**PATIENT INFORMATION**

Date:

Marital Status:

Last Name: First: Middle:

Sex:

Date of Birth: Social Security #:

Home Ph: Cell Ph: Cell Provider\*:

\*To receive text message appointment reminders please provide your Cell Provider

Patient Address:

City: State: Zip:

Email Address:

Employed By:

Emergency Contact Name/Relationship: PH:

How did you hear of our office? 🞏 Google 🞏 Friend/Word of Mouth

🞏Medical Referral 🞏 Insurance Website Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE INFORMATION**

Patient’s insurance member ID/ claim information:

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, AND/OR various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic AND/OR doctor of physical therapy named below and/or other licensed personnel who now or in the future work at the clinic or office listed below or any other office or clinic.

I have an opportunity to discuss with the doctor of chiropractic or doctor of physical therapy named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications and I wish to rely upon the doctor to exercise judgment during the course of the treatment which the doctor feels at the time, based upon the facts then known to him or her is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Dr. Jonathan Hancock, DC

Dr. Esperansa Niño, DC

Dr. Lindsay Taylor, DC

Dr. Justin Spiegel, PT DPT CMP

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Patient Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Signature Date

Financial Policy

We make every effort to provide you with high quality care and convenient financial options. Our office participates with many insurance providers and if you choose to use your insurance you will need to pay your estimated copay/coinsurance. Please note that we can only give you an ESTIMATE and not a guarantee of payment by your insurance company. We give estimates according to the benefits quoted to us by your insurance company. Ultimately, your insurance company does not care about you or us, they care about money, and that is the harsh reality. The contract you sign with them leaves you responsible for any underpayment by them. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any specific questions you may have regarding your coverage.

The estimated patient responsibility for an appointment is due on the day of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your patient responsibility at each visit.

*How Deductibles Work*

*Deductible: A fixed-dollar amount that a plan member must pay for eligible services before the insurance company begins applying benefits. Deductibles are part of certain health care plans and based on a member's specific benefit period.*

*For example, if you have a $1,500 deductible, then you are responsible for paying the first $1,500 of health costs incurred. After you pay the first $1,500, your insurance will begin paying toward healthcare costs as laid out under the terms of the policy.*

If your account is over 90 days past due, you will receive a letter stating that you have 14 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency. You agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 50% of the debt, and all costs, and expenses, including but not limited to reasonable attorney’s fees, that we may incur in such collection efforts.

We accept checks, cash, and the following credit cards: Master Card, Visa, American Express and Discover. Another option we offer is "Care Credit". This is a separate line of credit for health care needs.

Our practice is committed to providing the best treatment to our patients. Our fees are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I understand the above policy.

Patient Signature

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart.

By signing below I authorize being contacted for practice reminders

* Email
* Telephone (voice mail)
* By text message

If applicable, fill in the name and relationship of the person(s) or organization(s) to which you will allow Florida Injury & Wellness Center to disclose your personal health information:

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(Examples may include: spouse or other family member, attorney, primary care physician or other physician involved in your care, etc. )

You have the right to take back (“revoke”) your authorization at any time, in writing, except to the extent that Florida Injury & Wellness Center has already acted based on your permission. If you would like to revoke your authorization, send in a written request.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name (please print) Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Parent, Guardian or Patient’s legal representative

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient, Parent, Guardian or Patient’s legal representative

# CANCELLATION POLICY

We regret the need to implement the policy below, but we have had an increasing number of patients who fail to keep their scheduled appointments. As a courtesy, we agree to confirm your appointment by an automated reminder text and/or email, or call to you one day before your scheduled appointment. You will at that time have the opportunity to cancel, confirm, or submit a request to have someone from the office contact you to re- schedule. If you have scheduled your appointment within 24 hours, you will not receive a confirmation call. The result of patients not canceling their scheduled appointment is that the physicians are then unable to accommodate those patients with sudden medical problems that require medical intervention.

All new patients are required to provide a valid credit card number, including expiration date and billing zip code, in order to schedule a new patient appointment. If you cancel with less than 24 hours’ notice, or fail to show for your appointment, your credit card will be charged $45.00.

I hereby acknowledge that I am aware and accept the financial responsibility for fees assessed to my account for failing to provide a 24 hour cancellation notice of any scheduled appointment at Florida Injury & Wellness Center, LLC.

The fee of $45.00 for any missed appointment will be charged to the credit card I provide. I understand that this fee is not reimbursable by my insurance carrier. The fee for the first cancellation or no show will be waived.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_\_\_

Credit Card # Expiration CVV Billing Zip Code

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

Patient Signature Date

# *\*This document will be securely shredded*

**LATE SHOW POLICY**

Our providers do their best to keep appointments on schedule. Out of respect for patients who have arrived on time for their appointment, you may be asked to reschedule your appointment if you arrive later than your scheduled appointment time. We will make every effort to honor your appointment as a “work in” appointment as the schedule allows. The policy is that new patients arrive 15 minutes prior to their scheduled appointment time and established patients arrive 5 minutes before their scheduled appointment time.

