University Health Center, P.A.
Chiropractic ✦ Physical Therapy
Massage Therapy ✦ Primary Medicine

Accident History:

Today's Date:________________

Name:____Phone:_________________________

Address:____

City:_______________________State:___________________Zip Code:__________________ Date of

Birth:_____________________________Social Security:________________________ _______Married

______Single ______Divorced

Employer:________________________________Occupation:__________________________ Driver's

License Number:____ Emergency

Contact:_______________________Phone Number:________________________

How did you hear about our office:

____

✮✮
✮✮✮✮✮✮✮✮

Was it a:

_____Auto Accident _____Slip & Fall _____Worker's Compensation

Were you the:

_____Driver _____Passenger _____Pedestrian _____Other

Traveling/Stopping Facing: ___North ___South ___East ___West

Location of Accident/Incident :____

____

City:_________________State:_______________Date of Accident:______________________

Time:_________am/pm

7797 N University Drive, Suite 101 Tamarac, Florida 33321
Telephone: (954)722-6050 Fax: (954)720-7776

Consent To Treat

I hereby request and consent to the performance of chiropractic adjustment and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below for whom I am legally responsible) by the doctors and staff members who work at the office located at the address below.

I have had an opportunity to discuss with the doctors of chiropractic, at the location listed below, and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

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

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

Patient Signature:_____Date:_____

Consent to treat minor:_____ Guardian Signature

Print Name:_____

Relationship:_____

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Descriptions of Accident (Check appropriate description):

- ❏ Rear-ended while stopped or turning
- ❏ Side swiped by another vehicle traveling in the same direction
- ❏ Collided head-on with vehicle traveling in opposite direction
- ❏ Other vehicle ran a red light/ stop sign and struck my car
- ❏ Involved in a multi-car collision
- ❏ I was injured my back/neck/arm/leg in lifting accident
- ❏ I slipped and fell injuring my back/neck/leg/arm
- ❏ Other:_____ **Were**

you wearing a seatbelt? ___Yes ___No

Select any body parts that were struck in the accident/incident:

___Head ___Face ___Chest ___Neck ___Back ___Shoulder (R/L)

___Arm(R/L) ___Leg(R/L) ___Knee(R/L)

Select objects struck by:

___Windshield ___Back of seat ___Headrest ___Seat broke ___Dashboard ___Steering Column

____Door frame ___Rear view mirror ____Jarred & thrown ___Rendered unconscious

Other:_____

If applicable, indicate any pains or abnormal sensations experienced immediately following the impact:

___Headache ___Saw stars ___Semi-conscious ___Neck pain (R/L) ___Mid back pain (R/L) ____Low

back pain(R/L) ___Upper extremity pain ___Lower extremity pain

Other:_____

Indicate any actions taken by you immediately following the accident: ___Went home and rested ___Went to hospital ___Went about normal business

___Went to physician ___Doctored myself thinking the pain would go away

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Hospitalization
(if you consulted this office first, please skip to past history)

Name of Hospital: _____City:_____ Were

you seen in the emergency room? ___Yes ___No

Were you admitted to hospital? ___Yes ___No

Admitting physician's name:_____Length of stay:_____

Indicate any procedures performed at the hospital:
___Examination ___Stitches ___X-rays ___Prescription __Injections ___Physiotherapy
___Cervical Collar ___Wounds dressed
Other:_____

Indicate method of delivery to hospital:
___Ambulance ___Drove myself ___Driven by spouse/relative/friend

What did you do after being released from hospital?
___Returned home and took it easy ___Returned home and visited physician next few days ___Returned to work

When did you first consult a physician?
___Same day ___Following day ___Withing few days Other:_____

Who was the first physician you consulted? Dr._____ ___Family physician ___Chiropractor ___Orthodepist ___Nuerologist ___Osteopath ___Walk in clinic
Other:_____

Did your doctor refer you to any other physicians? ___Yes ___No
Who?_____
How long were you under their care?_____
Indicate frequency of visits:_____

Have you been sent for an Independent Medical Exam by your carrier? ___Yes ___No If so, to what Dr:_____Date:_____
Any other pertinent information:_____

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Past History:

Have you been involved in any previous accidents of any kind? ___Yes ___No

*If so, when was this and explain*_____

_____ **Have**

you ever been treated previously for any back or neck problems? ___Yes ___No

Explain:_____

_____

If you've been previously treated by a chiropractor, please explain:_____

_____

If you have undergone any surgery or experienced any conditions that may be pertinent to this condition, please explain:_____

_____

Did you have good health prior to this accident?

