FLORIDA MEDICAL & INJURY CENTER, INC.
322 N. John Young Pkwy ~ Kissimmee, Florida 34741
Phone (407) 944-9355 ~ Fax (407) 933-1237

Date: ____________________ **Birth Date:** _____________________

Last Name:___________________________________ **First Name**:_________________________ **Mid Init**:_______

Address:____ **City**:____________________ **St**:____ **Zip**:__________

Home Ph: _____________________ **Cell #**:__________________ **Work Ph#**:__________________ Ext:_________

Social Security #____________________ **Sex: M F Marital Status: Married Single Divorced Widowed**

E-Mail:____

****IF PATIENT IS A MINOR*: Responsible Party's Name:** ____

Attorney Name____Phone #______________________________

If we need to contact you at home, what is the best time to call? ___ AM ___ PM ___ Evenings Time: ________

Employer: ____ Ph #: ________________________

Employers Address: ____Occupation______________________________

Auto Insurance: **Date of Accident:**______________

Insurance Name:__________________________________

Address: ____

State:__________________________ Zip:_____________

Policyholder Name:________________________________

Policyholder DOB: ________________________________

Policy ID#:_______________________________________

Claim#: ____

Health Insurance:

Insurance Name:__________________________________

Address: ____

State:______________________Zip:___________________

Policyholder Name:________________________________

Policyholder DOB:_________________________________

Policy ID#:_______________________________________

SS #:________________________________if used as ID #

Spouse's Name: _________________________________or Emergency Contact:_______________________________________

Spouse's Birthdate: __________________________________Relationship: ____

Employer:________________________ Phone #________________ Phone#: ___________________ Cell#: ____________________

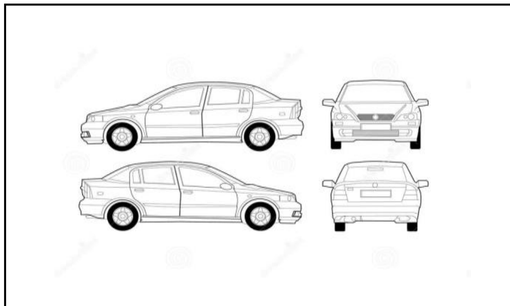
Family Doctor (name)____Phone #_________________________________

Patient Signature: ____ Date:_________________________

Patient Name____Date___________________

DOB____________________Height____________________Weight____________________

1. Date of accident __________________
2. What time did the accident happen? __________________________
3. How many vehicles were involved in the accident? _______________
4. What street or intersection were you on when the accident occurred? __________________________________
5. What direction were you traveling in? _________________________
6. What city did the accident occur? _____________________________
7. What state did the accident occur? ____________________________
8. What type of impact was the accident? Front _______ Rear ______ Driver Side ______ Passenger Side_______
9. Did your vehicle hit anything after the accident? Yes ______ No ______
   If yes, please describe ____
10. Where were you sitting in your vehicle during the accident? Driver ___ Passenger ___Front ___Rear ___
11. Did you know the accident was coming? Yes ____ No ____
12. Did you lose consciousness during the accident? Yes ____ No ____
13. How was your head positioned during the accident? Looking forward ___ Looking down ___ Left ___ Right___
14. How was your torso positioned? ____
15. How were your hands positioned on the steering wheel? ____
16. Did your head hit anything in the car? No ______ Yes, describe ___________________________________
    Did your face hit anything in the car? No ______ Yes, describe ___________________________________
    Did your shoulders hit anything in the car? No ______ Yes, describe ___________________________________
    Did your neck hit anything in the car? No ______ Yes, describe ___________________________________
    Did your chest hit anything in the car? No ______ Yes, describe ___________________________________
    Did your hips hit anything in the car? No ______ Yes, describe ___________________________________
    Did your knees hit anything in the car? No ______ Yes, describe ___________________________________
    Did your feet hit anything in the car? No ______ Yes, describe ___________________________________
17. Did you have your seat belt on? Yes ____ No ____
18. Where is the damage to your vehicle?



