Patient Information/ Financial Responsibility

Patient Name: _____

Address: _____

City_____ State _____ Zip _____

Home # _____ Cell # _____ Work/Alternate # _____

DOB _____ SS#_____

E-mail address: _____

Employed by: _____ Occupation: _____

Parent/Legal Guardian Name_____

In Case of Emergency Notify: _____ Phone # _____

Pharmacy Name _____ Pharmacy # _____

Pharmacy Address or Location _____

CONSENT FOR TREATMENT: I authorize the physicians at Coastal Plus Medical Center, Inc to provide medical and surgical care to myself and/or my minor children. The signed statement will serve as my authorization for the treatment of my minor children if I am unavailable. I authorize all diagnostic testing including laboratory studies and x-rays studies as well as any treatment modality that the physician deems appropriate in my medical care. I understand that Coastal Plus Medical Center, Inc is strictly for non-emergent medical care. I acknowledge that if any medical problem occurs during the hours that Coastal Plus Medical Center, Inc is not open, I have been advised to be evaluated and treated at a hospital emergency room or by another physician of my choice.

ASSIGNMENT OF BENEFIT:
I hereby authorize payment to be assigned by my insurance company directly to the physicians at Coastal Plus Medical Centers. PLEASE DIRECT ALL MEDICAL BENEFITS TO THEIR OFFICE. I authorize the release of any information acquired in the course of my examination and/or treatment that may be needed to facilitate payment for the medical services rendered. I accept financial responsibility for any and all payment not received from my insurance carrier.

RELEASE OF MEDICAL RECORDS: I give my consent to Coastal Plus and all it's agents to make report to or otherwise cooperate with any law enforcement officials or regulatory agencies in any investigation which may arise as a result of or related to my receiving prescriptions as a patient of Coastal Plus or if Coastal Plus or its agents suspect illegal activity. I waive any and all rights of privacy and privilege in this regard and these authorities may be given full access to my records held by Coastal Plus without order of the clerk or court.

FINANCIAL RESPONSIBILITY: I hereby acknowledge and accept financial responsibility for all medical services rendered to me and/or my minor children, by the physicians at Coastal Plus Medical Center, Inc. I agree to remit payment in full at the time services are rendered.

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

NOTICE:
We require 24-hour notice for canceling any appointments. There is a $25.00 charge for weekday appointments and $30.00 charge for Saturday appointments if they are not canceled OR if 24-hour notice is not given. A $35.00 fee will be charged for any checks returned for insufficient funds, plus any bank fees incurred. We charge for medical records, and all disability, FMLA, work and/or insurance paperwork. The medical record fee may vary on # of pages; the paperwork fee is $25.00 flat fee.

Signature _____ Date _____

ASSIGNMENT OF INSURANCE BENEFITS, DIRECTION TO PAY AND AUTHORIZATION FOR INSURANCE INFORMATION

I hereby instruct and direct any insurance carrier that is providing insurance benefits on my behalf under any policy of insurance to make out a check to, and to directly pay COASTAL CARE MEDICAL CENTER, INC. for professional medical and rehabilitative services rendered to me. This includes a direct assignment of my rights and benefits under any policy of insurance and may only be revoked with the express written consent of COASTAL CARE MEDICAL CENTER, INC. This assignment of insurance benefits pertains to any and all professional services, including past services, provided by COASTAL CARE MEDICAL CENTER, INC. in relation to my health insurance and/or motor vehicle accident of _____.

This assignment of insurance benefits is provided so that COASTAL CARE MEDICAL CENTER, INC. may attempt to collect any unpaid or overdue insurance benefits from the insurance carrier. This includes the assignment of any cause of action that might accrue against such insurance carrier for its failure to pay insurance proceeds. Such assignment is given in consideration of professional medical and rehabilitative services.

I authorize any holder of insurance information about me to release such information to COASTAL CARE MEDICAL CENTER, INC. needed to determine the insurance benefits or to assist in the collection of payment for services. I authorize COASTAL CARE MEDICAL CENTER, INC. to contact the insurance company for an exact dollar amount of insurance benefits that are available under any policy of insurance that affords coverage, and to obtain any payout or check ledger reflecting insurance benefits that have been paid out on my behalf.

