TAMPA

SPORTS & WELLNESS CHIROPRACTIC

Date: _____ Patient File Number_____

PATIENT DEMOGRAPHICS

Name _____
Address _____
City _____State _____ Zip _____
Home Number _____
Cell Number _____
Social Security # _____ _____
Birth Date _____Age ____ Sex: M__ F__
E-Mail Address _____
Marital Status:
Single__ Married___Divorced____Other_____
Number of Children _____
Occupation _____
Work Phone_____

EMERGENCY INFORMATION

Emergency Contact _____
Relationship _____
Phone Number_____

DESIRED METHOD OF PAYMENT

- □ Self
- □ Self & Auto Insurance
- □ Other _____

DESIRED CARE

- □ Patch-Care (Crisis)
- □ Corrective Care/Maintenance

OCCUPATIONAL ACTIVITIES

- □ Sitting # of hours_____
- □ Standing # of hours_____
- □ Computer # of hours_____
- □ Lifting Weight_____

ATHLETIC INFORMATION

- □ Cycling Mileage_____
- □ Swimming Mileage_____
- □ Running Mileage_____
- □ Other_____

MEDICATIONS

(Prescription or OTC)

1._____
2._____
3._____
4._____
5._____

SURGERIES/DISEASES/CONDITIONS

1._____ Date_____
2._____ Date_____
3._____ Date_____
4._____ Date_____
5._____ Date_____

TRAUMAS (ACCIDENTS)

1._____ Date_____
2._____ Date_____
3._____ Date_____
4._____ Date_____
5._____ Date_____

TAMPA

SPORTS & WELLNESS CHIROPRACTIC

Patient Name _____ SSN____-____-____

RELEASE OF INFORMATION

I hereby authorize Tampa Sports & Wellness Chiropractic, LLC to release medical and financial data to my insurance and attorney.

INITALS _____

RESPONSIBILITY OF BILL

The undersigned hereby accepts full financial responsibility for charges and service rendered to the patient. The undersigned understands that services are rendered and charged to the patient and not the insurance company. Tampa Sports & Wellness Chiropractic, LLC cannot accept total responsibility for collection an insurance claim or negotiating a disputed settlement. The undersigned also agrees that this obligation shall exist regardless of private contractual agreement between the patient and any insurance carrier, attorney, or third party not signing this agreement. Financial responsibility will also include charges and services not covered by insurance for which payment is denied through any utilization review or pre-certification procedures.

INITALS _____

CONSENT FOR TREATMENT OF A MINOR

Consent is hereby given by the undersigned for chiropractic treatment and diagnostic studies as ordered by the doctors and performed by the technical staff of Tampa Sport & Wellness Chiropractic, LLC. The undersigned states that he/she is the patient's legal guardian.

INITALS _____

AUTHORIZATION FOR PAYMENT OF INSURANCE BENEFITS TO PROVIDER

I hereby irrevocably authorize payment of the medical benefits otherwise payable to me to be made payable and mailed directly to Tampa Sport & Wellness Chiropractic for professional services rendered. **NO OTHER THIRD PARTY**, including my attorney, should receive payment of my bills except this office for the remainder of this claim. It will be assumed and relied upon that the insurance carrier has agreed to and acknowledges medical coverage and will send payments directly to this office.

INITALS _____

TERMS OF ACCEPTANCE

I understand that chiropractic **IS NOT** the diagnosis or treatment of disease. I understand that chiropractic **CAN NOT** cure or fix me. The chiropractors sole purpose is finding nerve interference in my body, known as VERTEBRAL SUBLUXATION, correcting or reducing the interference, so that my body can heal, regulate and function optimally once more. I accept care on this premise.

INITALS _____

X-RAY WAIVER

I AUTHORIZE Dr. Jeffrey Bourguignon, DC, and Tampa Sport & Wellness Chiropractic, LLC to adjust my spine **WITHOUT** having seen my x-rays. I understand that it is important for them to have a clear image of my spine and will not hold them responsible for anything they cannot see.

INITALS _____

I have read and understand these terms of acceptance.

Patient, Agent or Representative Relationship Date

Tampa Sports & Wellness Chiropractic

Patient Consent
For use and/or disclosure of protected health information
To carry out treatment, payment and healthcare operations

_____ hereby states that by signing this consent, I acknowledge and agree as follows:

The Practice's Privacy notice has been provided to me prior to my signing this consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent.