Please describe how the accident happened:________________

____

____

____

____

19. Did you go to the hospital? Yes ___ No ___ If yes, what hospital? _________________________________
20. How did you get to the hospital? ____
21. Were you hospitalized? Yes ___ No ___ If yes, how long? ______________________________________
22. Were you prescribed medication? Yes ___ No ___ If yes, what medication __________________________
    ____
23. Have you treated at another clinic for this accident? _____Yes _____No
24. If Yes, what clinic? ____Phone #________________________

Initial________________Date______________

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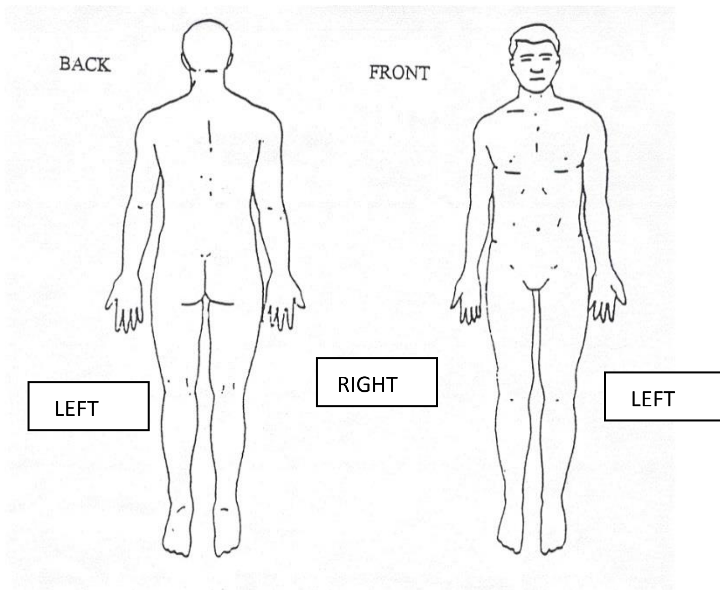
Patient Name____



Rate your overall

pain, soreness or achiness.

(circle one of the following)

No Pain is 0 **Severe Pain is 10**

1 2 3 4 5 6 7 8 9 10

On the picture, mark with an X the areas where you are experiencing pain or discomfort.

Additional Symptoms and Complaints:

____

____

Have you lost time from work due to your injury? ___yes ___no

If yes, please give dates:____

Type of employment:________________________

Have you had previous injuries or accidents? ___yes ___no

Description of previous injury and/or accident

____

____

____

Is there any residual pain from the previous injuries and/or accident? ___yes ___no

How much better did you feel prior to your current condition? (example 100%, 80% etc.)___________________

Patient initials_________________

Date_________________________

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MEDICAL HISTORY FORM

Name____ Date________________________

Medical Doctor Name____________________________ Phone Number______________________________

Main Problem

What pain causes you to come to the office? ____

What caused this pain? ____

When did this pain start? ______________________ How long does this pain last? _____________________

Does this pain travel to any other area? ____

What makes this pain better? ____

What makes this pain worse? ____

What else have you done to treat this pain? ____

Other Problem

What other pain do you have? ____

What caused this pain? ____

When did this pain start? _________________________How long does it last?_________________________

How often does the pain occur? (Circle the one that applies) Occasional, Frequent, Constant

Does this pain travel to any other area? ____

What makes this pain better? ____

What makes this pain worse? ____

What else have you done to treat this pain? ____

Medical History:

Allergies	Anemia Bleeding	Arthritis	Asthma
Back Problems	Hearing Disorders	Cholestrol Disorder	Heart Murmur
Diabetes Problems	Heart Disease	Kidney Disorder	Stroke
HIV/Hepatitis	Hypertension	Lung Disease	Other Skin Problems
Prostate Disorder	Seizures	Depression	Stomach/Digestive Disorder
Vision Problems	Cancer (type)___________		

Other/Additional Information:

____

____

____

Patient initials________________

Date______________________

Family History

Please tell us about the health of you parents, siblings and children. Circle or check everything that applies. If someone is deceased, please check or write in the cause.

