Name (First & Last): **DOB:** **Today's Date:**

NEW AUTO INJURY

Please print an answer for all questions, if you have no answer then mark N/A.

Today's Date _____/_____/_____ **Date of Injury** _____/_____/_____ **Time of Injury** _____/_____am / pm

Location of Accident (City and State) _____

Name (First & Last)_____ **Sex** F M **Date of birth** _____/_____/_____

Address _____ **City** _____ **State** _____ **Zip**_____

Home Telephone: _____-_____-_____ **Cell phone**: _____-_____-_____ **Social Security No**._____/_____/_____

Marital status: S D M W E-mail address: _____ If none check here ( )

Who referred you to our office? _____

Type of Occupation _____ (or please circle one: child, student, housewife, retired)

Employer's Name_____ **Employer's Phone Number** _____

Spouse Name _____ **Date of birth** _____/_____/_____

Emergency contact _____ **Telephone No**_____-_____-_____

Race (circle one) American Indian or Alaska Native / Asian / Black or African American / White / Native Hawaiian or Pacific Islander / Decline to answer

Ethnicity (circle one) Hispanic or Latino / Non-Hispanic or Latino / Decline to answer

Preferred Language _____**Religious Preference (optional)** _____

Auto Insurance (please note that we need a claim number from your insurance company, even if you were not at fault)

Company _____ **Policy/Claim Number** _____

Are you the primary Insured ( ) Yes ( ) No if not Name of Primary Person _____

Health Insurance

Company _____ **Policy Number** _____

Attorney Information Name, Phone number, and Firm/Company _____

Our office is fully compliant with HIPPA (Health Insurance Portability and Accountability Act of 1996) and as such we will do our best to protect the privacy of your medical records and information, in both paper and electronic, and will in most circumstances only release what is needed for medical treatment and insurance payments. Our privacy policy is posted in the waiting room and a copy is available upon request at our receptionist's desk. I understand this will be in my chart and maintained for 6 years.

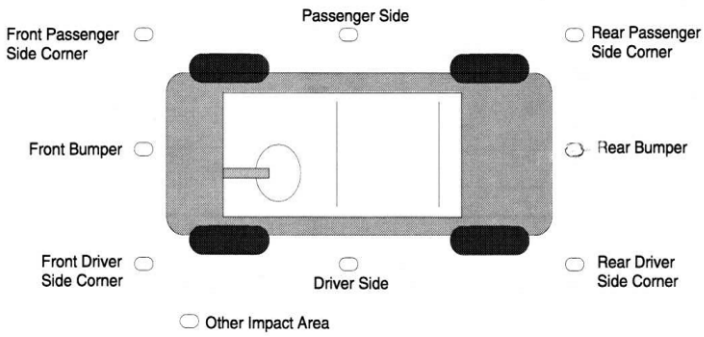
Patient Name _____ **Date** _____

Signature of Patient, Parent or Guardian, or Legal Representative _____

Access
INJURY & PRIMARY CARE

Name (First & Last): **DOB:** **Today's Date:**

Mark where you vehicle was struck



Where in the vehicle were you sitting? Circle one: Driver / Front seat Passenger / Back Left seat passenger / Back Right seat passenger

Briefly describe your accident _____

_____

_____

_____

_____

Were you wearing a seat belt:	*Yes / No*	**Did you hit your head:**	*Yes / No*
Did the air bags deploy:	*Yes / No*	**Any issues with Anxiety due to injury:**	*Yes / No*
Did you go to the hospital:	*Yes / No*	**Any issues with Sleeping due to injury:**	*Yes / No*
Circle All area of pain or discomfort:	*Headaches / Neck / Right Shoulder / Left Shoulder / Right Arm / Left Arm*		
Upper Back / Mid Back / Stomach / Ribs / Lower Back / Right Hip / Left Hip / Right Leg / Left Leg / Other:			
Quality of Pain	*Sharp / Stabbing / Shocking / Pins & Needles / Tingling / Numbness Aching*		
Cramping / Dull / Stiffness / Soreness / Throbbing / Burning / Tightness / Other:			
Severity of Pain	*On a scale of 1 to 10, with 10 being the worst. Your pain level is:*		
When is the pain worst?	*In the morning / in the evening / the pain is constant / intermittent*		
Did you ever have any of these issues before the accident?	*Yes / No, if Yes please explain*		

Please List ALL medications, Prescription and Over the Counter, you are taking. Or give a current List to the receptionist to Copy.

Medication Name	Dosage	Reason for Use	Approximate start date

Please List ALL allergies to Medications. Or if: No Known Drug Allergies check here ( )

Name of Drug/Medication	Type of Reaction to drug/medication

Name (First & Last): **DOB:** **Today's Date:**

Assignment of Benefits

I authorize the release of any medical or other information necessary to process my claims. I also request payment of government benefits to ACCESS INJURY CARE, LLC. I authorize payment of medical benefits to Access Injury Care, LLC or supplier for the appropriate medical services.
PLEASE REMEMBER THAT INSURANCE IS CONSIDERED A METHOD OF REIMBURSING THE PATIENT for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance company. I understand any unpaid balance within 30 days will result in an additional 1%interest charge. If this account is assigned to a collection agency, an additional fee of 40% of amount owed will be added.

