Patient Demographics Form

Patient Information

Patient Name: Date of Birth: Date of Accident:

Address: City: State: Zip:

Home Phone: Cell Phone:

Email: Social Security number:

Primary Doctor: Phone:

Did you go to the Hospital or Urgent Care?
Yes No

If yes, which Hospital or Urgent Care?

Insurance Information

Do you have Auto Insurance? Yes No

If yes, Auto Insurance Company:

(Please enter only the patient's auto insurance information)

Policy Number: Claim #:

Policy Holder's Name:

Policy Holder Relationship to Patient:

Do you have Health Insurance? Yes No

If yes, name if health insurance company:

Member ID:

Group #:

DIRECT ASSIGNMENT OF BENEFITS & RIGHTS

PROVIDER: **PATIENT:** **Date:**

In consideration of your undertaking to render care, I agree to the following:

1. RELEASE OF INFORMATION: You are authorized to release any information you deem appropriate concerning my physical condition to any Insurance company, attorney, or adjuster To process any claim for reimbursement of charges incurred by me at your treatment facility.

2.RIGHT TO RECEIVE INFORMATION: I authorize my chiropractic provider authority to affix my necessary signature as noted below to obtain medical information from any hospital, medical provider, etc., as It relates to the care being provided by my chiropractic doctor.

3. RIGHT TO RECEIVE PAYMENT: I irrevocably authorize and assign to you, the chiropractic provider, the right to receive direct payment from my attorney or any Insurance company which may become obligated to pay me any sums. The Patient(s) grant(s) to the Provider a Limited Power of Attorney to receive funds, negotiate any drafts or checks and execute any documents related to payment for services rendered to me.

4.ASSIGNMENT OF RIGHT TO SUE: In the event, any insurance company or attorney obligated by contractual agreement to make payment to me for your service charges refuses to make such payment upon demand by you, I irrevocably hereby assign and transfer to you the cause of action that exists in my favor against any such company or attorney and authorize you to prosecute said action either in my name or your name as you otherwise resolve the said claim as you see fit. I understand that whatever amounts you do not collect from said insurance proceeds (whether it be all or part of what is due) shall be paid by me.

5.RIGHT TO LIEN: I also irrevocably assign to you, the chiropractic provider, and grant the right of lien against any and all claims against any third party whose negligence may have caused my Injury, Including their insurance, up to the amount of the bill for treatment, as it relates to my healthcare as provided by you. I also irrevocably instruct my attorney to pay this office in full for services rendered to me for my accident-related injuries from any proceeds or settlements, claims, or judgment regarding said injuries. My legal counsel or successor or any representative is to pay the doctor/ clinic before distributing any proceeds to me. I instruct said legal counsel or representative not to attempt to reduce by means of negotiation my Doctor's bill for services that have been provided to me for the accident/ injury/illness, which I have agreed to pay in full.

6. RIGHT FOR INFORMATION: I irrevocably authorize my attorney, or successor or legal representative, insurer, or any other party regarding my care or case to release financial information about the proposed settlement, settlement/verdict payments, or amounts owed included, but not limited to other providers or legal representatives, liens, billing amounts, and balances. I also instruct all representatives to include all financial information from all facets of my case, including, but not limited to, third-party, uninsured motorists and underinsured motorists.

7. I irrevocably waive the Statute of Limitations regarding my Doctor's right to recover from me directly.

8.I hereby acknowledge that I am receiving (or about to receive) health care services, and I am advised that they are willing to wait for payment for these services, provided there continues to be a reasonable chance that payment will be made either by insurance proceeds or out of the settlement of a liability claim. I understand that if it is determined either (a) there Is no insurance company obligated to pay for the services, or if the insurance company Involved refuses to acknowledge an assignment to the Doctor(s) or make other provisions for the protection of the interest of the Doctor(s); or (b) if a liability claim exists and my attorney refuses to agree to protect the interest of the Doctor(s) or If I have not engaged the services of an attorney, payment for services rendered by the above-named Doctor(s) will be made on a current basis and my account paid In full Immediately. In any event, I hereby promise to pay my bill in full within (10) days from the date my liability claim Is settled or after the passage of three (3) months from the date of my last treatment, whichever comes first.

9. If any payment for any services rendered under this agreement becomes delinquent, the patient or patient's guardian shall be responsible for payment of any and all court costs, attorney's fees, service of process fees, and any reasonable additional costs incurred in order to collect or that are associated with collecting monies due on the patient's account.

