



**OFFICE OF INSURANCE REGULATION**  
*Bureau of Property & Casualty Forms and Rates*

**Standard Disclosure and Acknowledgement Form**  
**Personal Injury Protection - Initial Treatment or Service Provided**

The undersigned insured person (or guardian of such person) affirms:

1. The services set forth below were **actually rendered**. This means that those services have **already been provided**.

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2. I have the right and the **duty to confirm** that the services have already been provided.
3. I was **not solicited** by any person to seek any services from the medical provider of the services described above. This means that no person has initiated contact with me and/or persuaded me to use the doctor or licensed professional, clinic, or medical institution that provided the services.
4. The medical provider has **explained** the services to me for which payment is being claimed.
5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to \$500.

The undersigned licensed medical professional affirms the statement numbered 1 above and also:

- A. I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.
- B. I have **explained** the services rendered to the insured person, or his or her guardian, **sufficiently** for that person to sign this form with informed consent.
- C. The accompanying statement or bill is **properly completed** in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to **truthfully, accurately, and in a substantially complete manner**.
- D. The coding of procedures on the accompanying statement or bill is proper. This means that **no service has been upcoded, unbundled, or constitutes an invalid or not medically necessary diagnostic test** as defined by Section 627.732 (15) and (16), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Insured Person (patient receiving treatment) or Guardian of Insured Person:

Name ( <i>PRINT or TYPE</i> )	Signature	Date
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Licensed Medical Professional Rendering Treatment (*Signature by his or her own hand*):

Name ( <i>PRINT or TYPE</i> )	Signature	Date
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Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of Claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234(1)(b), Florida Statutes.

**Note: The original of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may not be electronically furnished. Failure to furnish this form may result in non-payment of the claim.**



# EMERY NEUROSCIENCE CENTER

Patient Name:		Chart #:	
DOB:		Age:	

## PATIENT INFORMATION

*(Name and Birth Date is only necessary if the information on the header above is not correct):*

Patient's last name:	First:	Middle:	Patient Birth Date:
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Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital status (circle one) Single / Married / Divorced / Separated / Widowed		
Primary Care Physician:	Office Phone: ( )		
Referring Physician:	Office Phone: ( )		
Street address:	Social Security Number:	Home Phone: ( )	
City:	State:	Zip Code:	Cell Phone: ( )
Occupation:	Employer:	Employer Phone: ( )	

## IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home Phone: ( )	Work Phone: ( )
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# EMERY NEUROSCIENCE CENTER

Patient Name:		Chart #:	
DOB:	Age:	Date:	

## Allergies, X-rays, Surgeries

Are you allergic to:						
Medicine			Medicine			Any Foods:
Penicillin	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Antitoxin	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Sulfa Drugs	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Mycins	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Aspirin	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Other Antibiotics	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Codeine	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Adhesive Tape	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Morphine	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Any Other Drugs:			
Tetanus	<input type="checkbox"/> Yes	<input type="checkbox"/> No				

Have you ever had X-rays, MRI scans, CAT scans, or other radiological studies of your:		
	Date:	Findings:
Skull/Head		
Back		
Neck		
Chest		
Extremities		
Other Area(s)		

If you have had surgery to the following areas, please enter date/name of hospital in space provided:		
Focus Operation:	Date:	Hospital
Tonsils		
Ovary(ies)		
Gall Bladder		
Uterus		
Appendix		
Hemorrhoids		
Other Operations		
Have you had a transfusion?		<input type="checkbox"/> Blood <input type="checkbox"/> Plasma
Any other illnesses or hospitalizations:		Date: _____ Hospital: _____



# EMERY NEUROSCIENCE CENTER

Patient Name:		Chart #:	
DOB:		Age:	
		Date:	

## Emotions

<i>Prior to your neurological symptoms, have you felt/or have you been treated for:</i>			
Emotion/Action	Response	Emotion/Action	Response
Depressed		Jumpy	
Irritable		Jittery	
Anxious		Difficulty Concentrating	

<i>Since the onset of your current neurological symptoms, have you felt:</i>			
Emotion/Action	Response	Emotion/Action	Response
Depressed		Jumpy	
Irritable		Jittery	
Anxious		Difficulty Concentrating	

Have you ever been treated for the **same** or **similar** condition for which you are currently seeking treatment?  
Please Explain:

Have you ever been treated by a neurologist before?