	Living/Deceased	Heart Disease	Stroke	Cancer	Diabetes	Rheumatoid Arthritis	Multiple Scerolsis	Lung Disease	Bone Disease
Father	L D Cause:								
Mothe r	L D Cause:								
Sibling M child F	L D Cause:								
Sibling M child F	L D Cause:								

:

Past and Social History

Are you employed? Y N Where______________________________ How is your health?______________

Do you Drink alcohol? Y N Use tobacco? Y N Use recreational drugs? Y N

Have you had any illnesses in the past? ____

____

Have you had any injuries? ____

____

Have you been hospitalized? ____

____

____

____

Have you had any surgeries? ____

____

____

____

List any medications that you are taking? ____

____

____

I certify that the information that the information that I have given here is true and accurate to the best of my knowledge.

Signed____ Date_____________________

Patient Name_______________________________

SYSTEM REVIEW

Circle the items in each category that presently cause you problems or discomfort.

GENERAL
Recent weight change
Fever
Fatigue
Headache

INTEGUMENTARY (skin/breast)
Rash or itching
Change in skin color
Change in hair or nails
Varicose veins
Breast pain
Breast limp
Breast discharge
History of breast cancer
Last mammogram____________
History of cyst

EYES
Eye disease or injury
Glasses/contact lenses
Blurred/double vision
Glaucoma

EARS/NOSE/THROAT/MOUTH
Hearing loss or ringing
Earache or drainage
Chronic sinus problems
Nose bleeds
Mouth sores
Bleeding gums
Bad breath or bad taste
Sore throat or voice change
Swollen glands in neck

RESPIRATORY
Chronic or frequent cough
Spitting up blood
Shortness of breath
Asthma or wheezing

CARDIOVASCULAR
Heart trouble or murmur
Chest pain
Palpitation
Shortness of breath
Swelling of feet

GASTROINTESTINAL
Loss of appetite
Change of bowel movement
Nausea or vomiting
Frequent diarrhea
Constipation/painful bowel
Rectal bleeding/bloody stool
Abdominal pain or heartburn
Peptic ulcer

GENITORINARY
Frequent urination
Burning/painful urination
Blood in urine
Forced/strained urination
Incontinence/dribbling
Kidney stones
Sexual difficulty
Painful menstruation
Vaginal discharge
Irregular menstruations
Are you pregnant now________
Last PAP smear______________
Total pregnancies____________
#of deliveries________________
#of miscarriages______________
Method of birth control________
____

MUSCULOSKELETAL
Joint stiffness
Joint pain
Muscle weakness
Back pain
Cold extremities
Difficulty walking
Muscle pain/cramps

NEUROLOGICAL
Frequent headaches
History of concussion
Light headed/dizziness
Seizures
Numbness/tingling
Tremors
Paralysis
Stroke

ENDOCRINE
Glandular/hormone problem
Thyroid disease
Diabetic
Excessive thirst/urination
Heat or cold intolerance
Dry skin
Change in hat or glove size

HEMATOLOGICAL/LYMPHATIC
Slow to heal after cuts
Bleeding or bruising
Anemia
Phlebitis
Past transfusions
Enlarged glands
Hepatitis A B C/HIV

LIST YOUR ALLERGIES
____
____
____
____
____
____

LIST ALL MEDICATIONS
____
____
____
____
____
____
____
____
____
____
____

Patient initials_________________

Date_________________________

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LETTER OF PROTECTION

Patient: ____ **Date of Incident:** __________________________

Provider: Florida Medical & Injury Center, Inc. hereinafter referred to as (FMIC)

This is a Letter of Protection, which I, _________________________, am issuing to FMIC in consideration for delayed payment for the medical services provided by FMIC to treat the injuries sustained by the Patient in the incident on the above date. This letter of protection acts as a lien against any settlement, judgment or verdict related to the incident occurring on the above date.

