Infinite Health & Spine Center
820 Palmway Street
Kissimmee, FL 34744
Phone 407-931-3700
Fax 407- 567-7900

Patient and Insurance Information

Name	
Address	
Email Address	
Phone Number(s)	
Social Security #	
DOB	
Employer	
Occupation	
Work Phone Number	
Work Address	

Health Insurance Information

Insurance Carrier	Insurance Phone#
Policy#	Group#
Select Patient Relationship to the Insured	Self Spouse Child Other

Auto Accident Insurance

Company	Policy#
Claim#	Adjuster Name
Date of Accident	Adjuster Phone#
Attorney Name	Attorney Phone#

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):*

Sandra Nelson, D.C.		
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 BENEFITS / CAUSE OF ACTION / PAYMENTS

I hereby assign from any and all automobile insurance policies, which provide medical benefits or no-fault benefits, all rights, title and interest to Infinite Health and Spine Center, PA ("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 owing 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 me by Assignee in relation to my accident or illness. This assignment may only be rescinded / reassigned by mutual consent of the patient / insured/ assignor and the health care provider / assignee. If there is an overpayment on your medical account it is understood and agreed that such excess funds will be applied to any outstanding balances.

RESERVATION OF BENEFITS

Please be advised that I am hereby placing you on notice pursuant to Florida case law that should you deny, reduce or fall to either a part or an entire bill, which was submitted on my behalf from this health care provider. I am requesting you reserve, or hold aside, that same amount until this dispute is resolved. Should you submit a check to this healthcare provider that is less than the correct contractual amount, and / or contains any language referring to payment as a "Full and Final Payment," I have instructed this healthcare provider to return the check to you and consider the bills still due and owing. 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 this fact at once.

DIRECTION OF PAYMENT / RELEASE OF INFORMATION

-I hereby authorize any insurance company or attorney to pay to Assignee the amount of this day and/or any future bills services rendered unto me. I also agree to pay in a current manner any differences between the total charges and the amount paid by the insurance company directly to Assignee. In the event that any payment is withheld by any insurance company, attorney, etc., I agree to pay all of Assignee's attorney fee(s), costs and expenses incurred in connection with collecting the amount due, including any interpleaded action, settlement negotiations, court cost, collection efforts and/or litigation related to the amount due.

-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 the Florida Statutes 627.736, this assignment of benefits, as well as the controlling insurance policy. I hereby request a copy of the PIP log and declaration sheet, which reflects the policy limits available at the time of this accident, to be provided by the insurance company to Assignee, I hereby authorize Assignee permission to request and receive a copy of my PIP log periodically as they deem necessary.

LIMITED POWER OF ATTORNEY TO ENDORSE CHECKS

KNOWN ALL MEN BY THESE PRESENT: That the undersigned has made, constituted and appointed Assignee, and any of its duty authorized agents and employees as and to be the undersigned's true and lawful Attorney in Fact for and in the undersigned's name, place and stead to endorse any and all checks, drafts or money orders which are made payable to the undersigned alone or to the undersigned and the said Assignee which checks, drafts, or money orders are to pay for health services or the like which have been rendered by Assignee.

RELEASE OF INFORMATION AND ASSIGNMENT

I hereby authorize my physician and his office/group, to disclose PHI information concerning any illnesses, diseases, disorders, condition, or injuries protected by the federal HIPAA and irrevocably assign all rights, benefits, and causes of action under my policy to the physician/office and direct the insurer to pay without equivocation directly to the physician/office and all benefits due them for services rendered by the office and covered by my insurance.

DUTY TO REVIEW SERVICES

I understand and agree that I have a duty to review, verify, and confirm that all professional medical services, procedures, supplies indicated each visit on the Fee Slip or Encounter Form or Medical Charge Record have been provided as required by state law.

TRUTH STATEMENT

I hereby attest that all illnesses, diseases, disorders, conditions, or injuries for which I have sought medical care are genuine and that statements provided by me are correct in all material provisions, and that all relevant information has been provided, and that each request for information has been responded to truthfully, accurately and in a substantially complete manner.

