BEST SURGERY & THERAPIES

REGISTRATION FORMS

PERSONAL INFORMATION

First name: _____ MI: _____ Last name: _____ Date: _____

Date of birth: _____ Age: _____ Social Security#: _____

Current mailing address: _____ Email: _____ Home phone#: _____ Cellphone#: _____

City: _____ State: _____ ZIP code: _____

Sex: ☐ Male ☐ Female ☐ Intersex Marital status: ☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Widowed

If you are married or otherwise partnered, what is the person's name?

_____

Race:

☐ Black/African-American ☐ White ☐ Native Hawaiian/Pacific Islander ☐ American Indian ☐ Hispanic or Latino

☐ Decline to answer ☐ Asian ☐ Alaska Native ☐ Other: _____

Ethnicity:

☐ Not Hispanic or Latino ☐ Decline to answer ☐ Hispanic or Latino ☐ Unknown

Preferred language:

☐ English ☐ Spanish ☐ Decline to answer ☐ Other

INSURANCE INFORMATION

We MUST obtain this information to coordinate with your insurance company and provide the best care.

Primary insurance:

_____

Secondary insurance:

_____

Do you have an open personal injury case? ☐ Yes ☐ No If yes, lawyers name and phone number.

Lawyers Name: _____ Phone Number: _____

Do you have an open workers compensation claim?

☐ Yes

If yes, claim# _____

☐ No

SIGNATURE NEEDED

Patient/guardian signature: _____ Printed name: _____ Date: _____

ACTIVITY/LIFESTYLE MODIFICATIONS

What is your primary concern?

How long have you had this problem, when did it start?

What additional treatment options have you received for this problem?

Please list any restrictions you have:

Are you able to perform household chores? ☐ Yes ☐ No

Are you able to stand for long periods of time? ☐ Yes ☐ No

Are you able to sit for long periods of time? ☐ Yes ☐ No

Does your pain interfere with your daily job functions? ☐ Yes ☐ No

If yes, please explain:

Primary physician name: Phone#:

Specialist name: Type of physician: Phone #:

Please list all medications including vitamins, supplements, etc

Please clearly list below any medications you take including vitamins, supplements, etc.

Name and dose	Daily dosage	Last date taken	Reason for taking
Ex: Med name 20mg	Twice a day	4-1-2017	Cholesterol

Patient Pharmacy

Name: Phone:

Address: City: State: ZIP code:

MEDICAL HISTORY

Please indicate if you have any of the following and explain below:

- ☐ Angina
- ☐ Atrial Fibrillation
- ☐ Headaches/migraines
- ☐ Pacemaker/defibrillator
- ☐ Arthritis
- ☐ Heart attack
- ☐ Prior infections
- ☐ Asthma
- ☐ Heart murmur
- ☐ Pulmonary (lung) disease
- ☐ Bleeding disorders
- ☐ Heart rhythm abnormalities
- ☐ Rheumatic fever
- ☐ Cancer
- ☐ Hepatitis
- ☐ Seizures
- ☐ Cholesterol disease
- ☐ High blood pressure
- ☐ Skin disorders
- ☐ Congestive heart failure (COPD)
- ☐ HIV/AIDS
- ☐ Sleep apnea
- ☐ Heart disease
- ☐ Kidney/bladder disease
- ☐ Strokes/TIA
- ☐ Depression/anxiety
- ☐ Liver disease
- ☐ Tremors
- ☐ Diabetes
- ☐ MRSA
- ☐ Thyroid disease
- ☐ Fibromyalgia
- ☐ Multiple sclerosis
- ☐ Tuberculosis
- ☐ Gastrointestinal disease
- ☐ Nervous system disease
- ☐ Vascular disease
- ☐ GERO
- ☐ Osteoporosis
- ☐ Anesthesia Complications
- ☐ Other

ALLERGIES

Please clearly list any allergies, medical or nonmedical.

Type of allergy	Reaction	Severity (please check one)			
		Mild	Moderate	Severe	Life Threatening
Example: Penicillin	Hives, itching and rash	☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐

FAMILY HISTORY

Place a check by any family conditions and fill in the rest of the row.

