SEMINOLE CHIROPRACTIC MEDICINE

MOTOR VEHICLE ACCIDENT PATIENT FORM

Please answer all the questions completely. All information provided is strictly confidential. If you do not understand a question or are unsure of the information, please ask for assistance.

Name: _____ Date: _____

Address: _____ Apt. #: _____ City: _____ State: _____

Date of Birth: _____ Age: _____ Phone #: _____

In the accident, you were the: ❑ DRIVER ❑ PASSENGER ❑ PEDESTRIAN / CYCLIST ❑ OTHER

Date of accident: _____ Time of accident: _____ ❑ AM ❑PM

City were accident occurred: _____ Was the street wet or dry? ❑ Wet ❑ Dry

Street (location) where accident occurred: _____ State where accident occurred: _____

What was the weather like when accident happened? _____

Who owns the vehicle you were in? _____

Did the police come to the accident scene? ❑ YES ❑ NO Did the police make a written report? ❑ YES ❑ NO

Do you have automobile medical insurance coverage? ❑ YES ❑ NO Policy #: _____

Company Name: _____ Phone Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Have you reported this injury to your car insurance company? ❑ YES ❑ NO Claim #: _____

Adjuster's Name: _____ Phone Number: _____

Is an attorney representing you? ❑ YES ❑ NO Attorney's Name: _____

Company Name: _____ Phone Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Have you been in a motor vehicle accident before? ❑ YES ❑ NO If yes, when? _____

DESCRIBE HOW THE ACCIDENT HAPPENED:

_____

_____

_____

_____

_____

_____

COLLISION DESCRIPTION:

Check all that apply to you. Indicate which type of automobile accident you were involved in:

❑ Single-car crash ❑ Two-car crash ❑ Three or more vehicles

❑ Rear-end crash ❑ Side crash ❑ Rollover

❑ Head-on crash ❑ Run off the road ❑ Hit guard rail, tree, or object

❑ Other (Describe:) _____

DESCRIBE THE VEHICLE YOU WERE IN:

❑ Small-sized car ❑ Mid-sized car ❑ Large-sized car

❑ Pick-up Truck ❑ Van ❑ Sport Utility Vehicle

❑ 2 Door Vehicle ❑ 4 Door Vehicle ❑ Large truck, bus, semi-truck

❑ Sedan ❑ Hatchback ❑ Station wagon

DESCRIBE THE OTHER VEHICLE

❑ Small-sized car ❑ Mid-sized car ❑ Large-sized car

❑ Pick-up Truck ❑ Van ❑ Sport Utility Vehicle

AT THE TIME OF IMPACT YOUR VEHICLE WAS:

❑ Slowing down ❑ Gaining speed ❑ Stopped, brake engaged ❑ Stopped, no brake

❑ Moving at steady speed

AT THE TIME OF IMPACT THE OTHER VEHICLE WAS:

❑ Slowing down ❑ Gaining speed ❑ Unknown Speed ❑ Moving at a steady speed

❑ Stopped ❑ Other

DURING AND AFTER THE ACCIDENT, YOUR VEHICLE:

❑ Kept going straight, not hitting anything ❑ Spun around, not hitting anything

❑ Kept going straight, hitting car in front ❑ Spun around, hitting another car

❑ Was hit by another vehicle ❑ Spun around, hitting object other than car

INDICATE IF YOUR BODY HIT SOMETHING OR WAS HIT BY ANY OF THE FOLLOWING:

Please draw lines from the body regions on the left side and match to the right side.

BODY REGION	**OBJECT YOU HAD CONTACT WITH**
Head	Windshield
Face	Side Window
Shoulder	Side Door
Arm/Hand	Dashboard
Front Chest Wall	Knee Bolster/Glove Compartment
Side Chest Wall	Seatbelt
Hip/Abdomen	Frame of car near windows
Knee	Another Occupant/Animal
Leg	Roof
Foot	Steering Wheel/Column

CHECK IF ANY OF THE FOLLOWING VEHICLE PARTS BROKE, BENT, OR WERE DAMAGED IN YOUR CAR:

❑ Windshield ❑ Seat Frame ❑ Knee Bolster ❑ Steering Wheel

❑ Side or rear window ❑ Brake Pedal ❑ Dash ❑ Mirror ❑ Other

ALL TYPES OF COLLISIONS *(Indicate those relevant to you)*

YES	NO	
❑	❑	Did any of the front or side structures, such as the side door, dashboard, or floorboard of your car dent inward during the crash?
❑	❑	Did the side door touch your body during the crash?
❑	❑	Was the door(s) of your vehicle damaged to a point where you could not open it?
❑	❑	Did your body slide under the seatbelt?
❑	❑	Did an airbag deploy in your vehicle during the crash?
❑	❑	Were you intoxicated (alcohol) at the time of the crash?