GENERAL CONSENT FOR TREATMENT

I voluntarily consent to the rendering of medical care, including examinations, treatments, and the administration of performance of diagnostic x-ray or tests, manipulation procedures, surgical, injections, or other procedures deemed necessary and advisable by my physician or under his direction and supervision by whomever he designates as his physician(s), associate(s), assistant(s), staff, agent(s), designee(s), as well as any office personnel.

FINANCIAL RESPONSIBILITY AND FRAUD STATUTES

I understand that I am personally responsible for all charge and outstanding balances including; deductibles, coinsurance payments, and any outstanding balances. I understand that 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 third degree felony per Section 817.234(1)(b). Florida Statutes.

PRINT NAME PATIENT SIGNATURE DATE

Infinite Health & Spine Center
820 Palmway Street
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Fax 407- 567-7900

Medical Pay

Your car insurance company will only release this information to you, the policy holder. ***Please call your car insurance provider to obtain this information.***

Do you have Medical Pay? YES NO

Is your medical pay primary or secondary? _____

If so, how much? $1,000 $2,000 $5,000 $10,000

Do you have uninsured motorists policy on your insurance? YES NO

If so, what is the limit? _____

Patient Name _____

Auto Accident Claim # _____

Claim Adjuster Name _____

His/Her Telephone # _____

Date of Accident _____

Using your medical pay will not raise your car insurance rates

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NOTICE OF INITIATION OF MEDICAL TREATMENT PURSUANT TO FLORIDA STATUTE 627.736

PATIENT _____ DATE OF LOSS ___/___/_____

INSURANCE COMPANY _____

CLAIM NUMBER _____

Dear Sir/Madam: Please be advised that the above medical provider is hereby giving notice pursuant to F.S. 627.736 of initiation of medical treatment within 21 days after first examination or treatment of the claimant. By giving the aforementioned notice, the medical provider may bill for charges for treatment or services rendered up to, but not more than, 75 days before the postmark date of the billing statement.

Very truly yours,

Billing Address:

Infinite Health & Spine Center 820 Palmway Street, Kissimmee FL 34744

OFFICIAL CERTIFICATION OF PATIENT AS TO INSURANCE COVERAGE

PATIENT _____ DATE OF LOSS ___/___/____

INSURANCE COMPANY _____

CLAIM NUMBER _____

I, as the above captioned patient hereby attest that to the best of my knowledge, that the insurance claims information I have provided above is in fact the correct insurance information under which I am entitled to medical and/or PIP coverage.
I understand that the medical provider is relying on this correct information in order to receive the appropriate coverage and qualify for payment for medical services provided to me.

SIGNATURE _____ DATE ___/___/____

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LETTER OF PROTECTION & HEALTH CARE PROVIDER LIEN

I hereby authorize my attorney's office to release any pertinent information to this health care provider as it relates to paying for services rendered. This is a Letter of Protection, which I am issuing to this health care provider. I am eliminating the need for my attorney to issue a separate document to this effect. I am instructing my attorney to satisfy the lien at the conclusion of my case. This lien is against any judgment, verdict, or pursuit settlement that may arise from my case. I also agree that regardless of the outcome of my case, I am still indebted for any unpaid balance for services rendered from this health care provider. A faxed copy of this signed agreement is valid as the original. My attorney's signature is not needed on this agreement as I am issuing a valid health care provider lien against my proprietary right in any potential injury settlement that may arise.

I have read and fully understand the above statements.

Attorney Signature _____

Patient Signature _____

Date _____

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TREATMENT PLAN

Patient Name _____

Today's Date _____

☐ Therapy – 3 Times Per Week

☐ Therapy – 2 Times Per Week

☐ Therapy – 1 Time Per Week

☐ Therapy- Every Other Week (2x per month)

☐ Therapy – Once a Month

Special Instructions: _____

Referral: _____

I understand the importance of following through on my care in order to achieve the best results. It is my responsibility to attend my scheduled appointments promptly out of respect for both my time and the time of the Infinite Health & Spine Center.