The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

I understand that, and consent to, the following appointment reminders that will be used by the Practice: a postcard mailed to me at the address provided by me; and telephoning my home and leaving a message on my answering machine or with the individual answering the phone, or by email.

The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.

I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.

I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the Practice agrees to a requested restriction, then the restriction is binding on the Practice.

I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.

I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

_____ _____

Name of Patient/Individual (Please print) Signature of Patient/Individual

Date_____

Dr. Jeffrey D. Bourguignon, D.C.
Tampa Sports & Wellness Chiropractic, LLC
3712 W. Euclid Ave.
Tampa, FL 33629

The primary treatment used by doctors of chiropractic is the spinal adjustment. I will use that procedure to treat you.

-The nature of the chiropractic adjustment.

Spinal joints that are locked up, fixated, or not moving properly can irritate nerves that are in a close proximity. Chiropractic adjustments add motion to these areas. I will use my hands or a mechanical device upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. This helps restore nervous system integrity and can improve the healing process.

-The material risks inherent in chiropractic adjustment.

As with any health care procedure, there are certain complications which may arise during a chiropractic adjustment. Those complications include: fractures, disc injuries, dislocations, and muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. 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. Some patients will feel some stiffness and soreness following the first few days of treatment.

-The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement within and without the profession with one prominent authority[1] saying that there is at most a one-in-a-million chance of such an outcome. Since even that risk should be avoided if possible, we employ tests in our examination which are designed to identify if you may be susceptible to that kind of injury. The other complications are also generally described as "rare."

-Ancillary treatment.

In addition to chiropractic adjustments, I intend to use the following treatments:

Stretching and icing the areas of concern relating to the patient's injuries.

-The risks and dangers attendant to remaining untreated.

Remaining untreated allows the formation of adhesions and reduces mobility which sets up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed. The probability that non-treatment will complicate a later rehabilitation is very high.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

By signing below I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated:_____

_____
Printed Name

_____
Signature

_____
Signature of Parent or Guardian (if a minor)

ASSIGNMENT OF BENEFITS, LIENS, DIRECT PAYMENT AUTHORIZATION, AUTHORIZATION TO RELEASE INSURANCE INFORMATION, AND AUTHORIZATION TO ESCROW UNPAID MEDICAL & PIP BENEFITS

TAMPA SPORTS & WELLNESS CHIROPRACTIC, LLC

INSURANCE CARRIER: _____ CLAIM #: _____
DATE OF LOSS:_____

For and in consideration of Tampa Sports & Wellness Chiropractic, LLC agreeing to pursue the responsible automobile insurance carrier for payment of benefits due and not requiring prepayment for services, I hereby irrevocably assign all rights and benefits to Tampa Sports & Wellness Chiropractic, LLC for Personal Injury Protection, extended Personal Injury Protection, Medical Payment Coverage, and other benefits which I may have in accordance with Florida Statute §627.736. This includes any benefits from my insurance company and any other entity which may be responsible for medical expenses incurred. I further authorize Tampa Sports & Wellness Chiropractic, LLC to collect payments & prosecute any necessary actions to collect payment for services as they see fit and allowable by law and contract. THIS DOCUMENT CONSTITUTES AN ASSIGNMENT OF RIGHTS AND BENEFITS.

I hereby further give a lien to Tampa Sports & Wellness Chiropractic, LLC against any and all insurance benefits named herein, and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by Tampa Sports & Wellness Chiropractic, LLC as a result of the above stated loss date. This document acts as an irrevocable absolute assignment of my rights and benefits to the extent of the charges for services provided. I agree to cooperate with Tampa Sports & Wellness Chiropractic, LLC and their attorney's (at their choosing), and to do all things reasonable to effect payment of the bills by the insurance company or other entity to Tampa Sports & Wellness Chiropractic, LLC including, but not limited to, disclosing my medical condition, being available for factual discovery or other cooperation.