Patient's Initials ________

PROTECTION OF OUTSTANDING CHARGES: If ___________________ recovers money damages from any person or entity responsible for injuries sustained by the Patient in the incident on the above date, _______________________ agrees to withhold sufficient funds from any judgment, verdict, or settlement in order to reimburse FMIC for all charges incurred due to medical services provided to the Patient to treat the injuries sustained by the Patient in the incident on the above date.

Patient's Initials ________

DISPUTES: If ____________________ disputes any of FMIC's charges, or claims a setoff and the parties are unable to resolve the dispute, the settlement funds must be deposited into the court registry for Osceola County pending resolution of the dispute.

Patient's Initials ________

APPROVAL REQUIRED: This agreement becomes effective when executed by the Patient and FMIC. Any modification of this agreement will render it null and void.

Patient's Initials ________

RESOLUTION OF CHARGES IF THERE IS NO SETTLEMENT: In the event there is no settlement, the patient remains responsible for paying FMIC for the medical services related to the incident occurring on the above date.

Patient's Initials ________

X____________________ Date: __________
Attorney Signature

X____________________ Date: __________
Florida Medical & Injury Center
by Authorized Representative

X____________________ Date: __________
Patient Signature

NP/ces11/12

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INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic treatments (also known as chiropractic adjustments or chiropractic manipulative treatments) and any other associated procedures; physical examination, tests, diagnostic x-rays, physio therapy, physical medicine, physical therapy procedures, etc on me by the doctor of chiropractic medicine named above and/or other assistants and/or licensed practitioners.

I understand, as with any health care procedures, that there are certain complications which may arise during chiropractic treatments. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain Homers' Syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke.

I do not expect the doctor to be able to anticipate all risks of chiropractic, and I wish to rely upon the doctor to exercise judgement during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest.

I have had an opportunity to discuss the nature, purpose and risks of chiropractic treatments and other recommended procedures. I have had my questions answered to my satisfaction. I also understand the specific results are not guaranteed.

If there is any dispute about my care, I agree to a resolution by binding arbitration according to the American Arbitration Association guidelines.

I have read (or have had it read to me) the above explanation of the chiropractic treatments. I state that I have been informed and weighed the risks involved in chiropractic treatment at this health care office. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and any future condition(s)for which I seek treatment.

SIGN ONLY AFTER YOU UNDERSTAND AND AGREE TO THE ABOVE

Printed Name of Patient Date

Signature of Patient Date

Signature of Representative (of minor / handicapped) Date

Witness to Patient's Signature Date

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322 N. John Young Pkwy ~ Kissimmee, Florida 34741
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PATIENT CONSENT FORM

See attached addendum

I hereby give my consent for Florida Medical & Injury Center, Inc. or my physician(s) to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by Florida Medical & Injury Center, Inc. or my physician(s) describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Florida Medical & Injury Center, Inc. or my physician(s) reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Office Manager, 322 N. John Young Pkwy. Kissimmee, FL 34741

With this consent, Florida Medical & Injury Center, Inc. or my physician(s) may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Florida Medical & Injury Center, Inc. or my physician(s) may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, Florida Medical & Injury Center, Inc. or my physician(s) may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Florida Medical & Injury Center, Inc. or my physician(s) restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Florida Medical & Injury Center, Inc. or my physician(s) to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Florida Medical & Injury Center, Inc. or my physician(s) may decline to provide treatment to me.

Patient/guardian must be provided with a signed copy of this authorization form.

____
Print Name

____
Patients Signature

____
Date

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Addendum

RELEASE OF PATIENT RECORDS AUTHORIZATION

I hereby authorize Florida Medical & Injury Center, Inc. to release copies of my patient records or x-rays containing protected health information via email. This authorization is given pursuant to Florida Statute 456.057 and HIPAA regulations. I understand that Florida Statute 456.057 (12) makes clear that any third party to whom records are disclosed is prohibited from further disclosing any information in the medical record without the expressed written consent of the patient or the patient's legal representatives.

