New Patient Medical History Form

Patient Name: _____ Date: _____

Primary Care Physician: _____ Referring Physician: _____

Occupation: _____

Reason for your visit: _____

Symptoms:

When did symptoms begin: _____

Do you have an open claim, including but not limited to auto, slip and fall, premises liability, personal injury, medical malpractice or any other claim? _____ Yes _____No

Is this related to an auto accident? __Yes __No OR Workers' Compensation? __Yes __ No

When does the pain/problem occur (i.e.: morning/night) _____

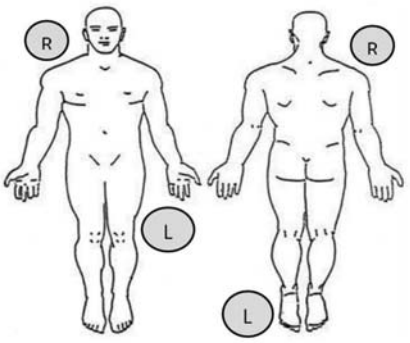
What aggravates the symptoms: _____

What reduced the symptoms: _____

Please check if you have other symptoms:

Symptom	Occurrence	Location
☐ Numbness	☐ Constant ☐ Intermittent	
☐ Pins/Needles/Tingling	☐ Constant ☐ Intermittent	
☐ Sharp Pain	☐ Constant ☐ Intermittent	
☐ Dull/Achy Pain	☐ Constant ☐ Intermittent	

Shade the areas you have pain



Types of Therapy	Effect on your Symptoms	Month/Year
☐ Physical Therapy	☐ Better ☐ Worse ☐ No Change	
☐ Nerve Blocks	☐ Better ☐ Worse ☐ No Change	
☐ Medication Use	☐ Better ☐ Worse ☐ No Change	
☐ Chiropractor	☐ Better ☐ Worse ☐ No Change	
☐ Other	☐ Better ☐ Worse ☐ No Change	

Rate Your Pain: Pain Scale 0 = No Pain 10 = Severe Today: ____ Last Week: ____

Patient Name: _____

Current Medications: List all medications you are taking, including over the counter and vitamins.

☐ No medications

Name	Dose/Mg	Frequency

Allergies: List all known allergies to medications, food and latex.

☐ No known drug allergies

Name	Reaction

Medical History: List all medical problems for which you are currently being treated for

☐ No Medical History

Medical Problem	Medical Problem

Patient Name: _____

Surgical History: List all surgical procedures and year.

☐ No Surgeries

Year	Procedure

Family History:

Is there a family history of: PLEASE CIRCLE YES OR NO

YES or NO	CANCER	YES or NO	STROKE
YES or NO	HYPERTENSION	YES or NO	ALZHEIMER'S
YES or NO	HYPERLIPIDEMIA	YES or NO	DEPRESSION
YES or NO	DIABETES	YES or NO	OSTEOPOROSIS
YES or NO	CORONARY ARTERY DISEASE	YES or NO	DOMESTIC VIOLENCE

Social History: Circle Yes or No

Alcohol Use: Yes or No ☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly

Tobacco Use: Yes or No_____ Packs per day for _____ # of years. Quit smoking _____ years ago.

Street Drug Use: Yes or No Type: _____Frequency: _____Date of last use: _____

Caffeine Use: Yes or No Soda/Coffee/Tea _____ Cups daily

Weight: _____ Height: _____

Vaccinations: Circle Yes or No

Pneumonia: Yes or No

Influenza: Yes or No

Colonoscopy: Yes or No

Room Number: _____

Room Number: _____

BRAIN AND SPINE
NEUROSCIENCE INSTITUTE

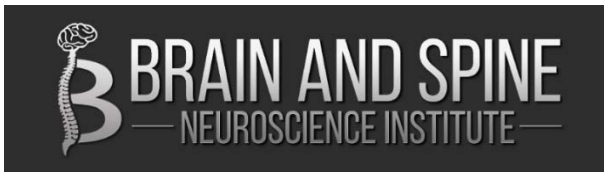
Review of Systems

*Please circle if you have had any of the below symptoms within the **last 2 weeks***

Neurological	Memory Loss • Dizziness • Fainting • Head Injury • Loss of Consciousness• Arm Numbness • Leg Numbness • Paralysis • Speech Disorder • Stroke • Arm Tingling • Leg Tingling • Tremors • Unsteady Gait • Leg Pain • Arm Pain • Weakness