SEATBELT USAGE AND STEERING WHEEL HAND PLACEMENT

YES	NO	
❑	❑	Were you wearing a seatbelt? Does your seatbelt has a ❑ Lap & shoulder strap ❑ Lap belt only?
❑	❑	Indicate if you have any portion of your seatbelt positioned behind your back or shoulder
❑	❑	Were you holding onto the steering wheel (driver only) at the time of impact?
❑	❑	If yes, indicate where each hand was positioned (use time clock face as your reference point)

LEFT Hand: ❑ at ____ o'clock ❑ Not on wheel ❑ Hand elsewhere

RIGHT Hand: ❑ at ____ o'clock ❑ Not on wheel ❑ Hand elsewhere

REAR-END COLLISIONS ONLY (*Answer this section only if you were hit from the rear)*

Describe your vehicle's head restraint system

❑ Movable/adjustable head restraint ❑ Fixed, non-movable head restraint

❑ No headrests in my vehicle ❑ Bench seat in my vehicle without head restraint

Please indicate how your head restraint was positioned at the time of the crash (if present)

❑ At the top of the back of my head ❑ Midway height of the back of my head

❑ Lower height of the back of my head ❑ Located at the level of the neck ❑ Level of shoulder blade

Estimate distance between back of head and front of headrest: _____

BRUISING AFTER THE ACCIDENT

Did your body have any bruising (areas that were visibly black and blue) after the crash? ❑ YES ❑ NO

If yes, indicate where: _____

AWARENESS AND BODY POSITION DESCRIPTIONS *(Check all areas that apply to you)*

❑ You were **unaware** of the impending collision. You did not see or hear breaks prior to the impact.

❑ You were **aware** of the impending crash and relaxed before the collision.

❑ You were **aware** of the impending collision and braced yourself.

❑ Your body, torso, and head were facing straight ahead.

❑ You were leaning forward at the time of impact resulting in a gap between your body and the seatback.

❑ You had your head and/or torso turned at the time of collision ❑ turned to the left ❑ turned to the right

Describe how far you were turned/twisted and why? _____

_____

❑ Your torso and body was positioned normally against the seatback with no gaps due to leaning/twisting.

EMERGENCY ROOM AND DISABILITY DATES

YES	NO	
❑	❑	Did you go to the emergency room?
❑	❑	Did you go to the emergency room in an ambulance?
❑	❑	Did you or another person drive you to the emergency room?
❑	❑	Were you hospitalized after being seen in the emergency room? If yes, how many days: _____
❑	❑	Did the emergency room doctor take X-rays? Check what regions were taken: O Skull/Face O Ribs/Chest O Neck or Middle Back O Collar Bone O Low back or Hip/Pelvis O Shoulder, Arm, or Hand O Leg or Foot O Other _____
❑	❑	Did the hospital or clinic take MRI or CT of your body? If yes, indicate where it was taken: O Skull O Neck O Low Back or Hip Pelvis O Other _____
❑	❑	Did you have any broker bones/fractures? If yes, where: _____
❑	❑	Did you have a cast put on for any sprain or fracture? If yes, where: _____
❑	❑	Did you have any dislocations? If yes, where: _____
❑	❑	Did you have any cuts or lacerations? If yes, where: _____
❑	❑	Did you have any skin abrasions? If yes, where: _____
❑	❑	Did you require any stitching for cuts? If yes, where: _____
❑	❑	Did you have any visible bruises or lumps? If yes, where: _____
❑	❑	Did you have any bruises along the shoulder or lap portions of your seatbelt?
❑	❑	Did the Emergency Room doctor give you any pain medications?
❑	❑	Did the Emergency Room doctor give you any muscle relaxants?
❑	❑	Did the Emergency Room doctor give you any other medications/prescriptions? If yes, list the medication and dosages: _____
❑	❑	Where you told you have a herniated or bulging disc in your neck or back? If yes, where: _____
❑	❑	Where you given a neck collar or back brace to wear?
❑	❑	Did you require any surgery after the accident? If yes, describe type and date: _____
❑	❑	Where you hospitalized overnight? If yes, indicate dates hospitalized: _____

HOW SOON DID YOU FIRST NOTICE ANY PAIN OR SORENESS AFTER YOUR INJURY?