_____ _____

Patient Signature Date

Name: _____ Date: _____Height _____ Weight_____ Age_____
L or R Handed L__ R __
Vehicle Information: Car___ Truck ___ SUV___ Motorcycle___ Bus___ Bike___
Where was the vehicle hit? Front___ Rear___ Right side___ Left side ___
Were you the? Driver ___ Passenger___ Pedestrian___ Bike___ Motorcycle___
Were seat belt restraints used: Yes ___ No___

Head:
1.Do you recall hitting your head during impact? Yes___ No___
2.If you have headaches in what area do you feel them _____
3.Were you dazed? Yes___ No___
4.Did you lose consciousness Yes___ No___
5.What is the first thing you remember after the impact? _____
6.Did you see a bright flash of light? Yes___ No___
7.Any dizziness? Yes___ No___
8.Any blurry vision? Yes___ No___
9.Any nausea/vomiting Yes___ No___
10.Do you notice a head rush/light headedness when you get up out of the chair or bed? Yes___ No___
11.Does your head or face have numbness ? Yes___ No___
12.Any ringing in the ears? Yes___ No___
13.When you open your jaw do you have? Clicking___ Popping___ None___

Cranial Nerves:
1.When you have headaches, do you have pain: Behind the eyes___ Sensitivity to light___
2.Loss of ability to move both eyes w/o a problem? Yes___ No___
3.Any problems winking eyes or closing them Yes___ No___
4.Any loss of ability to taste? Yes___ No___ Trouble moving your tongue? Yes___ No___
5.Any loss of ability to hear? Yes___ No___
6.Any difficulty swallowing? Yes___ No___
7.Any hoarseness in your voice? Yes___ No___
8.Any trouble shrugging you shoulders? Yes___ No___ Right___ Left___
9.Any trouble smiling? Yes___ No___

Medical History since the accident
1.Difficulty sleeping due to pain? Yes___ No___
2.Trouble with memory? Yes___ No___
3.Mood swings since the accident? Yes___ No___
4.Feel depressed? Yes___ No___
5.Feel tired or fatigued ? Yes___ No___
6.Any sexual problems? Yes___ No___
7.Are you employed, retired, disabled, student or minor? _____
8.Were you out of work? Yes___ No___
9.What type of work do you do? _____(computer,long sitting,standing,bending, etc)

Patient Signature:_____
Physician Signature:_____

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Email & Text Message Appointment Reminder(s) Consent Form

Today's Date ____/____/_____

Patient Name _____

Cell Phone Number _____

Cell Phone Provider _____

Email Address _____

I understand that by signing this form, I may receive appointment reminders via e-mail or text message in addition to receiving them via phone calls. I further understand that the provider e-mail & text message system is not encrypted. I understand that I am responsible for access to my e-mail & text messages and will not hold the provider's office responsible for any breach that may occur. Any changes to my email address or phone number must be delivered in writing, and not, by e-mail or text to the provider. Communications will be limited and used only for receiving and responding to appointment reminders. Except for the applicable names and times and dates of appointments, no other personal information about the patient shall be included in any e-mail or text message.

_____

Patient Signature

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AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

Patient Name _____

Date of Birth _____

SS # _____

I voluntarily authorize and direct my health care provider **Infinite Health & Spine Center** to use or disclose my health information during the term of this Authorization to and from the recipient I have identified below:

_____ **Hospital/Office Name**

☐ All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me

☐ All of my health information described above except

for the following: _____

☐ Only the following records:

Date of Service: _____

Signature _____ Date _____

If patient is unable to sign this authorization, please complete the information below:

_____ _____

Name of Guardian/ Representative Legal Relationship

Infinite Health & Spine Center
820 Palmway Street
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Patient Medical History

Patient Name _____

Do you take any addictive substances? YES NO

Are you allergic to anything? YES NO

List all allergies and describe your reaction:

_____

_____

Please check ALL previous illnesses or conditions below:

- ☐ Bleeding Problems
- ☐ Circulation Problems
- ☐ Diabetes
- ☐ Frequent Infections
- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Kidney/Urine Problems
- ☐ Liver Problems
- ☐ Lung Problems
- ☐ Psychological/Psychiatric Problems
- ☐ Seizure
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Cancer
- ☐ Hepatitis
- ☐ Surgery?

