Gulf Coast Injury Center

Medical | Chiropractic | Massage | Rehabilitation

Confidential Patient Case History

First Name:_____Last Name_____Middle Initial_____***Male/ Female***

Address:_____City State_____Zip_____Home /Cellphone _____

May we leave messages regarding your appointment or medical condition at the number listed above? Y/ N Age:_____DOB__/__/__

SS#:__/__/__ Marital Status: ***Married / Single /Widow*** Email_____

Do you have a DNR on file? **Y / N** -Do you have Advanced Directives in place? **Y / N** -If yes, may we have a copy? **Y / N** If no, would you like info? **Y/N**

Occupation:_____Employer_____Work Phone #_____

Emergency Contact Name:_____*Relation:*_____Phone#_____

Primary Care Physician_____Phone_____Fax_____

Pharmacy:_____Phone_____

Health Insurance

Insurance Company:_____Subscriber ID#:_____Group#_____Phone#_____

Are you the primary insured on this policy? ***YES / NO*** If No, Insured Name:_____Relation_____

Primary Insured's DOB__/__/__Address if different then above_____City/St/ Zip_____

Do you have secondary insurance? YES / NO If yes, Insurance company:_____Subscriber#_____

Auto Insurance

Date of accident__/__/__ Insurance Company Name:_____Phone#_____

Policy Number:_____Claim Number:_____Adjuster Name:_____Phone:_____

If you do not have auto insurance, Do you live with someone who does? Yes/No If yes, relation to insured:_____

Name of Insured:_____Address:_____Phone#_____

Workers Compensation

Date of injury__/__/__Employer:_____Phone#_____Manager Name:_____

WC Insurance Company:_____Phone#:_____

Claim#_____Claim Adjuster:_____Adjuster Phone#_____Fax#_____

Attorney Information

Do you have an attorney? ***YES / NO***

If yes, Firm Name_____Attorney Name:_____Case Manager:_____

Address:_____Phone:_____Fax:_____

I authorize the release of a full report of examination of findings, diagnosis, treatment programs, etc., to any referring or treating physician or dentist. I additionally authorize the release of any medical information to the insurance companies for legal documentation to process claims. I understand that I am responsible for all charges for the treatment rendered to me regardless of the insurance coverage. I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that ***Gulf Coast Injury Center, LLC****, will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to* ***Gulf Coast Injury Center, LLC.*** *will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will me immediately due*

Patient/ Guardian Signature _____**Date**_____

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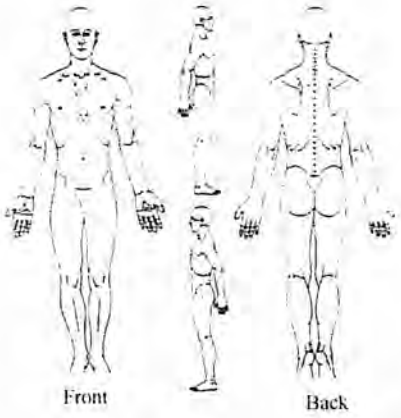
Accident Information

What type of accident? *(Circle)*
Motor Vehicle / Work related / Motorcycle / Struck by vehicle / Slip and Fall / Other _____
Date of Accident: _____ Location of accident _____ Time: _____
Were you the: *Driver/ Passenger/ Rear Passenger: Left side/right side/ Middle Seat* Were you wearing your Seatbelt? *YES / NO*
Year, Make, Model of the vehicle you were in: _____ Make and Model of the other vehicle: _____
Describe the accident briefly: _____

_____

Road condition and visibility at the time of the accident. _____ Did you anticipate the crash/brace for impact *YES / NO*
Hand position prior to the crash? _____ Did the airbags deploy? *YES / NO*
Was the vehicle was *TOWED | DROVE AWAY* Did EMT arrive on scene? *YES/NO* Did you go to the hospital? *YES/NO*
If yes, method of transport _____ Which hospital: _____ City/St _____
When did you go to the hospital? Date: _____

Medical Information



Briefly describe the pain _____

_____

_____

How long after the accident did you feel pain? _____
Is this pain progressively getting worse? *YES / NO*
How do you rate the pain? *(1 being no pain 10 being worse pain)* _____
What makes the condition feel better? _____
Is this condition interfering with any of the following *Work | Sleep | Daily Routine | Other* ___
Have you ever had any similar pain before the crash? *YES/NO*
If yes, how recent? _____ Have you suffer any other accidents? *YES / NO*
If yes, list injuries _____
Were diagnostics performed? *YES / NO*
If yes, type of study(s) and date(s) _____