❑ Less than 24 hours after the accident

❑ Began 1-7 days after the accident

❑ Began ___ after the accident

DISABILITY: HAVE YOU BEEN ABLE TO WORK SINCE INJURY?

Have you lost days of work? ❑ YES ❑ NO

If yes, have you lost work: ❑ Partially ❑ Completely Days off work: from _____ to _____

If you had neck and/or back pain so severe that you were unable to get out of bed, how many hours after the accident did you develop this disabling level of pain? _____

SYMPTOM QUESTIONNAIRE

It is important for this section to be filled out in detail. Look at each symptom listed on the left column and make a single check mark or several check marks in the appropriate columns for the specific symptom which applies to you. Be certain to indicate when you had the beginning of any of the following symptoms. Leave the row blank if the symptom does not apply to you.

SYMPTOM	BEGAN IN LESS THAN 24 HRS AFTER INJURY	BEGAN 1 TO 7 DAYS AFTER INJURY	YOU HAVE SYMPTOMS CURRENTLY	HAD SIMILAR SYMPTOMS WITHIN ONE YEAR BEFORE THE INJURY
Headache / Migraine				
Dizziness				
Tinnitus (ear ringing)				
Blurry vision				
Memory problems				
Poor concentration				
Irritability				
Balance Problems				
Loss of coordination				
Sensitivity to sound				
Sensitivity to light				
Fatigue				
Anxiety				
Pain/difficulty swallowing				
Jaw / pain soreness				
Neck pain / soreness				
Neck stiffness				
Shoulder pain / stiffness				
Arm pain/ tingling/numbness				
Wrist/hand/finger pain/numbness				
Weakness in arms/legs				
Upper/middle back pain/soreness				
Rib cage pain				
Low back pain/soreness				
Hip pain				
Leg pain				
Leg numbness/tingling				
Pain shoots down back of leg				
Knee pain				
Ankle/foot pain				

List any operations, surgeries, or medical procedures:

Date: _____ Procedure: _____ Date: _____ Procedure: _____

Date: _____ Procedure: _____ Date: _____ Procedure: _____

Any current loss of bowel or bladder control: □ Yes □ NoCurrent fever: □ Yes □ No

Any current seizures, paralysis, speech, vision problems: □ Yes □ No

Please list any significant family illnesses: _____

Do you have a family history of:

□ Cancer □ Heart problems/Stroke □ Diabetes □ Rheumatoid Arthritis □ High Blood Pressure

Have you had spinal X-Rays within the past 5 years? If yes, when and where _____

Please select one: □ I have never smoked □ Former smoker □ Current smoker, if so how much: ____pk./day

Please select one: □ I don't drink alcohol □ Rarely drink □ Social drinker □ Heavy drinker (_____oz. per day/week)

Have you ever had chiropractic care? □ Yes □ No

If yes, last date of treatment _____ By whom: _____

Similar or different condition: _____ Results: _____

List any medications you currently take: _____

Do you have any allergies? If so, please list: _____

Women Only □ I am □ I am not pregnant

What treatment have you already received for your condition?

□ Medications □ Surgery □ Physical Therapy □ Chiropractic Services □ None □ Other: _____

Name and address of other doctor(s) who have treated you for your condition: _____

_____

Date of last: Physical Exam: _____ Spinal X-Ray: _____ Blood Test: _____

Spinal Exam: _____ Chest X-Ray: _____ Urine Test: _____

Dental X-Ray: _____ MRI, CT-Scan, Bone Scan: _____

Place a mark on "Yes" or "No" if you have had any of the following:											
	Yes	No		Yes	No		Yes	No		Yes	No
AIDS/HIV			Diabetes			Measles			Rheumatic Fever		
Alcoholism			Emphysema			Migraine Headache			Stroke		
Allergy Shots			Epilepsy			Miscarriage			Suicide Attempt		
Anemia			Fractures			Mononucleosis			Thyroid Problems		
Anorexia			Glaucoma			Multiple Sclerosis			Tonsillitis		
Appendicitis			Goiter			Mumps			Tuberculosis		
Arthritis			Gonorrhea			Osteoporosis			Tumors, Growths		
Asthma			Gout			Pacemaker			Typhoid Fever		
Bleeding Disorder			Heart Disease			Parkinson's Disease			Ulcers		
Breast Lump			Hepatitis			Pinched Nerve			Vaginal Infections		
Bronchitis			Hernia			Pneumonia			Venereal Disease		
Bulimia			Herniated Disk			Polio			Whooping Cough		
Cancer			Herpes			Prostate Problem			Other		
Cataracts			High Cholesterol			Prosthesis					
Chemical Dependency			Kidney Disease			Psychiatric Care					
Chicken Pox			Liver Disease			Rheumatoid Arthritis					