  _____

- ☐ Current Medications

  _____

  _____

  _____

Personal Injury Questionnaire

Name _____ Phone # _____

Address _____City _____ State_____

Date of Accident _____ Time of Day _____

Were you: ( ) Driver ( ) Passenger ( ) Front Seat ( ) Back Seat

What city did the accident take place in? _____

Number of people in your vehicle _____Were you wearing seat belts? _____

What direction were you headed? ( ) North ( ) South ( ) East ( ) West

What direction was the other vehicle headed? ( ) North ( ) South ( ) East ( ) West

Were you struck from? ( ) Behind ( ) Front ( ) Left Side ( ) Right Side

Approximate speed of your car _____ mph Other car _____ mph

Were you knocked unconscious? _____ Did the airbag deploy? _____

Were police notified? _____

In your own words, please describe the accident:

_____

_____

_____

Please describe how you felt:

During the accident _____

Immediately after the accident _____

Were you taken to the hospital? _____ By ambulance? _____

Name of Hospital _____

Make, model, and year of your car _____

Make, model, and year of car that was involved _____

Did you see a MD, go to the ER or Urgent Care? _____If so, when? _____

Amount of damage to your car? _____

Number of cars involved in accident? _____

Did you lose any time from work? _____

Did the accident force you to take any medications? _____ If so, what? _____

Did the car that hit you have insurance? _____

Do you have an Attorney? _____

Do you have Medical Pay on your car insurance? If so, what dollar amount?

$1,000 $5,000 $10,000

Patient Name: _____ Patient File #: _____

Loss of Enjoyment of Sports, Hobbies, Travel, Daily Activities, & School

Date _____ Date of Injury _____

☐ Initial ☐ Update ☐ Final

Please check all that apply to your EXERCISE & SPORTS Activity *because of the accident*

- ☐ My exercise was affected by this crash
- ☐ I go to the gym & work out in pain
- ☐ I no longer go to the gym to work out
- ☐ I run but in pain
- ☐ I no longer run
- ☐ I take walks & have pain while walking
- ☐ I no longer take walks
- ☐ I used to make income at sports
- ☐ I have lost sports income since crash
- ☐ I am an amateur athlete
- ☐ I am a professional athlete
- ☐ _____
- ☐ _____

- ☐ I have gained _____ pounds since the accident
- ☐ I had to quit my _____ team after the accident
- ☐ I had to quit my _____ team after the accident
- ☐ I had to quit my _____ team after the accident
- ☐ I had to quit my _____ team after the accident
- ☐ I don't enjoy the sport of _____ __ anymore
- ☐ I didn't enjoy the sport of _____ for ____ weeks
- ☐ I don't enjoy the sport of _____ anymore
- ☐ I didn't enjoy the sport of _____ for ____ weeks
- ☐ I don't enjoy the sport of _____ anymore
- ☐ I didn't enjoy the sport of _____ for ____ weeks
- ☐ I don't enjoy the sport of _____ anymore
- ☐ I didn't enjoy the sport of _____ for ____ weeks

Please check all that apply to your HOBBY Activities *because of the accident*

- ☐ My hobbies were affected by accident
- ☐ Hobby #1 _____
- ☐ I can't do hobby #1 anymore
- ☐ I do hobby #1 but in pain
- ☐ I have lost money from not doing #1
- ☐ I didn't do hobby #1 for _____ weeks
- ☐ Hobby #2 _____
- ☐ I can't do hobby #2 anymore
- ☐ I do hobby #2 but in pain
- ☐ I have lost money from not doing #2
- ☐ I didn't do hobby #2 for _____ weeks

- ☐ Hobby #3 _____
- ☐ I can't do hobby #3 anymore
- ☐ I do hobby #3 but in pain
- ☐ I have lost money from not doing #3
- ☐ I didn't do hobby #3 for _____ weeks
- ☐ Hobby #4 _____
- ☐ I can't do hobby #4 anymore
- ☐ I do hobby #4 but in pain
- ☐ I have lost money from not doing #4
- ☐ I didn't do hobby #4 for _____ weeks
- ☐ _____

Please check all that apply to your TRAVEL Activities *because of the accident*

- ☐ Business travel was affected by crash
- ☐ Pleasure travel was affected by crash
- ☐ I hurt driving in my own car
- ☐ I am in too much pain to drive
- ☐ I hurt when a passenger in a car
- ☐ I am in too much pain to sit in a car
- ☐ I have anxiety when I'm in a car
- ☐ I hurt when I'm on an airplane
- ☐ I am in too much pain to travel by plane