Mother= M, father = F, sibling= S, child = C, maternal grandparent= MG, paternal grandparent= PG

Condition (Please check)	**Which family member?**						**Onset**	**Current family member condition**
	M	**F**	**S**	**C**	**MG**	**PG**		
☐ Arthritis								
☐ Bleeding disorders								
☐ Cancer								
☐ Cholesterol disease								
☐ Coronary heart disease								
☐ Diabetes								
☐ Heart attack								
☐ High blood pressure								
☐ Kidney/bladder disease								
☐ Liver disease								
☐ Neuromuscular disease								
☐ Osteoporosis								
☐ Pulmonary disease								
☐ Stroke								
☐ Thyroid disease								
☐ Anesthesia Complications								

PATIENT HISTORY

Have you ever used any form of nicotine or tobacco? ☐ Yes ☐ No If you answered yes: How many packs per day? _____ How many year used: _____

Do you drink coffee, tea or soda? ☐ Yes ☐ No If you answered yes: How many cups per day? _____ Per week? _____

Do you drink alcohol? ☐ Yes ☐ No If you answered yes: How many drinks per day? _____ Per week? _____

SURGICAL HISTORY

Please indicate if you have had any of the following procedures, conditions or surgery on any of these areas:

☐ Abdominal (stomach)	☐ Gallbladder	☐ Nerve stimulator or pump	☐ Anesthesia complications	☐ Hand
☐ Pacemaker/defibrillator	☐ Angioplasty/stents	☐ Hemorrhoids	☐ Prostate	☐ Appendix
☐ Hernia	☐ Shoulder	☐ Hip	☐ Breast	☐ History of dura leak
☐ Thyroid	☐ Chest/lung	☐ Knee	☐ Coronary artery bypass	☐ Uterus/ovary
☐ Elbow	☐ Low back/lumbar spine	☐ FooUankle	☐ Neck/cervical spine	☐ Wrist ☐ Other

SIGNATURE NEEDED

Patient/guardian signature: _____ Printed name: _____ Date: _____

PATIENT HISTORY

Please bring all medical records for the treatment of your neck and back pain.

Physical therapy

Provider name: _____ City: _____ State: _____

Percentage of relief: _____ When: _____

If discontinued before 6- 12 weeks, state why: _____

Pain management care

Physician name: _____ City: _____ State: _____

Percentage of relief: _____ When: _____

Injection (steroid, epidural, diagnostic, facet, radio frequency ablation)

Physician name: _____ City: _____ State: _____

Epidural nerve block Percentage of relief: _____

Joint Injection Percentage of relief: _____

Other Percentage of relief: _____

Chiropractic care (traction, inversion, manipulation, decompression)

Physician name: _____ City: _____ State: _____

If discontinued before 6- 12 weeks, state why: _____

Massage ☐ Yes ☐ No When: _____

Acupuncture ☐ Yes ☐ No When: _____

Exercise program ☐ Yes ☐ No When: _____

Heat therapy ☐ Yes ☐ No When: _____

Ice therapy ☐ Yes ☐ No When: _____

BEST SURGERY & THERAPIES

PATIENT AUTHORIZATION TO REQUEST/RELEASE MEDICAL INFORMATION

THIS FORM ALLOWS BEST HEALTH CLINIC TO RELEASE RECORDS ON YOUR BEHALF.

Patient name:

Date of birth: | Last four digits of SSN: | Phone #:

Address: | City: | State: | ZIP code:

I hereby authorize BEST Health Clinic its affiliates, medical staff, employees and their representatives to release my protected health information in the manner listed below, and to the following:

Choose only one method to send by:

☐ Mail ☐ Fax ☐ Secure email (records will expire after 60 days if left unopened)

RECORDS REQUESTED:

☐ All records (notes, labs, reports, images) ☐ Disc of ALL images (only)

☐ Specific item only (please list):

If images are requested, a mailing address must be provided or records will not be sent.

Send to:

☐ Send to the address listed above ☐ Send to a different address listed below

Name:

Address: | City: | State: | ZIP code:

Email: | Phone #: | Fax #:

There may be a charge for copies of records, in accordance with federal and state laws.

