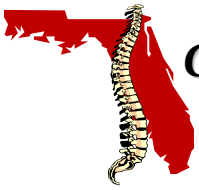

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Confidential Patient Case History

First Name:_____Last Name_____Middle Intial_____

Address:_____City&State_____Zip_____

Home Phone _____Cell Phone _____Email_____

Male/ Female Age_____DOB___/____/____ SS#:_____/_____/____ Marital Status: ***Married / Single /Widow***

Do you have a DNR on file? **Y / N** -Do you have Advanced Directives in place? **Y / N** -If yes, may we have a copy? **Y / N**

Occupation:_____Employer_____Work#_____

Emergency Contact Name:_____Phone#_____

Family/Referring Dr_____Phone_____Fax_____

Specialist: _____Phone_____Fax_____

Health Insurance

Insurance Company: _____Subscriber ID#_____Group#_____

Are you the primary insured on this policy? ***YES / NO*** If No, Insured Name:_____Relation_____

Address if different then above_____City/St_____Zip_____Phone_____

SS#_____/_____/_____DOB_____/_____/_____ Do you have secondary insurance? ***YES / NO***

Pharmacy: _____

Auto Insurance

Date of accident ___/_____/____ Insurance Company Name_____Phone#_____

Policy Number: _____Claim Number: _____

Adjuster Name_____Phone#_____Fax#_____

If you do not have auto insurance, do you live with anyone who does? ***YES / NO***

If yes, Name of Insured:_____Address:_____City/St_____Zip_____

Relation to insured _____Insurance Company: _____Policy Number: _____

Workers Compensation

WC Insurance Company: _____Date of injury_____/_____/_____

Employer: _____Phone#_____Claim#_____

Nurse Case Manager:_____Phone#_____Fax#_____

Attorney Information

Do you have an attorney? ***YES / NO***

If yes, Office Name_____ Attorney

Name_____

Address_____Phone_____Fax_____

I authorize the release of a full report of examination of findings, diagnosis, treatment programs, etc., to any referring or treating physician or dentist. I additionally authorize the release of any medical information to the insurance companies for legal documentation to process claims. I understand that I am responsible for all charges for the treatment rendered to me regardless of the insurance coverage. I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that ***Gulf Coast Injury Center, LLC****. will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to* ***Gulf Coast Injury Center, LLC.*** *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 and treatment, any fees for professional services rendered to me will me immediately due and payable.*

Patient/ Guardian Signature _____ ***Date***_____

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Health Information

Please mark on the figure below, your areas of pain.

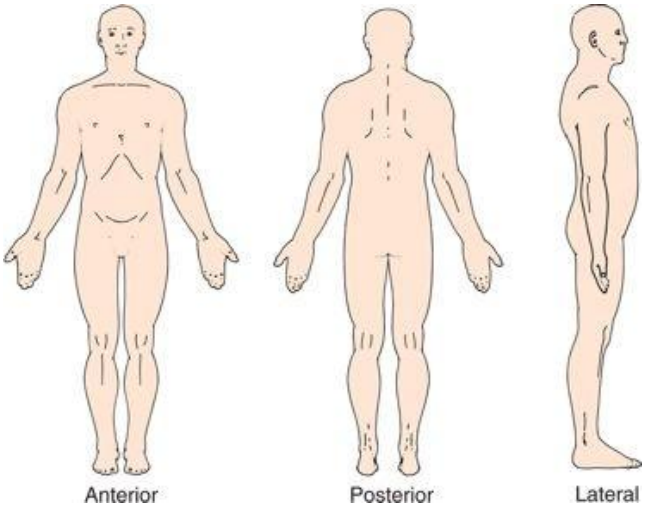
Key

X SHARP

O DULL/ ACHY

Y NUMBNESS

/ PINS NEEDLES



Briefly describe your chief complaints.

_____

_____

How long have you had this condition? _____What makes the condition feel better?_____

Is this condition progressively getting worse**?** ***YES / NO*** How do you rate the pain? (**1** being no pain **10** being worse pain). _____

Is this condition interfering with any of the following: ***WORK / SLEEP / DAILY ROUTINE / OTHER*** _____

Have you had this condition in the past? ***YES/ NO*** Are you currently being treated for this condition ***YES / NO*** If yes, list the doctors and treatment you have had currently or previously regarding this problem.

