ChiroStandard, PLLC
1962 Main Street Ste 100
Sarasota, FL 34236

Electronic Health Records Intake Form

This form complies with CMS EHR incentive program requirements

First Name:__________________________ **Last Name:**__________________________

Email address: _________________@_________________

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** ___________________

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Smoking Start Date (Optional): ___________________

Family Medical History ***(Record one diagnosis in your family history and the affected***				
Diagnosis (Write in below)	Father	Mother	Sibling: (___________)	Offspring: (___________)
Example: Heart Disease		*X*		

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? *(Include regularly used over the counter medications)*	
Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?			
Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: ____ Date: ________________

For office use only
Height:_________ Weight:___________ Blood Pressure:______/______

ChiroStandard®
Your Partner in Healthcare

RehabStandard
Your Choice for Sports Physical Therapy
Commitment • Dedication • Results

PATIENT INFORMATION FORM

1) Patient Number________________(office use only) Dr._______________________________
2) First Name__________________M.I.___4)Last Name__________________Phone#( )______
3) Address______________________City_______________State_____Zip_______________
5) Age___6) Sex______Birth date__________Marital Status (S M W D) Soc Sec #______________
6) Email____

Occupation_______________________Employer________________Work Phone( )________
Person Responsible for this account_____________________

INSURANCE INFORMATION: Group____ Private________Work/Comp________Automobile_______
Name of insured________________________Relationship to Patient__________Policy #_________
Insurance Co.____Group #_______________
Street Address____________________________________City_____________State____Zip_______

ADDITIONAL INSURANCE: Group _________Private_________Work/Comp_____Auto___________
Name of insured________________________Relationship to Patient__________Policy #_________
Employer______________________Employee #__________________Work Phone # ( )________
Work Address__________________City_________________________State_______Zip________
Insurance Co.____Group #_______________
Street Address____________________________________City_____________State____Zip_______

ATTORNEY INFORMATION:
Attorney Name____Phone ( )_________________
Street Address____________________________________City_____________State____Zip_______

I hereby assign any and all legal rights required with respect to the enforcement of medical benefit provisions of any insurance policy under which I qualify for benefits, including the right to proceed in AAA arbitration, necessary to collect monies due and owing to the ChiroStandard® for medical services which were provided to me.

I understood and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I authorize payment from my Insurance carrier directly to this office with the understanding that all monies will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature____Date____________________

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Patient History

Patient Name____ Date___________________________

Reasons for seeking care:

Primary reason:

____

Secondary reason:

____

Have you ever received Chiropractic or Physical Therapy Care? Yes No
If yes, when?______________________________________

History of Complaint:

Location of Complaint:

____

Complaint Began when and how?

____

Please circle the Quality of the complaint/pain: dull aching sharp shooting burning throbbing deep nagging other _______

Does this complaint/pain radiate or travel (shoot) to any areas of your body?
Where?_______________________________________

Do you have any numbness or tingling in your body? Where?

____

Grade Intensity/Severity (No complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible pain/complaint imaginable)

How frequent is complaint present, how long does it last?

____

Does anything aggravate the complaint?

____

Does anything make the complaint better?

____

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Patient Name____

Previous interventions, treatments, medications, surgery, or care you've sought for your complaint:

____

____

Please List all Medical Doctors including Primary, Orthopedic, OBGYN, Podiatrist

____

____

Past Health History:

Previous illnesses you've had in your life:

____

Previous injury or trauma:

____

____

Have you ever broken any bones?

____

____

Medications: Reason for taking

____

____

____

Surgeries:
Date Type of Surgery

____

____

____

____

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RehabStandard Your Choice for Sports Physical Therapy Commitment • Dedication • Results

Patient Name____

Family Health History:

Health problems of relatives:

____

____

____

Social and Occupational History:

Job description:

____

Work schedule:

____

Recreational activities:

____

Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet):____

Goals of Treatment:

(please circle all that apply)

Pain Relief Only

Pain Relief and Prevention

Return to Specific Activity or Sport ___________________________

Performance Enhancement

Improvement in Overall Health

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office to provide me with care, in accordance with this state's statutes.

Patient or Guardian Signature ____________________________________ Date ______________________

Doctors Signature ____________________________________ Date ______________________

ChiroStandard® Your Partner in Healthcare

RehabStandard

INFORMED CONSENT TREATMENT & FINANCIAL AGREEMENT

Consent for Health Services & Treatment

I hereby request and consent to treatment, diagnostic and/or therapeutic services as ordered and/or provided by ChiroStandard®. I understand that there are certain complications, which may arise during treatment. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. I do not expect the doctor to be able to anticipate all risks and complications.