Per HIPPA guidelines, Florida Medical & Injury Center, Inc. may use unencrypted email to send medical records as long as the patient has been advised of risks related to using unencrypted email. Hence, the undersigned patient signs this Release with full knowledge and awareness of the method used to disclose his/her medical and treatment records.

____ ____________________
Patient's or Patient's Legal Representative's Signature Patient's Date of Birth

____
Date Signed

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State Law Required New Patient Acknowledgement And Disclosures Form

DOCUMENTATION OF INITIAL SERVICES PROVIDED - ORIGINAL

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

1. The services set forth below were **actually rendered.** This means that those services have **already been provided.**
   ʘ 99201 Initial Eval-Low ʘ 97010 Hot/Cold Packs ʘ 97012 Mechanical Traction ʘ G0283 EMS
   ʘ 99202 Initial Eval-Mod ʘ 97035 Ultrasound ʘ 97110 Therapeutic Exercise
   ʘ 99203 Initial Eval-Comp ʘ 97112 Neuromuscular Re-ed ʘ A9150 Topical Analgesic
   ʘ 99204 Initial Eval-High ʘ Other____

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. This means that no person has initiated contact with me and/or persuaded me to use the doctor or licensed professional, clinic, or medical institution that provided the services.

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.

The undersigned licensed medical professional 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. I have **explained** the services rendered 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 procedure on the accompanying statement or bill is proper. This means that **no service has been upcoded, unbundled,** or constitutes and invalid **or not medically necessary diagnostic test** as defined by Section 627.732 (15) and (16), Florida Statutes 627.736(5)(b)6, Florida Statutes.

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

____________________ ____________________ ______________
Name (PRINT or TYPE) Signature Date

Licensed Medical Professional Rendering Treatment (*Signature by his or her* ***own hand***)

Caroline De Jesus, DC
____________________ ____________________ ______________
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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ASSIGNMENT OF INSURANCE BENEFITS, RELEASE, & DEMAND

Insurer and Patient Please Read the Following in its Entirety Carefully!

I, the undersigned patient/insured knowingly, voluntarily and intentionally assign the rights and benefits of my automobile Insurance, a/k/a Personal Injury Protection (hereinafter PIP), Uninsured Motorist, and Medical Payments policy of insurance to the above health care provider. I understand it is the intention of the provider to accept this assignment of benefits in lieu of demanding payment at the time services are rendered. I understand this document will allow the provider to file suit against an insurer for payment of the insurance benefits or an explanation of benefits and to seek §627.428 damages from the insurer. If the provider's bills are applied to a deductible, I agree this will serve as a benefit to me. This assignment of benefits includes the cost of transportation, medications, supplies, overdue interest and any potential claim for common law or statutory bad faith/unfair claims handling. If the insurer disputes the validity of this assignment of benefits then the insurer is instructed to notify the provider in writing within five days of receipt of this document. Failure to inform the provider shall result in a waiver by the insurer to contest the validity of this document. The undersigned directs the insurer to pay the health care provider the maximum amount directly without any reductions & without including the patient's name on the check. To the extent the PIP insurer contends there is a material misrepresentation on the application for insurance resulting in the policy of insurance is declared voided, rescinded, or canceled, I, as the named insured under said policy of insurance, hereby assign the right to receive the premiums paid for my PIP insurance to this provider and to file suit for recovery of the premiums. The insurer is directed to issue such a refund check payable to this provider only. Should the medical bills not exceed the premium refunded, then the provider is directed to mail the patient/named insured a check which represents the difference between the medical bills and the premiums paid.

