NAPOLI CHIROPRACTIC CENTER

CHECK ONE: □ Health Insurance □ Cash

Today's Date: _____

Name: _____ Age: _____ Date of Birth: _____

Address: _____ City/State: _____ Zip: _____

SS#: _____ Home Phone: _____ Cell Phone: _____ Cell Phone Carrier _____

Work Phone:_____ Email: _____ Marital Status: □ M □ S □ D □ W

Sex: Male: ___ Female: ___ Number of Children: ____ Email Address: _____

Spouse's Name: _____ Your Occupation: _____

Employer: _____ Work Number: _____

Emergency Contact: _____ Relation: _____ Contact Number: _____

Primary Care Physician: _____ Telephone Number: _____

Explain the Main Reason for your visit today (Describe Pain /Location): _____

_____

_____

_____

Start Date of current problem: _____

Have you seen another physician for this condition? □ Yes □ No if yes, Physician Name: _____

Is this condition due to: Auto Accident: _____ Work Injury: _____ Sports Injury: _____ Unknown: _____

Please Explain: _____

_____

Is it possible you are pregnant? □ Yes □ No If yes, when are you due _____

Were you referred to us by anyone? If so who: _____

Patient Health History

Please check if you have ever had any of the disease(s) and or condition(s) listed below:

____ Disc Herniation ____ Heart Attack ____ Alcohol/Drug Abuse _____ HIV+/AIDS _____

____ Spinal Surgery ____ Congenital Heart Defect ____ Heart Surgery/Pacemaker _____ Heart Murmur

____ Neurological Surgery ____ Frequent Neck Pain ____ Low Back Problems ____ Artificial Bones

____ Arthritis ____Severe Frequent Headaches _____ Anemia ____ Diabetes ____ Artificial Valves

____ Emphysema/Glaucoma ____ Asthma/Difficulty Breathing _____ Sinus Problems ____ Ulcers/Colitis

____ High/Low Blood Pressure ____ Kidney Problems _____ Psychiatric Problems ____ Venereal Disease

____ Shingles _____ Hepatitis _____ Fainting/Seizures/Epilepsy ____ Chemotherapy ____ Cancer

____ Rheumatic Fever ____ Tuberculosis

Complete Applicable Section Below

Health Insurance Information

MEDICAL ONLY

Primary Insurance Company: _____ Policy # _____ Group # _____
Insured Name: _____ SS# _____ Date of Birth: _____ Employer: _____
Insured Address: _____ City/State: _____ Zip: _____
Secondary Insurance Company: _____ Policy # _____ Group # _____
Insured Name: _____ SS# _____ Date of Birth: _____ Employer: _____
Insured Address: _____ City/State: _____ Zip: _____
Do you have a deductible? [] Yes [] No

Auto Accident Insurance Information

AUTO ACCIDENT ONLY

Date of Accident: _____ Time of Accident: _____ Attorney: [] Yes [] No
If Yes, Attorney Name: _____ Attorney Phone: _____ Fax: _____
Insurance Company: _____ Policy # _____ Claim # _____
Adjuster's Name: _____ Adjuster's Phone # _____
Do you have a deductible? [] Yes [] No If yes, Deductible amount_____ Has it been met [] Yes [] No
Are you the policy holder?: [] Yes [] No If no, please fill out the next section
Policy holder name: _____ SS# _____ Date of Birth: _____
Employer: _____ Employer TN: _____

ACCOUNT INFORMATION: Please check the payment method you will be using for today's visit
_____ Cash, Check, Credit Card _____ Medical Insurance ____ Auto Insurance

Past Surgical / Hospitalization History

List any prior surgeries and reason for surgery.

_____ Date: _____

_____ Date: _____

_____ Date: _____

List all Medications you are Currently Taking

Medication/Dose

_____

Medication/Dose

_____

Medication/Dose

_____

Medication/Dose

_____

FOR WOMEN: Are you currently on any form of birth control? ☐ Yes ☐ No If yes, What kind: _____

Pharmacy Name: _____ Phone # _____

Pharmacy Address: _____

Current Height: _____ ft _____ inches

Current Weight: _____ lbs

****

Do you smoke? ☐ Yes ☐ No If yes how many packs a week? _____

Do you drink? ☐ Yes ☐ No If yes, number of drinks per week. _____

Please check all Past/Present Medical Problems (Show Month and Year)

- ☐ Abdominal Pain: _____
- ☐ Allergies: _____
- ☐ Anemia: _____
- ☐ Anorexia: _____
- ☐ Arthritis: _____
- ☐ Cancer: _____
- ☐ Chest Pain: _____
- ☐ Diabetes: _____
- ☐ Dizziness: _____
- ☐ Eye Problems: _____
- ☐ Headaches: _____
- ☐ Sinus Problems: _____

Please list any additional medical problems that have not been addressed above. Make sure to include the month and year.

_____

_____

_____

_____

_____

NAPOLI CHIROPRACTIC CENTER

CONSENT FOR TREATMENT AND ASSIGNMENT OF BENEFITS

By signing below I have given my consent for treatment by the attending physician/doctor to provide medical treatment including the administration of injections and superficial procedures.