This assignment concerns only the bills for Tampa Sports & Wellness Chiropractic, LLC and those costs including, but not limited to, attorney's fees, other costs, and interest necessary in procuring payment from the above-named insurance company and/or other entities. This assignment is not intended to assign any other causes of action that may belong to the undersigned patient. I agree to pay any applicable deductible or co-payment not covered by any policy of insurance cited above. I understand that as a benefit and convenience to me, Tampa Sports & Wellness Chiropractic, LLC will bill and pursue collection against the insurance company or other responsible entity on my behalf. I hereby instruct and direct my insurance company to pay my benefits directly to Tampa Sports & Wellness Chiropractic, LLC at the address provided on the bill. If my current policy prohibits direct payment to doctors, then I hereby instruct and direct my insurance company or other responsible entity to make the check payable to me and mail it to Tampa Sports & Wellness Chiropractic, LLC at the address on the bill. Tampa Sports & Wellness Chiropractic, LLC's medical care is being provided for a reasonable fee for treatment causally related to the above loss date and is medically necessary. I instruct my insurance carrier or other responsible entity to pay these bills to the full extent of my available benefits under the insurance policy and Florida law. If any portion of the charge for these services is either reduced or denied in whole or in part, my insurance company or other entity is to place funds equal to the amount of the reduced or denied charges into escrow and hold the escrowed funds until agreement or resolution of legal action by Tampa Sports & Wellness Chiropractic, LLC. I further instruct my insurance company to make payment for charges submitted by Tampa Sports & Wellness Chiropractic, LLC in priority to any other requests to escrow benefits, including a request by myself to reserve benefits for pending disability claims. I hereby give Tampa Sports & Wellness Chiropractic, LLC limited power of attorney to endorse and sign my name on any draft for payment to either Tampa Sports & Wellness Chiropractic, LLC or myself if said draft represents payment for charges related to services rendered by Tampa Sports & Wellness Chiropractic, LLC.

I further direct my insurance carrier or responsible other entity to provide information to Tampa Sports & Wellness Chiropractic, LLC which is otherwise available to me including but not limited to a copy of any applicable insurance policy, declaration page, all applicable endorsements, transcripts and/or copies of any recorded statements, examinations under oath and requests for same, independent medical evaluations and requests for same, peer review reports, and a listing of all PIP benefits paid to date which shall include when claims were made, when the claims were received, the payment or denial of each claim, the amount of the deductible and the claims applied thereto, and whether benefits have been exhausted and the amount of PIP benefits available, commonly known as a "PIP log". This request includes the name of other medical providers to whom payments have been under my policy of insurance. This agreement is intended to serve as an assignment of rights and benefits under my policy of insurance in favor of Tampa Sports & Wellness Chiropractic, LLC. If any language within this agreement has the effect of invalidating this agreement, that language shall be deemed void and the remainder of the assignment shall maintain full force and effect. A photocopy of this assignment shall be considered as effective and valid as the original.

_____	_____	_____
Patient Signature	Date	Patient Name

If patient is incapacitated or under the age of 18, please indicate the patient name, guardian name and relation to patient, and obtain guardian signature.

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 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. This means that no person has initiated contact with me and/or persuaded me to use the doctor or licensed professional, clinic, or medical institution that provided the services.
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.

The undersigned licensed medical professional 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. I have explained the services rendered to the insured person, or his or her guardian, sufficiently for that person to sign this form with informed consent.

C. The accompanying statement or bill is properly completed in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to truthfully, accurately, and in a substantially complete manner.

D. The coding of procedures on the accompanying statement or bill is proper. This means that no service has been upcoded, unbundled, or constitutes an invalid or not medically necessary diagnostic test as defined by Section 627.732 (15) and (16), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Insured Person (patient receiving treatment) or Guardian of Insured Person:

Name (PRINT or TYPE)	Signature	Date

Licensed Medical Professional Rendering Treatment (Signature by his or her own hand):

Jeffrey Bourguignon, D.C.

Name (PRINT or TYPE)	Signature	Date

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of Claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234(1)(b), Florida Statutes.

Note: The original of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may not be electronically furnished. Failure to furnish this form may result in non-payment of the claim.