(Continued)

10. No Surprise Act: Our fees are derived from the Medical Fees in the United States by the Physicians Medical Information corporation 2022. They have been geographically modified and are billed at the 75t percentile. A good faith estimated cost for the items and services that would be furnished by this provider or facility plus the cost of any items or services reasonably expected to be provided in conjunction with such items or services will be provided after my first visit. I fully and completely understand that some or all amounts I pay might not count toward my health plan's deductible, out-of-pocket limit, or be covered. I'm giving up some consumer billing protections under federal law. I may get a bill for the full charge for these services or have to pay out-of-network cost-sharing under my health plan. I irrevocably consent in accident cases to have balances applied towards liens or letters of protection with my attorney. With my signature, I acknowledge that I am consenting of my own free will and am not being coerced or pressured.
11. I understand that this document is irrevocable, may not be rescinded, and that my attorney shall not honor any such recession. I hereby instruct that in the event another attorney is substituted in my case, the new attorney honor this lien as inherit to the settlement, judgment, verdict, or any other disposition of any litigation filed or contemplated on my behalf and enforceable upon the case as if it were executed by him/her. I hereby direct my attorney, on-demand, to provide the status of such litigation to the provider or his attorney engaged in any collection efforts. Furthermore, I direct my attorney to contact the provider before disbursement of any funds to ascertain any outstanding balances due and owing.

Dated Signature _____ **day of** **20** _____

Patient Signature _____

Witness Signature _____

Lawyer's Receipt Verification

☐ **Sent via Certified US Mail**

☐ **Sent via Fax with Receipt Confirmation**

Staff Name [print) _____

Staff Name [sign] _____

Date: _____

Authorization to Release Information

Patient Name: **DOB:**

Address: **Phone:**

City: **State:** **Zip Code:**

Enitre Records:

Xrays:

MRI:

Specific Information:

This authorization will atomically expire one year from the date signed. I understand that I may revoke this consent inwriting at any time except to the extend that action has been taken already. Mental health, alcohol, drug, HIV and/or AIDS information is confidentially protected by Federal and State law which prohibits disclosure without specific written authorization of the undersigned or as otherwise permitted by such regulations.

I authorized KK Health to release medical records to
for insurance related reasons.

I authorize_____ to release medical records to KK Health
.

Print Name:_____ Signature:_____

Witness:_____ Date:_____

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practice provides information about how we may use or disclose protected health information.

The notice contains a patient's right section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of this notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement.

The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare
- operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree
- to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments?	Yes	No
May we leave a message on your answering machine at home or your cell phone?	Yes	No
May we discuss our medical condition with any member of your family?	Yes	No

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____
(Print Name Please)

Signature: X _____ Date: _____

Witness: _____ Date: _____

LETTER OF PROTECTION AUTHORIZATION AND MEDICAL ASSIGNMENT

I,_____ , do hereby authorize and Direct my attorney's, to pay KK Health 250 Carillon Pkwy#313, Saint Petersburg, FL from the share of my proceeds of any recovery as a result of the settlement or litigation of the accident on (Date of Accident)_____ ,the unpaid balance for the reasonable and customary charges as determined by the insurance company, for professional services rendered by said hospital, physician, or other medical care provider, on my behalf.

In the event of a dispute between my insurance carrier and my physician, hospital or medical care provider, any assignment of benefits executed by me to my said physician, hospital, or medical care provider shall serve as my authority for my said physician, hospital, or medical care provider to proceed against my insurance carrier in the method and manner as provided in Florida Statute. Said professional services to include those for the medically necessary and reasonable diagnosis treatment and care heretofore and hereafter rendered to me as well as those medical reports, consultations, with my attorney, and court appearances on my behalf. Payment of these balances as herein stated shall be the same as if paid by me.

I understand that this assignment in no way relieves me of my personal responsibility and obligation to pay my physician, hospital, or medical care provider for such charges as herein stated for such services rendered, and that such physician's, hospital's, or other medical care provider's fee for such services rendered is not contingent upon the outcome of this litigation.

I further authorize the before said physician, hospital, or medical care provider to furnish my attorney with a full report of the physician's, hospital's or medical care provider's treatment evaluation of me in regard to the said incident. In exchange for this letter of protection, it is our understanding that all such related bills will be directed to this office and not to the client/patient and that client/patient's account will not be turned over to any type of collection agency or credit bureau, nor will any adverse credit information be reported against this client's credit during the pendancy of this case and if this account is turned over to a collection agency or credit bureau, or if any adverse information is reported against this client's credit by you, directly or indirectly, this Letter of Protection is null and void and this law has no further obligation to you whatsoever.

Client / Patient Name _____

Signature _____ Date_____

Firm Representative _____ Date_____