Are you pregnant? *YES / NO / MAYBE If yes, how far along* _____ Number of children _____
Do you currently smoke tobacco? *YES / NO* If yes, How much? _____ pack(s) per day. How long? _____ year(s)
Do you drink alcohol? *YES / NO* If Yes, How much? _____ drink(s) per day. How long? _____ year(s)
List any surgical procedures: _____
List any medical condition/ diagnosis: _____
Are you currently taking any medication? *YES/NO* If yes, list all medications _____

_____

Are you currently working? *YES /NO* If yes, what do you do? _____ Do you work : *Full Time / Part time*
Have you missed any days of work since the accident? *YES/NO* If yes, how many days? _____
Are you active outside of work? *YES / NO* If yes, types of activities _____

Family Health Information

Many health problems are the result of hereditary spinal weakness, thus information about your family member will give us a better picture of your total health picture. Please list any information you may know about your family members that may be helpful.

Mother: _____ Father: _____ Siblings: _____

Patient/ Guardian Signature _____ **Date** _____

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Consent for Treatment

I,_____, hereby authorize your practice and whomever the doctor may designate as his/her assistant to perform examination, physiotherapy, and physical therapy and to perform non-invasive diagnostic tests. This may include any unforeseen condition that arises in the course of the procedures which may call for judgment for procedures in addition to or different from those non-complicated. I further request and authorize this office to perform whatever my treating doctor deems advisable. The nature and purpose of these procedures have risks involved and the possibility of complications have been fully explained to me. I acknowledge that no guarantee has been made to me as to the result that may be obtained.

Is the patient a minor? ***Yes/No*** If Yes, Legal Guardian Name:_____Relation:_____

Patient/ Guardian Signature_____**Date**_____

Authorization for Medical Information

This authorization or photocopy hereof, will authorize you to furnish all information you may have regarding my condition while under your observation or treatment, including the history obtained, x-rays, physical findings, diagnosis and prognosis. You are authorized to provide this information in accordance with the auto personal injury protection law. (Chapter 71-252f)

I authorize that my medical records can be discussed with:_____Relation:_____

Patient/ Guardian Signature_____**Date**_____

Summary of the Florida Patient's Bill of Rights and Responsibilities

Florida law requires that your healthcare provider or healthcare facility recognize your rights while you are receiving medical care and that you respect the healthcare provider's or healthcare facility's right to expect certain behavior on the parts of patients. You may request a copy of the full text of this law from your healthcare provider or health facility. A Summary of your rights and responsibilities are as follows:

1. A patient has the right to be treated with courtesy and respect, with appreciation of his/her individual dignity, and with protection of his or her need for privacy.
2. A patient has the right to prompt and reasonable response to questions and requests.
3. A patient has the right to know who is providing medical services and who is responsible for his/her care
4. A patient has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.
5. A patient has the right to know what rules and regulations apply to his/her conduct.
6. A patient has the right to be given by the healthcare provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.
7. A patient has the right to refuse any treatment, except as otherwise provided by law.
8. A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his/her care.
9. A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment: whether the healthcare provider or health care facility accepts the Medicare assignment rate.
10. A patient has the right to receive a copy of a reasonable clear and understandable, itemized bill and upon request, to have the charges explained.
11. A patient has the right to receives, upon request, prior to treatment, a reasonable estimate of charges for medical care.
12. A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, physical handicap, or source of payment.
13. A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
14. A patient has the right to know if medical treatment is for the purpose of experimental research and to give his/her consent or refusal to participate in such experimental research.
15. A patient has the right to express grievances regarding any violation of his/her rights, as states in Florida law, through the grievance procedure of the healthcare provider or healthcare facility which served him/her and to the appropriate states licensing agency.
16. A patient is responsible for providing to the healthcare provider, to the best of his/her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his/her health.
17. A patient is responsible for reporting unexpected changes in his/her condition to the healthcare provider.
18. A patient is responsible for reporting to the healthcare provider whether he/she comprehends a contemplated course of action and what is expected for him/her.
19. A patient is responsible for keeping appointments and, when he/she is unable to do so for any reason, for notifying the healthcare provider for healthcare facility.
20. A patient is responsible for his/her actions if he/she refuses treatment or does not follow the healthcare provider's instructions.
21. A patient is responsible for assuring that the financial obligations of his/her healthcare are fulfilled as promptly as possible.
22. A patient is responsible for following healthcare facility rules and regulations affecting patient care and conduct.