- ☐ Travel Plan #1 _____
- ☐ I did not go on travel plan #1
- ☐ I went, but did not enjoy #1 as much
- ☐ I went and the accident had no effect on #1
- ☐ Travel Plan #2 _____
- ☐ I did not go on travel plan #2
- ☐ I went, but did not enjoy #2 as much
- ☐ I went and the accident had no effect on #2
- ☐ I missed time with my family/friends b/c can't travel

Patient Name: _____ Patient File #: _____

Duties Performed Under Duress at Work and Home

Date _____ Date of Injury _____

☐ Initial ☐ Update ☐ Final

Please check all that apply to your WORK because of the accident

- ☐ I go to work but work in pain
- ☐ I limit my work activities
- ☐ Bending at work hurts
- ☐ Stooping at work hurts
- ☐ Sitting at work hurts
- ☐ Using the Computer at work hurts
- ☐ Pushing at work hurts
- ☐ Pulling at work hurts
- ☐ Kneeling at work hurts
- ☐ I have lost status in my company
- ☐ I have lost job security.
- ☐ I didn't get a promotion
- ☐ I don't enjoy work as much as before
- ☐ I doze off at work
- ☐ I take unpaid time off work to go to Dr.
- ☐ I daydream at work more than before
- ☐ I feel tired at work
- ☐ _____
- ☐ _____

- ☐ I work in pain because I have bills to pay
- ☐ I can't take time off because I would lose my job
- ☐ I keep working so I don't lose stat us at company
- ☐ My business would fail if I took time off
- ☐ I believe in working even when I'm in pain
- ☐ I feel obligated to work even though I'm in pain
- ☐ My business would lose money if I took time off
- ☐ My work is not as good as it was before accident
- ☐ My boss reprimanded me for poor performance
- ☐ I got a different job within the same company
- ☐ I got a different job in another company
- ☐ I make less money than before the accident
- ☐ I cannot do the same work/job as before accident
- ☐ I can't concentrate as well at work
- ☐ I take paid time off to go to Dr.
- ☐ I make mistakes at work I didn't used to
- ☐ I hide my poor work performance from my boss
- ☐ _____
- ☐ _____

- ☐ My house is not as clean now
- ☐ My yard is not as neat now
- ☐ My garden is not as productive now
- ☐ I do yard work, but do it in pain
- ☐ I cannot do my normal yard work
- ☐ I do house work, but do it in pain
- ☐ I cannot do my normal house work
- ☐ Doing laundry hurts me
- ☐ I cannot do laundry now
- ☐ Washing dishes hurts me
- ☐ I cannot wash dishes now
- ☐ Vacuuming hurts me
- ☐ I cannot vacuum now
- ☐ Cooking hurts me
- ☐ I cannot cook now
- ☐ Washing the car hurts me
- ☐ I cannot wash my car
- ☐ _____
- ☐ _____

- ☐ I cannot take time off because I care for children
- ☐ I have _____ children ages _____
- ☐ I had to hire a paid housekeeper
- ☐ I asked someone for unpaid housekeeping help
- ☐ I had to hire a paid gardener
- ☐ I asked someone for unpaid yard work help
- ☐ Mowing the lawn hurts me
- ☐ I cannot mow the lawn
- ☐ Taking out the trash hurts me
- ☐ I cannot take out the trash
- ☐ I do not enjoy my gardening/yardwork like I used to
- ☐ I do not enjoy my housework like I used to
- ☐ Gardening hurts me
- ☐ I cannot do my gardening at all since the accident
- ☐ Others living with me do my share of the work now
- ☐ Others living with me do my share of the yard work
- ☐ Others living with me do my share of the gardening
- ☐ _____
- ☐ _____

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-RAY AND PHYSICAL FINDINGS DIAGNOSIS AND PROGNOSIS. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE FLORIDA "NO FAULT" AUTO INSURANCE LAW (CHAPTER 71-252 F.S.)

_____ _____

SIGNATURE DATE

AUTHORIZATION FOR WAGE AND SALARY INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY HEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY WAGES OR SALARY WHILE EMPLOYED BY YOU. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE FLORIDA "NO FAULT" AUTO INSURANCE LAW (CHAPTER 71-252 F.S.)