Why are you here today? _____

_____

List your worst complaint: _____ Date symptoms began: _____

How did it start? _____

How often do you have this pain? _____

Is it □ Constant □ Comes and goes

Is it: □ Improving □ Worsening □ Staying the Same

Is it: □ Mild □ Moderate □ Severe

What worsens it?

□ General activity □ Moving wrong □ Bending □ Lifting □ Walking □ Sports □ Getting up from a chair

□ Using a computer/desk work □ Other

What makes it better?

□ Rest □ General activity □ Ice Packs □ Heating pad □ OTC Meds □ Rx Meds □ Massage □ Chiropractic □ Other

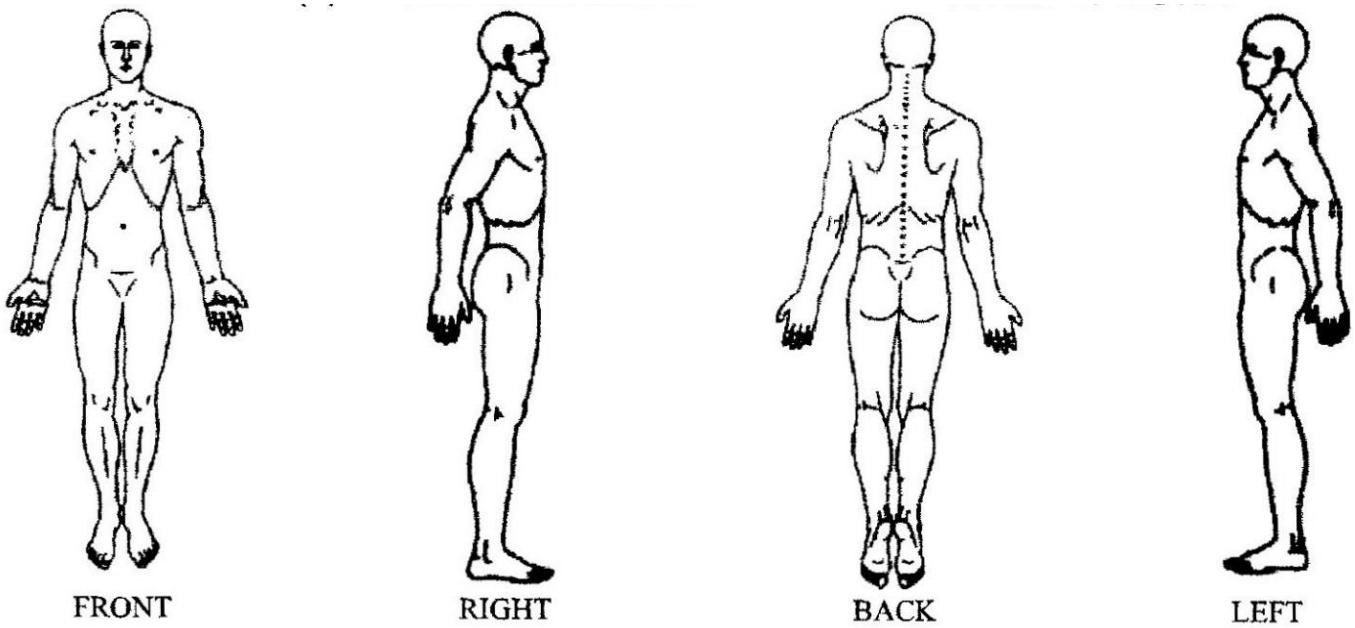
Is it worse in the: □ AM □ PM □ After day wears on □ Steady □ Off and On

Is the symptom:

□ Dull/Achy □ Tight/Stiff □ Sharp/Stabbing □ Numb/Tingly □ Shooting □ Burning □ Cramping □ Throbbing

Does it interfere with your: □ Work □ Sleep □ Daily Routine □ Recreation

On the images below, place an X on the areas where you are currently experiencing pain/discomfort.



