REJUVENX

REQUIRED ACCIDENT INFORMATION

Name_____ Today's Date _____

Date of accident _____

Have you reported this accident to your insurance company? _____YES _____NO

Have you reported an injury or opened a personal injury (medical) portion of a claim with your insurance company? _____YES _____NO

(If the answer to either of these questions is NO, you must call today an open a claim and/or report that you are seeking care for an injury).

Insurance Company_____ Phone#_____

Address_____City_____State_____Zip_____

Claim Number_____ Policy Number_____

PIP Adjustor_____ Phone Number_____ Extension_____

Have you signed with an attorney regarding this accident? _____YES_____NO

If yes, whom? _____

Address_____City_____State____Zip_____

Phone#_____ Fax#_____

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Injury Questionnaire

First Name: _____Middle In:___Last Name:_____Date: _____

Phone #: _____ (Cell/Work/Home) Last 4 of SS#: _____

Address: _____ City: _____

State:_____ Zip:_____ E-mail Address:_____

Age: _____ DOB: / / Race: _____Male / Female

Patient Information

Occupation:_____ Employer:_____

Average # Hours per Week Currently Worked:_____

At your job how many hours a day do you: Sit_____ Stand_____

Do your work activities mostly involve: ❑ Sitting ❑ Standing ❑ Light Labor ❑ Heavy Labor

---

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Minor

Spouse's Name:_____ # of Children?_____ Children's Ages:_____

Emergency Contact Name:_____ Relation: _____ Phone #:_____

Prior Treatment & Accidents

Have you had an auto accident? (X if applies): ☐ 0-6mo ☐ 6 mo-1 yr ☐ 1-3yrs ☐ 3+yrs ☐ Never

Had a recent fall/other accident? (X if applies): ☐ 0-6mo ☐ 6 mo-1 yr ☐ 1-3yrs ☐ 3+yrs ☐ Never

Have You Ever Received Chiropractic Care? ☐ Yes ☐ No Last Visit?_____

Have You Ever Received Physical Therapy? ☐ Yes ☐ No Last Visit?_____

Have You Ever Received Injections? ☐ Yes ☐ No Last Visit?_____

Have You Ever Had the Following: ☐ CT ☐ MRI If yes please explain the region and approximate Date(s) (i.e. Neck 2005)_____

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ACCIDENT INFORMATION:

Name: _____ **Date:**_____

Date of Accident:_____ State of Accident: _____

Where (Street/Intersection):_____

Were any tickets issued and to whom?_____

Were you the: ☐ Driver ☐ Front Seat Passenger ☐ Back Seat Passenger LEFT ☐ Back Seat Passenger RIGHT

Who else was in the car with you? ☐ No one _____

Did the impact to your vehicle come from the: ☐ Front ☐ Rear ☐ Driver Side ☐ Passenger Side

Since the accident have you experienced:☐ Confusion ☐ Memory Loss ☐ Nausea ☐ Vomiting ☐ Ringing in Ear(s)

☐ Light Sensitivity ☐ Excessive Fatigue ☐ Blackout

Did the ambulance/paramedics arrive at the scene? ☐ No ☐ Yes

Did you go to the hospital? ☐ No ☐ Yes If Yes, were you taken to the hospital via: ☐ Ambulance ☐ Drove myself/Driven

Which hospital? _____

Were x-rays taken? ☐ No ☐ Yes MRI? ☐ No ☐ Yes Body Part(s)_____ CT? ☐ No ☐ Yes Part(s)_____

Have you been prescribed new medication(s) since the accident? ☐ No ☐ Yes If so please list all:

Have you seen anyone else for this accident? ☐ No ☐ Yes If yes, what procedures did they do?

PREVIOUS ACCIDENT HISTORY: Have you ever been involved in another motor vehicle accident? ☐ No ☐ Yes

If yes, please describe and give dates: _____

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Pain Disability Index

Name: _____ Date: _____

Pain disability index: The rating scales below are designed to measure the degree to which aspects of your life are disrupted by pain. In other words, we would like to know how much your pain is preventing you from doing what you would normally do or from doing it as well as you normally would. Respond to each category by indicating the overall impact of pain in your life, not just when the pain is at its worst.