ASSIGNMENT-LIEN-AUTHORIZATION

FOR DIRECT PAYMENTS BY MY PAYERS TO TAMPA SPORTS & WELLNESS CHIROPRACTIC, LLC

Your doctor is sending your X-rays to TAMPA SPORTS & WELLNESS CHIROPRACTIC, LLC (TSWC, LLC) to obtain information which will help assist them in providing you with a highly accurate assessment of your condition. TSWC, LLC is a health facility with specialized equipment and technical expertise for assisting in determining mechanical derangements and biomechanical factors which when correlated clinically can result in a more accurate assessment and thereby assist your doctor in determining the best course of care. The information that your doctor receives from TSWC, LLC will indicate to him/her the potential severity of your condition, and is information that he/she will use in making the best possible treatment decisions. TSWC, LLC expects most insurance companies to pay the charges in full and also to pay TSWC, LLC directly, based on a document such as this. In some circumstances outside the control of TSWC, LLC, some payers may not pay the charges in full or directly. If such a circumstance occurs, you understand that you will be responsible for any balance remaining on those charges.

Purpose. The purpose of this Assignment & Lien is to assist the Office in collecting from various Payers who may be responsible for paying on my Charges. Accordingly, I agree to the following and direct all Payers as follows: I understand and agree that my X-rays will be presented by the doctor to TSWC, LLC for analysis; however, I understand that unless requested in writing by the doctor, my X-rays will not be analyzed by TSWC, LLC for pathology, that the TSWC, LLC biomechanical studies will not in any way test for pathology, and that the TSWC, LLC doctor performing the biomechanical studies will not be reading the X-rays for pathology. The purpose of this Assignment is to assist TSWC, LLC in collecting from various Payers who may be responsible for paying my Charges for TSWC, LLC services.

Definitions. In this Assignment & Lien, the following terms shall have the following meaning: "Office" and "Clinic" shall refer to TAMPA SPORTS & WELLNESS CHIROPRACTIC, LLC; "Payer" shall refer to without limit any insurance carrier, health benefit plan administrator and fiduciary, health maintenance organization, preferred and independent provider organization, attorney, at-fault party, individual, and any other entity, which may elect or be obligated to pay or disburse Proceeds, either now or in the future; "Proceeds" shall include without limit the proceeds from any settlement, judgment, or verdict, the proceeds from any promise to pay or reimburse, the proceeds relating to "health-care-insurance receivables" and/or "payment intangibles" as such are defined by the applicable Uniform Commercial Code, and the proceeds relating to the following benefits, plans, or coverage: individual and group health benefits, Medicare, Medicaid, workers' compensation, disability, liability, uninsured and underinsured motorist, no-fault, medical payments benefits, personal injury protection, lost wages, lost services, property damage, and malpractice; "Charges" shall include without limit the full fees for the Office's services (including without limit treatment, medical equipment, supplies, supplements, narrative reports, photocopies, depositions, and testimony), any Collection Costs incurred by the Office, interest and delinquency penalties to the extent permitted by law, and any other charges incurred by me at the Office; "Collection Costs" shall include without limit any pre- and post judgment court costs, filing fees, service of process charges, attorneys fees, fees or costs associated requests for reconsideration, independent reviews or appeals to any Payer, and any other costs of collection incurred by the Office in any effort or action to collect my Charges either from me or from any Payer.

Assignment and Lien Terms. I hereby assign to the Office to the extent permitted by law, but only to the extent of my Charges, all of my rights, remedies, and benefits relating to any Payer, including without limit my right to receive Proceeds from any Payer now or in the future, and any and all causes of action that I might have against any Payer now or in the future, the right to prosecute such causes of action either in my name or in the Office's name, and the right to settle or otherwise resolve such causes of action as the Office sees fit. I further grant a contractual lien to the Office with respect to my Charges. I further intend for this Assignment & Lien to create a secured interest under the applicable Uniform Commercial Code with respect to my Charges, which lien shall attach to all Proceeds to the extent permitted by law and shall also be automatically perfected effective as of the date and time that my condition first arose, and further authorize the Office to file the form(s) normally filed with the secretary of state or other governmental agency relating to such lien. Consistent with these terms, I hereby direct any and all Payers, to pay the Proceeds directly to, immediately to, and exclusively in the name of, the Office to the extent of my Charges.

Specific Direction to Any Attorney I Retain, Such as in Accident Cases. In the event that I retain one or more attorneys to assist me in collecting any Proceeds, I hereby direct (and the Office hereby requests) each attorney to provide immediate notice to the Office regarding any Proceeds received by the attorney, to promptly pay the Office in-full out of such Proceeds, and to provide a full accounting of such Proceeds to the Office. I agree that the purpose of any Proceeds received by the attorney shall be primarily to pay my Charges. I further agree to and hereby irrevocably waive any present or future right I may have, whether arising under a "Common Fund Doctrine" or other legal basis, to require the Office to reduce its Charges or balance by a proportionate or weighted share of my attorney's fees, costs, and other expenses of pursuing collection of my claims, including the Office's Charges.