PROVIDERS SEEN SINCE INJURY OR WHEN CONDITION BEGAN

Start with the first doctor you went to after your injury or condition began and list all providers (all types of doctors or therapists) up to your last provider seen and check all that apply for each. Be certain to list these in sequence form first to last.

❶ Name Emergency Room, hospital / doctor / therapist / Center:

Company Name: _____ Phone Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Indicate procedure done:

❑ Exam-consultation	❑ Rehabilitation	❑ Exercises
❑ IME exam or consult only	❑ Ultrasound	❑ Acupuncture
❑ X-ray of neck	❑ Spinal adjustment	❑ Injection(s)
❑ X-ray of chest/mid back	❑ Muscle massage / myotherapy	❑ Wrist brace / splint
❑ X-ray of low back	❑ Muscle stimulation	❑ Neck collar / brace
❑ Other X-rays	❑ Physical therapy	❑ Low back brace
❑ MRI / CT scan	❑ Anti-inflammatory medications	❑ Heat packs
❑ EMG / Nerve conduction study	❑ Pain medications	❑ Ice packs
❑ Other tests	❑ Muscle relaxants	❑ Other: _____
Indicate if treatment with this provider:	❑ Helped ❑ Did not help	❑ Other: _____

❷ Name Emergency Room, hospital / doctor / therapist / Center:

Company Name: _____ Phone Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Indicate procedure done:

❑ Exam-consultation	❑ Rehabilitation	❑ Exercises
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❑ EMG / Nerve conduction study	❑ Pain medications	❑ Ice packs
❑ Other tests	❑ Muscle relaxants	❑ Other: _____
Indicate if treatment with this provider:	❑ Helped ❑ Did not help	❑ Other: _____

Thank you for completing this questionnaire and intake form regarding your recent accident and injury.
The information provided will help us create the most effective treatment plan for your rapid recovery.

Son Nguyen, PLLC
7560 Red Bug Lake Road, Suite 1080
Oviedo, FL 32765
407-977-2240 ** 407-977-2446 fax

Patient Name: _____
Address: _____City: _____
State: _____ Zip Code: _____ Phone Number: _____

ASSIGNMENT OF BENEFITS

I hereby assign any and all automobile insurance policies which provide medical benefits, rights, title and interest to Seminole Chiropractic Medicine / Dr. Son Nguyen (Assignee), for payment of services rendered unto me both by reason of accident or illness. This is to act as an assignment of my rights and benefits to the extent of the Assignee's services provided.

ASSIGNMENT OF CAUSE OF ACTION

In the event my insurance company fails to pay Seminole Chiropractic Medicine / Dr. Son Nguyen (Assignee) the full amount due and owing to Assignee after notice is given, I hereby assign and transfer to Assignee any and all causes of action, and proceeds from such 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 Assignee's name and further I authorize Assignee to compromise, settler or otherwise resolve said claim or cause of action as they see fit.

DIRECTION OF PAYMENT

I hereby authorize my or any insurance company or attorney to pay directly to Assignee the amount of this and/or any future bills for services rendered to me. I also agree to pay in a current manner any difference between the total charges and the amount paid by the insurance company directly to Seminole Chiropractic Medicine / Dr. Son Nguyen (Assignee). In the event that I do not have insurance coverage, I understand that I remain personally responsible for payments or services rendered. I hereby further give an irrevocable lien to said Seminole Chiropractic Medicine / Dr. Son Nguyen (Assignee) against any and all insurance benefits names herein and any and all proceeds of any settlement judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by Seminole Chiropractic Medicine / Dr. Son Nguyen (Assignee).

PIP LOG REQUEST

I hereby authorize Assignee to release any information requested that is pertinent to my case to my insurance company or attorney involved in this case. Pursuant to 627.4137 Florida Statutes (2001), I hereby request a copy of the Pip Log and Declaration Sheet, which reflects the policy limits available at the time of this accident, to be provided to Seminole Chiropractic Medicine / Dr. Son Nguyen (Assignee), I hereby authorize Seminole Chiropractic Medicine / Dr. Son Nguyen (Assignee) to request and receive a copy of my Pip log periodically as they deem to be necessary.

RESERVATION OF BENEFITS

Please be advised that I am hereby placing you on notice that, pursuant to Florida case law, should you deny, reduce or fail to pay either a portion of or an entire bill submitted on my behalf from this healthcare provider. I am requesting that you reserve, or hold aside, that same amount until this dispute is resolved. If any term of this assignment or the application thereof to any person or circumstances shall be determined invalid or unenforceable the remainder of this assignment shall not be affected thereby, and each term and provision of this assignment shall be valid and to the fullest extent of the law.