I have read and understand the summary of the Florida patient's bill of rights and responsibilities.

Patient Signature:_____ ***Date:***_____

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Patient Name:_____ DOB_____

Address:_____ City/St_____ Zip_____

Date of Loss:_____ Claim#_____

Assignment of Benefits

I hereby assign from any and all automobile policies which provide medical benefits or no-fault benefits, all rights, title and interest ***to Galloway Chiropractic and Health. D/B/A Gulf Coast Injury Center.*** ("Assignee") for payment for services rendered unto me both by reason of accident or illness. In the event my insurance company fails to pay Assignee the full amount owed to Assignee after proper statutory notice, I hereby also assign by this instrument, all rights and causes of action in tort, in contract and the laws of Florida, against the personal injury protection carrier for the above named insured/patient, for its failure to pay for services rendered unto Assignee in relation to my accident or illness. This assignment may only be rescinded /reassigned by the mutual consent of the patient/insured/assignor and the healthcare provider/assignee.

Reservation of Benefits

Please be advised that I am here by placing you on notice pursuant to Florida case law that should you deny, reduce or fail to pay either part or an entire bill, which was submitted on my behalf from this healthcare provider. I am requesting you reserve, or hold aside, that same amount until this dispute is resolved. Additionally, should the remaining amount of my benefits approach an amount where there would be insufficient funds to pay the amount you reduced, denied or failed to pay, or if my benefits should become exhausted, please notify me and this healthcare provider of the fact immediately.

Direction of Payment/Release of Information

I hereby authorize any insurance company or attorney to pay direct to *Assignee* the amount of this and/or any future bills for services rendered unto me. I also agree to pay in a current manner any difference between the total charges and the amount pain by the insurance company directly to the *Assignee*. I hereby authorize *Assignee* to release any information requested that is pertinent to my case to any insurance company or attorney involved in this case. *Pursuant to FS 627.4137*, I hereby request a copy of this PIP payment log and any available policy insurance or declaration sheet, which reflects the applicable policy limits available at the time of this accident, to be provided by the insurance company to the *Assignee*. I hereby authorize *Assignee* permission to request and receive a current copy of my PIP payment log periodically as they deem necessary. A photocopy of this assignment shall be considered as valid and effective as the original

Patient/Guardian Signature_____ ***Date***_____

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

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

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

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

_____

_____

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 (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)*:

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.

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HIPAA Privacy Authorization Form

This is an authorization for the use or Disclosure of Protected Health Information.
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

This is an authorization for the release of health information that covers all past, present and future periods of my medical records. I, _____ __/__/____ ____/____/____
Patient Name *Date of Birth* *SS#*

Authorize the use or disclosure of the health information as described below to the following person and/or organization _____ _____
Name of Facility sending request to (Leave Blank) City, State

- ☐ Entire Medical Chart
- ☐ Demographic Information
- ☐ Hospital Records
- ☐ Consultations
- ☐ Labs/Diagnostics
- ☐ Other_____

I authorize the disclosure of the following information marked above to the following organization:

- ☐ *1104 W.Kennedy Blvd. Tampa, FL. 33606 Ph (813) 258-6051 Fx (813) 258-6064* ***South Tampa***
- ☐ *6963 E. Fowler Ave Temple Terrace, FL 33617 PH (813) 253-3111 FX (813) 514-0108* ***North Tampa***
- ☐ *322 S. Falkenburg Rd Brandon, FL. 33619 PH (813) 626-2311 FX (813) 343-4233* ***Brandon***
- ☐ *8142 Bellarus Way Ste. 102 Trinity,FL 34655 PH(727) 937-9726 FX (727) 934-2820* ***Trinity***
- ☐ *3830 Tampa Rd Ste 350 Palm Harbor, FL. 34684 PH (727) 500-1648* ***Palm Harbor***
- ☐ _____

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. I understand that the information in my medical record may include information relating to mental healthcare and treatment of alcohol and/or drug abuse. I also, understand that the information may include information realating to sexually transmitted disease, AIDS and/or HIV. Also, understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing. I understand that the revocation will not apply to information that has already been released in response to the authorization. I understand that the revocation, this authorization will not apply to my insurance policy. Unless otherwise revoked, this authorization will expire in one year.