This authorization is effective one (1) year from the date signed below, except when revocation or modification is requested in writing by the patient, legal guardian, power of attorney or health care surrogate accompanied by the applicable documentation. I understand that I have the right to revoke or modify this authorization at any time. I understand that if I revoke or modify this authorization, I must do so in writing and present my written request to the Medical Records Team. Additionally, I acknowledge my responsibility to confirm receipt by BEST of such revocation or modification; such confirmation is required via certified mail. I understand that the revocation or modification will not apply to information that has already been released in response to this authorization. I understand that once the information is disclosed, it may be redisclosed by the recipient and the information may not be protected under federal privacy laws or regulations.

I understand BEST will not condition treatment or payment based on this authorization or revocation of authorization unless otherwise allowed by law. A copy of this authorization may be utilized with the same effectiveness as an original. I am entitled to receive a copy of this authorization.

Signature of patient/guardian/power of attorney/health care surrogate | Date

Printed name | Relationship to patient

Use one form for each person from whom you wish BEST to send your health information. You may copy this form as often as needed.

AUTHORIZATION TO VERBALLY DISCUSS HEALTH INFORMATION

You may choose to give us permission to discuss information about you with family, friends and others you designate who are involved in your care or concerned about your health status and may ask about your condition or need information when you are not present. You can tell us who we may talk with about your medical care, including your appointment and scheduling information, lab and test results, treatment information and billing information. This does not mean that the person will have access to your medical records. Complete this form to let us know to whom we may speak about your information.

HERE ARE SOME EXAMPLES OF WHEN IT MIGHT BE USEFUL FOR YOU TO RELEASE INFORMATION:

- If you want a relative or friend to help you understand medical treatment instructions
- If a relative or friend is helping with billing instructions
- If a relative or friend calls to verify your appointment time
- If a relative or friend comes in and asks if you are here and in or out of the procedure room

Authorization to Verbally Discuss Health Information

Patient name: _____ Date of birth: _____

I hereby authorize BEST Centers of America - Ohio LLC to discuss and disclose specific health information as selected below to the following entity/individual.

Name: _____ Relationship: _____ Phone number: _____

Address: _____ City: _____ State: _____ ZIP: _____

Name: _____ Relationship: _____ Phone number: _____

Address: _____ City: _____ State: _____ ZIP: _____

DESCRIPTION OF SPECIFIC INFORMATION TO BE DISCUSSED AND DISCLOSED (PLEASE CHECK ALL THAT APPLY):

- ☐ All health and treatment information
- ☐ Appointment date/times
- ☐ Lab/test results
- ☐ Billing/payment information
- ☐ Other: _____
- ☐ Medical information (including symptoms, diagnosis, pregnancy, medication, and treatment plan)
- ☐ Procedure status/location (whether I'm waiting to go into procedure or have been released)

I understand the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

EFFECTIVE DATES FOR THIS AUTHORIZATION

Authorization automatically expires one (1) year from the date signed below. You have the right to revoke this authorization before the year has passed.

BY SIGNING, I UNDERSTAND THAT:

- I may inspect or copy the protected health information to be used or disclosed.
- I may notify the medical practice in writing if I would like to revoke this authorization.
- This authorization is giving the BEST Centers of America - Ohio LLC permission to discuss my health information as selected above with entity/individual listed above.
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act (HIPAA).
- I may refuse to sign this authorization, and that this authorization is not a condition of treatment or payment.

PATIENT/LEGAL REPRESENTATIVE

Signature _____ Date _____

Printed name _____

BEST

AUTHORIZATION OF PRIVACY INFORMATION

AUTHORIZATION TO RELEASE OR USE INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS

I hereby authorize the release or use of my individually identifiable health information (protected health information or PHI) and medical information by BEST Centers of America - Ohio LLC in order to carry out treatment, payment, or health care operations.

I acknowledge that I have been provided with a copy of BEST Centers of America - Ohio LLC Privacy & Security Practices Notice to review a complete description of privacy practices and the potential release and use of your protected health information, and that it is right to review such Notice prior to signing this Consent Form.

