this document. Failure to inform the provider shall result in a waiver by the insurer to contest the validity of this document. 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 being declared void, 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.

Additionally, I hereby assign the rights and benefits of any second or third party liability insurer, relative to direct payment of any claims for my injuries: Specifically, this extends to a claim against Bodily Injury Liability Coverage for a second or third party insurer. I hereby authorize and direct the second or third party insurer to pay directly, Good Business LLC dba Sarasota Medical Center, for any outstanding balance due to treatment of my injuries.

Further, I assign the rights and benefits or any settlement, received by my attorney on my behalf, to Good Business LLC dba Sarasota Medical Center, to pay any and all outstanding balances left unpaid, for any reason, by my automobile insurance carrier.

If no automobile insurance exists, or if automobile insurance exists and the limits of coverage have been exhausted, this assignment of benefits shall extend to direct my attorney or legal representative to pay any and all outstanding balances to Good Business LLC dba Sarasota Medical Center for my treatment, from the proceeds of any settlement received on my behalf.

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 fee schedule or any other fee schedule contained within FS §627.736 then the insurer is instructed and directed to provide this provider with a copy of the policy of insurance within 10 days. Any effort by the insurer to pay a disputed debt as full satisfaction must be mailed to the address above, after speaking with the office/billing manager and mailed to the attention of the **Office Manager.** See Fla. Stat. §673.3111.

EUOs and IMEs: If the insurer schedules a defense examination or examination under oath (hereinafter "EUO") or independent medical exam (hereinafter IME), 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 settlements, IMEs or EUOs given by the undersigned.

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 email, fax, or US Postal Service, with any and all information that may be contained in the medical records. I also authorize my insurance carrier to send insurance coverage information (declaration sheet & policy of insurance) in writing and by telephone to the above named provider: request from any insurer all explanation of benefits (EOBs) for all providers and non-redacted PIP payout sheets; obtain any written and verbal statements the patient or anyone else provided to the insurer; obtain copies of the entire claim file and all medical records, including but not limited to, all documents, reports, diagnostic testing results, scans, doctors and nurses notes, bills, opinions, IME reports, from any other medical provider or any insurer. The provider is permitted to produce my medical records to the 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 written permission. PLEASE NOTE: The insurer is not authorized to release protected health information (PHI) to third party vendors that schedule independent medical examination or independent medical examination physicians.

Demand: Demand is hereby made for the insurer to pay all bills within 30 days without reductions and to mail the latest non-redacted PIP payout sheet and the insurance coverage declaration sheet and the insurance policy to the above provider within 15 days, as well as notify the provider pursuant to FS 627.736(6)(f) when benefits have been exhausted. The insurer is directed to pay the bills in the order they are received. However, if a bill from this provider and a claim from anyone else is received by the insurer on the same day the insurer is directed to 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 this provider, until the dispute is resolved by a Court of law. Do not exhaust the policy. The insurer is instructed to inform, in writing, the provider of any dispute.

Certification: I certify that: I have read and agree to the above; I have not been solicited or promised anything in exchange for receiving health care; I have not received any promises or guarantees from anyone as to the results that may be obtained by any treatment or service; I agree the provider's prices for medical services, treatment and supplies are reasonable and customary.

Caution: Please read before signing. **If you do not completely understand this document please ask us to explain it to you. If you sign below we will assume you understand and agree to the above.**

Patient's Signature: _____

(If patient is a minor, signature of parent/guardian.)

Patient's Name, Please Print: _____Date:_____

(If patient is a minor, printed name of parent/guardian.)

SMC

SARASOTA MEDICAL CENTER

Effective Immediately

A **$25 charge** will be placed on your account for any scheduled appointments that are a **NO-SHOW**.

Please plan accordingly, reschedule or cancel any appointments you cannot attend.

Signature:_____ Date:_____