This assignment is meant to assign any and all rights and benefits of any and all of the undersigned patients' (assignors) insurance policies and any other benefits that cover services by Access Injury Care, LLC (assignee) its' employees, independent contractors, etc. This assignment includes, but is not limited to any and all health insurance, personal injury protection, Medicare, Medicaid, Worker's Compensation or any other health care benefit. This included the right of Access Injury Care, LLC, to file suit for any and all such benefits.
I, the patient/assignor, acknowledge that I have received, and will receive, good and sufficient consideration from assignee, Access Injury Care, LLC, to include, but not be limited to, documentation of billing relevant insurance companies, legal claim for said benefits, and if necessary, file suit for such benefits instead of assignor having to do so. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance.

_____ _____
Patient/Guardian's Signature Date

Consent to Treat

The patient and / or authorized representative of the patient, whose signature is affixed below, does hereby consent to any and all medical treatments and diagnostic examinations administered at or in offered in association with the operations of Access Injury Care, LLC which treatments / examinations may be deemed advisable by my / the patient's physician to diagnose and / or treat me / the patient during the period I/ the patient am accepted as a patient of Access Injure Care Center, LLC.

_____ _____
Patient/Guardian's Signature Date

Name (First & Last): **DOB:** **Today's Date:**

2014 S. Orange Ave, Ste. 101
Orlando, FL 32806
Phone: (407) 447-2273 Fax (407) 218-4621

FEE GUARANTEE AGREEMENT FOR

Access Injury & Primary Care

Patient Name: _____

Address: _____

Phone Number: _____

DOB: _____

Accident Date: _____

I, the above noted Patient, do hereby authorize and direct my present and any future attorney to honor this fee guarantee agreement. This agreement is made in favor of the above named Medical Provider and shall be termed a "Letter of Protection." The Letter of Protection shall serve to place a continuing lien on any proceeds I recover in any legal action related to the above noted accident date.

CONSIDERATION

In consideration of the medical treatment provided and time provided to pay for said medical treatment, I hereby grant a direct lien on any and all funds I may recover in any legal action related to the above accident date.

PROTECTION OF OUTSTANDING CHARGES

The above named Patient hereby agrees that if s/he recovers any money from any person or entity in connection with any legal action related to the above noted accident date, the Patient shall withhold from those funds, sufficient money pay the full outstanding balance of any bill(s) owed to the above named Medical Provider for treatment or any work completed in relation to the above noted accident date. Those funds shall be deducted prior to any other party removing funds for any reason, including but not limited to attorney's fees, costs, other court fees, or any other bill or lien whatsoever. Patient hereby directs their present and/or future attorney to pay said outstanding medical bill in connection with the above noted treatment. This agreement shall obligate each attorney who represents the above named patient in any way and recovers any funds related to the above noted accident date and creates a constructive trust with said

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attorney. Further, this agreement shall extend pay any outstanding balance for any copies, costs or reports the above named Medical Provider endures in relation to any legal issue for the above accident date. The Patient hereby agrees to waive any rights they have, under contract, law or equity, to have the Medical Provider bill a third party entity, including but not limited to any contracted payer, health insurer or government payer and further desires to pay for the medical treatments through the legal action's proceeds.

PATIENT RESPONSIBILITY

It is the Patient's responsibility to advise each and every attorney of the existence of this agreement. Further the Patient must advise the above named Medical Provider at reasonable intervals the status of the legal case. It is also the Patient's responsibility to advise the Medical Provider within 5 days of legal matter collecting any funds and to request a bill for any and all outstanding charges. The Patient hereby directs their present attorney and any future attorney to advise the Medical Provider, as soon as possible, about any funds related to the accident case becoming available to the above named Patient. Further, if the legal action fails to fully pay the Medical Provider's outstanding balance(s) then the remaining amounts are to be paid by the Patient. The Medical Provider may, at his/her discretion at any time, bill any third party payer or government payer.

DISPUTES

If there is a dispute over the Medical Provider's outstanding charges the Patient agrees to submit the full amount due to the Medical Provider and agrees to bring an action in Florida State Court for recovery of the disputed difference. If the Patient fails to pay the Medical Provider's full outstanding balance, and thereafter Medical Provider brings suit to collect said sums, Medical Provider shall then have the right to recover attorney fees and costs for bringing an action to enforce this particular provision.

APPROVAL REQUIRED

This agreement becomes effective when the Patient signs the agreement below. This agreement does not need the approval of any present or future attorney for the Patient. The parties agree that no party shall be considered the drafting party to this contract.

Patient Signature: _____

Date: _____