*Patient/Guardian Signature:*_____ *Date*_____

*If signed by Legal Rep., relation to Patient*_____

*Witness*_____ *Date*_____

Patient Name:_____

RBITRATION AGREEMENT

rticle 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 contrac ere unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state an ederal 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 thi ontract, by entering into, 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 o rbitration. 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 decide n a class action basis. An arbitration can only decide a dispute between the parties and may not consolidate or join the claims of other persons who have simila laims.

rticle 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 no dispute is subject to arbitration, as to whether this agreement is unconscionable, and any procedural disputes, will also be determined by submission to bindin rbitration. 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 service rovided 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. Thi greement 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 intende bind the patient and the health care provider and/or other licensed health care provider, preceptors, or interns who now or in the future treat the patient whil mployed 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 o ny 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 agains ie health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including ithout limitations, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create a pen book account unless and until revoked.

rticle 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (part bitrator) within thirty days, and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. Th eutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration incurred or approved by the neutral arbitrator, no ncluding counselor 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 th sues 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 entit iat 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 o ntity shall be stayed pending arbitration. The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence o y 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 dgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercia rbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

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

rticle 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, wil vern all professional services received by the patient and all other disputes between the parties.

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

any provision of the 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.

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

PATIENT SIGNATURE_____**DATE**_____

OFFICE SIGNATURE_____**DATE** _____

IROPRACTIC INFORMED CONSENT TO TREAT

ereby request and consent to the performance of chiropractic procedures, including various modes of physical therapy/physiotherapy, diagnostic x-rays, and any pportive therapies on me (or on the patient names below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed ctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with, or serving as back-up for the doctor of iropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

ave had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of iropractic adjustments and procedures.

nderstand that chiropractic adjustments and supportive treatment are designed to reduce and/or correct subluxations, allowing the body to return to improved alth. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, I understand and am formed that, as is with all healthcare treatments, results are not guaranteed, and there is no promise to cure. In addition, I understand and am informed that, as is th all healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, gravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns from heat lamps, ice or heating devices, fractures, disc injuries, okes, 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 on the doctor to ercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

urther understand that there are treatment options available for my condition other than chiropractic procedures. There treatment options include, but are not nited to, self- administered, over-the-counter analgesics and rest; medical care with prescription drugs, such as anti-inflammatories, muscle relaxants and inkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and to secure ner opinions if I have concerns as to the nature of my symptoms and treatment options.

nderstand that all payment(s) for treatment(s) are final and no refunds will be issues. However, prorated fees for unused, prepaid treatments will be refunded if I wi cancel the treatment.

ave 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 have the ove-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek atment.

PATIENT SIGNATURE: _____ **DATE:**_____

Chiropractor Name:_____

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Emergency Management Plan

1. If the patient has a caregiver, the caregiver must accompany the patient and remain with the patient during the course of treatment
2. Please be aware that each room contains an evacuation map near the doorway which will assist in guidance to the nearest exit in the event of an emergency.
3. It is the responsibility of the facility staff member to educate patients on the nearest exit in case of emergency.
4. During an emergency, your assigned staff member has been trained to guide you to the nearest exit for safety
5. In the event of facility closure, you will be contacted and informed by a designated member of the facility. When the facility has returned to normal operating hours, you will be notified.
6. Any treatment missed due to the event of an emergency will be documented as missed in your clinical records and made up at a later date.

Please note: The staff of the facility needs to be notified of any special needs you may have so that they may properly assist you during the unforeseen even of an emergency.

I have been educated on the Emergency Management Plan for the facility and I am clear about my responsibility as well as the responsibility of the trained staff members with regard to protocols during the event of an unforeseen emergency

Patient Signature:_____ Date:_____

ADVANCED BENEFICIARY NOTICE OF BILLING AND SERVICE OPTIONS (ABN)

By my signature below, I, _____ (print name), hereby acknowledge and understand that Gulf Coast Injury Center (hereinafter "the Practice"), have offered to provide medical treatment related to my liability incident dated _____. I have fully read this notice to make an informed decision about the payment for my medical care. I further acknowledge that I have been given the opportunity to ask any questions I may have and to consult with an attorney of my choice to discuss my rights and responsibilities prior to choosing my option and signing this form.

(INITIAL ONLY ONE BOX. WE CANNOT CHOOSE A BOX FOR YOU.)