Why? :

Have you ever been treated by a neurosurgeon before?

Why? :

Have you ever been treated by a chiropractor before?

Why? :

**Previous** car accidents/work related accidents/slip-and-fall accidents leading to medical treatment, emergency room visit, etc:

<i>Prior to your current complaints</i> have you ever had any of these medical problems?	
Head Injury:	
Neck Injury:	
Middle Back Injury:	
Lower Back Injury:	
Arm/leg Injury:	



# EMERY NEUROSCIENCE CENTER

Patient Name:		Chart #:	
DOB:	Age:	Date:	

Have you ever had:		When?	Since Injury?
Chest Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Angina	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Spitting up blood	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Night Sweats	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Shortness of breath	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
At night	<input type="checkbox"/> Yes <input type="checkbox"/> No		
With exertion	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Palpitations	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Fluttering Heart	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Swelling of hands	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Swelling of feet	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Swelling of ankles	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Extreme tiredness	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Extreme weakness	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Kidney Stones	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Bladder Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood in urine	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Problems w/urination	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Abnormal thirst	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Prostate trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Stomach problems	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Stomach ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Indigestion	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Frequent Gas	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Frequent Belching	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Rectal bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Constipation	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Parasites/Worms	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No



# EMERY NEUROSCIENCE CENTER

Patient Name:		Chart #:	
DOB:	Age:	Date:	

## Review of System

Have you ever had:	When?	Since Injury?
Eye Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Eye Injury	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Impaired Sight	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Ear Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Ear Injury	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Impaired Hearing	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Trouble with nose	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Trouble with sinuses	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Trouble with mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Trouble with throat	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fainting spells	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Convulsions	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Paralysis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Frequent	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Severe	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Enlarged Glands	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Thyroid	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Overactive	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Under active	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Skin Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Frequent	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Chronic	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Appendicitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Liver Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Gall Bladder Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Colitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hemorrhoids	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No



# EMERY NEUROSCIENCE CENTER

Patient Name:		Chart #:	
DOB:	Age:	Date:	

**Social History**

1.	Do you smoke?	<input type="checkbox"/> Cigarettes    PPD <input type="checkbox"/> Cigars <input type="checkbox"/> Pipe <input type="checkbox"/> Tobacco <input type="checkbox"/> Snuff
2.	Do you drink alcohol?	Ounces per week
3.	Do you drink caffeine?	<input type="checkbox"/> Coffee   cups per day <input type="checkbox"/> Tea   Cups per day
4.	Do you exercise?	How? Please Explain:
5.	Do you like your work?	<input type="checkbox"/> Yes <input type="checkbox"/> No      How many hours of work per day?
6.	Do you work?	<input type="checkbox"/> Inside <input type="checkbox"/> Outside
7.	Do you watch TV?	<input type="checkbox"/> Yes <input type="checkbox"/> No      Hours per day
8.	Do you read?	<input type="checkbox"/> Yes <input type="checkbox"/> No      Hours per day
9.	Do you take vacations?	<input type="checkbox"/> Yes <input type="checkbox"/> No      Weeks per year
10.	Have you ever been treated for drug abuse?	<input type="checkbox"/> Yes <input type="checkbox"/> No
11.	Have you ever been treated for alcoholism?	<input type="checkbox"/> Yes <input type="checkbox"/> No
12.	Change in appetite?	<input type="checkbox"/> Yes <input type="checkbox"/> No      Explain:
13.	Change in eating habits?	<input type="checkbox"/> Yes <input type="checkbox"/> No      Explain:
14.	Change in bowel movements?	<input type="checkbox"/> Yes <input type="checkbox"/> No      Explain:
15.	Change in stools?	<input type="checkbox"/> Yes <input type="checkbox"/> No      Explain:
16.	Do you take thyroid medicine?	<input type="checkbox"/> Yes <input type="checkbox"/> No      Explain:
17.	Do you take insulin?	<input type="checkbox"/> Yes <input type="checkbox"/> No      Explain:
18.	Do you take sedatives?	<input type="checkbox"/> Yes <input type="checkbox"/> No      Explain:
19.	Do you take tranquilizers?	<input type="checkbox"/> Yes <input type="checkbox"/> No      Explain:
20.	Do you take sleeping pills?	<input type="checkbox"/> Yes <input type="checkbox"/> No      Explain:
21.	Do you take aspirin?	<input type="checkbox"/> Yes <input type="checkbox"/> No      Explain:
22.	Do you take cortisone?	<input type="checkbox"/> Yes <input type="checkbox"/> No      Explain:
23.	Do you take laxatives?	<input type="checkbox"/> Yes <input type="checkbox"/> No      Explain:
24.	Do you take vitamins?	<input type="checkbox"/> Yes <input type="checkbox"/> No      Explain:
25.	Do you take oral contraceptives?	<input type="checkbox"/> Yes <input type="checkbox"/> No      Explain:
26.	Do you take hormone therapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No      Explain:
Height:	Feet	Inches
Current Weight:	Pounds	
Weight 1 year ago:	Pounds	
Maximum Weight:	Pounds	When:



# EMERY NEUROSCIENCE CENTER

Patient Name:		Chart #:	
DOB:	Age:	Date:	

## Family History

Age (if living):			
Father:	Mother:	Spouse:	Brother(s):
Sister(s):		Children:	

Age of death:			
Father:	Cause of death:	Mother:	Cause of death:
Relationship:	Age at death:	Cause of death	
Other Members Family			
Relationship:	Age at death:	Cause of death	
Relationship:	Age at death:	Cause of death	
Relationship:	Age at death:	Cause of death	

Does anyone in your family currently have or had the following illnesses?		
		Relationship to Patient
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Heart Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No	
High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Nervous Breakdown	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Hay Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Blood Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Hives	<input type="checkbox"/> Yes <input type="checkbox"/> No	
High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	



# EMERY NEUROSCIENCE CENTER

Patient Name:		Chart #:	
DOB:	Age:	Date:	

## Past Medical History

(PLEASE LIST ONLY IF YOU HAD BEFORE YOUR CURRENT COMPLAINTS OR INJURY)

Have you had:	Age:	Date:	Have you had:	Age:	Date:	
Scarlet Fever			Diabetes			
Scarlatina			Hay Fever			
Diphtheria			Asthma			
Rheumatic Fever			Hives			
Pneumonia			Eczema			
Pleurisy			High Blood Pressure			
Fever Fluctuation			Low Blood Pressure			
Arthritis			Frequent Infections			
Rheumatism			Concussion			
Bone Disease			Head Injury			
Joint Disease			Underactive Thyroid			
Neuritis			Overactive Thyroid			
Neuralgia			Food Poisoning			
Bursitis			Tuberculosis			
Sciatica			Heart Attack			
Polio			Other Heart Problems			
Meningitis			Epilepsy			
Gonorrhea			High Cholesterol			
Syphilis			Cancer			
Anemia			Migraine Headaches			
Jaundice			Other Headaches			
Drug Poisoning	Age	Date	Explain			
Broken Bones	Age	Date	Which Bone(s)			
Deliveries	Age	Date	# of Deliveries			
Tested for HIV?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative	T-Cell Count	Viral Load

Other Disease / Medical Problems not listed	Date:



# EMERY NEUROSCIENCE CENTER

Patient Name:		Chart #:	
DOB:	Age:	Date:	