I understand and agree that insurance policies are an arrangement between my insurance company and myself and payment is my responsibility should my insurance company refuse to pay. Dr. David A. Napoli will prepare and file all claims on my behalf to my insurance company. I hereby authorize all payments to be paid directly to their office for any and all services furnished to me by the physician. I am responsible and expected to pay Dr. David A. Napoli any co-payment, unsatisfied deductible, any non-covered service, termination of coverage along with any amount my insurance carrier deems my responsibility. I further agree that I will be responsible for all collection costs, including legal fees and court costs should my account be referred to an attorney or collection agency for non-payment.

I understand that by signing below I also authorize release of any medical information necessary to pay the claim. This assignment of benefits will remain in effect until revoked by me in writing.

I HAVE READ THE ABOVE INFORMATION AND AGREE TO BE FINANCIALLY RESPONSIBLE FOR SERVICES RENDERED BY DR. DAVID A NAPOLI.

Patient's Signature _____ Date _____

Guardian's Signature _____ Date _____

5700 Stirling Road, Suite 400 • Hollywood, FL 33021 • Office: 954.987.2229 • Fax: 954.987.1585
WWW.NAPOLICHIROPRACTICCENTER.COM

NAPOLI CHIROPRACTIC CENTER

DR. DAVID A. NAPOLI

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among multiple healthcare providers who may involve in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been given a copy to read your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact **Dr. David A. Napoli** at any time at 5700 Stirling Road, Suite 400, Hollywood, FL 33021 to obtain a current copy of the Notice of Privacy Practices. If you request copies of your clinical records, we will charge you $1.00 for each page up to 25 pages and $.25 for each page after 25 and any postage.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my requested restrictions, but you do agree that you are bound to abide by such restrictions.

Patient Name_____
Relationship to Patient_____
Signature _____
Date_____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date_____ **Initials**_____
Reason _____
_____
_____
_____

5700 Stirling Road, Suite 400 • Hollywood, FL 33021 • Office: 954.987.2229 • Fax: 954.987.1585
WWW.NAPOLICHIROPRACTICCENTER.COM

NAPOLI CHIROPRACTIC CENTER

ASSIGNMENT OF INSURANCE BENEFITS, RELEASE, & DEMAND 5/21/05

I, the undersigned patient/insured knowingly, voluntarily and intentionally assign the rights and benefits of my automobile insurance, also known as Personal Injury Protection (hereinafter PIP), and Medical Payments policy of insurance to the above health care provider.
I understand it is the intention of the provider to accept this assignment of benefits in lieu of demanding payment at the time services are rendered and that this document will allow the provider to file suit against an insurance company for payment of the insurance benefits.
I understand the provider may file a lawsuit against my insurer for payment and if the provider's bills are paid or applied to a deductible,
I agree this will serve as a benefit to me and I authorize and request such litigation. This assignment of benefits includes the cost of transportation, medications, supplies, over due interest and any potential claim for common law or statutory bad faith/unfair claims handling. If the insurer disputes the validity of this assignment of benefits then the insurer is instructed to notify the provider in writing within five (5) days of receipt of this document. Failure to inform the provider shall result in a waiver by the insurer to contest the validity of this document. The undersigned directs the insurer to pay the health care provider directly without reductions & without including the patient's name on the check. To the extent, the PIP insurer contends there is a material misrepresentation on the application for insurance resulting in the policy of insurance is declared voided, rescinded, or canceled, I, as the named insured under said policy of insurance, hereby assign the right to receive the premiums paid for my PIP insurance to this provider and to file suit for recovery of the premiums. The insurer is directed to issue such a refund check payable to this provider only. Should the medical bills not exceed the premium refunded, then the provider is directed to mail the patient/named insured a check, which represents the difference between the medical bills and the premiums paid.

The insurer is directed by the provider and the undersigned 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/patient from liability unless there has been a prior written settlement agreed to by the health provider and the insurer as to the amount payable under the insurance policy. The insured and the provider hereby contests and objects to any reductions or partial payments. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by the provider shall be done so under protest, at the risk of the insurer, and the deposit shall not be deemed a waiver, accord, satisfaction, discharge, settlement or agreement by the provider to accept a reduced amount as payment in full. The insurer is hereby placed on notice that this provider reserves the right to seek the full amount of the bills submitted.

If the insurer schedules a defense examination or examination under oath (hereinafter "EUO") the insurer is hereby INSTRUCTED to send a copy of said notification to this provider. The provider or the provider's attorney is expressly authorized to appear at any EUO or IME set by the insurer. The health care provider is not the agent of the insurer or the patient for any purpose.

This assignment applies to both past and future medical expenses and is valid even if undated. A photocopy of this assignment is to be considered as valid as the original. I agree to pay any applicable deductible, co-payments, for services rendered after the policy of insurance exhausts and for any other services unrelated to the automobile accident. The health care provider is given the power of attorney to: endorse my name on any check for services rendered by the above provider; and to request and obtain a copy of any statements or examinations under oath given by patient.