For each of the 7 categories of life activity listed, please circle the number on the scale that describes the level of disability you are experiencing. A score of 0 means no disability at all, and a score of 10 signifies that all of the activities in which you would normally be involved have been totally disrupted or prevented by your pain.

Family/Home responsibilities: This category refers to activities of the home or family. It includes chores/duties performed around the house (eg, yard work) and errands or favors for other family member (eg, driving the children to school).

No disability 0 1 2 3 4 5 6 7 8 9 10 Worst disability

Recreation: This category includes hobbies, sports, and other similar leisure time activities.

No disability 0 1 2 3 4 5 6 7 8 9 10 Worst disability

Social activity: This category refers to activities that involve participation with friends and acquaintances other than family members. It includes parties, theatre, concerts, dining out, and other social functions.

No disability 0 1 2 3 4 5 6 7 8 9 10 Worst disability

Occupation: This category refers to activities that are a part of or directly related to one's job. This includes nonpaying jobs as well, such as that of a housewife or volunteer worker.

No disability 0 1 2 3 4 5 6 7 8 9 10 Worst disability

Sexual behavior: This category refers to the frequency and quality of one's sex life.

No disability 0 1 2 3 4 5 6 7 8 9 10 Worst disability

Self Care: This category includes activities, which involve personal maintenance and independent daily living (eg, taking a shower, driving, getting dressed, etc.)

No disability 0 1 2 3 4 5 6 7 8 9 10 Worst disability

Life-support activity: This category refers to basic life-supporting behaviors such as eating, sleeping, and breathing.

No disability 0 1 2 3 4 5 6 7 8 9 10 Worst disability

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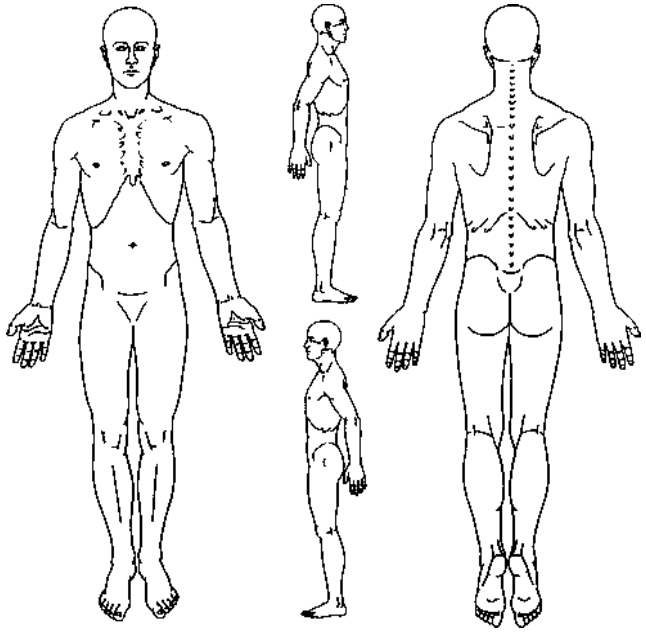
Patient Name:_____
Date:_____



CURRENT SYMPTOMS

Please check to indicate if you are currently experiencing any of the following conditions and then circle problematic areas on body to right:

- ❑ Neck Pain/Stiffness
- ❑ Back Pain/Stiffness
- ❑ Mid Back Pain/Stiffness
- ❑ Arm/Hand Pain
- ❑ Shoulder Pain
- ❑ Wrist Pain
- ❑ Headaches
- ❑ Fatigue
- ❑ Sleeping Difficulties
- ❑ Blurred/Double Vision
- ❑ Trouble Concentrating
- ❑ Shortness of Breath
- ❑ Numb/Pins/Needles in Arms
- ❑ Numb/Pins/Needles in Legs
- ❑ Hip Pain
- ❑ Leg/Knee Pain
- ❑ Elbow Pain
- ❑ Ankle Pain
- ❑ Loss of Memory
- ❑ Chest Pain
- ❑ Dizziness
- ❑ Swollen Joints
- ❑ Loss of Balance

HEALTH HISTORY

Please check if you have ever had any of the following:

- ❑ Aids/HIV
- ❑ Appendicitis
- ❑ Arthritis
- ❑ Asthma/Wheezing
- ❑ Bleeding Disorders
- ❑ Contacts/Glasses
- ❑ Diabetes
- ❑ Erectile Dysfunction
- ❑ Epilepsy
- ❑ Fractures
- ❑ Glaucoma
- ❑ Heart Attack
- ❑ Heart Problems
- ❑ Stroke
- ❑ High Cholesterol
- ❑ Parkinson's disease
- ❑ Incontinence
- ❑ Migraines
- ❑ Multiple Sclerosis
- ❑ Nosebleeds
- ❑ Osteoporosis
- ❑ Pacemaker
- ❑ Pinched Nerve
- ❑ Stroke
- ❑ Pneumonia
- ❑ Rheumatoid
- ❑ Psoriatic Arthritis
- ❑ Herniated Disc
- ❑ Pneumonia
- ❑ Thyroid Problem
- ❑ Vaginal Dryness
- ❑ High Blood Pressure

Please list any and all **medications** you are currently taking:

_____

Past History: Please list any **surgeries and/or hospitalizations** you have had (type & date):

_____

_____

SIGNATURE (X) _____ **DATE** _____

PRINT NAME: _____

REJUVENX

Patient Authorization and Consent for Treatment

(Also Used for Minors/Wards)

Patient/Minor/Ward Name: _____

Patient/Minor/Ward D.O.B: _____

I, the undersigned patient ("Patient") or parent or legal guardian ("Guardian") of the minor child/ward ("Minor /Ward"), as the case may be, by this written authorization authorize and give my consent to RejuvenX ("RejuvenX"), its physicians and their authorized clinical personnel ("Clinical Staff") to evaluate and administer medical, chiropractic, and therapeutic treatment, which may consist of examinations, and various forms of treatment including physical and physiotherapy, and diagnostic x-rays or other diagnostic imaging, to, me the Patient, or if my Minor/Ward is the person receiving care, to my Minor/Ward in those situations indicated by me below where I am not physically present with my Minor/Ward.

I understand that there are some risks in the practice of medicine and chiropractic care, including, without limitation, adverse side effects from medications, fractures, disc injuries, strokes, dislocations, and sprains, and I do not expect the Clinical Staff to be able to anticipate and explain all risks and complications. I wish to rely upon the Clinical Staff to utilize their best judgment during treatment in doing what is in my or my Minor's/Ward's best interest based upon the facts then known to the Clinical Staff.

(Please skip the section in this box if the person receiving care is not a Minor/Ward)
To be Completed by Guardian of Minor/Ward

I have read and have had the opportunity to ask questions about this consent, and by signing below I agree to proceed with all aspects of the care and treatment outlined above. As initialed below to indicate my consent and/or the delegation of my authority to consent to the medical, chiropractic, and therapeutic evaluation, diagnosis, and treatment of me the Patient, or my Minor/Ward, I agree to and authorize the following actions by Clinical Staff, until such time as I revoke in writing such authorizations and consents:

_____ (Initials)

I authorize Clinical Staff to see, examine, evaluate and treat my Minor/Ward, in accordance with the personal requests of my Minor's/Ward's following family member (other than mother or father), if I am not present, in accordance with the consent communicated by the following individual(s) to Clinical Staff pursuant to the delegation of my authority granted here, and consistent with the Clinical Staff's professional judgment of my Minor's/Ward's medical and/or therapeutic needs.

Note: If you are acting in the capacity as a court ordered and appointed legal guardian, kindly supply us with a certified copy of the guardianship order evidencing such authority.

Names of Other Authorized Family Members: Relation of Authorized Family Member(s) to Minor/Ward:

_____ _____

Nothing herein shall be deemed a request, direction, authorization, or consent for Clinical Staff to administer or deliver any examination, diagnostic testing, treatment, or other services that Clinical Staff, in their sole professional judgment, deem to be inappropriate.

This document is intended to be a valid authorization and consent pursuant to Florida Medical Consent Law, Fla. Stat. s. 766.103, and other applicable law, and shall remain in force until revoked by me in writing.