## Neurological Evaluation No-Fault Patient's History

Records Available			
<input type="checkbox"/> Brought by patient	<input type="checkbox"/> Sent by doctor's office	<input type="checkbox"/> Sent by attorney's office	<input type="checkbox"/> Sent by ins. Company.
Patient referred by:			
Work Status			
Place of Employment		Occupation:	
<input type="checkbox"/> Full-time	<input type="checkbox"/> Part-time	<input type="checkbox"/> Light-duty	<input type="checkbox"/> Full-duty
<input type="checkbox"/> Not working Date last Worked:	<input type="checkbox"/> Patient has been seen previously in this office for:		
This    year old	<input type="checkbox"/> Right		<input type="checkbox"/> Left-handed
<input type="checkbox"/> married	<input type="checkbox"/> Single	<input type="checkbox"/> Divorced	<input type="checkbox"/> Separated <input type="checkbox"/> Widowed
<input type="checkbox"/> Asian	<input type="checkbox"/> Hispanic	<input type="checkbox"/> Caucasian	<input type="checkbox"/> Black <input type="checkbox"/> Other:
<input type="checkbox"/> Male		<input type="checkbox"/> Female	
Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Creole <input type="checkbox"/> French <input type="checkbox"/> Italian <input type="checkbox"/> German    Other:			
Seen With:		<input type="checkbox"/> Interpreter <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Patient Was:		<input type="checkbox"/> Driver <input type="checkbox"/> Passenger	<input type="checkbox"/> Was wearing a safety belt <input type="checkbox"/> Was not wearing a safety belt
Description of injuries occurred			
Loss Of Consciousness:		<input type="checkbox"/> Yes <input type="checkbox"/> No	Time:
Patient	<input type="checkbox"/> Remembers events before the accident		<input type="checkbox"/> Remembers events after the accident
Went to:	<input type="checkbox"/> Continued to work <input type="checkbox"/> Home <input type="checkbox"/> Worker's compensation clinic <input type="checkbox"/> Hospital		
Was Used:	<input type="checkbox"/> Back-board	<input type="checkbox"/> Cervical collar	Studies obtained:
Patient:	<input type="checkbox"/> Was released the same day	<input type="checkbox"/> Was Admitted	<input type="checkbox"/> Stayed overnight for    days, treated by Dr.
Medications given at hospital:			
Any other treatment received:			
Other information regarding patient's injuries:			
Patient (for these injuries):	<input type="checkbox"/> Has not been seen previously by other doctors		
	<input type="checkbox"/> Has been treated by:		
	For these complaints:		
Symptoms:	<input type="checkbox"/> With relief		<input type="checkbox"/> Without relief
The patient estimates that the amount of damage done to the vehicle was \$			

The patient has a previous history of accident / injuries:			
<b>1.</b>	Dated:	Injuries:	
	<input type="checkbox"/> Workmen's Compensation	<input type="checkbox"/> Auto Accident	Other:
Diagnosis(es):			
<b>2.</b>	Dated:	Injuries:	
	<input type="checkbox"/> Workmen's Compensation	<input type="checkbox"/> Auto Accident	Other:
Diagnosis(es):			
<b>3.</b>	Dated:	Injuries:	
	<input type="checkbox"/> Workmen's Compensation	<input type="checkbox"/> Auto Accident	Other:
Diagnosis(es):			
Other Notes:			