Signature: _____ Date: _____

AUTHORIZATION FOR DIRECT PAYMENT OF INSURANCE BENEFITS TO MEDICAL PROVIDER

I HEREBY AUTHORIZE and direct _____ Insurance Company to pay by check made payable to and mailed directly to **Dr. Son Nguyen; 7560 Red Bug Lake Road, Suite 1080, Oviedo, FL 32765**, the medical and professional expenses allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered by the above-named medical provider. This payment will not exceed my indebtedness to the above-mentioned medical services provider. **I understand that I remain personally liable for, and agree to pay in a timely manner, any balance of said professional service charges over and above this insurance payment.** I further understand that such payment is not contingent upon any settlement claim or verdict, by which, I may recover said fee. If my current policy prohibits direct payment to my medical services provider, then I hereby instruct and direct you to make the check payable to me and **DR. SON NGUYEN** (medical care provider), and mail it to the above listed address.

I authorize the above-mentioned office to, and hereby give power of attorney to, said office to endorse/sign my name on any and all checks for payment of medical services received from my insurance company for medical services provided by said office and grant a lien to said medical services provider for any proceeds of insurance benefits payable under my policy.

Furthermore, I, the undersigned patient, hereby irrevocably make, constitute and appoint Dr. Sion Nguyen (medical care provider) and any person designated by Dr. Son Nguyen (medical care provider) as my special attorney-in-fact and agent, with full power:

1. To bring an action/lawsuit against said insurance company or organization to recover any unpaid personal injury protection/medical payment benefits;
2. To take all steps necessary to insure payment of any and all amounts due and owing from any insurance company or organization;
3. To bring any action/lawsuit for bad faith against any insurance company or organization obligated to make personal injury protection/medical payment benefits payment.

All previous assignments, authorizations and records release agreements entered into between the parties are hereby rescinded, repealed and otherwise null and void as if I never entered into, effective immediately. **This instrument is not intended to operate as an assignment as that term is used in Florida Statutes 627.756 and any provision(s) of this instrument that may be interpreted as such shall be considered null and void from the beginning and the remaining provision(s) of this instrument shall be served from said provision(s) and will remain in full force, effect and operation.**

A photocopy of this instrument shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to the insurance company and its adjuster to the extent necessary to obtain payment for medical services.

Executed this ___ day of _____, 2017.

_____ _____

Claimant Witness/Rep. of Medical Provider

FINANCIAL DISCLOSURE POLICY

As a result of the changes to the 2003 Florida No Fault Statute (PIP Statute), it is a third degree felony for any health care provider to agree to waive your co-payment (if applicable) as a routine business practice.

We therefore require payment of all balances due, whether co-payments or deductibles, after all attempts by us (including litigation) to collect from the PIP (insurance company) carrier and the at fault driver's carrier have been exhausted.

Two exceptions are permitted under the law:

1. Reduction of the balance in conjunction with a personal injury settlement.
2. Documented financial hardship.

Please speak with our billing manager if you have any questions.

Patient Signature: _____ Date: _____

HIPPA Notice of Privacy Practices
Seminole Chiropractic Medicine
Dr. Son Nguyen

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition, and related health care services.

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information as necessary to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situation without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroner, Funeral Directors, and Organ Donation, Research, Criminal Activity, Military Activity and National Security, Workers' Compensation, Inmates, Required Uses and Disclosures, Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.
Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

17You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction on your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your dare or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before April 14, 2003

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at our main phone number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: _____

Signature: _____

Date: _____

PERSONAL INJURY PROTECTION (PIP)

What is PIP?

Personal Injury Protection, or simply PIP, is mandatory medical coverage provided by your own auto insurance company in the event of an accident. Because PIP is applicable even if you are at fault, it is sometimes also referred to as "no-fault insurance."

PIP is governed by Florida Statute Sec. 627.736(1). Pursuant to this statute, an insurance company is required to provide their insured with a minimum of coverage should they be involved in an auto-accident. The minimum coverage is $10,000 per person, and it will cover or reimburse the following expenses:

1. 80% of any and all medical bills relating to injuries sustained
2. 60% of any loss of income (wages) or earning capacity
3. 80% of prescriptions for medication prescribed as a result of injury
4. Reimbursement of mileage to and from any medical facility

If you do not have an "emergency medical condition," you will not be able to receive more than $2,500 in benefits. Florida law defines "emergency medical condition" as a medical condition that requires immediate medical attention and could reasonably be expected to result in serious jeopardy to the patient's health. A medical doctor will need to determine whether you qualify for this condition. If you qualify for this condition, you can receive up to the $10,000 limits of coverage.