___Yes ___No. *If so, explain*_____

Present complaints:

What are your present complaints, starting with the most severe?_____

_____

Disability:

Have you lost time from work since this accident?

___No ___Yes, *Number of days*_____*Date range*:_____

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Are you still off from work?

___Yes ___No, *when did you return?*_____

What is your job description?_____

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Legal Representation

If you have any attorney, indicate his/her name, address, and phone number:

_____

_____

_____

_____

Insurance information:

(MUST BE YOUR AUTO INSURANCE INFORMATION- PER FLORIDA NO- FAULTY LAW)

Have you reported this accident to your own insurance agent or carrier?

___Yes ___No

Name of company:_____ Claim Number:_____

Adjuster:_____

Telephone:_____ **Is the vehicle you were traveling in owned by you or someone else?**

_____ **If you do not have insurance, does someone in your household own a vehicle and have insurance?**_____

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Assignment of Insurance Benefits, Release, and Demand

Insurer and Patient Please Read the Following in its Entirety

I, the undersigned patient/insured knowingly, voluntarily and intentionally assign the rights and benefits of my automobile Insurance, also known as Personal Injury Protection (P.I.P), 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 and that this document will allow the provider to file suit against an insurance company for payment of the insurance benefits. This assignment of benefits includes overdue interest payments and any potential claim for common law or statutory bad faith. If the insurer disputes the validity of this assignment of benefits then the insurer is instructed to notify the provider in writing within five (5) 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 directly without including the patient's name on the check. 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 and the insurer as to the amount payable under the insurance policy or contract. The provider hereby objects to any reductions or partial payments. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by the provider shall be done so under protest, at the risk of the insurer, and the deposit shall not be deemed a waiver, accord, satisfaction, discharge, settlement, or agreement by the provider to accept a reduced amount as payment in full. The insurer is hereby placed on notice that this provider reserves the right to seek the full amount of the bills submitted. If the insurer schedules a defense examination or examination under oath (herein after "EUO") the insurer is hereby INSTRUCTED to send a copy of said notification to this provider. 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 any statements or examinations under oath the patient provided to any insurer. **Release of information:** I hereby authorize this provider to furnish an insurer, an insurer's intermediary, the patient's other medical providers, and the patient's attorney via mail, fax, or email, with any and all information that may be contained in the medical records; to obtain insurance coverage information in writing (declaration sheet) 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 statements the patient provided to the insurer: obtain copies of 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 myt medical records to its attorney in connection with any pending lawsuits. The insurer is directed to keep the patient's medical records from this provider private and confidential and the insurer is not authorized to provide these 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 above the 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 are received by the insurer on the same day the insurer is directed to not apply this provider's bills to the deductible. If the insurer receives a bill from this provider and claim from anyone else on the same day then the insurer is directed to pay this provider first before the policy is exhausted. In the event this provider's medical bills are disputed by the insurer for any reason the undersigned hereby instructs the insurer to set aside any amount disputed (i.e., to escrow the money) and not pay the disputed amount to anyone, including myself, or any entity until the dispute is resolved. The insurer is instructed to immediately explain in writing to the above provider of any dispute. **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 s to the results that may be obtained by any treatment or service: I agree the provider's prices for medical services, treatment and supplies are reasonable 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.**

Date:_____

Print Patient's Name:_____ **Patient's Signature:**_____

If patient is a minor, signature of parent/guardian is requested

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Medical Records Release

Patient's Name:_____ Date of Birth:____/_____/_____

I hereby request and authorize:

University Health Care Center

7797 North University Drive Suite 101

Tamarac FL, 33321

Phone number: (954)722-6050 **Fax: (954)720-7776**

____To disclose information ____To receive information

Name/Provider:_____

Address:_____City:_____Zip:_____

Phone:_____ FAX:_____ Information to be disclosed

include copies of:

___Entire Record ___X-ray Reports ___Progress Notes

___X-ray Films ___Physical Exam ___Daily Chart Notes

Other:_____

Purpose for Disclosure:

_____ This authorization will be effective for six months after the date signed unless cancelled in writing. I understand that the cancellation will have no effect on information released prior to receiving the cancellation. A copy of this authorization is as valid as the original

Patient's Signature:_____ Date:_____

_____ Date:_____

Signature of Legal Representative/Relationship

If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law. Notice to recipient of information: this information has been disclosed to you from confidential records, which are protected by law. Unless you have further authorization, laws may prohibit you from making any further disclosures of this information without the specific written consent of the patient or legal representative.