I acknowledge that BEST Centers of America - Ohio LLC reserves the right to change the terms of its privacy practices at any time and that in the event the terms of BEST Centers of America - Ohio LLC Privacy & Security Practices Notice change, you I will be notified as required by prevailing laws and may also request a current copy of our the Notice by requesting a copy from our the BEST clinic's front desk staff at any time.

I understand that I retain the right to request to change my consent to the below disclosures, and that I must do so in writing. I understand I may request that BEST Centers of America - Ohio LLC further restrict how your my protected health information is released or used to carry out care, payment, or heath care operations.

Please Note: BEST Centers of America - Ohio LLC encourages you to read the privacy practices and standards of your email and phone provider(s) as their privacy policy may differ from those of BEST Centers of America - Ohio LLC.

IN CONSIDERATION OF ABOVE, I AGREE AND CONSENT TO RELEASING INFORMATION TO ME IN THE FOLLOWING MANNERS:

VIA EMAIL	CONTACT INFO	DATE
☐ Ok to send PHI to email address	_____	_____
☐ Ok to send PHI to alternate email	_____	_____
VIA HOME TELEPHONE		
☐ Ok to leave detailed message	_____	_____
☐ Leave call back number only	_____	_____
VIA CELL PHONE		
☐ Ok to leave detailed message	_____	_____
☐ Leave call back number only	_____	_____
VIA ALTERNATE COMMUNICATION METHOD		
☐ Ok to leave detailed message	_____	_____
☐ Leave call back number only	_____	_____
☐ Ok to FAX PHI to:_____	_____	_____

BY SIGNING BELOW, I ATTEST THAT THE INFORMATION PROVIDED ABOVE IS TRUE AND ACCURATE.

SIGNATURE: _____ DATE: _____

EMERGENCY CONTACT INFORMATION

I authorize BEST Surgery & Therapies to VERBALLY discuss my selected information with the following people, including translation from/to another language:

Contact name 1: _____ Relationship: _____ Home phone#: _____ Cellphone#: _____

Street address: _____ City: _____ State: _____ ZIP code: _____

Contact name 1: _____ Relationship: _____ Home phone#: _____ Cellphone#: _____

Street address: _____ City: _____ State: _____ ZIP code: _____

By selecting the following options and signing, I authorize BEST Surgery & Therapies to discuss the following information with my emergency contact(s)

☐ My appointment information ☐ My billing and payment information ☐ My lab/test results ☐ My location within the facility

☐ My medical information (including symptoms, diagnosis, medication and treatment)

Cancellation of this authorization must be submitted in writing.

PATIENT FRAUD/SOLICITATION DISCLOSURE

Name of Patient:

Insurance Fraud at any BEST Location will not be tolerated. It is a crime in for any person to offer to pay, and any patient to receive a commission, bonus, rebate, kickback, or bribe, directly or indirectly, in cash or in kind to induce a patient to be referred to or receive treatment at a health care facility.

It is also a Felony and insurance fraud for a patient to present any statements pertaining to treatment that will result in a claim for insurance benefits that contain false, incomplete, misleading information or documents.

In consideration of and as an express condition to the Medical Provider agreeing to treat to you- I, the undersigned patient, under the penalty of perjury, hereby acknowledge the following to be true and correct:

1. That I am seeking treatment as a direct result of injuries that I have sustained.
2. That I have not been offered or otherwise promised a commission, bonus, rebate, kickback, or bribe, cash or payment of any kind, directly or indirectly, from anyone as an inducement to seek treatment at BEST. In addition, I have not received any promises at this location that applicable deductibles and co-payments that I may be financially responsible for will be waived in the future as an inducement to receive treatment.
3. That all statements concerning my involvement in a motor vehicle accident, the injures that I have sustained, and any supporting documentation that I have provided in connection with the treatment that I am seeking are true and correct to the best of my knowledge and belief.