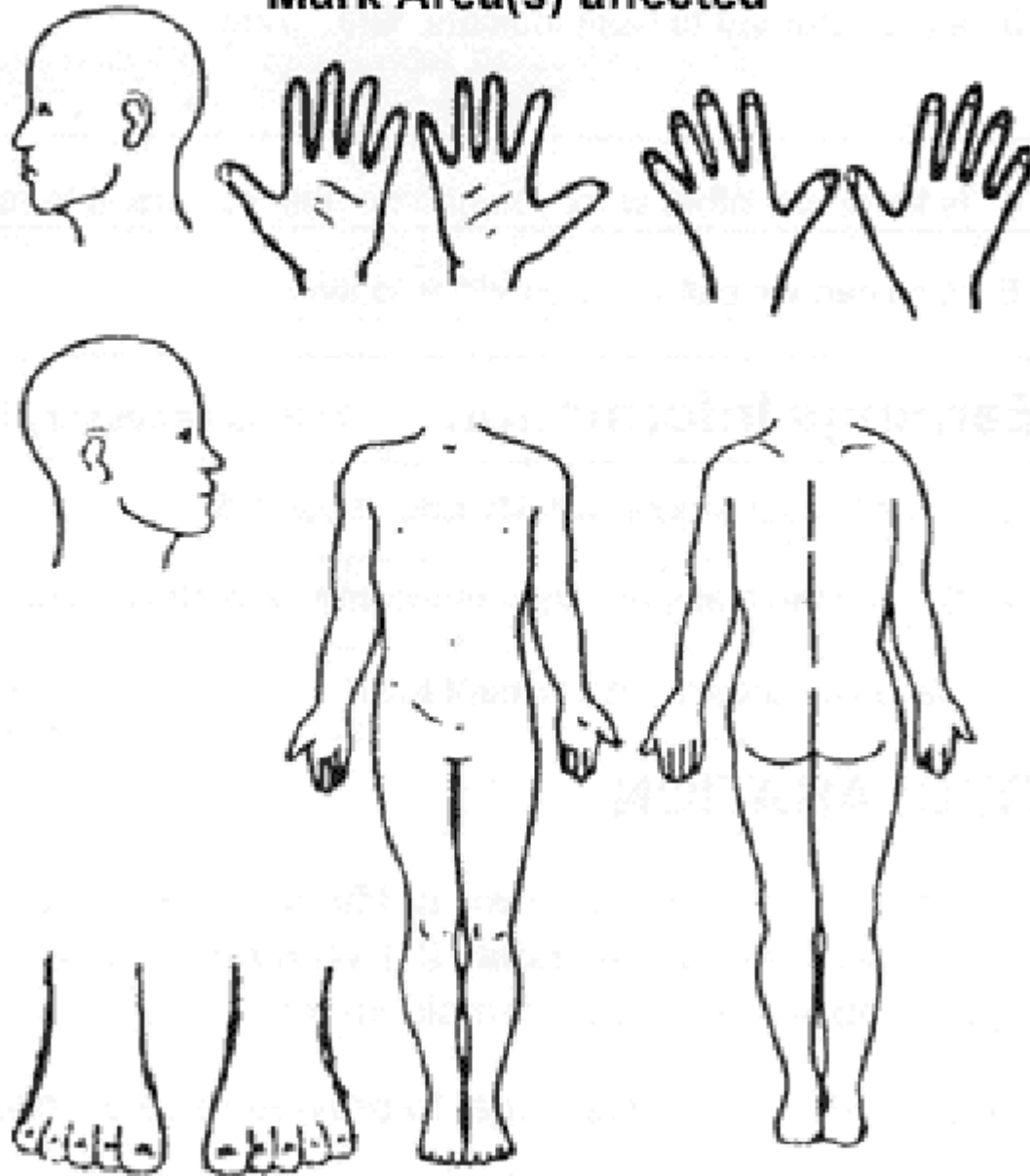




# EMERY NEUROSCIENCE CENTER

Patient Name:				Chart #:	
DOB:		Age:		Date:	

## Mark Area(s) affected





# EMERY NEUROSCIENCE CENTER

Patient Name:		Chart #:	
DOB:		Age:	
		Date:	

## Neurological Symptom Checklist

Please check ***ONLY*** the areas where you are having neurological problems that you would like Dr. Emery to evaluate. A questionnaire for each area you check will then be given to you which you are to bring into the examining room with you so that Dr. Emery will evaluate your specific neurological symptoms.

Are your neurological symptoms a result of an accident of any kind? <input type="checkbox"/> YES <span style="margin-left: 200px;"><input type="checkbox"/> NO</span>
--

<b>If your symptom is a result of an accident then please specify:</b>	
<input type="checkbox"/> Auto Accident	<input type="checkbox"/> Slip and Fall
<input type="checkbox"/> Workmen's Compensation	
<input type="checkbox"/> Other	Describe:

<input type="checkbox"/>	HEADACHES
<input type="checkbox"/>	NECK PAIN
<input type="checkbox"/>	MIDDLE BACK PAIN
<input type="checkbox"/>	LOW BACK PAIN
<input type="checkbox"/>	VISION PROBLEMS
<input type="checkbox"/>	VERTIGO OR DIZZINESS
<input type="checkbox"/>	WALKING PROBLEMS
<input type="checkbox"/>	NUMBNESS OR WEAKNESS OF FACE
<input type="checkbox"/>	NUMBNESS OR WEAKNESS OF ARMS/HANDS
<input type="checkbox"/>	NUMBNESS OR WEAKNESS OF LEGS/FEET
<input type="checkbox"/>	MEMORY DISTURBANCE
<input type="checkbox"/>	DEPRESSION
<input type="checkbox"/>	ANXIETY
<input type="checkbox"/>	TREMOR
<input type="checkbox"/>	SEIZURE OR SPELLS OF LOSS OF CONSCIOUSNESS
<input type="checkbox"/>	SPEECH DIFFICULTY
<input type="checkbox"/>	SLEEP DISTURBANCE



# EMERY NEUROSCIENCE CENTER

Patient Name:		Chart #:	
DOB:		Age:	