Release of information: I hereby authorize this provider to: furnish an insurer, an insurer's intermediary, the patient's other medical providers, ant the patient's attorney via mail, fax, or email, with any and all information that may be contained in the medical records; to obtain insurance coverage information (declaration sheet & policy of insurance) in writing and telephonically from the insurer; request from any insurer all explanation of benefits (EOBs) for all providers and non-redacted PIP payout sheets; obtain any written and verbal statements the patient or anyone else provided to the insurer; obtain copies of the entire claim file and all medical records, including but not limited to, documents, reports, scans, notes, bills, opinions, X-rays, IMEs, and MRIs, from any other medical provider or any insurer. The provider is permitted to produce my medical records to its attorney in connection with any pending lawsuits. The insurer is directed to keep the patient's medical records from this provider private and confidential and the insurer is not authorized to provide these medical records to anyone without the patients and the provider's prior express written permission.

Demand: Demand is hereby made for the insurer to pay all bills within thirty (30) days without reductions and to mail the latest non-redacted PIP payout sheet and the insurance coverage declaration sheet to the above provider within fifteen (15) days. The insurer is directed to pay the bills in the order they are received. However, if a bill from this provider and a claim from anyone else is received by the insurer on the same day the insurer is directed to not apply this provider's bill to the deductible. If a bill from this provider and claim from anyone else is received by the insurer on the same day then the insurer is directed to pay this provider first before the policy is exhausted. In the event the provider's medical bills are disputed or reduced by the insurer for any reason, or amount, the insurer is to: set aside the entire amount disputed or reduced; escrow the full amount at issue; and not pay the disputed amount to anyone or any entity, including myself, until the dispute is resolved by a Court. Do not exhaust the policy. The insurer is instructed to inform, in writing, the provider of any dispute.

Certification: I certify that: I have read and agree to the above; I have not been solicited or promised anything in exchange for receiving health care; I have not received any promises or guarantees from anyone as to the results that may be obtained by any treatment or service; and I agree the provider's prices for medical services, treatment and supplies are reasonable, usual and customary.

Caution: ***Please read before signing. Please ask to view a copy of our charges. 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 above.***

_____ Patient's name (please print)

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

____/____/____ Date

5700 Stirling Road, Suite 400 • Hollywood, FL 33021 • Office: 954.987.2229 • Fax: 954.987.1585
WWW.NAPOLICHIROPRACTICCENTER.COM

PRO IMAGING, Inc.

ASSIGNMENT OF BENEFITS

PATIENT: _____ **FILE:** [ ]

Pro Imaging is a chiropractic radiology services company that uses a board certified chiropractic radiologist to provide an opinion at the request of the referring DC.

A written radiographic report is forwarded to the referring DC. This is done under the guidance of HIPAA confidentiality guidelines.

1- **I hereby instruct and direct that _____ insurance company or any other collateral source for which I am entitled to benefits with, to pay by check monies owed for medical services rendered by the above payable to the above.**

2- **I further instruct my insurance company to cooperate with the above captioned healthcare provider in resolving all medical billing disputes. Cooperation includes but is not limited to providing the following information:**

- **A- Providing a payout sheet within thirty (30 days upon request.**
- **B- Investigating and paying all claims within thirty (30) days after receipt of billing.**
- **C- Providing said healthcare provider with a prompt and reasonable explanation in writing of the basis in the insurance company, in relation to the facts of the case or applicable law, for denial of a claim or for the offer of a compromise settlement or payment or delay in payment past thirty (30) days from receipt of this notice.**
- **D- Informing the healthcare provider promptly as to what additional information is necessary for processing of this claim within thirty (30) days from receipt of this notice.**
- **E- Returning all phone calls from the provider promptly.**

These payment instructions are for benefits payable to me under my current insurance policy as payment toward the total charges for professional services rendered.
I fully understand that said healthcare services are being provided to me in consideration for me providing these instructions to my insurance company and for me granting this irrevocable assignment of benefits.

By executing this document, I am placing my insurance company on notice that this is a direct assignment of benefits pursuant to Florida law. As the insured or beneficiary of said insurance policy, I am irrevocably assigning whatever rights I have under my insurance policy and under Florida law to this healthcare provider.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my care to any insurance company, adjuster, or attorney involved in this care.

I authorize Pro Imaging, Inc. to initiate a complaint to the Insurance Commissioner for any reason on my behalf.
Patient authorizes the Doctor to deposit checks received on patient's account when made out to the patient.

PRINT YOUR NAME: _____

PATIENT'S SIGNATURE _____ **PARENT (if minor)** _____

Dated at _____ **this** _____ **day of** _____, **20** _____

Radiologist
472 SW FUGE RD.
STUART, FL 34997
(O) 772-600-7827
(F) 772- 600-7824

Billing
9000 SHERIDAN ST. STE. 171
PEMBROKE PINE, FL 33024
(O) 954-862-2269
(F) 954-862-2270