Patient Print: _____ Patient Signature_____ Date _____

Imaging Provided:
MRI _____CD ☐ Rpt ☐ None ☐
CT _____ CD ☐ Rpt ☐ None ☐
X-Ray _____ CD ☐ Rpt ☐ None ☐



Patient Information:

Patient Name:_____ Social Security Number:_____-____-_____
Date of Birth:____/____/_____ Sex: M/F (Circle one) Married/Single/Divorced
Race: _____ Ethnicity: _____
Address: _____
(Street) (City/State/Zip)
Home Phone: (_____) _____-_____Cell: (_____) _____-_____
E-mail Address_____
Primary Care Physician: _____
Referring Physician:_____

How did you hear about our practice?_____

Employer Name:_____ Employer Phone: (_____) _____-_____
Employer Address:_____
(Street) (City/State/Zip)

Person Responsible for this account (if different from the above):

Patient Name:_____ Social Security Number:_____-____-_____
Date of Birth:____/____/_____ Sex: M/F (Circle one) Married/Single/Divorced
Address: _____
(Street) (City/State/Zip)
Home Phone: (_____) _____-_____ Cell: (_____) _____-_____

First Insurance Information:
Plan Name: _____ I.D. Number:_____
Group Number:_____ Effective Date:_____
Policy Holder:_____ Policy Holder SS#:_____-_____-_____
Policy Holder's Date of Birth: ____/____/____ Sex: M/F

Second Insurance Information:
Plan Name: _____ I.D. Number:_____
Group Number:_____ Effective Date:_____
Policy Holder:_____ Policy Holder SS#:_____-_____-_____
Policy Holder's Date of Birth: ____/____/____ Sex: M/F

Third Insurance Information:
Plan Name: _____ I.D. Number:_____
Group Number:_____ Effective Date:_____
Policy Holder:_____ Policy Holder SS#:_____-_____-_____
Policy Holder's Date of Birth: ____/____/____ Sex: M/F

Pharmacy Information:
Pharmacy Name: _____Phone Number: (____) _____-_____
Pharmacy Address: _____
Consent to access your pharmacy for a medication list:
(circle one) YES or NO Patient Initials: _____ Date:_____

IF THIS IS WORKERS COMPENSATION OR PERSONAL INJURY PLEASE NOTIFY THE FRONT DESK.

John Soliman, D.O. Board Certified Neurosurgeon
Eric Sincoff, M.D. Board Certified Neurosurgeon
Suzanne Newby, PA-C Sara Beard, APRN
3519 Palm Harbor Blvd, Palm Harbor, FL 34683
17849 Hunting Bow Circle, Suite 101, Lutz, FL 33558
11373 Cortez Blvd, Suite 304 Brooksville, FL 34613
Phone: (813) 336-4461 Fax: (813) 336-4466
www.BrainandSpineNI.com

2024 FINANCIAL POLICY

We are committed to providing you with the highest quality of care and believe it is important for you to clearly understand your financial commitment to Brain and Spine Neuroscience Institute so that we may focus on what is most important; your quality of care. To do this, you must agree to the following:

- That you, the patient or legal guardian of the patient are personally responsible for all services rendered to you by our offices. Any insurance policies are contracts between you and your insurance company. We may only call or electronically verify the insurance coverage. We accept that the information we are provided is an accurate representation of your coverage at that time. We request that you personally confirm with your insurer all your benefits, limitations, and policy guidelines.
- That you are considered a SELF PAY patient until YOU produce a copy of your insurance card and this office can verify your insurance coverage. If no insurance card is provided at the time of service, payment is forthwith due.
- That your co-payment, co-insurance, and deductibles will be paid in full at the time of service and you will not be billed for them at some future date. Our contracts with the insurance companies mandate our adherence to these policies.
- That a pre-authorization for service and provision of a qualified referring provider is your responsibility. If you are seen and your insurance company denies payment based on a pre-authorization or a lack of a qualified referring provider, the visit will become the patient's responsibility and therefore: you will be responsible for the full amount of the visit.
- That if your insurance company has not paid a claim within 45 days of submission, you are responsible for taking an active part in the recovery of that claim. After 90 days, you will be responsible for payment in full for any outstanding balance. That all patient accounts over 180 days past due without payment arrangements made may be turned over to our collection agency. You may be liable for all legal and collection fees.
- That patient will be charged a $25.00 returned check fee, in addition to existing outstanding balance, should check be returned.
- That any patient who requires FMLA or Disability forms to be filled out, is aware the cost is $50.00 per person per FMLA packet. For Disability forms, the cost is $75.00 for 1-2 pages, 3+ pages the cost is $125.00. It will take up to 10 business days for our providers to complete the paperwork. If you need expedited FMLA or Disability paperwork, (i.e., less than 10 business days) the Rush cost is an additional $75.00 per person per FMLA packet and $25.00 for Disability paperwork. Disability parking form fee $50.00. All fees must be paid in advance.
- Copies of Medical Records are $1.00/page for the first 25 pages, and $0.25/page for every page thereafter.
- That our providers try to accommodate every patient, when you do not show up for an appointment or cancel without notice you take away from patient care. You will be charged $50.00 per Office visit if you do not show up or do not give 24-hour notice. You will be charged $150.00 per EMG/NCV visit if you do not show up or do not give 48- hour notice. You will be charged $150.00 per Injection visit if you do not show up or do not give 48- hour notice. Any incurred No Show Fee must be paid prior to next scheduled appointment. No show fee can be paid upon check-in.
- That this office will not rely on the reports of other health care professionals in diagnosing or treatment; and that your insurance will be billed for this office conducting diagnosis. You may have a co-payment or co-insurance that is your responsibility and you may receive a bill for additional cost beyond what you have already paid.
- I understand there are financial obligations, along with surgical co-pay, our payment and cancellation policies prior to undergoing surgery with Brain and Spine Neuroscience Institute**.**
- **Patients are responsible to bring their imaging CD's to every appointment and take them back after each visit. BSNI will only hold CD's for 30 days, after that they will be discarded.**

I, _____, have read, understand, and agree to the above noted policies.

Signature: _____ Date: _____

Witness: _____ Date: _____

Surgical Copay and Cancellation Agreement

It is very important to us that all our patients fully understand their financial obligations, along with our payment and cancellation policies prior to undergoing surgery with Brain and Spine Neuroscience Institute.

When you schedule surgery, we must reserve time in the operating room at the chosen facility. At these facilities, our physicians have secured operating room time, involving surgical nurses, technicians, and anesthesiologists to be available. Both facilities hold our physicians accountable if this time is not used. Furthermore, we must turn down every other patient who wants surgery on the day and the time we have reserved on your behalf.

The foregoing policy also holds for procedures done in our office: Based on both the financial and time commitments our physicians must make, we ask that you be definite about your desire for surgery, and certain you have the funds available before scheduling your surgery. The Surgical Deposit Agreement is outlined below. When you feel you understand the contents of this form, and agree to the terms, please sign, and date on the line indicated below.

I understand that:

- Prior to scheduling surgery and reserving time in the operating room my health benefits will be verified. If I have a patient responsibility, that will be collected up front prior to scheduling. Once the surgical copay is collected, surgery will be scheduled.
- Cancellation fees are not covered by the insurance company, and I will be responsible for the charge.

Cancelation and Rescheduling Policy:

- Cancellation at least 4 weeks prior to surgery date - Full Refund of copay.
- Cancellation less than 4 weeks prior to surgery date- Full Refund of copay and $750.00 cancellation fee.
- All fees must be paid prior to confirming any new surgical date.
- Cancellation 2 days or less prior to surgery - Full refund of surgical copay and $1,500 cancellation fee.
- Rescheduling your surgery more than once - Rescheduling Fee of $300.

There will be no funds held back in the event of rescheduling or cancellation by us, or in the event of a documentable medical reason with a treating doctor's statement. Any other reason will be at the operating physician's discretion.

I UNDERSTAND AND AGREE TO THE ABOVE TERMS Please sign and return. Thank you.

PATIENT SIGNATURE: _____ DATE: _____

NOTICE OF PRIVACY PRACTICES
Effective Date: January 1, 2024

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Your health information is private, and no one without a legitimate need to know may have access to it. Brain and Spine Neuroscience Institute ("**Practice**") is required by law to maintain the privacy of your health information and to provide you with a notice of its legal duties and privacy practices. We safeguard information about your health and person. We collect information from you and store it in an electronic medical record. Charts are stored in a secure area and are available only to designated staff for designated reasons. In the unlikely event that your health information becomes unsecured, Practice will provide you with prompt notification.

Practice will not use or disclose your health information except as described in this Notice of Privacy Practices ("Notice"). This Notice applies to all of the medical records generated during your treatment at Practice.

