# Informed Consent for Examination and Treatment

I (we) hereby consent to the performance of examination and treatment on me or on ______________________________________, by the licensed doctors of chiropractic, medical doctors, and/or licensed physical therapists who may be employed by or engaged in practice in this clinic.

I have had an opportunity to discuss with the doctor(s) or other clinic personnel the nature and purpose of the different physical therapy procedures and chiropractic treatment (manipulation/adjustment). I understand that neither chiropractic nor medical treatment is an exact science and that my care may involve judgments based upon facts and information known to the doctor. The doctor uses this judgment to attempt to anticipate or explain risks and complications and an undesirable result does not necessarily indicate an error in judgment. No guarantee for results can be made or expected but rather I wish to rely on the doctor to choose and recommend a best course of treatment based upon facts known that is in my best interests.

I further understand that there are certain degrees of risk associated with chiropractic health care and physical therapy, which includes rarely, but not limited to fractures, disc injuries, strokes, and strain/sprains and am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

I have read, or the above information has been explained regarding consent. I have had an opportunity to ask questions about my examination and treatment. By signing below, I agree and intend this consent form to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment.

Female Patients: By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time. Date of last menstrual period _____________.

______________________________
Patient's Name (Print)

______________________________
Patient's Signature

______________
Date

______________________________
Relationship or authority if not signed
By patient

______________________________
Witness

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# RECORD RELEASE AUTHORIZATION

DOCTOR / HOSPITAL ______________________________________________

ADDRESS ________________________________________________________

________________________________________________________________

________________________________________________________________

I HEREBY AUTHORIZE AND REQUEST THE RELEASE OF MY MEDICAL RECORDS TO:

THANK YOU IN ADVANCE FOR YOUR COOPERATION.

| | |
|---|---|
| ______________________________ | ______________ |
| Patient's Signature | Date |
| ______________________________ | |
| Patient's Name (Please Print) | |
| ______________________________ | ______________ |
| If Patient Is A Minor Signature Of Parent Or Legal Guardian | Relationship to Patient |
| ______________________________ | ______________ |
| Witness To The Above Signatures | Please Print Name |

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# OFFICE FINANCIAL POLICY

Our policy is to extend to you the courtesy of allowing you to assign your insurance benefits directly to us. This policy reduces your out-of-pocket expense and allows you to place your family under care.

1. **If You Do Not Have Insurance:** All payments are expected at the time of service or by an authorized payment plan. Your personal balance may not exceed $100 at any time or care may be terminated. Our payment plans make care an affordable part of your family budget.

2. **If You Have Insurance:** All deductibles and co-payments are expected at the time of service or by an authorized payment plan. Your co-insurance balance may not exceed $100 or care may be terminated. Our payment plans make care an affordable part of your family budget.

   You are considered a cash patient until you bring in your completed insurance forms, and we qualify and accept your insurance coverage. We do not accept assignment for secondary insurance carriers, but will be happy to provide you with a claim form for your secondary carrier.

   Our fees are considered usual, customary and reasonable by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard and of care in this area.

   If your carrier has not paid a claim within sixty (60) days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid within ninety (90) days of submission, you accept responsibility for payment in full of any outstanding balance and authorize us to use your credit card to collect full payment.

   When your schedule of visits is once per month or longer, you will not be eligible for insurance assignment. Charges for services rendered will be due as they are rendered. We will continue to provide you with an insurance claim form.

   If you discontinue care for any reason other than discharge by the doctor, all balances will become immediately due and payable in full by you, regardless of any claim submitted.

Patient's Printed Name: ______________________________

Signature: ________________________________________ Date: __________________

Finance Counselor: _________________________________ Date: __________________

Front Desk: _______________________________________ Date: __________________

For your convenience you may retain your credit card number on file with us.

Card #: __________________________________________ Expiration Date: ___________

Name as appears on card: ____________________________________________________

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# ACKNOWLEDGMENT OF RECEIPT OF

# NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

| | | |
|---|---|---|
| Print Patients Name | Patient's Signature | Date |
| Print Parent or Legal Guardian Name | Signature | |
| Print Front Desk Name | Signature | Date |

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.