_____ **OPTION 1** - Due to the time and nature of treatment to be rendered by the Practice, in addition to the risk in undertaking my medical treatment of either underpayment or nonpayment by my health insurance carrier, I want the medical services prescribed by the Practice but do not want my health insurance to be billed. I do not want to pay out-of-pocket for my co-pays, deductibles, co-insurance, or other patient responsibility costs related to these medical services. I understand that by choosing this option, I will remain personally liable for the payment of all medical services rendered but I am being offered the ability to pay for those medical services at a later time and with no additional interest on the amount owed. I understand that the term "health insurance carrier" includes health insurance, Medicare, Medicaid and/or managed healthcare of any kind.

_____ **OPTION 2** - I hereby agree that the Practice will bill my health insurance carrier, Medicare, Medicaid, or other applicable carrier for the medical services by the Practice, but I will be required to pay in full all co-pays, deductibles, co-insurance, or patient responsibility estimated to be payable as a result of the rendering of these medical services prior to receiving any medical treatment.

By signing below, I hereby acknowledge that I have read and understand this notice and have freely made my own decision as to which option to choose. Any questions I have about this document have been answered to my satisfaction by the Practice and I have had an opportunity to consult my attorney if needed.

_____ _____

Signature of Patient Date

_____ _____

Signature of Medical Provider Date

PATIENT FINANCIAL AGREEMENT (PFA):

AUTHORITY TO TREAT AND GUARANTEE OF PAYMENT FOR MEDICAL SERVICES

Re: Patient Printed Name: _____ (hereinafter "Patient")
Date of Birth: _____
Date of Incident: _____

Initial:

_____ 1. Gulf Coast Injury Center (hereinafter "the Practice") has agreed to provide medical care to the Patient.

_____ 2. Because the Patient is being seen at this medical practice due to injuries received as a result of a traumatic event, this document becomes reasonable and necessary. The Practice will bill any and all applicable insurance coverages and/or governmental benefit programs which are accepted by the Practice for any services rendered, unless otherwise directed in the Advanced Beneficiary Notice of Billing and Service Options. However, often times, standard insurance coverages and/or governmental benefit programs will not pay all of the medical bills incurred and/or for the services rendered for one or more reasons. Any balance for medical services which are not paid by the patient's insurance coverage or accepted governmental benefits shall remain the responsibility of the patient.

_____ 3. Presently, the Patient is not a subscribing member of any group or individual commercial health insurance policy and/or does not participate in any government sponsored health insurance plans (Medicare, Medicaid, Tricare, etc.) OR the Patient does possess valid health insurance or a sponsored health plan but requires medical care which may not be fully reimbursable under said policy or program.

_____ 4. The Patient does not want to pay any out-of-pocket costs associated with his/her medical care and as a result, has requested an alternate payment arrangement with the Practice. The Practice agrees to provide medical care and to defer collection of his/her medical charges including, but not limited to, co-pays, deductibles and/or patient responsibilities until the conclusion of any liability claim/claims being made as a result of his/her traumatic incident.

_____ 5. As one potential payment source, the Practice has the right to seek payment for the medical services provided from the proceeds of the Patient's settlement or jury verdict in his/her liability claim/claims. The Patient hereby agrees and directs his/her Attorney to pay for his/her medical treatment out of the proceeds of any settlement or verdict the Patient may receive from the Patient's case.

_____ 6. In consideration for this Patient Financial Agreement/Authority to Treat and Guarantee of Payment. the Practice agrees to defer attempts to collect payment until the conclusion of the Patient's legal claim/claims for this incident.

_____ 7. The Patient understands that this type of Patient Financial Agreement/Authority to Treat and Guarantee of Payment is vastly different from the traditional contractual relationship between the Practice and a commercial insurance carrier or government sponsored insurance plan. In that instance, there is a predictable certainty in the contractual relationship wherein the contract defines the responsibility of each respective party. The parties pre-emptively agree upon terms such as: utilization/pre-authorization, reimbursement rates, billing practices, aging of receivables and the appeals process for denials. Conversely, this arrangement covered by this agreement has an unpredictable outcome which presents certain risks to the Practice. The consequence of uncertainty in litigation matters requires compliance with the terms of this agreement in order to adequately reflect such risks as well as to account for the additional costs and responsibilities which this medical practice will be required to undertake.

_____ 8. Regardless of the outcome of any liability claim/claims which is/are the subject of the traumatic incident that has required the need for the medical services, the below signed Patient understands and agrees that he/she is personally responsible for any unpaid balance that remains unpaid at the conclusion of the liability claim/claims.