I understand that there may be services provided that may not be paid under the benefits of my insurance plan and therefore I am responsible to pay for these services in addition to any co-payment amounts.

A copy of this agreement will be as valid as the original.

I have read and I do understand this Assignment of Benefits thoroughly.

Patient's Signature: _____

Signature of Legal Guardian: _____ Date: _____

(when patient is a minor child)

DIAGNOSTIC IMAGING CONSULTANTS

A. Scott Thorpe, DC, DACBR, Rudy N. Heiser, DC, MS, DACBR,
Terry Sandman, DC, MPH, DACBR

CLINIC NAME: COASTAL CARE MEDICAL CENTER REF. DR.:_____
10909-9 ATLANTIC BLVD. JACKSONVILLE, FL 32225
PH:(904)642-3304 FAX:(904) 642-8375

Films/Date Exposed _____ ***Medical History***_____

Please print and complete form with patient's signature

Patient Name _____ **Date of Birth** _____ **Sex** ___**M**___**F**
Address _____ City/State/Zip _____
Phone _____ SS# _____ Case/Acct# _____

BILL: ____ PIP ____ Health/Other Ins. ____DR. ____Atty. ____Patient

Primary Insurance: _____ Phone _____
Adjuster_____ ID/Claim#_____
Address_____ Insured _____
City/State/Zip_____ Date of Injury____/____/____

Attorney: _____ Phone_____
Address_____City/State/Zip_____

ASSIGNMENT, LIEN AND AUTHORIZATION/INSURANCE BENEFITS

For and in consideration of receiving services by "Assignee" and for other good and valuable consideration, I hereby agree to the following: I authorize assignee to release any information pertinent to my case to any insurance company, adjuster, or attorney to facilitate collection under this Assignment, Lien, Reservation of Benefits and Authorization.

ASSIGNMENT OF BENEFITS, RESERVATION AND REQUEST TO ESCROW ANY DISPUTED BENEFITS:

I HEREBY ASSIGN MY insurance benefits and any and all causes of action available under my policy of automobile insurance to, DIAGNOSTIC IMAGING CONSULTANTS OF ST. PETERSBURG, PA d/b/a DIAGNOSTIC IMAGING CONSULTANTS hereinafter, collectively referred to as the Assignee. Additionally, both the assignee and the undersigned patient acknowledge they are foregoing or assuming certain rights under this agreement that they would not otherwise have under normal circumstances, and as such, agree the same serves as additional consideration for this assignment of benefits to the provider/assignees. In the event my insurance company, obligated to make payments to me upon charges made by assignee for services, refuses to make or reduces such payments and in order to maximize the benefits available under my policy coverage, I hereby request the insurance company (assuming there is coverage remaining at the time the company receives the Assignees' bill and if the company fails to pay Assignee the full amount of the bill(s) submitted), to avoid exhaustion of coverage while Assignee pursues its rights under this Agreement, both parties to this agreement (the Assignee and I) further authorize, direct, notice and request the Insurance Company to set aside and place in escrow an amount equal to the full amount of any such denial or reduction, and to hold that amount in escrow until the dispute is resolved in the appropriate forum.

IN THE EVENT MY insurance company obligated to make payments to me upon the charges made by Assignee for their services refused to make such payments, upon demand by me or Assignee, I hereby assign and transfer to Assignee any and all causes of action that I might have or that might exist in my favor against such company and authorize Assignee to prosecute said cause of action either in my name or in Assignee name and further I authorize Assignee to compromise, settle or otherwise resolve said claim or cause of action as they see fit.

I AUTHORIZE ASSIGNEE to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under this Assignment, Lien and Authorization. I agree that the above mentioned Assignee be given Special Power of Attorney to endorse/sign my name on any and all checks and claim forms for payment of my bill.

I UNDERSTAND THAT I remain personally responsible for the total amounts due the Assignee for their services as insurance coverage may only pay a certain percentage of the bill; as, I may have an insurance deductible or my insurance benefits may exhaust or otherwise be limited. I further understand and agree that this Assignment, Lien and Authorization does not require Assignee to await payments and they may demand payments from me immediately upon rendering services at their option, although the Assignee agrees to first demand immediate payment from the insurance company as their first means of pursuing payment for services rendered. Also, I understand that if this account is assigned to an attorney for collection and/or suit, the assignee shall be entitled to reasonable attorney fees and costs of collection. I also understand that, if any bad check is written, I agree to pay for those added costs.