List below anyone to whom you authorize the Practice to release your medical/treatment information.

| Name | Relationship |
|---|---|
| | |
| | |
| | |

# PATIENT RECORDS AND DOCTOR'S LIEN

**TO: ATTORNEY/INSURANCE CARRIER**

____________________________________

____________________________________

____________________________________

____________________________________

I do hereby authorize the above provider to furnish you, my attorney/insurance carrier, with a full report of his/her case history, examination, diagnosis, treatment, and prognosis of myself in regard to my injury/illness which occurred/began on: ___________________________

I hereby give a lien to said provider on any settlement, judgment, or verdict as a result of said injury/illness, and authorize and direct you, my attorney/insurance carrier, to pay directly to said provider such sums as may be due and owing him/her for services rendered me, and to withhold such sums from such settlement, claim, judgment or verdict as may be necessary to protect said provider adequately.

I fully understand that I am directly and fully responsible to said provider for all bills submitted by him/her for service rendered me, and that this agreement is made solely for said provider's additional protection and in consideration of his/her awaiting payment. I further understand that such payment is not contingent on any settlement, claim, judgment, or verdict by which I may eventually recover said fee.

I further agree to be fully responsible for reasonable attorney's fees and costs that have accrued due to the pursuance of payment of my account. Also, that in the event of noncompliance to payment agreement I understand the amount of balance due will be subject to a 1% per month service charge.

Patient's Signature: ___________________________________ Dated: ____________

The undersigned, being attorney of record or authorized representative of insurance carrier for the above patient does hereby acknowledge receipt of the above lien, and does agree to honor the same to protect adequately the above named provider.

Attorney's Signature: __________________________________ Dated: ____________

**Please sign, retain a copy for your records, and return this copy to us promptly.**

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# LIMITED POWER OF ATTORNEY

KNOW ALL MEN BY THESE PRESENT: That the undersigned has made, constituted and appointed, and by these presents does here by make, constitute and appoint

Practice Name ______________________________

Address ______________________________

City, State, Zip Code ______________________________

and any of it's duly authorized agents and employees as and to be the undersigned's true and lawful Attorney 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. Said checks, drafts, or money orders are to pay for services which have been or are to be performed at the request or with the knowledge and approval of the undersigned and/or the maker of the check, draft or money order.

The undersigned by these presents does thus give and grant this limited power of attorney to the above named office or doctor the full power and authority to do and perform to intents and purposes as the undersigned might or could do if personally present insofar as the endorsing and cashing of said checks are concerned

The undersigned does hereby ratify and confirm any and all actions taken by the said attorney in accordance with this special power of attorney and which the said attorney shall do or cause to be done by virtue of these presents.

IN WITNESS THEREOF the undersigned have hereunto set their hands,

this day of ____________________, ____________________

Patient's Full Name: ______________________________

Patient's Signature: ______________________________

Witness to Patient's Signature: ______________________________

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# CONSENT TO PARTICIPATE IN TELEMEDICINE CONSULATION

**Consultant:** Andrew Akerman, M.D. Florida License: ME 93824

Patient's Name: ______________________________ Medical Record No.: ______________________

1. I understand that my health care provider, ______________________________, wishes me to engage in a telemedicine consultation with Andrew Akerman, M.D.

2. My health care provider has explained to me how the video conferencing technology will be used to affect such a consultation. I understand that this consultation will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.

3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my health care provider(s) or myself can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.

4. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my health care provider and consulting health care provider in order to operate the video equipment. The above mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine
examination room; and/or (3) terminate the consultation at any time.

5. I have had the alternatives to a telemedicine consultation explained to me, and in choosing to participate in a telemedicine consultation, I understand that some parts of the exam involving physical tests may be conducted by individuals at my location at the direction of the consulting health care provider.

6. In an emergent consultation, I understand that the responsibility of the telemedicine consulting specialist is to advise my local practitioner and that the specialist's responsibility will conclude upon the termination of the video conference connection.

7. I understand that billing will occur from both my practitioner and as a facility fee from the site from which I am presented.

8. I have read this document carefully, and understand the risks and benefits of the teleconferencing consultation and have had my questions regarding the procedure explained and I hereby consent to participate in a telemedicine visit under the terms described herein.

9. I understand that there will be no video taping or recording of any materials, unless additional written consent is given. Recording of the medical examination is typically not required, and no recording will be done for the express purpose of maintaining confidentiality and patient privacy.

______________________________ ______________________
Patient's/parent/guardian signature Date and Time

______________________________ ______________________
Witness signature Date and Time

**South Lake Wellness and Injury Center, PL**
2575 East SR 50 Suite E
Clermont, FL 34711

## ASSIGNMENT OF BENEFITS/POLICY RIGHTS

**PATIENT:**

I, the undersigned patient herby assign the rights and benefits of insurance of the applicable personal injury protection, medical payments, and/or other insurance to **South Lake Wellness & Injury Center, PL** for services and/or supplies rendered for treatment of personal injuries sustained in the incidents of (date of occurrence) ____________ to the undersigned patient and covered by Personal Injury Protection (P.I.P).Coverage or other insurance coverage under (Insured's Name) __________________ in accordance with Florida Statue 627.736(5). The undersigned agrees to pay an applicable deductible or co-payment not covered by P.I.P. or other insurance coverage. I have read the information herein and it is true to the best of my knowledge and belief.

