



Dr. Curtis Reynolds, D.C., 721 7th Street West, Palmetto, Florida 34221

Patient Last Name _____ First Name _____

DOB _____ Age _____ SS# _____

How did you hear about us _____

Address _____

City _____ State _____ Zip _____

Phone (Cell) _____ Cell Phone Carrier _____

Email _____

Emergency Contact _____ Relationship _____

Phone _____

Your Occupation _____ Employer _____

FEMALES: Are you pregnant? yes no If yes, How many weeks _____

Chief Complaint for today's visit _____

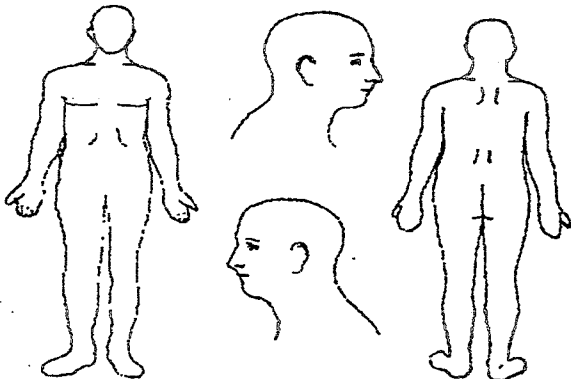
When was your last visit to a Chiropractor? _____ Did it help? yes no

Any Surgeries? yes no If yes, Please list them _____

Place an "X" on the drawing to the left on the areas causing you pain and a letter describing it

S-STABBING N-NUMBNESS
B-BURNING A-ACHING
P-PINS AND NEEDLES

Please circle the number that best describes your pain
0 1 2 3 4 5 6 7 8 9 10
NONE LITTLE MEDIUM SEVERE



Patient Signature _____



Dr. Curtis Reynolds, D.C.

OFFICE POLICIES

1. It is our office policy that any patient and /or insurance company that pays up-front or in advance is entitled to an administrative discount.
2. The fee paid for treatment x-rays is for analysis only. The film itself is the property of this office. Once films are taken, they cannot be released, but may be copied. There may be a fee for copying of the x-rays.
3. If you have any out of pocket responsibility what will be your method of payment?

Cash Check Credit Card/Debit Card Attorney /Letter of Protection.

I understand and agree that health and accident insurance policies are an agreement between the insurance carrier and my self. Furthermore, I understand Injury & Chiropractic Centers of Florida (DBA ChiroMed Health Spa) will prepare any necessary reports, and forms to assist in making collections from my insurance company and that any amount authorized to be paid directly to Injury & Chiropractic Centers of Florida 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 also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered to me will be immediately due and payable. I agree that I will be responsible for all attorney and legal fees if legal action becomes necessary to collect this amount.

Print Patient Name: _____

Patient/Guardian Signature authorizing care: _____ Date: _____



Dr. Curtis Reynolds, D.C.

**THIS DOCUMENT CONSTITUTES INFORMED CONSENT FOR
CHIROPRACTIC CARE**

Our office has one goal, to aid the patient in achieving optimal health as quickly and safely as possible, through the removal of interference in their body. We do this through safe and gentle chiropractic care.

We will attempt to identify and diagnose any ailments you may have that may be corrected through chiropractic care, massage therapy and/or active/passive rehabilitation. If any condition or disease appears to be present out of our scope of practice, we will refer you to an appropriate physician to diagnose and/or treat that condition.

Our primary focus is the detection and correction of vertebral subluxation. This is the misalignment of one spinal bone or multiple bones with interference to the nervous system. Any interference to the nervous system may or may not cause various different symptoms. Again, our focus is to correct the cause, not the symptom.

Vertebral subluxations come on from physical, chemical, and/or emotional stress or trauma. Through specific chiropractic adjustments, we reduce and/or correct these subluxations. It is also important to note that the sooner we are able to treat your subluxations and the degenerative processes that are involved the faster and more completely your body will heal. It may be necessary to examine an individual each time a new injury occurs and often x-rays are necessary to maintain the utmost safety when dealing with your body. The risks of chiropractic care or massage therapy are minimal when dealing with a licensed professional; however, if you have concerns about these risks, please discuss them with the doctor prior to the examination.

I have read and I accept the terms above and understand them fully. I hereby give consent to Injury & Chiropractic Centers of Florida (DBA ChiroMed Health Spa) to evaluate me to determine my condition and treat me for such conditions. I also understand that I may at anytime discontinue with the exam and/or x-rays or any treatment if I so choose.

PRINT _____

SIGNATURE _____

DATE _____

PARENT OR GUARDIAN SIGNATURE _____



Dr. Curtis Reynolds, D.C.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Injury & Chiropractic Centers of Florida (DBA ChiroMed Health Spa) (hereinafter referred to as the "Practice") to use and disclose protected Health Information (PHI) about me to carry out treatment, payment and helathcare operations (TPO). The Practice's Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy prior to signing this consent. The Practice reserves the right to revise its Notice of Privacy any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to:

Dr. Curtis Reynolds, our Privacy Officer, at the following address:
721 7th Street West, Palmetto, FL 34221

With this consent, the Practice may call my home or other alternate locations and leave a message on voice mail or in person in reference to any items that assist the Practice in carrying out TPO, such as appointment reminders, insurance items, and calls pertaining to my clinical care, including laboratory results among others.

With this consent, the Practice may mail to my home or other alternate locations and any items that assists the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, the Practice may email to my home or other alternate locations any items that assist the Practice in carrying out TPO, such appointment reminder cards and patient statements. I have the right to request that the Practice restrict how it uses or discloses my PHI to carry out TPO. However, the Practice is not required to agree to my requested restrictions. But if it does, it is bound by this agreement.