Patient's Signature

Date

Witness Signature

Date

APPLICATION FOR "NO FAULT" BENEFITS (1 OF 2)

THIS FORM ONLY APPLIES TO RESIDENTS OF THE FOLLOWING STATES- FLA, MI, NJ, NY, PA, HI, KY, MA, MN, ND and UT

Name of Insurance Company _____ Date _____

Our Policy Holder _____ Date of Accident _____ File # _____

TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE PERSONAL INJURY PROTECTION LAW, PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURANCE COMPANY. MAKES A STATEMENT OF CLAIM CONTAINING ANY FALSE INCOMPLETE OR MISLEADING IN- FORMATION, IS GUILTY OF A FELONY OF THE THIRD DEGREE.

Complete Address: _____

Permanent Address, if different: _____

Date of Birth _____ Social Security No. _____ How long have you lived in your State? _____

Date and Time of Accident: _____ Place of Accident (Street, City, ST) _____

Brief description of accident and vehicles involved:

☐ Rear end ☐ Side Impact ☐ Head on ☐ Slip and Fall

What type of car were you in at time of accident _____

As a result of this accident, were you injured? ☐ Yes ☐ No If Yes, complete the rest of this form. If no, sign below.

SIGNATURE _____ **DATE** _____

Describe your injury below

_____

_____

_____

_____

_____

Were you treated by a doctor? ☐ Yes ☐ No

Doctor's name and address: _____

If you were treated in a hospital, were you: ☐ In-patient ☐ Outpatient

Hospital Name and Address _____

Will you have more medical expenses? ☐ Yes ☐ No At the time of the accident, were you in the course of your employment? ☐ Yes ☐ No

APPLICATION FOR "NO FAULT" BENEFITS (2 OF 2)

List names and addresses of your present employer(s) and give your occupation and dates of employment.

EMPLOYER AND ADDRESS	YOUR OCCUPATION	FROM	TO

As a result of your injury have you had any other expenses? ☐ Yes ☐ No If Yes, explain below.

TO BE ELIGIBLE FOR BENEFITS, COMPLETE AND SIGN THIS APPLICATION, SIGN AND ATTACH AUTHORIZATION(S) and RETURN PROMPTLY WITH ANY MEDICAL BILLS RECEIVED TO DATE.

Patient's Signature **Date**

LETTER OF PROTECTION

Patient Name: _____ Accident Date: _____ Initial Visit Date: _____

Accident Location State (check one): ☐ Ohio ☐ Kentucky ☐ Indiana ☐ Other: _____

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

Consideration. In consideration of the medical treatment provided, and the medical provider's willingness to wait until the conclusion of my legal case and finalization of applicable insurance obligations to pay for said medical treatment, I hereby grant a direct lien on any and all funds I may recover in any legal action or proceeding related to the above accident date.

Protection of Outstanding Charges. In the event that a financial recovery is made on my behalf by any person, attorney or other entity, in connection with any legal action or other proceeding related to the above accident date, I hereby direct and instruct my present, and any future attorney(s) representing me (including myself in a pro-se capacity) to withhold from said recovery, funds sufficient to pay the full outstanding balance of any bill(s) owed to the above-named Medical Provider, for treatment provided in connection with same. I understand that my Medical Provider has agreed to work with my Attorney, and as part of my settlement or verdict, to the extent allowed by applicable law, depending on the State in which the Accident occurred, may accept a reduced amount, or waive my outstanding balance altogether. I hereby irrevocably instruct my present and/or future attorney(s) not to disburse any settlement funds for any reason, including but not limited to attorney's fees, costs, and other medical liens, until my Medical Provider has been contacted and my financial responsibility obligations are resolved.

Patient Responsibility. I understand that it is my responsibility to advise each attorney representing me of the existence of this agreement. I further direct my present attorney(s) and any future attorney(s) to advise the Medical Provider, as soon as possible, about any funds that are recovered in connection with my case. I understand that under certain circumstances, I may not obtain any financial recovery and if that is the case, I am responsible for the payment of the Medical Provider's outstanding balance(s), and in such event, the remaining amounts are to be paid by the Patient.

Payment. All payments made pursuant to this agreement shall be made to:
BEST Surgery & Therapies
644 Eden Park Dr.
Cincinnati OH 45208

Enforcement. I further agree to be fully responsible for reasonable attorney's fees and costs, if any, that have been accrued by the Medical Provider in the pursuit of payment of my account. Also, that in the event of my failure to comply with the payment agreement, I understand the amount of balance due will be subject to a one percent (1%) per month service charge, or the maximum allowed by law.