This assignment includes, but is not limited to, all rights to collect benefits directly from the insurance company for services that I have received and all rights to proceed against the insurance company fails to make payments of benefits which I am due. Specifically, this assignment includes the right to collect payment for the reasonable costs connected with copying and mailing records to the insurer at the insurers request and in accordance with Florida Statute 627.736(6). This assignment also includes any right to recover attorney's fees and costs for such action brought by the provider as Patient's assignee. I agree that **South Lake Wellness & Injury Center. PL** may select an attorney he/she wishes and understand and agree that the attorney selected by them may be different than the attorney handling my personal injury/bodily injury claim or case.

As part of this assignment of rights and benefits, which only becomes binding upon the insurance carrier upon their receipt of said assignment after it having been executed and dated by the health care provider, I hereby instruct the insurance carrier that in the event the subject medical benefits are disputed for any reason, including medical reasonableness and/or necessity, that the amount of benefits claimed by **South Lake Wellness & Injury Center, PL** is to be set aside and not disbursed until the dispute is resolved as part of this assignment of rights and benefits, I further instruct the insurance carrier to notify the provider immediately of any dispute as to payment so that he/she may exercise their legal rights. I understand that any person who knowingly and with intent to injure, defraud or deceived any insurance company files a statement containing false, incomplete or misleading information is guilty of a felony of the third degree. I have read the information herein and it is true to the best of my knowledge and belief.

_________________________ Patient signature

_________________________ Patient print

_________________________ If under age of 18, parent/legal guardian signature

_________________________ Date

**PROVIDER:**
The undersigned on behalf of **South Lake Wellness & Injury Center, PL** hereby accepts assignemnts of the insurance rights and benefits for the services rendered to (Patient's Name) ______________________ and to be paid directly to **South Lake Wellness & Injury Center, PL** under (Insured's name) ____________________ Personal Injury Protection(P.I.P.) or other insurance coverage with (Insurance Company's Name) ____________________ and in accordance to Florida Statute 627.736 et. Seq, (5)
**South Lake Wellness & Injury Center, PL**

By: ________________________________
Authorized Agent/Representative

_________________ Date

TAX ID # 20-0965743

# APPLICATION FOR FLORIDA "NO FAULT" BENEFITS

**Date:**____________________ **File Number:**____________________

**Insurance Company:**________________________________________

**Policy Number:**____________________ **Date of Accident:**____________________

**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.**

**Name:**____________________ **Address:**____________________

**Phone Number:**____________________ **City, State, Zip Code:**____________________

**Date of Birth:**____________________ **Social Security Number:**____________________

**How long have you been a resident of Florida?**____________________

**Date of accident:**____________________ **Time of accident:**____________________

**Location of accident:**________________________________________

**Description of accident:**________________________________________

**Make and model of vehicle you were occupying during accident:**____________________

**As a result of this accident, were you injured?**__________ **If yes, complete the form. If no, sign below and return to us.**

Signature ____________________ Date ____________________

**Description of Injury:**________________________________________

**Were you treated by a doctor?**__________ **If yes, name and address:**____________________

**Were you treated at a hospital?**__________ **If yes, name and address:**____________________

**Amount of medical expenses to date: $**__________ **Will you have more expenses?**__________

**At the time of accident, were you employed?**__________ **If yes, did you lose any wages?**__________

**If yes, amount lost? $**__________ **Your weekly salary or wage: $**__________

**Date disability from work began:**__________ **Date you returned to work:**__________

**Have you received benefits under Worker's Compensation?**______ **If yes, amount and frequency: $**__________

**Name and addresses of employer or previous employer along with occupation and dates of employment:**

**As a result of this accident, have you had any other expenses?**__________ **If yes, explain below with expense amounts.**

Signature ____________________ Date ____________________


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## 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, PHYSICAL AND X-RAY FINDINGS, DIAGNOSIS AND PROGNOSIS. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE FLORIDA "NO FAULT" AUTO INSURANCE LAW.

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.

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.**

_______________________________________________

_______________________________________________

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.

**OIR-B1-1571**
**Pub. 1/2004**