I hereby acknowledge and accept the above policy.

Patient Signature Date

Authorization to Release Protected Health Information

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Request:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Information Requested from**:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby authorize the above named office and any of its employees to disclose my Patient Health Information to:

Florida Injury & Wellness Center LLC

27454 Cashford Circle Wesley Chapel, FL 33544

PHONE: 813.973.4747 FAX: 813.973.3799

Effective Dates of this authorization: \_\_\_\_\_\_\_\_\_\_\_\_\_\_through \_\_\_\_\_\_\_\_\_\_

This authorization will expire at the end of the above period.

I understand I have the right to:

* Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.
* Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
* Inspect a copy of Patient Health Information under federal law.
* Refuse to sign this authorization.
* Receive a copy of this authorization.
* Restrict what is disclosed with this authorization.

I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected patient health information.

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Signature or Patient or Patient's Authorized Representative Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Authorized Signature- Florida Injury & Wellness Center Date

Jonathan Hancock, D.C.

Lindsay Taylor, DC

Esperansa Niño, D.C.

Justin Spiegel P.T., D.P.T., C.M.P.

**OUR OFFICE POLICY REGARDING INSURANCE PLANS**

Our office is pleased to accept your insurance plan. The deductible and any amount that is not paid by the insurance company is the patient’s responsibility. The patient will be billed for any balance not paid by the insurance company within 60 days, unless other arrangements are made with Florida Injury & Wellness Center. We will do our best to provide you an ESTIMATE of your responsibility based on information we gather from your insurance plan. We will file your claim forms and assist you in every way we can.

TIME OF SERVICE (TOS) DISCOUNT

What is a Time of Service Discount?

Whether your insurance plan covers chiropractic services or not, Florida Injury & Wellness Center offers a Time of Service (TOS) Discount to everyone. There is approximately a 20% savings if you choose to pay for your services with this method of payment. In order to qualify for this discounted payment option, you would have to agree to the following:

All services are paid THE SAME DAY they are provided (at the discounted rate).

You would submit to your insurance company the paperwork for the services provided at our office. We would not do this on your behalf.

You understand that your insurance company may or may not reimburse you at a later date for the services performed at our office.

I have read the above and understand my options for payment of services rendered at Florida Injury & Wellness Center. Please initial option 1 or 2 below.

Self-Pay

1. \_\_\_\_\_\_\_ I choose to take the TOS discount. I understand that I will pay for the services at the time of service and I will be responsible for sending the claim in to the insurance company in order to be reimbursed.

Insurance

2. \_\_\_\_\_\_\_I choose not to take the time of service discount. I understand that Florida Injury & Wellness Center will bill my insurance and I will be responsible for any outstanding amounts applicable after any insurance payments or balances applied toward my deductible/copay.

Signature Date

**ASSIGNMENT OF BENEFITS, AUTHORIZATION TO SETTLE CLAIM**

**AND DIRECTION TO PAY MEDICAL PROVIDER DIRECTLY**

Assignment of benefits in the context of health care refers to an agreement or arrangement between a beneficiary and an insurance company, by which a beneficiary requests the insurance company to pay the health benefit payment directly to the physician or medical provider. The patient or guardian signs the assignment of benefits form so that reimbursement checks will be sent directly to the doctor or medical provider.

By my signature below, for good and valuable consideration (including but not limited to the extension of credit to me), I hereby assign, transfer and convey to **Florida Injury & Wellness Center** (hereinafter “the Provider”) all of my rights, title and interest in and to medical expense reimbursement in whatever form, including but not limited to health benefits indemnification **or** any automobile liability medical expense payments and/or agreement otherwise payable to me. This payment shall not exceed my indebtedness to the above named assignee and I acknowledge that I will timely pay any indebtedness owed by me to the assignee that is not otherwise satisfied by the above-mentioned assigned proceeds. I also acknowledge that any medical expenses not covered under my insurance policy will be my responsibility.

The Provider hereby 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.

I further direct my insurer to direct all payments for services rendered by the Provider directly to Provider at the billing address contained on Provider’s medical bills.

THIS IS A DIRECT AND IRREVOCABLE ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER MY POLICY OF INSURANCE.

**A photocopy of this form shall be considered as effective and valid as the original.**

I have read the foregoing and understand and agree to each of the above provisions:

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Patient Name (Print) Patient Signature Date