## Patient Consent Form

<input type="checkbox"/>	I consent to have my medical records provided to my other active treating physicians.
<input type="checkbox"/>	I consent to have my medical records provided to physicians whom Dr. Emery refers me to for additional treatment or whom Dr. Emery wants a second opinion, e.g., a Professor of Neurology.
<input type="checkbox"/>	I consent to have my medical records provided to Social Security Disability (should the need ever arise.)
<input type="checkbox"/>	I consent to have my medical records provided to any attorney who represents me either in civil litigation (personal injury) or in a Workman's Compensation claim. I understand that in a Workmen's Compensation claim a Defense Attorney (the attorney representing the company you work for) as well as adjustors, nurse case managers, secretaries, or any other personnel working for the Insurance Company have the right to my medical records as well as the right to talk with Dr. Emery <u>without my permission</u> , according to Florida State Law.
<input type="checkbox"/>	I consent to have my medical records provided to any and all of my family members if requested.
<input type="checkbox"/>	I consent to have my medical records provided to my insurance company should they request them for billing purposes or should they request them prior to authorizing a test or tests that Dr. Emery has recommended.
<input type="checkbox"/>	I consent to have my medical records provided to any Law Enforcement agency should a situation arise in which Dr. Emery feels it would be in <u>my</u> best interest to do so, e.g. I get involved in a bad accident and a law enforcement agency wants to know what my Neurological condition is or what medicines I am taking.
<input type="checkbox"/>	I consent to being Video taped if Dr. Emery orders a Video EEG.
<input type="checkbox"/>	None of These options

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



# EMERY NEUROSCIENCE CENTER

Patient Name:		Chart #:	
DOB:		Age:	
		Date:	

## Doctor's Lien

To: Attorney:	
Date of Accident:	

RE: MEDICAL REPORTS AND DOCTOR'S LIEN  
(In this document "doctor" means Dr. Waden E. Emery III, M. D., P. A. and any of it's nurses, staff, agents, or employees.)

I DO HEREBY AUTHORIZE WADEN E. EMERY III, M.D. TO FURNISH YOU, MY ATTORNEY, WITH A FULL REPORT OF HIS EXAMINATION, DIAGNOSIS, TREATMENT, PROGNOSIS, ETC., OF ME IN REGARD TO THE ACCIDENT IN WHICH I WAS INVOLVED.

I HEREBY AUTHORIZE AND DIRECT YOU, MY ATTORNEY, TO PAY DIRECTLY TO SAID DOCTOR SUCH SUMS AS MAY BE DUE AND OWING HIM FOR MEDICAL SERVICES, AND ANY DIAGNOSTIC TESTING OR APPLIANCE DEEMED NECESSARY BY THE DOCTOR AND RENDERED ME BOTH BY REASON OF THIS ACCIDENT AND BY REASON OF ANY OTHER BILLS THAT ARE DUE HIS OFFICE AND TO WITHHOLD SUCH SUMS FROM MY SETTLEMENT, JUDGMENT, OR VERDICT AS MAY BE NECESSARY TO ADEQUATELY PROTECT SAID DOCTOR. I DO HEREBY FURTHER GIVE A LIEN ON MY CASE TO SAID DOCTOR FOR ANY AMOUNTS DUE AND OWING SAID DOCTOR AGAINST ANY AND ALL PROCEEDS OF ANY SETTLEMENT, JUDGMENT OR VERDICT WHICH MAY BE REPAID TO YOU, MY ATTORNEY, OR MYSELF AS THE RESULT OF THE INJURIES FOR WHICH I HAVE BEEN TEASTED OR INJURIES IN CONNECTION THEREWITH.

WITH REGARD TO FUNDS THAT MAY COME INTO THE ATTORNEY'S HANDS, WHETHER JOINTLY PABLE TO THE ATTORNEY OR NOT FROM MEDICAL PAYMENT PROVISIONS, PERSONAL INJURY PROTECTION PROVISIONS, HEALTH INSURANCE PROVISIONS, PAYMENTS BY H.M.O.'S OR LIKE PROVISIONS PAID PURSUANT TO CONTRACT, YOU, THE ATTORNEY, ARE DIRECTED TO EITHER:

1. Pay to the above Doctor that portion of the funds received by you, the attorney, which correspond to the bills submitted to the payer and paid by the payer, or
2. Deliver the draft, check or money order to this doctor, along with the attorney's endorsement, if necessary, so that the doctor can obtain the patient's endorsement. All funds now owed the doctor will be paid back to the patient.