Who qualifies for PIP?

When involved in an auto-accident, regardless of who is at fault, every person involved will report to their own insurance company for PIP benefits. If you are not covered on an auto-insurance policy you may still qualify for PIP through other means such as residing with a relative who owns an insured vehicle, or riding in a vehicle that is insured.

You must seek treatment within 14 days of an auto accident to qualify for PIP coverage. Failure to seek treatment during this time period disqualifies you from receiving PIP benefits.

Do I have to use PIP?

Many people do not want their own insurance company to pay for treatment when another party was at fault. However, the law requires that PIP be used, as it is considered primary insurance coverage for medical treatment following an auto accident in Florida. You have paid for PIP coverage as part of the premium; and built into that premium cost is the consideration that PIP is used no matter who is at fault.

Can I use PIP if I am at fault for the accident?

If you are injured in an accident, you can use PIP benefits *no matter who was at fault* for the accident.

Why can't I use health insurance?

Some people inquire why they should use their PIP insurance when they have health insurance. Under existing law, PIP is considered primary coverage for medical treatment following an auto accident. If PIP is applicable, most health insurers will not pay for treatment until the PIP benefits have been exhausted. Additionally, when your PIP provider makes payments, you are never required to reimburse the PIP insurer for these payments if you receive a recovery from another party. However, most health insurers have a right of subrogation where they are allowed to recover what they have paid.

Who pays for the balance of the bills?

PIP will only pay 80% of any medical bill. The remainder of the bill remains your responsibility. These outstanding balances constitute “out-of-pocket expenses”. These can be claimed as damages against the at-fault party. There may be other forms of coverage available to cover the remaining balance including Health Insurance, Medical Payment Auto Coverage, Medicaid or Medicare.

If you make a claim against the at fault insurer, this insurer may pay for the 20% balance that has not been paid by PIP insurance. In our experience, the insurer does not pay the balance until you or an attorney makes a demand for the balance. The insurance company will not pay the 20% balance after each visit. We are also aware that insurance companies have advised our patients that they will pay the 20% balance only to later state that they will only pay a portion of the balance, due to some claimed issue by the insurer. This is one of the reasons we sometimes recommend that you seek counsel who can best protect you.

How do I handle my medical bills?

While you are focusing on recovering and getting better, our office will handle the processing of your medical bills. We will submit the bills to your PIP insurer, and your insurer will directly reimburse our office for the treatment. As a reminder, we are not fully reimbursed for the treatment since PIP only pays 80% of the bill.

INFORMED CONSENT FOR CHIROPRACTIC TREATMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by Dr. Son Nguyen and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for Dr. Son Nguyen, including those working at the clinic or office listed below or any other office or clinic.

I will have/had an opportunity to discuss with Dr. Son Nguyen and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to, fractures, disk injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests. I understand that I have the right to seek other healthcare professionals for my condition and treatment.

Patient's Name: _____
Signature of Patient: _____ Date: _____

NON-PREGNANCY VERIFICATION

This is to confirm that I have been advised by the Doctor that x-rays can be hazardous to an unborn child. At this time, to the best of my knowledge, I am not pregnant, and I consent to chiropractic treatment and radiographic pictures.

Patient's Name: _____
Signature of Patient: _____ Date: _____

CONSENT TO TREAT A MINOR OR PHYSICALLY OR LEGALLY INCAPACITATED PERSON

I hereby authorize the Doctor to examine and treat as deemed necessary, my _____ (indicate your relationship to the child).

Patient's Name: _____
Signature of Patient: _____ Date: _____
Signature of Representative: _____
Relationship or Authority of Patient's Representative: _____

Dr. Son Nguyen, PLLC

(Seminole Chiropractic Medicine)
7560 Red Bug Lake Road, Suite 1080
Oviedo, FL 32765
407-977-2240

Dear Patient,

Dr. Son Nguyen is requesting a Letter of Protection for your outstanding balance.

This letter would authorize your attorney, in the event of settlement, to pay the entire outstanding balance or a negotiated amount, with Dr. Son Nguyen prior to your receiving any settlement proceeds.