Dates Treated	Physicians Name	Specialty	Treatment Type

Are you pregnant? ***YES / NO / MAYBE*** If yes, how far along_____ Number of children_____

Do you currently smoke tobacco? ***YES / NO*** If yes, How much? _____ pack(s) per day. How Long?_____year(s)

Do you drink alcohol? ***YES / NO*** If Yes, How much? _____ drink(s) per day. How long? _____year(s)

List any surgical operations and the years they occurred._____

Have you had any prior diagnostic studies (ie, x-ray, MRI, CT scan, ultrasound) ***YES / NO*** If yes, List the type and date they took place _____

Are you allergic to anything? (ie, medications, lotions, food, etc)_____

List any medications/supplements that you are currently taking?

1._____2._____3._____4._____5._____

Do you currently use a pharmacy? ***YES/NO*** If yes, Name and location _____

Patient/ Guardian Signature _____ ***Date***_____

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Medical History

Please check the following conditions you currently or in the past have.

Allergies
- _ Hay fever
- _ Sinus disorder
- _ Insects_____
- _ Food_____
- _ Other_____

Artificial Implant
- _ Heart pace maker
- _ Breast augmentation
- _ Insulin pump
- _ Heart valve
- _ Joint Replacement _____
- _ Other_____

Arthritis
- _ Gout
- _ Osteoarthritis
- _ Rheumatoid Disease
- _ Other_____

Blood
- _ Anemia
- _ Leukemia
- _ Hemophilia
- _ HIV/AIDS
- _ Sickle Cell Anemia
- _ Other_____

Endocrine
- _ Diabetes Type 1
- _ Diabetes Type 2
- _ Thyroid Disease
- _ Hypoglycemia
- _ Parathyroid Disease
- _ Other_____

Eye
- _ Glaucoma
- _ Ocular herpes
- _ Hypoglycemia
- _ Other:_____

Heart/Circulatory
- _ Arteriosclerosis
- _ Congenital Heart Disorders
- _ Parathyroid Disease
- _ Heart attack
- _ Coronary Artery Disease
- _ Heart Murmur
- _ High/Low Pressure
- _ Rheumatic fever
- _ Congestive Heart Failure
- _ Poor circulation
- _ Heart palpitations
- _ Other_____

Kidney/Urinary
- _ Bladder Infection
- _ UTI
- _ Blood in Urine
- _ Kidney Disease
- _ Sugar in urine
- _ Other:_____

Liver Disease
- _ Cirrhosis of the liver
- _ Hepatitis A
- _ Hepatitis B
- _ Other:_____

Lung/Respiratory
- _ Asthma
- _ Emphysema
- _ Bronchitis
- _ Lung Cancer
- _ COPD
- _ Shortness of Breath
- _ Tuberculosis
- _ Other_____

Muscle
- _ Neck Pain
- _ Mid Back Pain
- _ Lower Back Pain
- _ Muscle tremors or shaking
- _ Other:_____

Nerve /Other
- _ Cerebral Palsy
- _ Epilepsy
- _ Neuralgia
- _ Multiple Sclerosis
- _ Parkinson's Diseases
- _ Stroke
- _ Headaches
- _ Dizziness
- _ Migraines
- _ Vertigo
- _ Anxiety
- _ Depression
- _ Bipolar Disorder
- _ Other_____

Stomach/Intestinal
- _ Bloating
- _ Ulcerative Colitis
- _ Constipation
- _ Gallbladder issues
- _ IBS
- _ Other:_____

Family Health Information

Many health problems are the result of hereditary spinal weakness, thus information about your family member will give us a better picture of your total health picture. Please list any information you may know about your family members

Father: _____

Mother: _____

Siblings: _____

Patient/ Guardian Signature _____ *Date*_____

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Accident Information

Please fill this section out if you were involved in an auto accident or a traumatic incident.

What type of accident (Circle)

Motor Vehicle / Work related / Motorcycle / Struck by vehicle / Slip and Fall / Other_____

Did you go to the hospital? ***YES / NO If*** yes Name: _____Date_____

Location of accident_____ Date of Accident _____Time_____

Briefly describe the accident.

_____

_____

_____

_____

_____

Did you experience any pain or discomfort after the accident? ***YES / NO*** If yes please describe_____

_____

Did you hit your head? ***YES / NO*** If yes did you experience unconsciousness ***YES / NO***

How long after the accident did you feel pain?_____

What makes the pain worse?_____

What makes the pain better? _____

Have you had any prior accidents? (ie, auto, falls , injuries, traumas) ***YES / NO***

If yes, what type of accident (Circle)

Motor Vehicle / Work related / Motorcycle / Struck by vehicle / Slip and Fall / Other_____

Describe the type of injuries: _____

Was there any diagnostic studies performed? ***YES / NO***

If yes, Type of study and date_____

Did your symptoms resolve? ***YES / NO***

Patient/ Guardian Signature _____ ***Date***_____

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Consent for Treatment

I hereby authorize your practice and whomever the doctor may designate as his/her assistant to perform examination, physiotherapy, physical therapy and to perform non-invasive diagnostic tests and, if any unforeseen condition arises in the course of the procedures calling for judgment, procedures in addition to or different from those non complicated. I further request and authorize this office to perform whatever my treating doctor deems advisable. The nature and purpose of these procedures have risks involved and the possibility of complications has been fully explained to me. I acknowledge that no guarantee has been made to me as the result that may be obtained.