Financial Agreement

The undersigned individually obligates him/herself and guarantees prompt payment of all charges for services rendered to the patient when not covered by insurance carriers or others. A minimum fee of $35 will be charged for each returned check. The maximum charge permitted by law is the greater of $40 or 5% of the face amount of the check. The check writer is also responsible for all of the cost of collection. Payment of any unpaid balance is due within 30 days of final billing. If payment is not received within 30 days from the date of billing, finance charges may begin to accrue at the maximum rate allowable by law. In addition, such balance may be turned over for collection activity, at which time the undersigned shall be liable for attorney's fees and/or collection agency's fees and expenses. The undersigned understands that ChiroStandard® has the right to examine credit bureau files for financial information regarding collection of unpaid debt.

Assignment of Benefits

In the event that I am entitled to benefits of any and all types, I assign such benefits to ChiroStandard® for services rendered to me. I authorize payment directly to ChiroStandard® of all such insurance benefits payable to me. Such insurance includes, but is not limited to private commercial insurance, auto/liability insurance, or any governmental program such as Medicare, Medicaid, or Worker's compensation. I authorize ChiroStandard® to release medical information to such insurance providers as necessary to satisfy conditions for payment of the assigned benefits. I certify that the information given regarding my insurance is accurate and correct.

Release of Information

I authorize ChiroStandard® to release all or part of my medical record information when required or permitted by law or government regulation, including any physician(s) or healthcare provider responsible for continuing care.

Cancellation Policy

If you are unable to keep your appointment, please call us at least 24 hours in advance. Failure to do so will result in a cancellation fee of $20.

Please initial her acknowledging our policy: _______

Insurance Benefits

I have been verbally explained and/or read the benefit coverage that has been provided to ChiroStandard® by my insurance company. I understand that this is not a guarantee of benefits and that I am ultimately responsible for payment. I also understand that Medicare and/or my insurance company does not pay for maintenance care visits and only provides care for acute issues or exacerbations of such issues.

Please initial here verifying the above statement is true: __________

Chirostandard has been informed that I am not currently being treated by other chiropractic physicians at this time. I take full responsibility for any omission or intent to deceive insurance and/or medicare claims.

Please initial here verifying the above statement is true: __________

Medicare Recipient Notification

As of January 1 2010 Medicare has implemented a capitation for therapy services. Medicare recipients are limited to a total of $1840 towards physical therapy services. To help ChiroStandard® in obtaining the most accurate information as possible, it is my responsibility to inform ChiroStandard® of any therapy services I have received within the calendar year. I will be fully responsible for any charges exceeding the capitation amount.

During this calendar year, have you received prior Physical, Occupational or Speed Therapy? □ Yes □ No

If yes, approximate # of visits:________________

Please initial here verifying the above statement is true: __________

Insurance Precertification

I understand that before services are rendered, I personally am responsible for any required notification to my insurance company to obtain authorization for treatment. If this is not done, insurance benefits may be reduced and I am responsible for all charges not covered by my insurance.

Evaluation of Services and Follow-Up

I give permission for ChiroStandard® and/or its agent(s) to contact me for the purpose of evaluating the services rendered to me. □ Yes □ No

The undersigned certifies that he/she has been offered, read, and understands the above, fully accepts all specified terms, therein, and has **received a copy of the HIPPA Notice of Privacy Practices**.

Signature of Patient or Legal Representative   Print name   Date

ChiroStandard, PLLC
(941)487-8118

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Chirostandard, PLLC
1962 Main Street, Suite 100
Sarasota, FL 34236
Phone: 941-487-8118
Fax: 941-487-8121

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I, the above named patient, have had full opportunity to read and consider the contents of the Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment,

Signature: ***X*** ______________________________ **Date:** ________________

If a personal representative on behalf of the patient signs this Consent, complete the following:
Personal Representative's Name: ______________________________
Relationship to Patient: ______________________________

WE CANNOT SHARE YOUR INFORMATION WITH FRIENDS, FAMILY AND/OR SPOUSE WITHOUT YOUR CONSENT.
DO YOU HAVE ANYONE THAT YOU WOULD LIKE TO LIST AS A PERSON WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person/Organization
Name ______________________________ Phone (____)__________ Relationship______________

Name ______________________________ Phone (____)__________ Relationship______________

Name ______________________________ Phone (____)__________ Relationship______________

Name ______________________________ Phone (____)__________ Relationship______________

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

___ All health information ___History/Physical Exam ___Past/Present Medications ___Lab Results
___ Physician's Orders ___ Progress Notes ___ Diagnostic Test Reports ___Billing Information
___Radiology Reports & Images __Other______________

******PATIENT REQUEST FOR RECORDS *******

If you would like us to review records from another provider, please inform the receptionist.

CHIROSTANDARD, PLLC
NOTICE OF INITIATION OF MEDICAL TREATMENT
PURSUANT TO FLORIDA STATUTE 627.736

PATIENT ______________________________ **DATE OF LOSS** ____________________

INSURANCE CO __________________________ **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.