By signing this form. I am consenting to the Practice's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the Practice has already make disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, the Practice may decline to provide treatment to me.

PRINT _____

SIGNATURE _____

DATE _____

PARENT OR GUARDIAN SIGNATURE _____



Dr. Curtis Reynolds, D.C.

RECORDS RELEASE AUTHORIZATION

Date: _____ To Doctor or Hospital: _____
Address _____
Phone #: _____ Fax#: _____

I Hereby authorize and request release to:

**CHIROMED HEALTH SPA
721 7TH STREET WEST
PALMETTO, FLORIDA 34221
TEL. 941-479-4999 FAX. 941-479-4998**

The complete history records in your possession, concerning my illness and/or treatment during the period

Patient: _____ From: _____ To: _____

Social Security Number: _____ DOB: _____

Date of Injury/Illness: _____

Patient Signature: _____ Date: _____

Witness: _____ Date: _____

THIS FAX IS INTENDED ONLY FOR THE USE OF THE PERSON OR OFFICE TO WHOM IT IS ADDRESSED, AND CONTAINS PRIVILEGED OR CONFIDENTIAL INFORMATION PROTECTED BY LAW. ALL RECIPIENTS ARE HEREBY NOTIFIED THAT INADVERTENT OR UNAUTHORIZED RECEIPT DOES NOT WAIVE SUCH PRIVILEGE, AND THAT UNAUTHORIZED DISSEMINATION, DEISTRIBUTION, OR COPYING OF THIS COMMUNICATION IS PROHIBITED. IF YOU HAVE RECEIVED THIS FAX IN ERROR, PLEASE DESTROY THE ATTACHED DOCUMENT (S) AND NOTIFY THE SENDER OF THE ERROR BY CALLING THE NUMBER BELOW. IF YOU DO NOT RECEIVE ALL OF THE PAGE, OR IF YOU HAVE ANY PROBLEMS WITH THIS TRANSMISSION, PLEASE CALL THE NUMBER BELOW.



Dr. Curtis Reynolds, D.C.

SIGNATURE ON FILE

Please initial by each:

_____ **I authorize use of this form on all my insurance submissions**

_____ **I authorize release of information to all my Insurance Companies**

_____ **I understand that I am responsible for my bill**

_____ **I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies**

_____ **I authorize payment directly to my doctor**

_____ **I permit a copy of this authorization to be used in place of the original**

(NAME)

(S.S. #)

(SIGNATURE)

(DATE)



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA PICA													
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK/LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare#) (Medicaid#) (ID#/DoD#) (Member ID#) (ID#) (ID#) (ID#)</small>					1a. INSURED'S I.D. NUMBER (For Program in Item 1)								
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)				3. PATIENT'S BIRTH DATE MM DD YY		SEX M <input type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)					
5. PATIENT'S ADDRESS (No., Street)				6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>				7. INSURED'S ADDRESS (No., Street)					
CITY		STATE		8. RESERVED FOR NUCC USE				CITY		STATE			
ZIP CODE		TELEPHONE (Include Area Code) ()				ZIP CODE		TELEPHONE (Include Area Code) ()					
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				10. IS PATIENT'S CONDITION RELATED TO:				11. INSURED'S POLICY GROUP OR FECA NUMBER					
a. OTHER INSURED'S POLICY OR GROUP NUMBER				a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO				a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>					
b. RESERVED FOR NUCC USE				b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO				b. OTHER CLAIM ID (Designated by NUCC)					
c. RESERVED FOR NUCC USE				c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO				c. INSURANCE PLAN NAME OR PROGRAM NAME					
d. INSURANCE PLAN NAME OR PROGRAM NAME				10d. CLAIM CODES (Designated by NUCC)				d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>					
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.			
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.					SIGNED _____ DATE _____					SIGNED _____			
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.				15. OTHER DATE MM DD YY QUAL.				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY					
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE				17a. _____		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY							
				17b. NPI _____									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)						20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										22. RESUBMISSION CODE _____ ORIGINAL REF. NO. _____			
A. _____		B. _____		C. _____		D. _____		E. _____		F. _____			
E. _____		F. _____		G. _____		H. _____		I. _____		J. _____			
I. _____		J. _____		K. _____		L. _____							
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER			E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. ICD-9-CM Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #	
1													
2													
3													
4													
5													
6													
25. FEDERAL TAX I.D. NUMBER				SSN EIN		26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$		29. AMOUNT PAID \$	30. Rsvd for NUCC Use
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)				32. SERVICE FACILITY LOCATION INFORMATION				33. BILLING PROVIDER INFO & PH # ()					
SIGNED _____ DATE _____				a.	b.	a.	b.						

CURTIS M. REYNOLDS DC
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 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 _____



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 (15) and (16), 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.



Dr. Curtis Reynolds, D.C.

To: _____

Patient: _____

RE: HEALTH RECORDS AND PROVIDER'S LIEN

I do hereby authorize the above provider, Injury and Chiropractic Centers of Florida, to furnish you, my attorney, with a full report of this examination, diagnosis, treatment, prognosis, etc., of myself in regard to the injury in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to Injury and Chiropractic Centers of Florida such sums as may be due and owing them for medical service rendered me both by reason of this injury and by reason of any other bills that are due their office and withhold sums from any settlement, judgment or verdict as may necessary to adequately protect said provider. And I hereby further give a lien on my case to said company against any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries for which I have been treated or injuries in connection herewith.

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

I forbid you, my attorney, from paying my provider any sums less than the full amounts owed to said provider, without its written consent.

Dated: _____ Patient's Signature: _____

The undersigned being attorney of record for this above patient does hereby agree to observe all of the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may necessary to adequately protect said providers above named.

Dated: _____ Attorney's Signature: _____