I have read this document carefully and I have been given an opportunity to ask any questions and/or have this agreement reviewed by an attorney of my choice prior to signing this agreement. I understand and agree with this document as evidenced by my voluntary signature below.

_____ _____

Signature of Patient Date

_____ _____

Signature of Medical Provider Date

Gulf Coast Injury Center

Medical | Chiropractic | Massage | Rehabilitation

Patient Responsibility Form

Patient Name: _____

Law Firm/Attorney Name: _____

I, _____ (the "Patient"), injured and pursing a personal injury claim or cause of action, Acknowledge that *the entitles checked on page two have provided medical services to me in connection with the injuries that I sustained in the accident(s) or other event (s) in which I was involved that occurred on _____ (the "Injury"). In recognition of the foregoing, I hereby authorize and *irrevocably direct* _____ (the "Attorney"), upon receipt by Attorney of any proceeds of claim or lawsuit to my Injury (whether such proceeds arise from a settlement, judgement, structured settlement or otherwise) (collectively, "Proceeds"), to pay directly to Medical Services Provider my entire bill for services rendered to me by Medical Services Provider (the "Services Bill"). Payment of my Services Bill shall be paid to Medical Services Provider prior to the Attorney disbursing any Proceeds to me.

For clarification purposes, I hereby *irrevocably direct* Attorney to withhold from the Proceeds and disburse to Medical Services Provider the amount of the Services Bill (to the extent that the Proceeds that are recovered are sufficient to pay the Services Bill), *subject to disbursement to attorney for attorney's fees and costs*, and further irrevocably direct Attorney to retain the remaining Proceeds in the Attorney's trust account until such time as Medical Services Provider and the Attorney agree to the amount of distribution.

To the extent that I have health insurance benefits, I hereby relinquish those rights voluntarily, knowingly, and intentionally. I fully understand that I am directly responsible to Medical Services Provider for the entire amount of the Services Bill. Furthermore, I understand that my payment obligation is not contingent upon my recovery of any Proceeds.

In order to secure my obligation to pay the amount of my Services Bill to Medical Services Provider, and in consideration for Medical Service Provider's agreement to forebear from taking action to collect the Services Bill while I am pursuing my lawsuit relating to the Injury, I hereby grant to Medical Services Provider, in accordance with the uniform Commercial Code as in effect in the applicable jurisdiction, a security interest in and lien upon: (i) the Proceeds; and (ii) all proceeds thereof, in each case whether now owned or hereafter existing, acquired or arising, and wherever located. I authorize Medical Services Provider to file one or more UCC financing statements (and continuations thereof) naming me as debtor and evidencing Medical Services Provider's security interest in such collateral. By my signature below I acknowledge that I have read, understand and agree to this agreement.

Patient Signature: _____

Patient Name: _____

Attorney Name: _____

Gulf Coast Injury Center _____

DISCLOSURE FORM

PURSUANT TO SECTION 456.052. FLORIDA STATUTES

This Disclosure Form is advise you that Dr. Richard P. Galloway, D.C. of Gulf Coast Injury Center, has an investment interest as defined by Section 456.053, Florida Statutes, in the following entity:

Tampa Bay Orthopedic Surgery Group, LLC, whose address is 1100 West Kennedy Blvd., Tampa Florida 33606 and 3808 Tampa Road , Suite 300 Palm Harbor, FL. 34684**. YOU,AS THE PATIENT , HAVE THE RIGHT TO OBTAIN THE ITEMS OR SERVICES FOR WHICH YOU HAVE BEEN REFERRED AT THE LOCATION OR FROM THE PROVIDER OR SUPPLIER OF YOUR CHOICE, INCLUDING THE ENTITY IN WHICH THE REFERRING PROVIDER IS AN INVESTOR.**

The following are the names and addresses of at least two alternative sources of such items or services available to you:

Trinity Spine Center 2040 Short Ave Odessa, FL. 33556

Universal Spine and Joint Specialist 8318 N. Habana Ave Tampa, FL. 33614

Bio Spine Institute 4211 W Boy Scout Blvd Floor 4 Tampa, FL., 33607

Patient Signature_____ Date:_____

HEALTH INSURANCE CLAIM FORM

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

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

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? PLACE (State) YES NO

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

PHYSICIAN OR SUPPLIER 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	

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. b.

33. BILLING PROVIDER INFO & PH # ( )

a. b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)