Disputes: The insurer is directed by the provider and the undersigned to not issue any checks or drafts in partial settlement of a claim that contain or are accompanied by language releasing the insurer or its insured/patient from liability unless there has been a prior written settlement agreed to by the health provider (specifically the office manager) and the insurer as to the amount payable under the insurance policy. The insured and the provider hereby contests and objects to any reductions or partial payments. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by the provider shall be done so under protest, at the risk of the insurer, and the deposit shall not be deemed a waiver, accord, satisfaction, discharge, settlement or agreement by the provider to accept a reduced amount as payment in full. The insurer is hereby placed on notice that this provider reserves the right to seek the full amount of the bills submitted. If the PIP insurer states it can pay claims at 200% of Medicare then the insurer is instructed & directed to provide this provider with a copy of the policy of insurance within 10 days**. Any effort by the insurer to pay a disputed debt as full satisfaction must be mailed to the address above, after speaking with the office manager, and mailed to the specific attention of the Office Manager. See Fla. Stat. §673.3111.**

EUOs and IMEs: If the insurer schedules a defense examination or examination under oath (hereinafter "EUO") the insurer is hereby INSTRUCTED to send a copy of said notification to this provider. The provider or the provider's attorney is expressly authorized to appear at any EUO or IME set by the insurer. The health care provider is not the agent of the insurer or the patient for any purpose. This assignment applies to both past and future medical expenses and is valid even if undated. A photocopy of this assignment is to be considered as valid as the original. I agree to pay any applicable deductible, co-payments, for services rendered after the policy of insurance exhausts and for any other services unrelated to the automobile accident. The health care provider is given the power of attorney to: endorse my name on any check for services rendered by the above provider; and to request and obtain a copy of any statements or examinations under oath given by patient.

Release of information: I authorize this provider to: furnish an insurer, an insurer's intermediary, the patient's other medical providers, and the patient's attorney and hired experts via mail, fax, or email, with any and all information that may be contained in the medical records; to obtain insurance coverage information (declaration sheet & policy of insurance) in writing and telephonically from the insurer; request from any insurer all explanation of benefits (EOBs) for all providers and non-redacted PIP payout sheets; obtain any written and verbal statements the patient or anyone else provided to the insurer; obtain copies of the entire claim file, the property damage file, and all medical records, including but not limited to, documents, reports, scans, notes, bills, opinions, X-rays, IMEs, and MRIs, from any other medical provider or any insurer. The provider is permitted to produce my medical records to its attorney and experts 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 the patient's medical records to anyone without the patient's and the provider's prior express written permission.

Demand: Demand is hereby made for the insurer to pay all bills within 30 days without reductions and to mail the latest non-redacted PIP payout sheet and the insurance coverage declaration sheet to the above provider within 15 days. The insurer is directed to pay the bills in the order they are received. However, if a bill from this provider and a claim from anyone else is received by the insurer on the same day the insurer is directed to not apply this provider's bill to the deductible. If a bill from this provider and claim from anyone else is received by the insurer on the same day then the insurer is directed to pay this provider first before the policy is exhausted. In the event the provider's medical bills are disputed or reduced by the insurer for any reason, or amount, the insurer is to: set aside the entire amount disputed or reduced; escrow the full amount at issue; and not pay the disputed amount to anyone or any entity, including myself, until the dispute is resolved by a Court. Do not exhaust the policy. The insurer is instructed to inform, in writing, the provider of any dispute and when the policy is exhausted.

Certification: I certify that: I have read and agree to the above; I have not been solicited or promised anything in exchange for receiving health care; I have not received any promises or guarantees from anyone as to the results that may be obtained by any treatment or service; and I agree the provider's prices for medical services, treatment and supplies are reasonable, usual and customary.
Caution: Please read before signing. If you do not completely understand this document please ask us to explain it to you. If you sign below we will assume you understand and agree to the above.