EXAMPLES OF USE AND DISCLOSURES OF YOUR INFORMATION

The following categories describe the ways that Practice may use and disclose your health information:

Treatment: Practice will use your health information in the provision and coordination of your healthcare. We may disclose all or any portion of your medical record information to your physician, consulting physician(s), nurses and other healthcare providers who have a legitimate need for such information in the care and continued treatment of the patient. For example, a healthcare provider treating you for an injury can ask another healthcare provider about your overall health condition.

Payment: Practice may release medical information about you for the purposes of determining coverage, billing, claims management, medical data processing and reimbursement. The information may be released to an insurance company, third-party payor or other entity (or their authorized representatives) involved in the payment of your medical bill and may include copies or excerpts of your medical record that are necessary for payment of your account. For example, we may give information about you to your health insurance plan so it will pay for your services.

Routine Healthcare Operations: Practice may use and disclose your medical information during routine health care operations to run our practice, improve your care, and contact you when necessary. For example, we can use your health information to manage your treatment and services.

Business Associates: Practice may use and disclose certain health information about you to its business associates. A business associate is an individual or entity under contract with Practice to perform or assist Practice in a function or activity that necessitates the use or disclosure of medical information. Examples of business associates include but are not limited to, a copy service used by the Clinic to copy medical records, consultants, independent contractors, accountants, lawyers, medical transcriptionists and third-party billing companies. Practice requires the business associate to protect the confidentiality of your medical information. In addition, Practice requires any subcontractor of Practice's business associate to protect the confidentiality of your medical information.

Regulatory Agencies: Practice may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability. For example, billing practices may be audited by the State Auditor and records are subject to review by the Secretary of Health and Human Services and his/her authorized representatives.

Workers' Compensation: Practice may release medical information about you for workers' compensation or similar programs that provide benefits for work-related injuries or illnesses.

Law Enforcement: Practice may disclose your medical information for law enforcement purposes or with a law enforcement official.

Military Veterans: Practice may disclose your medical information as required by military command authorities if you are a member of the armed forces.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement officer, Practice may release your medical information to the correctional institution or law enforcement official.

Organ and Tissue Donation Requests: Medical information can be shared with organ procurement organizations.

Medical Examiner or Funeral Director: Medical information can be shared with a coroner, medical examiner, or funeral director when an individual dies.

Lawsuits and Legal Actions: Practice may disclose your medical information in response to a court or administrative order, or in response to a subpoena.

Required by Law: Practice will disclose medical information about you when required to do so by law.

Other Purposes: We will not use or disclose your medical information for any purpose not listed without your specific written authorization. For example, we will not disclose your information for marketing purposes, sell your information, or share your psychotherapy notes (except in limited circumstances allowed by law) unless we receive a specific authorization from you. Any specific written authorization you provide may be revoked at any time by notifying us in writing. We will never share any substance abuse treatment records without your written authorization.

PATIENT INFORMATION RIGHTS

Although all records concerning your treatment obtained at Practice are the property of Practice, you have the following rights concerning your medical information:

Right to Confidential Communications: You have the right to receive confidential communications of your medical information by alternative means or at alternative locations. For example, you may request that Practice contact you only at work or by mail.

Right to Inspect and Copy: You have the right to inspect and copy your medical information. We require your request to be in writing

Right to Amend: You have the right to amend your medical information. Any request for amendment should be submitted to Practice in writing, stating a reason in support of the amendment.

Right to an Accounting: You have the right to obtain an accounting of the disclosures of your medical information made during the preceding six (6) year period.

Right to Request Restrictions: You have the right to request restrictions on certain uses and disclosures of your medical information. Practice is not required to honor your request except where: (i) the disclosure is for the purpose of carrying out payment or healthcare operations and is not otherwise required by law, and (ii) the medical information pertains solely to a healthcare item or service for which you, or person other than the health plan on your behalf, has paid Practice in full.

Right to Receive a Paper Copy: You have the right to receive a paper copy of this Notice.

Right to Receive Electronic Copies: You have the right to receive electronic copies of your medical information.

Right to Choose Someone to Act For You: If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.

Right to Revoke Authorization: You have the right to revoke your authorization to use or disclose your medical information, except to the extent that action has already been taken in reliance on your authorization. A request to exercise any of these rights must be submitted, in writing, to Practice at Brain and Spine Neuroscience Institute, 3519 Palm Harbor Blvd, Suite B, Palm Harbor, FL 34683, or by contacting Practice at 813-336-4461.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have questions and would like additional information, you may contact our office at 813-336-4461. If you believe your privacy rights have been violated, you may file a complaint (1) with us by contacting our Privacy Officer, at info@brainandspineni.com or 813.336.4461 and (2) with the U.S. Department of Health and Human Services.