In the event that a settlement is not reached, for whatever reason, the bill would be submitted to your medical insurance company and you will be responsible for the regular co-pay and any "patient responsibility" amount indicated by your medical provider.

Please be advised that we may or may not be willing to make an appointment or treat you should you decide not to follow the prescribed treatment of care, and without the letter of protection protecting our future outstanding balance.

By signing below you authorize your attorney to communicate with Dr. Son Nguyen, PLLC, regarding your injuries and available insurance monies in the case should we request the same.

_____ I **DO** authorize _____ to provide a letter of protection to the above indicated health care provider.

_____ I **DO NOT** authorize _____ to provide a letter of protection to the above indicated health care provider.

Print Name: _____ Signature: _____

PROVIDER'S LIEN

Patient's Name: _____

First Date of Treatment: _____

PROVIDER INFORMATION

Dr. Son Nguyen, PLLC
7560 Red Bug Lake Road, Suite 1080
Oviedo, FL 32765
Ph: 407-977-2240
Fax: 407-977-2446

ATTORNEY INFORMATION

Name: _____
Address: _____
_____

Phone: _____
Fax: _____

I hereby authorize and direct you, my attorney, pursuant to Florida Statute F>S. 627.422 to pay directly to the above named provider such sums as may be due and owing them for professional services rendered to me by them. I also direct you to withhold any such sums or balance thereof that may be due to the above named provider from any settlement, judgment, payment, or verdict which may be paid to you, my attorney or me as the result of the injuries for which I have been treated.

I fully understand that I am directly and fully responsible to the above named provider for all bills submitted by them for services rendered to me by them. And that this agreement is made solely as additional protection for any balance owed to them. I further understand that such payment is not contingent on any settlement, judgment, payment or verdict by which I may re over said payment.

I hereby acknowledge that this Provider's Lien is irrevocable and may not be terminated, ignored or subjectively complied to without the expressed written consent of the Provider.

The undersigned hereby acknowledges that I have read and understand the above information. I am signing without any threat of coercion, force or against my will. I am signing freely, voluntarily and with my full consent.

Patient Signature: _____ Date: _____

DR. SON NGUYEN, PLLC
7560 RED BUG LAKE ROAD, SUITE 1080, OVIEDO, FL 32765
407-977-2240 ** 407-977-2446 (Fax)

AUTHORIZATION TO OBTAIN, RELEASE OR REVIEW PROTECTED HEALTH INFORMATION

Patient Name: _____Last 4 digits of Social Security #: _____
Address: _____
Date of Birth: _____ Date of Service: _____ Phone #: _____
Identification Shown: _____
I hereby authorize _____to use and disclose to:
Seminole Chiropractic Medicine / Dr. Son Nguyen, DC , of the above listed address and phone number to fax or mail the following information contained in my medical record regarding hospitalization and or care and treatment in your office:

____Complete Record ____All Diagnostic Test Results ____Pathology Report(s)
____ Abstract of Record ____Consultation ____ Lab Only
____Therapy Records ____Radiology / MRI ____ Progress Note(s)
____Operative Report ____Other (please specify) _____

The purpose for the release of information at the request of the individual is:

____Insurance ____Legal Action ____Continued Treatment
____Personal Use ____Patient Communication (Behavioral Health)
____Family and Medical Leave Act/Disability Other (please specify) _____
This authorization will expire on the following date, event or condition: _____
I understand that this authorization extends to all or any part of the records designated above, which may include psychiatric information, and/or genetic counseling/testing, and/or alcohol/drug abuse and/or AIDS (Acquired Immunodeficiency Syndrome), and/or may include the result of an HIV test or the fact that an HIV test was performed. I expressly consent to the release of information as designated above unless initialed below or otherwise required by law.

MAY NOT include information related to (please initial):

____HIV/AIDS ____Mental Health ____Drug and/or Alcohol Abuse ____Genetic Counseling/Testing information

If I fail to specify an expiration event or condition, the authorization will expire in one year. I understand that this authorization is revocable upon written notice to the office where the original authorization is retained, except to the extent that action has already been taken on this authorization. I understand that my protected health information that is used or disclosed under this authorization may be subject to re-disclosure by the recipient and the privacy of my protected health information may no longer be protected by law. I further understand that Seminole Chiropractic Medicine / Dr. Son Nguyen, DC my not condition the provision of treatment, payment, enrollment in the health plan, or eligibility for benefits on the provision of this authorization. I understand that I will receive a signed copy of this form.

Patient Signature: _____ Date: _____