Patient/ Guardian Signature ✕ _____***Date***_____

Authorization for Medical Information

This authorization or photocopy hereof, will authorize you to furnish all information you may have regarding my condition while under your observation or treatment, including the history obtained, x-rays, physical findings, diagnosis and prognosis. You are authorized to provide this information in accordance with the auto personal injury protection law. (Chapter 71-252f)

Patient/ Guardian Signature ✕ _____***Date***_____

Consent for Treatment of a Minor

I, _____, hereby grant ***Gulf Coast Injury Center, LLC.*** _____

(Parent/guardian name) ***(Name of Minor)***

medical treatment authorize your practice and whomever the doctor may designate as his/her assistant to perform examinations, physiotherapy, physical therapy, and perform non-invasive diagnostic tests and, if any unforeseen condition arises in the course of the procedures calling for judgment, procedures in addition to or different from those non complicated. I further request and authorize this office to perform whatever my treating doctor deems advisable. The nature and purpose of these procedures have risks involved and the possibility of complications has been fully explained to me. I acknowledge that no guarantee has been made to me as to the result that may be obtained.

Patient/guardian Signature ✕ _____***Date***_____

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Summary of the Florida Patient's Bill of Rights and Responsibilities

Florida law requires that your healthcare provider or healthcare facility recognize your rights while you are receiving medical care and that you respect the healthcare provider's or healthcare facility's right to expect certain behavior on the parts of patients. You may request a copy of the full text of this law from your healthcare provider or health facility. A Summary of your rights and responsibilities are as follows:

- A patient has the right to be treated with courtesy and respect, with appreciation of his/her individual dignity, and with protection of his or her need for privacy.
- A patient has the right to prompt and reasonable response to questions and requests.
- A patient has the right to know who is providing medical services and who is responsible for his/her care.
- A patient has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.
- A patient has the right to know what rules and regulations apply to his/her conduct.
- A patient has the right to be given by the healthcare provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.
- A patient has the right to refuse any treatment, except as otherwise provided by law.
- A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his/her care.
- A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment; whether the healthcare provider or health care facility accepts the Medicare assignment rate.
- A patient has the right to receive a copy of a reasonable clear and understandable, itemized bill and upon request, to have the charges explained.
- A patient has the right to receives, upon request, prior to treatment, a reasonable estimate of charges for medical care.
- A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, physical handicap, or source of payment.
- A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- A patient has the right to know if medical treatment is for purpose of experimental research and to give his/her consent or refusal to participate in such experimental research.
- A patient has the right to express grievances regarding any violation of his/her rights, as states in Florida law, through the grievance procedure of the healthcare provider or healthcare facility which served him/her and to the appropriate states licensing agency.
- A patient is responsible for providing to the healthcare provider, to the best of his/her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his/her health.
- A patient is responsible for reporting unexpected changes in his/her condition to the healthcare provider.
- A patient is responsible for reporting to the healthcare provider whether he/she comprehends a contemplated course of action and what is expected for him/her.
- A patient is responsible for the following the treatment plan recommended by the healthcare provider.
- A patient is responsible for keeping appointments and, when he/she is unable to do so for any reason, for notifying the healthcare provider for healthcare facility.
- A patient is responsible for his/her actions if he/she refuses treatment or does not follow the healthcare provider's instructions.
- A patient is responsible for assuring that the financial obligations of his/her healthcare are fulfilled as promptly as possible.
- A patient is responsible for following healthcare facility rules and regulations affecting patient care and conduct.

I have read and understand the summary of the Florida patient's bill of rights and responsibilities.