Patient/ Guardian

_____ _____

Signature of Patient/Guardian

Relation to Patient/Minor/Ward (If person receiving care is not a Minor/Ward, write "Self")

_____ _____

Print Patient/Guardian Name

Date

REJUVENX

ACKNOWLEDGEMENT OF LIABILITY
ASSIGNMENT OF BENEFITS & RECORDS RELEASE

The undersigned patient and/or responsible party, hereby acknowledges personal responsibility and liability for all the medical services which are provided by RejuvenX LLC. This personal obligation is not affected by any obligation of insurance companies to pay health care costs. If an insurance company pays, the payment(s) shall be credited to your account. If no insurance payment is received, you are completely responsible to pay for all medical treatments. In addition to continuing personal responsibility, and in consideration of treatment rendered or to be rendered, the undersigned hereby assigns to the physician or facility named above the following rights, power, and authority.

CONSENT FOR TREATMENT: The undersigned hereby consents to provision of examination, fitness evaluations, treatment, therapies, medical and laboratory procedures, and drugs and supplies to the patient as ordered by the patient's healthcare provider RejuvenX LLC, their physicians, nurse practitioners, physical therapist, chiropractors or staff and acknowledges that no guarantee or assurance has been made to the results of such treatments, procedures or examinations.

RECORD RELEASE AND RELEASED INFORMATION: I authorized RejuvenX LLC to release and to permit the examination or copying of any of my medical records, x-rays, laboratory reports, and the results of all tests of any type or character to such person(s) as the Physician and or Facility deems appropriate. I hereby authorize and request you to release my complete pertinent accident medical records to RejuvenX LLC.

ASSIGNMENT OF RIGHTS: You are assigned to exclusive, irrevocable rights. Any cause of action that exists in my favor against any insurance company or other person or entity to the extent of your bill for total services, including the exclusive, irrevocable right to receive payment for such services, make demand in my name for payments, and prosecute and receive penalties, interest, court costs, or other legally compensable amounts owned by an insurance company or other person or entity. I, as the patient and or responsible party further agree to cooperate, provide information as needed, and appear as needed, wherever to assist in the prosecution of such claims for benefits upon request. The physician and or facility is also assigned the exclusive, irrevocable right to request and receive from any insurance company or health care plan any and all information and documents pertaining to my policies including a copy of such policy and my information or supporting documentation concerning or touching upon the handling, calculation, processing or payment of any claim.

DEMAND FOR PAYMENT: As to any insurance company providing benefits of any kind to me/us for treatment rendered by the physician/facility names above, you are hereby tendered the right to demand payment in full the bill for services rendered by the physician/facility named above following your receipt of such bill for services to extent such bills are payable under the terms of my/our policy for benefits, less any amount which I/we owe personally which are not payable under the terms of your policy.

THIRD PARTY LIABILITY: If patient(s) treatments for injuries are the result of the negligence of any third party, then patient(s) grant a secured interest (lien) against any recovery from such third party(s) to the extent of the bills for treatment in favor of the physician/facility named above.

In the event that any provision of this Agreement is determined to be invalid or unenforceable, all other provisions of this Agreement shall remain enforceable.

A PHOTOCOPY OF THIS INSTRUMENT SHALL SERVE AS ORIGINAL
Signature of patient and/or responsible party.

Patient Signature:_____ Date:_____

Print Name: _____ Date of Accident: _____ Relationship to Patient: _____

REJUVENX

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ DOB: _____

I acknowledge that I have reviewed the Notice of Privacy Practices of RejuvenX LLC. (Please initial one of the following options and sign below.)

_____ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office.

_____ I wish to receive a paper copy of Privacy Notice.

_____ I wish to receive an electronic copy of Privacy Notice.

My email address is: _____@ _____

Please initial below:

_____ I acknowledge that it is the policy of RejuvenX LLC to leave reminder messages on my answering machine or with another person in my home. I may make a request of an alternative means of communication (within reason) in writing.

_____ I acknowledge that if I should have a problem or question in regard to my rights, I may speak with the Privacy Officer, Chase Fifarek, about my concerns.

_____ _____

Signature of Patient/Guardian Date

_____

Print Name

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Co-Payment's & Deductible & Services Rendered

Following your initial visit RejuvenX will bill your Insurance Company for the services and goods you have received during that visit. You are responsible for any CO-PAYMENT, DEDUCTIBLE and/or unpaid amounts exceeding available no-fault benefits. We have not agreed, nor do we intend to waive Insurance Policy deductibles or co-pays, or other unpaid amounts.