Dated this _____ day of _____, 20 ___.

Patient Signature_____

Printed Name_____Witness_____

Patient History

NAME **DATE OF BIRTH** **DATE**

OCCUPATION: _____ **MARITAL STATUS:** _____

CHILDREN/AGE: _____

MAIN PROBLEMS **ADDITIONAL INFORMATION**

1.

2.

3.

ALLERGIC TO:

LIST ALL MEDICATIONS YOU ARE NOW TAKING

1. **3.** **5.**

2. **4.** **6.**

HOSPITAL ADMISSIONS	YEAR	ILLNESS OR SURGERY	YEAR	ILLNESS OR SURGERY
Not Including Pregnancies				

Smoking Y N How many packs per day? # years **Alcohol** Y N How many per week? # years

PAST MEDICAL HISTORY (DO NOT include today's symptoms) PLEASE CHECK ALL THAT APPLY

☐ Heart Problems
☐ Heart Attack
☐ Heart Valve Problems
☐ Mitral Valve Problems
☐ Heart Failure
☐ High Blood Pressure

☐ Stroke
☐ Lung Problems
☐ Asthma

☐ Emphysema/COPD
☐ Bronchitis
☐ Diabetes
☐ Diabetes - Pregnancy
☐ Glaucoma
☐ Kidney Stones
☐ Thyroid/Goiter Problems
☐ Ulcers
☐ Hepatitis
☐ Cancer

☐ HIV/AIDS
☐ History of STD's

☐ Rheumatic Fever

☐ Scarlet Fever
☐ Tuberculosis
☐ Anemia/Sickle Cell
☐ Gout
☐ Chicken Pox
☐ Polio

☐ Mumps
☐ Measles
☐ German Measles

☐ Chronic Fatigue
☐ Osteoporosis
☐ Chest Pain
☐ Chest Pressure
☐ Chest Tightness
☐ Palpitations
☐ Fainting/Dizzy Spells
☐ Shortness of Breath
☐ Difficulty Breathing
☐ Wheezing

☐ Cough
☐ Leg Blood Clots
☐ Swollen Ankles/Varicose Veins

☐ Diarrhea
☐ Constipation
☐ Bloody or Tarry Stools
☐ Diverticulitis
☐ Abdominal Pain
☐ Hemorrhoids/Hernia

☐ Difficulty Swallowing
☐ Heartburn
☐ Nausea & Vomiting

☐ Weight Loss
☐ Loss of Appetite - recent
☐ Weight Gain - recent
☐ Indigestion/Ulcers
☐ Kidney/Bladder Problems
☐ Frequent Urination
☐ Burning Urination
☐ Night Urination - frequent
☐ Blood in Urine
☐ Nose Bleeds – recurrent

☐ Sinus Trouble
☐ Sore Throats - frequent

☐ Hayfever/Allergies

☐ Hoarseness-prolonged
☐ Arthritis/Rheumatism
☐ Back Pain
☐ Shoulder Pain
☐ Knee Pain
☐ Multiple Pain Location

☐ Bone Fracture/Joint Injury
☐ Accidents (Auto or Falls)
☐ Foot Pain
☐ Injuries – neck, back, knee, spine
☐ Gallbladder Disease
☐ Seizures/Convulsions
☐ Hearing Problems
☐ Headaches - frequent
☐ Rashes/Hives
☐ Psoriasis
☐ Eye Pain/Problems
☐ Double or Blurred Vision
☐ Depression

☐ Nervous Disorders
☐ Emotional Disorders

Females – Please Complete
Possibly Pregnant? Y N
Menstrual Flow
☐ Regular
☐ Irregular
☐ Pain/Cramps
1st day of last period: _____
☐ Pain/Bleeding during or after sex
Number of:
☐ Pregnancies _____
☐ Miscarriages _____
☐ Abortions _____
☐ Live Births _____
Birth Control Method:
☐ Pill:_____
☐ Other: _____
☐ Flushing/Menopause
Date of last PAP test :_____
☐ Normal
☐ Abnormal
Date of last Mammogram: _____
☐ Normal
☐ Abnormal