Patient's Name________________________________ Patient's Signature ____ Date ______________

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

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AUTHORIZATION TO OBTAIN, RELEASE, OR REVIEW PROTECTED HEALTH INFORMATION

I, ___________________________________, hereby authorized the **Florida Medical & Injury Center, Inc.** to obtain, release, or review protected health information in accordance with federal law and state law. This authorization will expire on the following date __________________________ or in one year from the date of my signature, if I fail to specify a date, event, or condition of expiration.

Issued To:

____
Name Of Physician, Individual, Agent, Agency, Or Health Care Facility

____
Address City State Zip

For the purpose of: [ ] **Medical Treatment** [ ] **Other** ____
Dates of Service: **FROM** ______________________ **TO** ____

I understand that this authorization is revocable upon written notice to the office where the original authorization was retained, except to the extent that action has already been taken on this authorization. Mental health, alcohol, drug, HIV and/or AIDS information is confidentially protected by Federal and State law which prohibits disclosure without specific written authorization of the undersigned, or as otherwise permitted by such regulations. I further request that no genetic counseling/testing information in my record be released without my written authorization, except as otherwise required by law. I understand that I may select the information from the list below to be released by placing my initials in the space provided. Furthermore, I understand that any disclosure of information from my records carries with it the potential for an unauthorized redisclosure of my health information. I understand that medical records with protected health information will be released to insurance companies for billing purposes during the processing of claims. I further understand that Florida Medical & Injury Center may not condition the provision of treatment, payment and enrollment in health plan or eligibility for benefits on the provision of this authorization.

Place your initial by each item to be obtained, released, or reviewed.

______Complete Medical Record/Medical Record Abstract/All Diagnostic Tests.
______Medical Reports and Progress Notes
______Pathology Reports/ Laboratory Medicine
______Therapy & Rehabilitation Records
______Consultations/Disability Evaluations
______Operative Reports/Procedural Reports
______Radiology/Nuclear Medicine Studies
______Imaging Studies/MRI/CT/VF/Ultrasound
______Emergency Room/Hospital Records
______Mental Health Reports
______Electrodiagnostic Medicine
______HIV Testing/AIDS Information
______Drug or Alcohol Testing
______IME Reports
______Other____

REVOKED AUTHORIZATIONS OR DENIED RELEASES

______ I do not want my medical record released to the following persons, agencies, or individuals and revoke any prior authorizations to such persons or entities.

____
NAME AND ADDRESS OF WITHHELD RELEASE ENTITIES

____
NAME AND ADDRESS OF WITHHELD RELEASE ENTITIES

____
NAME AND ADDRESS OF WITHHELD RELEASE ENTITIES

PATIENTS SIGNATURE/AUTHORIZATION

____
PATIENT NAME (PRINT) PATIENT SIGNATURE DATE

SOCIAL SECURITY No: ___________________________________ DATE OR BIRTH ____

ADDRESS: _________________________________ CITY _________________________ STATE ___________ ZIP CODE _____________

FLORIDA MEDICAL & INJURY CENTER, INC.

322 N. John Young Pkwy ~ Kissimmee, Florida 34741
Phone (407) 944-9355 ~ Fax (407) 933-1237

MISSED APPOINTMENT POLICY

DOCTOR OF OSTEOPATHIC MEDICINE (DO)

Appointments with our medical doctors are very important for your medical treatment.

We understand that unplanned issues can arise and you may need to reschedule an appointment. We respectfully ask for scheduled appointments with our Doctor of Osteopathic Medicine (DO) be cancelled and/or rescheduled 24 hours prior to your appointment, if needed.

Our providers are available for your needs and the needs of all of our patients. When a patient does not show up for a scheduled appointment, another patient misses the opportunity to be seen.

AS OF JULY 1st, 2014, THERE WILL BE A $45.00 FEE ASSESSED TO PATIENTS WHO DO NOT PROVIDE 48 HOUR NOTICE TO CANCEL THEIR APPOINTMENTS WITH OUR MEDICAL DOCTORS.

Thank you for being a valued patient and for understanding the importance of this policy.

~ Florida Medical & Injury Center ~

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PATIENT SIGNATURE **DATE**