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D/A:___________________

To:________________________________ RE:__________________________

__________________________________ _____________________________

I do hereby authorize the above physician to furnish you with a report of his/her examination, diagnosis, treatments, prognosis, etc.., of myself in regard to the accident in which I was involved.

I hereby authorize and direct you to pay directly to said physician such sums as may be due and owing his/her for medical service rendered me both by reason of this accident and by reason of this accident and by the reason of any other bills that are due to our office and to withhold such sums from settlement, judgement, or verdict as may be necessary to adequately protect the said physician. And I hereby further give a lien on my case to the said physician against any and all proceeds of any settlement, of the injuries for which I have been treated or injuries in connection with.

I fully understand that I am directly and fully responsible to the said physician for the total medical bills submitted by his/her for the service rendered to me not withstanding any insurance company reductions, usual and customary reductions, assignment reductions or reduction of any kind, and that this agreement is made solely for said the physician's additional protection and in consideration of his/her awaiting payment. And I further understand that such payment is not contingent on any settlement, judgement, or verdict by which I may eventually recover said fees.

Date:_____________________

Print Patient's Name:________________________ Patient's Signature:____________________

If patient is a minor, signature of parent/guardian is requested

✯✯
✯✯✯✯✯✯✯✯

The undersigned do hereby acknowledge and agree to observe all the terms of the above and agree to withhold such sums from any settlement, judgement or verdict as may be necessary to adequately protect said physician above named.

Date:_____________

Print Attorney's Name:________________________Attorney's Signature:_________________

Please sign, date, and fax 954-720-7776 or Email back at universityhealthcenter@gmail.com

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Fax:(954)720-7776

Multi Consent Form

I,_____authorize the performance of diagnostic x-rays examination of myself, which the above doctor or his associates may consider necessary or advisable in the course of my examination and treatment.

Signature:_____

Non-Pregnancy Verification

This is to certify that to the best of my knowledge, I am not pregnant and the above doctor and his associates have my permission to perform diagnostic x-ray examination. I have been advised that x-rays can be hazardous to an unborn child.

Date of last menstrual cycle:_____

Signature:_____

Consent to X-Ray/ Treat a Minor

I,_____authorize the performance of diagnostic x-ray examination and/or treatment of my child or ward _____which the above doctor or associates might consider necessary or advisable in the course of examination and treatment. The patient is a minor, _____years of age.

Signature:_____

Date:_____

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COVID-19 SCREENING QUESTIONNAIRE

Please respond to each of the following questions truthfully and to the best of your ability. Your participation is important to help us take precautionary measures to protect you and those around you.

Name:_____ Date:_____

1. Are you currently experiencing, or have experienced in the past 14 days, any of the following symptoms?

- ❏ Fever (100.4° F/37.8° C or greater as measured by an oral thermometer)
- ❏ Cough
- ❏ Shortness of breath or difficulty breathing
- ❏ Sore throat
- ❏ New loss of taste or smell
- ❏ Chills
- ❏ Head or muscle aches
- ❏ Nausea, diarrhea, vomiting
- ❏ I have not experienced none of the options above

2. In the past 14 days, have you been in contact with someone who tested positive for Covid-19? ☐ Yes ☐ No

3. In the past 14 days, have you been on commercial flight or traveled outside of the United States? ☐ Yes ☐ No

4. Have you tested positive for Covid-19? ☐ Yes ☐ No **5. Have you been tested for Covid-19 and are waiting to receive test results?** ☐ Yes ☐ No

_____

I hereby certify that the responses provided above are true and accurate to the best of my knowledge.

Signature:_____Date:_____

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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.**

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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(14) and (15), 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**):*

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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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