_____ _____

SIGNATURE DATE

_____

SOCIAL SECURITY NUMBER

Infinite Health & Spine Center
820 Palmway Street
Kissimmee, FL 34744

FEDERALLY MANDATED PRIVACY REGULATION REQUIREMENT
PATIENT CONSENT FORM

I hereby give my consent for **Infinite Health and Spine Center, PA** 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 **Infinite Health and Spine Center,** PA 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. **Infinite Health and Spine Center, PA**. 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 **Infinite Health and Spine Center, PA** at 820 Palmway Street Kissimmee, FL 34744.

With this consent, **Infinite Health and Spine Center, PA** 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 item 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, **Infinite Health and Spine Center, PA** or my physician(s) may e-mail 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 **Infinite Health and Spine Center, PA** 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.

With this consent, **Infinite Health and Spine Center, PA** 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 card and patient statements as long as they are marked "Personal and Confidential."

By signing this form, I am consenting to allow **Infinite Health and Spine Center, PA** 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, **Infinite Health and Spine Center, PA** or my physician(s) may decline to provide treatment to me.

_____ _____

Patient Signature Date

Infinite Health & Spine Center
820 Palmway Street
Kissimmee, FL 34744
Phone 407-931-3700
Fax 407- 567-7900

The 14 Day Rule:

A recent change in Florida Law requires automobile accident victims to act fast or risk losing any chance to claim personal injury protection (PIP) awards from your insurance company. **As of January 1st, 2013, auto accident victims have 14 days to seek medical treatment or otherwise forfeit any coverage for PIP coverage.** Florida Law requires you to pay for $10,000 in personal injury protection coverage, but if you delay in seeking appropriate medical care, you may find yourself unable to claim anything.

FLORIDA NO FAULT LAW

Florida is a "No Fault" state which means: If you are involved in a motor vehicle collision, you are required to report the collision to your auto insurance agent or insurance company immediately. No matter which party is at fault, it is your own auto insurance company that is the primary payer for medical payment. This is before any health insurance or liability insurance.

If a child living with a parent is either hit by a vehicle as a pedestrian or as a passenger in a vehicle, it is the parent's auto insurance company that is the primary payer for medical payment. Again, this is before any health insurance or liability insurance.

The only time the "other party's" auto insurance would pay medical bills would be would be: (1) if the patient did not own a vehicle or live with a resident relative who owned a vehicle or (2) if the patient's vehicle or resident relative's vehicle was inoperable, in this case, a sworn affidavit stating the vehicle was not working is required.

You may verify that this information is correct with your auto insurance agent.

After speaking with your agent, please contact us promptly with your automatable insurance information, including the name of the insurance company, the policy number, the name of the person carrying the insurance policy, and the effective date.

_____ _____

Patient Signature Date

Infinite Health & Spine Center
820 Palmway Street
Kissimmee, FL 34744
Phone 407-931-3700
Fax 407- 567-7900

MagnaCharger: Pulsed Magnetic Cellular Exerciser
Consent for Demonstration or Session

Disclaimer

The MagnaCharger produces magnetic energy, which passes freely through tissue for the purpose of cellular exercise to promote and support a sense of wellbeing. The MagnaCharger is not a medical device. The MagnaCharger has not been evaluated by the FDA. It is not intended for the diagnosis, treatment or cure of any medical condition. If you are experiencing the symptoms of a medical condition you should seek the advice of a medical professional. If you are unsure whether a demonstration or exercise program of pulsed magnetic cellular exercise is right for you, consult with your licensed health care provider(s).
As with any exercise program, you may experience natural reactions that include but are not limited to; nausea, headache, fatigue or muscle aches.

Precautions & Recommendations

- Additional hydration is recommended before and after a session with the MagnaCharger
- Do not use the MagnaCharger if you have an implanted electronic device including: **pacemaker, defibrillator, cochlear hearing device, etc.**
- Remove all the following from your person: **Electronic or battery operated devices, keys, wallets, jewelry and hearing aids**
- **Do not use the MagnaCharger if you are pregnant**
- Do not use **during active bleeding, hemorrhaging or during heavy menstruation**

Informed Consent

I understand that the MagnaCharger creates a fully adjustable pulsed magnetic field. I understand that the information shared by the demonstrator are his/her personal opinions and are intended for educational purposes only.