Disclosure Directives. I hereby direct each and every Payer to immediately release to the Office any Pertinent Information relating to (a) any coverage I may have and (b) any Determination by the Payer relating to the Office's Charges. "Pertinent Information" shall include without limit the amount of total coverage available and remaining, as well as the amount of any outstanding claims which the Payer has received from any claimant relating to my condition. "Pertinent Information" shall also include without limit copies of all documents, records, and other information (a) relied upon by the Payer in making a Proceeds Determination, or (b) was submitted, considered, or generated in the course of making a Proceeds Determination without regard to whether such document, record, or other information was relied upon in making the Proceeds Determination. "Proceeds Determination" shall include without limit any determination by the Payer to pay, deny, or delay payment of any Proceeds relating to the Office's Charges, as well as a decision to refer the Charges to an independent review or audit, utilization review, or independent medical exam. I further authorize and direct the Office to release any information relating any services rendered to or for me by the Office to all Payers, including without limit a copy of my Charges and a copy of this Assignment & Lien.

Miscellaneous. Except as provided in this paragraph, this Assignment & Lien shall not be modified or revoked without the expressed, written consent of the Office. I hereby revoke, with the Office's consent, the terms of any previously signed documents, but only to the extent those terms conflict with the terms of this Assignment & Lien. I agree that each and every provision of this Assignment & Lien is reasonably necessary for the protection of the rights and interests of the Office and myself. However, should any provision of this Assignment & Lien be found to be invalid, illegal or unenforceable, or for any reason cease to be binding on any party hereto, all other portions and provisions of this Assignment & Lien shall, nevertheless, remain in full force and effect. This Assignment & Lien shall be governed under the laws of the state where the Office is located, and is performable in the county where the Office is located. In any action based upon this Assignment & Lien, I hereby consent to personal jurisdiction and venue of any court in said county and waive all objections based on improper jurisdiction, venue, or forum inconvenience. I further waive any statute of limitations which may apply in any action based upon this Assignment & Lien.

I have read, understood, and agree to the terms of this Assignment & Lien.

Patient Name (print): _____

Patient Signature: _____ Date: _____/_____/_____

Name of Custodial Parent or Legal Guardian, on Behalf of the Patient (please print): _____

Parent/Guardian Signature: _____ Date: _____/_____/_____

TAMPA

SPORTS & WELLNESS CHIROPRACTIC

Insurance Verification Log

Referring Doctor:_____

Phone #:_____ Exam Date:_____

PATIENT

Name:_____ Date of Birth:_____

Address:_____ City/State/Zip:_____

Home Phone:_____ Work Phone:_____

INSURANCE

Type of Claim: PIP Maj. Medical Workers Comp. Other

Deductible Met: Yes No

Insurance Company:_____ Policy Holder:_____

Address:_____ City/State/Zip:_____

DOA:_____ Claim#:_____

Adjuster: _____ Phone #:_____

ATTORNEY

Attorney Name:_____

Address:_____ City/State/Zip:_____

Phone #:_____ Fax #:_____

TAMPA SPORTS & WELLNESS CHIROPRACTIC
DR. JEFF BOURGUIGNON
813.600.5391
3712 W EUCLID AVE, TAMPA, FL 33629
WWW.TAMPASPORTSANDWELLNESS.COM

Medical Records Release Form

By signing this form, I authorize _____ to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/person/facility/entity listed below. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

Patient Name:_____ Date of Birth:_____

The information you may release subject to this signed release form is as follows:

- Diagnostic imaging
- Radiology reports
- Complete medical records
- Auto Insurance/Claim Information

Release my protected health information to the following physician/person/facility/entity and/or those directly associated in my medical care:

Jeffrey Bourguignon, DC
Tampa Sports & Wellness Chiropractic
3712 W. Euclid Ave.
Tampa, FL 33629
P: (813) 600-5391 F: (813) 600-5291

Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

Unless otherwise revoked, this Authorization expires _____. If no date is indicated, the Authorization will expire one year from the date above.

Patient Sign:_____ Date:_____

○