We will not retaliate against you for filing a complaint.

CHANGES TO THIS NOTICE

Practice can change the terms of this Notice, and the changes will apply to all information we have about you. The new Notice will be available upon request, in our office, and on our website. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

X _____ Date:_____

Patient Name

HIPAA PRIVACY POLICY PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information (PHI). I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct and indirect treatment by other healthcare providers that are involved in my treatment)
- Obtaining payments from third-party payers (i.e. my insurance company)
- Conduct normal healthcare operations such as quality assessments and physician certifications.

Patient initial____

You have informed me of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time, and that I may contact the organization at any time to the address above to obtain a current copy of the Notice of Privacy Practices.

Patient initial____

I understand that I have the right to request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient initial____

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name:_____ Date:_____

Signature:_____

Relationship to patient:_____

Witness:_____

Disclosure to Family Members and/or Friends

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? Yes or NO (circle one)

I give permission for my Protected Health information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

Patient initial____

Name	Relationship	Contact Number

Consent for Treatment and Payment Agreement

I _____(name of patient), agree and consent to receive a neurosurgical evaluation and medical treatment provided by practitioners at the Brain and Spine Neuroscience Institute. Treatment includes but is not limited to the administration and performance of all treatments, surgical interventions, procedures, the administration of any needed anesthetics, the use of prescribed medications, the performance of such procedures as may be deemed as necessary or advisable in the treatment of the patient such as diagnostic procedures, the taking and utilization of cultures and of other medically necessary laboratory tests, all of which in the judgement of the attending physician or the assigned designee may be considered medically necessary or advisable.
Patient initial____

Payment includes but is not limited to the authorization of payment directly to Brain and Spine Neuroscience Institute, LLC of benefits otherwise payable to me. I hereby acknowledge the release of my medical records to the third- party entities or authorized persons to whom describes is necessary to establish or collect a fee for the services provided, such as billing and collection services, insurance payers, auto accident insurers, or for work related injury/personal injury to my employer or designee understand that I am financially responsible for charges not covered. I acknowledge that patient records may be absorbed electronically and made available through computer networks.
Patient initial_____

FOR MEDICARE PATIENTS ONLY
MEDICARE PART B SIGNATURE AUTHORIZATION – LIFETIME

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare Claim. I permit a copy of this authorization to be used in place of the original. I request that payment of the authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organizations furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.
Patient initial____

A Non-Disparagement or Protection of Reputation clause restricts individuals from taking any action that negatively impacts an organization, its reputation, products, services, management or employees.
Patient initial_____

IF THE PATIENT IS UNDER THE AGE OF EIGHTEEN OR UNABLE TO CONSENT TO TREATMENT, I attest that I have legal custody of the above- named individual and am authorized to initiate and consent for treatment on the behalf of this individual.

Patient Name:_____ Signature:_____
Relationship to Patient_____ Date:_____

Signature:_____ **Date:_____**

REQUEST FOR MEDICAL RECORDS RELEASE

Patient Name:	DOB:
Information Requested and Needed From (Requestee): Name: Address: Phone: Fax:	**Recipient of Records (Requestor):**

INFORMATION TO BE DISCLOSED:

Description:	**Description:**	**Super Confidential Records:** Signature required by patient
☐ Entire medical record (all info) ☐Physician Dictated Notes ☐Office Notes & Reports ☐Clinician office chart notes ☐Billing Statements	☐Most recent one-year history ☐Records for continuity of care ☐Hospital Reports ☐Diagnostic Imaging reports ☐Laboratory Reports	_____ Alcohol and drug therapy notes _____ Communicable Disease (HIV, TB) _____ Psychotherapy Notes _____ Other _____ Other

Purpose of Disclosure:

☐Ongoing medical care ☐Ongoing medical care ☐Other: _____
☐Patient's Request ☐Insurance

I hereby authorize the use or disclosure of my individually identifiable health information as described above. I understand that this authorization is voluntary. Under Florida Law, fees for copying cannot exceed $1.00 per page for the first 25 pages, and $0.25 for each copy thereafter.

I understand that this consent shall be valid for a period of one year from the date of authorization and may be revoked at any time upon written notice to the Brain and Spine Neuroscience Institute, 3519 Palm Harbor Blvd, Suite B, Palm Harbor, FL 34683, Attn: Office Manager, except to the extent that the information has already been released in reliance upon this authorization.