Beyond what is stated above, I understand that other risks associated with a pulsed magnetic exercise session are unforeseeable and that the demonstrator, the manufacturer, the marketer, employees, agents and affiliates cannot accept any liability for loss or damages incurred as the result of the MagnaCharger session. I reserve the right to use the knowledge I have gained in the care of my own body in any legal manner I may choose. I have read this form and voluntarily agree to the MagnaCharger session on my person assuming all liability for any and all results or consequences.

Print Name _____ Signature _____

Date _____

APPLICATION FOR FLORIDA "NO FAULT" BENEFITS

NAME OF INSURANCE COMPANY

DATE	OUR POLICY HOLDER	DATE OF ACCIDENT	FILE NUMBER

TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE FLORIDA PERSONAL INJURY PROTECTION LAW, PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURANCE COMPANY MAKES A STATEMENT OF CLAIM CONTAINING ANY FALSE INCOMPLETE OR MISLEADING INFORMATION, IS GUILTY OF A FELONY OF THE THIRD DEGREE.

YOUR NAME	PHONE NO.	HOME	BUSINESS

YOUR ADDRESS (NO, STREET, CITY OR TOWN, STATE AND ZIP CODE)	DATE OF BIRTH	SOCIAL SECURITY NO.

PERMANENT ADDRESS, IF DIFFERENT	HOW LONG HAVE YOU LIVED IN FLORIDA?

DATE AND TIME OF ACCIDENT	PLACE OF ACCIDENT (STREET, CITY OR TOWN AND STATE)

BRIEF DESCRIPTION OF ACCIDENT AND VEHICLES INVOLVED:

DESCRIBE MOTOR VEHICLE YOU OWN -	DESCRIBE MOTOR VEHICLE OWNED BY ANY MEMBER OF YOUR FAMILY-

AS A RESULT OF THIS ACCIDENT, WERE YOU INJURED? IF YOUR ANSWER IS YES, COMPLETE THE REST OF THIS FORM. IF NO, SIGN HERE AND RETURN THIS FORM TO US.

SIGNATURE: DATE:

DESCRIBE YOUR INJURY

WERE YOU TREATED BY A DOCTOR?		DOCTOR'S NAME AND ADDRESS

IF YOU WERE TREATED IN A HOSPITAL, WERE YOU AN IN PATIENT ___ OUT PATIENT ___	HOSPITAL'S NAME AND ADDRESS

AMOUNT OF MEDICAL BILLS TO DATE	WILL YOU HAVE MORE MEDICAL EXPENSE?	AT THE TIME OF YOUR ACCIDENT, WERE YOU IN THE COURSE OF YOUR EMPLOYMENT?

DID YOU LOSE WAGES OR SALARY AS A RESULT OF YOUR INJURY?	IF YES, AMOUNT OF LOSS TO DATE WHAT IS YOUR AVERAGE WEEKLY WAGE OR SALARY?

IF YOU LOST WAGES:	DATE DISABILITY FROM WORK BEGAN	DATE YOU RETURNED TO WORK

HAVE YOU RECEIVED, OR ARE YOU ELIGIBLE FOR, PAYMENTS UNDER ANY WORKMEN'S COMPENSATION OR EMPLOYMENT LAW?	IF YES, AMOUNT PER WEEK PER MONTH

LIST NAMES AND ADDRESSES OF YOUR PRESENT EMPLOYER(S) AND GIVE YOUR OCCUPATION AND DATES OF EMPLOYMENT FOR EACH

EMPLOYER AND ADDRESS	YOUR OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	YOUR OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	YOUR OCCUPATION	FROM	TO

AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES?	IF YES, EXPLAIN ON REVERSE SIDE
SIGNATURE: DATE:	

IMPORTANT: 1. TO BE ELIGIBLE FOR BENEFITS COMPLETE AND SIGN THIS APPLICATION
2. SIGN AND ATTACH AUTHORIZATION(S)
3. RETURN PROMPTLY WITH ANY MEDICAL BILLS YOU HAVE RECEIVED TO DATE