Regards,

ChiroStandard, PLLC
1962 Main Street Suite 100
Sarasota FL 34236

OFFICIAL CERTIFICATION OF PATIENT AS TO INSURANCE COVERAGE

PATIENT ______________________________ **DATE OF LOSS** ____________________

INSURANCE CO __________________________ **CLAIM NUMBER** ____________________

I, as the above captioned patient herby 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** _____/_____/________

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(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)*:

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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Pub. 1/2004

ChiroStandard
1962 Main Street Suite 100 Sarasota FL 34236
(941)487-8118

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, also known as 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 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. 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 he 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 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 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 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 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 (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 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 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 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 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.

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; 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.

Patient's Name ______________________________ Patient's Signature ____
(Please Print) (If patient is a minor, signature of parent/guardian)

Date ___________________________

DATE: **NAME:**

ASSIGNMENT AND AUTHORIZATION

For good and valuable consideration, including the agreement of ChiroStandard, PLLC to accept this assignment in lieu of demanding full payment for services from the undersigned on the date each service is rendered, the undersigned patient executes this document hereby assigning to ChiroStandard, PLLC the right to receive insurance benefits directly from any insurance company that may be obligated to provide insurance benefits, to me or on my behalf, for services rendered by ChiroStandard, PLLC, for a motor vehicle accident that occurred on or about ________________, .

Any insurance company that may be obligated to pay any insurance benefits to me, or on my behalf, for the aforesaid accident for services provided by ChiroStandard, PLLC, is hereby directed to issue payment for those benefits directly to and payable to ChiroStandard, PLLC.

I also authorize and assign to ChiroStandard, PLLC the right to file suit and pursue all legal remedies to obtain payment for services provided to me by ChiroStandard, PLLC. This authorization to file suit is an assignment of my cause of action to obtain payment for services provided to me by ChiroStandard, PLLC and includes the assignment to pursue declaratory relief or any other legal remedies.

ChiroStandard, PLLC accepts the aforesaid assignment and hereby notifies any insurer issuing payment that ChiroStandard, PLLC objects to any "repricing" or reduction of billed amounts unilaterally made by any insurer. Any such reduced payments issued by any insurer are accepted under protest

and without waiving any right of the provider to pursue all legal remedies against the insurer.

Please read this document completely before signing. If you do not completely understand this document or have any questions about this document, please ask us to explain it to you. If there is any portion of this document that you do not wish to authorize, we will remove that portion from this document. Your signature below is your agreement you fully understand this document and you fully agree to the terms of this document.

____ ________________

Patient's signature (or guardian's signature) Date

____ ________________

Witness to patient or guardian's signature Date

____ ________________

Authorized signatory for medical provider Date

ADDITIONAL AUTHORIZATIONS AND DIRECTIONS TO INSURER

AUTHORIZATION FOR DISCLOSURE OF INSURANCE DECLARATIONS PAGE: I, the patient and insured, further authorize and direct any insurance company that may be obligated to pay any insurance benefits to me, or on my behalf, to provide to ChiroStandard, PLLC a copy of any declarations page of any insurance policy that may provide any insurance benefits to me for the aforesaid accident.

AUTHORIZATION FOR DISCLOSURE OF INSURANCE PAYMENT RECORD: I further authorize and direct any insurance company that may be obligated to pay any insurance benefits to me, or on my behalf, to provide to ChiroStandard, PLLC a copy of any ledger or payment record of payments made under any insurance coverage available to me, without redacting the names of any other medical provider or entity to whom insurance benefits have been paid and without redacting the amount of any insurance benefits that have been paid.

DIRECTION NOT TO EXHAUST BENEFITS BY PAYMENT OF OTHER CLAIMS: I further authorize and direct any insurance company that may be obligated to pay any insurance benefits to me, or on my behalf, to not exhaust insurance benefits or coverage until all claims submitted by ChiroStandard, PLLC have been paid in full, or at 80% if the insurance policy is limited to pay 80% coverage of medical claims. If any insurance company obligated to pay any insurance benefits to me, or on my behalf, has denied payment of a claim submitted by ChiroStandard, PLLC, or made payment to ChiroStandard, PLLC at an amount lesser than the amount billed, or lesser than 80% of the amount billed if my coverage is limited to 80% for medical claims, I direct the aforesaid insurance company to hold in escrow the amount in dispute, and if other claims would exhaust benefits I direct the aforesaid insurance company to hold in escrow the disputed amount and to not exhaust benefits or coverage by payment of the amount I have hereby requested be held in escrow. I further authorize and direct the aforesaid insurance company to notify ChiroStandard, PLLC that benefits have been exhausted except for the amount held in escrow, to enable ChiroStandard, PLLC to

attempt to resolve the disputed claim in a manner acceptable to ChiroStandard, PLLC.