Patient/guardian Signature  _____ ***Date*** _____

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HIPAA Privacy Authorization Form

This is an authorization for use or Disclosure of Protected Health Information.
(Requires by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

This is an authorization for release of health information that covers all past, present, and future periods of my medical record. I, _____ ____/_____/_____ _____/____/_____

Patient Name *Date of Birth* *SS#*

authorize the use or disclosure of the health information as described below to the following person or organization_____ _____

Name /Facility *City/St*

□ Entire Medical Record	□ Demographic Information
□ Emergency Department Record	□ Consultations
□ Operative Reports	□ Laboratory results
□ Diagnostic Imaging	□Other_____

I authorize the disclosure of the following information marked above to the following organization:

Gulf Coast Injury Center	***Gulf Coast Injury Center***	***Gulf Coast Injury Center***
6963 East Fowler Ave.	***1104 W Kennedy Blvd***	***1023 US Highway 19***
Temple Terrace, Fl 33617	***Tampa FL 33607***	***Holiday, Fl 34691***
(813)253.3111 Fax (813)514.0108	***(813)258.6051 Fax (813)258.6064***	***(727)937.9726 Fax (727)934.2870***

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. I understand that the information in my medical record may include information relating to mental healthcare, and treatment of alcohol or drug abuse. I also understand that the information may include information relating to sexually transmitted disease, AIDS or HIV. I also understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing. I understand that the revocation will not apply to information that has already been released in response to the authorization. I understand that the revocation will not apply to my insurance policy. Unless otherwise revoked, this authorization will expire in one year.

Patient /Guardian Signature ✕_____***Date***_____

*If signed by Legal Rep., relation to Patient*_____

Witness_____***Date***_____

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Irrevocable Lien of Insurance

&

Settlement Proceeds

To the extent for the bill of services rendered by ***Gulf Coast Injury Center***, I_____hereby
(Patient Name)

consent that this agreement constitutes an irrevocable lien against any recovery of proceeds paid by and insurance carrier from whatever source, including, but not limited to, PIP coverage, bodily injury coverage, health insurance coverage, uninsured/underinsurance motorist coverage, medical payments coverage, general liability coverage, or any other coverage that may be available to pay me for my medical bills or my damages stemming from the accident occurring on _____. Further, and to extent of bills incurred, the undersigned agrees that this
(Date of Accident)

agreement shall constitute an irrevocable lien against any recovery resulting from the aforementioned accident, or any judgment or verdict obtained in the pursuit of my claim for damages stemming from said accident.

This lien is provided to me by *Gulf Coast Injury Center* in consideration *of Gulf Coast Injury Center's* agreement to refrain from any collection efforts against me, the patient, until my claim for damages stemming from the above referenced accident is settled, resolved in litigation, or abandoned. The undersigned agrees that it has a duty to keep *Gulf Coast Injury Center* informed of the status of the patients' claim for damages by immediately advising *Gulf Coast Injury Center* of any settlement reached, or any verdict or judgment rendered, whether favorable or not. The undersigned agrees that it had the duty to advise *Gulf Coast Injury Center* should the patient choose to abandon its claims for damages. The claimant further recognizes, that should his/her claim for damages results in no recovery, or in an amount insufficient to pay this provider's medical bill in full, that it shall remain obligated to pay outstanding balance owed to *Gulf Coast Injury Center.*

I hereby authorize any attorney I choose to represent me in my personal injury claim/case, to discuss my case, or provide *Gulf Coast Injury Center* with any and all information necessary to assist in the payment of medical bills incurred with Gulf Coast Injury Center. I further authorize and irrevocably instruct said attorney(s) to with hold such sums from any insurance payments made, from any settlement reached, or from any verdict or judgment paid, and pay Gulf Coast Injury Center and to deposit any disputed amount in the registry of the *Court of Hillsborough County*, *Florida*. The parties agree that *Gulf Coast Injury Center* is an interested party in the outcome of my claim for damages, and shall remain an interested party, until the balance owed by me, *to Gulf Coast Injury Center* is paid in full. I acknowledge my understanding that this lien shall remain in force, and effect, even if I should decided to substitute consul or represent myself.

Patient/guardian Signature ✕_____***Date***_____

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Letter of Protection

I, _____, hereby authorize and direct my attorney, _____to pay directly from any proceeding payable to client and received throughout the efforts of the Law Office of _____, any deductible, applicable co-pay or any outstanding balance due to ***Gulf Coast Injury Center*** for reasonable services rendered to me in connection with injuries I received as a result of a motor vehicle accident, which occurred on_____, 20_____, in _____.This Letter of Protection is subordinate to any applicable attorney's fees and costs.

_____

(Patient Signature)

_____

(Attorney Signature)

_____

Scott Drummond for Gulf Coast Injury Center
Michelle Velez for Gulf Coast Injury Center
Dr. Richard Galloway Gulf Coast Injury Center
William Bullwinkel for Gulf Coast Injury Center

Date this_____Day Of _____, 20_____