_____Initials

I acknowledge that I will be receiving statements & EOB's (Explanation of Benefits) from my insurance company which reflect the amount being billed for the services rendered. I acknowledge that I will receive copies of billing and medical records upon request or as periodically submitted by RejuvenX.

I _____(patient name) understand I am financially responsible to pay for all services provided to me a part of my treatment, including any deductibles, copayments or other amounts not covered by personal injury protection and medical payments coverage insurance benefits for the services rendered.

_____ _____

Signature Date

RejuvenX Marketing and Staffing, Florida Imaging, and Precision Pain Management, Authorization for Release of Health Information Pursuant to HIPAA

Section A: This section must be completed for all Authorizations.		
Patient Last Name:	First Name:	MI:
Date of Birth:	Social Security Number (optional):	
My health information may be released to (name of recipient):		
Address:		
City:	State:	Zip:

I hereby authorize the use or disclosure of protected health information as described below:

Description of information being disclosed for the following date(s) of service:

❒Complete health record	❒Abstract/Pertinent Information	❒Consultation Reports
❒History/physical exam	❒HIV/AIDS Information	❒Laboratory Reports
❒Progress Notes	❒Drug/Alcohol Treatment Information	❒Other:
❒Radiology Reports	❒Discharge summary	

Purpose of the Disclosure: (Example: "At the request of the patient"): _____

_____

Expiration: If the health information to be disclosed contains HIV/AIDS or drug and alcohol abuse treatment records, this Authorization expires within sixty (60) days. Otherwise, you may select either of the following expiration events:

❒ 1 year from the date in which I, or my legal representative, signs this Authorization.

❒ Upon the happening of the following event: _____

_____

(Example: "Upon release of the above records")

In addition to the authorization for release of my PHI described above in this Authorization, I authorize disclosure of information regarding my billing, condition, treatment and prognosis to the following individual(s):

Name: _____ Phone: _____Relationship: _____

Name: _____ Phone: _____Relationship: _____

Name: _____Phone: _____Relationship: _____

RejuvenX Marketing and Staffing, Florida Imaging, and Precision Pain Management, Authorization for Release of Health Information Pursuant to HIPAA	
I understand that: 1. I may revoke this Authorization at any time by providing written revocation to RejuvenX Marketing and Staffing. I understand that I may revoke this authorization except to the extent that action has already been taken in reliance on this authorization. 2. Signing this authorization is voluntary. My treatment, payment, enrollment, or eligibility for benefits will not be conditioned upon whether I sign this authorization. 3. The information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by HIPAA upon its release to the recipient. 4. I have the right to inspect or copy the health information to be used or disclosed pursuant to this Authorization.	
TO BE COMPLETED BY THE ORGANIZATION IF THIS AUTHORIZATION IS FOR MARKETING, FUNDRAISING, RESEARCH, OR SALE OF PROTECTED HEALTH INFORMATION:	
The organization will receive financial or in-kind compensation in exchange for using or disclosing the health information described above:	❒ Yes ❒ No
Signatures: I have read the above and authorize the disclosure of the protected health information as stated.	

Signature of Patient (or Patient's Representative):	Date:
Print Name of Patient (or Patient's Representative):	
If you are the representative of a patient, check the scope of your authority to act on the patient's behalf:	
❒ Power of Attorney ❒Legal Guardian ❒ Surrogate Decision-Maker ❒ Executor or Personal Representative ❒ Parent❒ Other:	
For internal use only: Records were delivered by: ❒Fax ❒Mail ❒Personal Delivery on the date of:	

TO THE RECIPIENT: This information has been disclosed to you from confidential records protected by Federal Law. You are prohibited from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. If you have received this information in error, please notify RejuvenX Marketing and Staffing immediately.

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.**

☐ 99203 ☐ E0730 ☐ 98940 ☐ 98941 ☐ 97140 ☐ 97110

☐ 72040 ☐ 72050 ☐ 72052 ☐ 72070 ☐ 72100 ☐ 72110

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.

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Pub. 1/2004