DIRECTION TO INSURER TO MAINTAIN CONFIDENTIALITY: I further direct any insurance company that may be obligated to pay any insurance benefits to me, or on my behalf, to maintain the privacy and confidentiality of my medical records. I do not authorize any insurer to provide my medical records to anyone without first obtaining a written authorization from me to provide the medical records to any other entity.

AUTHORIZATION FOR RELEASE OF RECORDS TO PROVIDER: I hereby authorize any insurance company that may be obligated to pay any insurance benefits to me, or on my behalf, to release a copy of my complete medical records in possession of such insurer to ChiroStandard, PLLC upon the request of ChiroStandard, PLLC. This authorization includes the authorization to release to ChiroStandard, PLLC a copy of any medical examination or evaluation of me requested by any insurance company.

DIRECTION TO INSURER TO PROVIDE TO PROVIDER ADVANCE NOTICE OF IME OR EUO: I further authorize and direct any insurance company that may be obligated to pay any insurance benefits to me, or on my behalf, to provide at least 15 days advance notice to ChiroStandard, PLLC of any physical examination or examination under oath of myself that any insurance company may schedule.

Please read this document completely before signing. If you do not completely understand this document or have any questions about this document, please ask us to explain it to you. If there is any portion of this document that you do not wish to authorize, we will remove that portion from this document. Your signature below is your agreement you fully understand this document and you fully agree to the terms of this document.

____________________________________ __________

Patient's signature (or guardian's signature) Date

____________________________________ __________

Witness to patient or guardian's signature Date

FEE GUARANTEE AGREEMENT FOR

CHIROSTANDARD, PLLC

PATIENT NAME:

DATE OF ACCIDENT:

MEDICAL PROVIDER:

I, ________________________________, the above noted Patient, do hereby authorize and direct my present and any future attorney to honor this fee guarantee agreement. This agreement is made in favor of the above named Medical Provider and shall be termed a "Letter of Protection." The Letter of Protection shall serve to place a continuing lien on any proceeds I recover in any legal action related to the above noted accident date.

Consideration. In consideration of the medical treatment provided and time provided to pay for said medical treatment, I hereby grant a direct lien on any and all funds I may recover in any legal action related to the above accident date.

Protection of Outstanding Charges. The above-named Patient hereby agrees that if s/he recovers any money from any person or entity in connection with any legal action related to the above noted accident date, the Patient shall withhold from those funds, sufficient money pay the full outstanding balance of any bill(s) owed to the above named Medical Provider for treatment or any work completed in relation to the above noted accident date and without regard to any suggested peer review or

insurance company reduction. Those funds shall be deducted prior to any other party removing funds for any reason, including but not limited to attorney's fees, costs, other court fees, or any other bill or lien whatsoever. Patient hereby directs their present and/or future attorney to pay said outstanding medical bill in connection with the above noted treatment. This agreement shall obligate each attorney who represents the above named patient in any way and recovers any funds related to the above noted accident date and creates a constructive trust with said attorney. Further, this agreement shall extend pay any outstanding balance for any copies, costs or reports the above named Medical Provider endures in relation to any legal issue for the above accident date. The Patient hereby agrees to waive any rights they have, under contract, law or equity, to have the Medical Provider bill a third party entity, including but not limited to any contracted payer, health insurer or government payer and further desires to pay for the medical treatments through the legal action's proceeds.

Patient Responsibility. It is the Patient's responsibility to advise each and every attorney of the existence of this agreement. Further the Patient must advise the above named Medical Provider at reasonable intervals the status of the legal case. It is also the Patient's responsibility to advise the Medical Provider within 5 days of legal matter collecting any funds and to request a bill for any and all outstanding charges. The Patient hereby directs their present attorney and any future attorney to advise the Medical Provider, as soon as possible, about any funds related to the accident case becoming available to the above named Patient. Further, if the legal action fails to fully pay the Medical Provider's outstanding balance(s) then the remaining amounts are to be paid by the Patient. The Medical Provider may, at his/her discretion at any time, bill any third party payer or government payer.

Disputes. If there is a dispute over the Medical Provider's outstanding charges the Patient agrees to submit the full amount due to the Medical Provider and agrees to bring an action in Florida State Court for recovery of the disputed difference. If the Patient fails to pay the Medical Provider's full outstanding balance, and thereafter Medical Provider brings suit to collect said sums, Medical Provider shall then have the right to recover attorney fees and costs for bringing an action to enforce this particular provision.

Approval Required. This agreement becomes effective when the Patient signs the agreement below. This agreement does not need the approval of any present or future attorney for the Patient.

The parties agree that no party shall be considered the drafting party to this contract.

DATED:____________________, **20**____

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PATIENT