Family History: Please specify any blood relatives who had the following:

DIABETES _____ THYROID _____

ASTHMA _____ HEART DISEASE _____

STROKE _____ HYPERTENSION _____

CANCER WHAT KIND:

11761 Beach Blvd Ste 8. Jacksonville, Fl 32246.

Patient Request for Copies of Records and Authorization for Release of Information and Accounting Disclosures

Name _____

Date of Birth _____ SSN#_____

Address _____

City _____ State _____ Zip Code _____

I hereby request and authorize copies of and/or release of my medical records and or x-rays from Coastal Plus Medical Center: From: _____ To:_____

_____ _____

_____ I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information.

I, undersigned, have read the above and authorize the staff of the disclosing facility named to disclose such information as herein contained. I understand this authorization may be revoked by me at any time, expect to the extent that action has been taken in reliance upon it. I understand that re-disclosure of this information to a party other than the one designated above is forbidden without additional authorization on my part. The information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected. This facility is released and discharged of any liability and the undersigned will hold the facility harmless, for complying with the "Authorization for Release of Information."

I hereby authorize Coastal Plus Medical Center to release a copy of my patient records or x-rays containing protected health information to. This authorization is given pursuant to Florida Statute 456.057 and HIPAA regulations. I understand that Florida Statute 456.057 (12) makes clear that any third party to whom records are disclosed is prohibited from further disclosing any information in the medical record without the expressed written consent of the patient or the patient's legal representatives

This authorization expires 180 days from the date signed below and covers treatment for the dates specified above. Fees/charges will comply with all laws and regulations applicable to release of information.

I understand that Section 460.413 (1) (m), Florida Statutes, and Board of Chiropractic Medicine Rule 64B2-17.006 require chiropractic physicians to retain records and x-rays for at least four years. Therefore, a chiropractic physician receiving a request for a patient's x-ray within that four-year period must retain the x-ray and provide a copy of it in lieu of the original x-ray. I, further, understand that Section 456.057 (18), Florida Section 457.057 (16), Florida Statutes, authorizes a health care practitioner or patient records owner furnishing copies of reports or records or making the reports or records available for digital scanning pursuant to this section to charge no more than the actual cost of copying, including reasonable staff time, or the amount specified in administrative rule by the appropriate board, or the department when there is no board. The Board of Chiropractic Medicine Rule 64B-17.0055, Florida Administrative Code, authorizes chiropractic physicians to charge patients $1.00 per page for the first 25 pages, and 25 cents for each page in excess of 25 pages. The Board of Chiropractic Medicine Rule defines the reasonable costs of reproducing x-rays, and such other special kinds of records as the actual costs. The phrase "actual costs" means the cost of the material and supplies used to duplicate the record, as well as the labor costs and overhead costs associated with such duplication. The Board of Chiropractic Medicine Rule 64B-17.0055, Florida Administrative Code, authorizes chiropractic physicians to charge people who are not patients authorized to seek copies of my patient records $1.00 per page. I understand that the HIPAA regulations authorize the practice to charge the cost of labor and hardware onto which the records are electronically copied unless the Board of Chiropractic Medicine sets lower costs. I understand that there is no cost for transmitting the electronic records by email.

There is a record of any and all disclosures of information contained in the medical record to any third party, including the purpose of the disclosure, required to be maintained by Florida Statute 456.057 (12) and provided to a patient upon request pursuant to HIPAA regulations. This record/form shall be maintained as part of the patients' records pursuant to Florida Statute 456.057 (12). A copy of this form shall be provided to any patient requesting an accounting or a copy of their patient records. This form will be maintained as part of the medical records for at least six years. I am aware I can request a list of disclosures at any time.

_____ _____ _____

Date Patient/Parent/Guardian Relationship to Patient

Documents furnished to: _____ on: _____

Staff Signature: _____ Date: _____

11761 Beach Blvd Ste 8. Jacksonville, Fl 32246.