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, however it is recommended that the Patient submit any forms to their attorney for review.

The parties agree that no party shall be considered the drafting party to this contract.

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

Attorney Signature: _____ Date: _____ RETURN VIA FAX: _____

-FOR KENTUCKY RESIDENTS ONLY-

No-Fault (PIP Coverage) Information

To the best of your (the patient and/or patients guardians) knowledge, what Personal Injury Protection (PIP) do you, or the owner of any vehicle in which you were a passenger on the accident date, have?

☐ Basic Coverage ☐ Extra Coverage ☐ No Coverage ☐ I do not know

-FOR OHIO AND INDIANA RESIDENTS ONLY-

Medical Payment Insurance (MedPay) Information

To the best of your (the patient and/or patients guardians) knowledge, do you, or the owner of any vehicle in which you were a passenger on the accident date, have Medical Payments Insurance (MedPay) coverage?

☐ Yes ☐ No ☐ I do not know If yes, what is the amount of coverage? $ _____

ASSIGNMENT OF INSURANCE BENEFITS & RELEASE OF INFORMATION

The undersigned patient/insured, _____ **(print name of patient/insured or parent/ guardian if patient is a minor)**, knowingly, voluntarily and intentionally assigns the benefits of insurance or Medical Payments policy of insurance or the responsible insurer to the above described Medical Provider for any and all services rendered to the undersigned patient/insured. It is the intent of this Medical Provider to accept this assignment of benefits. The undersigned patient/insured directs the insurer to pay the Medical Provider directly (i.e. payments to be mailed and made payable to the medical provider only and not to me- however, if any payment is sent to me, I hereby agree to immediately forward or endorse such payments directly to the Medical Provider) for the services rendered. The insurer is further directed by the Medical Provider and the patient to not issue any checks or drafts in partial settlement of a claim that contain or are accompanied by language releasing the insurer or its insured from liability unless there has been a prior written settlement agreed to by the Medical Provider and the insurer as to the amount payable under the insurance policy or contract. The Medical Provider hereby objects to any reductions or partial payments made at the discretion of the insurer. Any partial or reduced payment issued by the insurer and deposited by the Medical Provider shall be done so under protest and the deposit shall not be deemed a waiver, accord, satisfaction, discharge, settlement or agreement by the Medical Provider to accept a reduced amount as payment in full. The insurer is hereby placed on notice that this Medical Provider reserves the right to seek the full amount of the bills submitted. In the event the subject medical benefits are disputed for any reason, including but not limited to, medical reasonableness and/or necessity, the undersigned patient/insured hereby instructs the insurer to set aside any amount disputed and not pay the disputed amount to anyone, including myself, or any entity until the dispute is resolved. Any partial payment, regardless of the accompanying language, will be deemed a partial payment and the insurer will be making the payment at its own risk unless there is a prior written settlement agreed to by this provider. I hereby instruct the insurer to notify the above provider immediately of any dispute.

The undersigned patient/insured hereby agrees to pay any deductible or co-payments for services rendered after the policy of insurance exhausts. The undersigned understands this assignment will remain in full force and effect and will NOT be revoked unless the revocation is agreed to by both the Medical Provider AND the undersigned patient or the patient's attorney/representative. This assignment applies to both past and future medical expenditures. A photocopy of this assignment is to be considered as valid as an original.

Release of information: I hereby authorize this medical provider or their representative to furnish my insurance company or companies and my attorney, as listed on the patient information form, with any and all information, that may be contained in my medical records and obtain any insurance coverage information in my file. I also hereby authorize this medical provider to obtain copies of my medical records, including but not limited to, documents, reports, scans, notes, opinions, x-rays, and MRIs, from any other medical provider or any insurance company.

Please read before signing. If you do not completely understand this document, please ask us to explain it to you. If you sign below, we will assume you understand and agree to the terms. If you have an attorney, please ask them to review and explain anything you do not understand.

Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete, or misleading information may be guilty of a felony of the third degree.

Patient's Signature: (If patient is a minor, signature of parent/guardian) Date:

_____ _____