I hereby hold harmless and release Brain and Spine Neuroscience Institute from all claims, demands and causes of action which I, my heirs, representatives, executors, administrators or any other persons acting on my behalf or on behalf of my estate have or may have by reason of this authorization.
I understand that the confidentiality of this information may be protected by Federal Regulations (42CFR, Part II), prohibiting any further disclosure of this information without specific written authorization of the undersigned, or as otherwise regulated. I also understand that my refusal to sign this authorization will have no effect on the medical treatment I receive from Brain and Spine Neuroscience Institute.

_____
Printed Name of Patient Date

_____
Signature of Patient or Legal Representative Date

_____
Witness Signature Date

IF YOU ARE NOT BEING SEEN FOR AN AUTOMOBILE ACCIDENT, PERSONAL INJURY, PREMISES LIABILITY OR WORKERS COMPENSATION OR ANY OTHER CLAIM, PLEASE ACKNOWLEDGE THE BELOW.

My visit today is NOT for an automobile accident or workman's compensation and I have no open claims, including but not limited to auto, slip and fall, premises liability, personal injury, medical malpractice or any other claim. I want everything to be billed to my health insurance on file.

_____ _____

PATIENT SIGNATURE Date

AUTO/ PERSONAL INJURY/ PREMISIS LIABILITY/ATTORNEY/ WORKERS COMPENSATION/MEDICAL MALPRACTICE INFORMATION

Patient Information:

Patient Name: _____Date of Birth: _____/_____/_____ Social Security Number: _____-____-_____

(Circle one) Married/Single/Divorced Sex: M/F Race: _____ Ethnicity: _____

Address: _____ E-mail: _____
(Street) (City/State/Zip)

Home Phone: (_____) _____-_____Cell: (_____) _____-_____

Primary Care Physician: _____ Referring Physician: _____

Employer Name: _____ Employer Phone: (_____) _____-_____

Employer Address: _____
(Street) (City/State/Zip)

Auto Information: Insurance Company: _____ Policy Number _____

Claim Number: _____ Adjustor Name: _____ Adjustor Phone: (_____) _____-_____

Attorney Information: Law Firm Name: _____Attorney Name: _____

Paralegal Name: _____ Firm Phone: (_____) _____-_____

Workers Comp Information: Insurance Company: _____ Policy Number _____

Claim Number: _____ Adjustor Name: _____ Adjustor Phone: (_____) _____-_____

Case Manager Name: _____ Case Manager Phone: (_____) _____-_____

CONTINUE- PAGE 1 OF 2

IF YOU ARE BEING SEEN FOR AN AUTOMOBILE ACCIDENT

Florida is a “No-Fault” car insurance state; therefore; it follows a “no-fault” practice when it comes to the payment of auto insurance claims after a car accident. In a “no-fault” state drivers are required to carry auto insurance that pays personal injury protection (PIP) benefits. Due to PIP laws, the BRAIN AND SPINE NEUROSCIENCE INSTITUTE will file your claim for the dates of service to the auto insurance you provide. If no auto insurance is provided you will be responsible for the full amount of your bill. If you would like your claim filed in another way you must notify BRAIN AND SPINE NEUROSCIENCE INSTITUTE in writing below. Select ONLY ONE:

☐ I DO NOT have auto insurance and I will be fully responsible for any charges incurred during treatment at BRAIN AND SPINE NEUROSCIENCE INSTITUTE

☐ I HAVE auto insurance as listed above and I DO NOT have an attorney. Once auto benefits are exhausted, I will be fully responsible for any charges incurred during treatment at BRAIN AND SPINE NEUROSCIENCE INSTITUTE

☐ I HAVE an attorney. I want all medical claims sent to them and NOT to any insurance.

☐ Please bill my auto until my auto benefits are exhausted and then bill my attorney

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IF YOU ARE BEING SEEN FOR WORKERS COMPENSATION

Workers compensation is a form of insurance providing wage replacement and medical benefits to employees injured in the course of employment in exchange for mandatory relinquishment of the employee’s rights to sue their employer for the tort of negligence. Cited: http://www.myfloridacfo.com/division/wc/pdf/WC-System-Guide.pdf

☐ I am being seen for an employment related injury and would like all medical claims filed to my workers compensation insurance

---

_____ _____

PATIENT SIGNATURE DATE

_____ _____

WITNESS SIGNATURE DATE