I FULLY UNDERSTAND THAT I AM DIRECTLY AND FULL RESPONSIBLE TO SAID DOCTOR FOR ALL MEDICAL BILLS SUBMITTED BY HIM FOR SERVICES RENDERED ME AND THAT THIS AGREEMENT AND LIEN IS MADE SOLELY FOR SAID DOCTOR'S ADDITIONAL PROTECTION AND IN CONSIDERATION OF HIS AWAITING PAYMENT AND I FURTHER UNDERSTAND THAT SUCH PAYMENT IS NOT CONTINGENT ON ANY SETTLEMENT, JUDGMENT OR VERDICT FROM WHICH I MAY EVENTUALLY PAY SAID FEE. I AGREE TO PAY ATTORNEY'S FEES AND COSTS OF ANY LITIGATION ARISING FROM THE ENFORCEMENT OF COLLECTION OF PAYMENT FOR MEDICAL SERVICES RENDERED ME BY SAID DOCTOR.

PATIENT'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

THE UNDERSIGNED, BEING ATTORNEY OF RECORD FOR THE ABOVE PATIENT, DOES HEREBY AGREE TO OBSERVE ALLTHE TERMS OF THE ABOVE AND AGREE TO WITHHOLD SUCH SUMS FROM ANY SETTLEMENT, JUDGMENT OR VERDICT AS MAY BE NECESSARY TO ADEQUATELY PROTECT SAID ABOVE-NAMED DOCTOR AND PAY SAW DOCTOR'S FEES PRIOR TO DISBURSEMENT OF ANY FUNDS FROM ANY OTHER COSTS OR CLAIMS. IN THE EVENT THE UNDERSIGNED ATTORNEY FAILS TO OBSERVE SAID TERMS, HE OR SHE AND HIS OR HER LAW FIRM WILL BE LIABLE FOR PAYMENT OF ANY BALANCE DUE TO FOR SERVICES RENDERED. FURTHER, I AGREE TO PAY ATTORNEY'S FEES AND COSTS OF ANY LITIGATION ARISING FROM THE ENFORCEM OR COLLECTION OF PAYMENT FOR MEDICAL SERVICES RENDERED BY SAID DOCTOR.

ATTORNEY'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_



# EMERY NEUROSCIENCE CENTER

Patient Name:		Chart #:	
DOB:	Age:	Date:	

**PATIENT CONTRACT**

The undersigned, whether he/she signs as guardian, agent or as patient, agrees that in consideration of the service to be rendered to the patient, he/she hereby individually obligates himself/herself to pay the account of **Waden E. Emery III, M.D., P.A.**. Should the account be referred to an attorney or collection agency, the undersigned shall pay all reasonable attorney's fees and collections expense.

This authorization or photocopy thereof, will authorize the release of full and complete medical records when necessary to authorized physicians, hospitals, medical attendants, attorneys and/or insurance companies.

If the insured's policy prohibits direct payment to the physician, then the insured person/persons hereby instructs and directs the insurance company to make the payment out to the insured person/persons as patient and mail payment to the insured person/persons as follows:

**c/o Waden E. Emery III, M.D., P.A.**  
**5340 North Federal Highway**  
**Suite 205**  
**Lighthouse Point, Florida 33064**

- The undersigned agrees to sign a letter of protection before the initial visit of the patient.
- The undersigned agrees to the approval of any and all attorneys representing the insured/patient at any time to sign a letter of protection. (A letter of protection is not acceptable as a guarantee of payment, it will only protect the bill from "delinquency" until the case is settled.)
- The insured will submit health insurance information along with auto insurance information.
- If the insured's personal injury protection benefits exhaust or have been exhausted for this case the undersigned agrees to allow **Waden E. Emery III, M.D., P.A.** to bill the insured's/patient's health insurance for the remaining balance and/or instead of the auto insurance.
- The undersigned agrees that assignment of each medical claim to any insurance or agent will be taken by **Waden E. Emery III, M.D., P.A.** and the undersigned is responsible for any difference, between the amount charged.
- The undersigned agrees that the total amount for each visit is due and payable at the time of service.
- The undersigned agrees telephone calls to this office requiring medical or medical staff attention will be subject to the appropriate levels of service charge.
- The undersigned agrees that a disruption fee will be charged if, at least, 24 hour notice of cancellation of an appointment is not given.

Waden E. Emery III, M.D., P.A. contracts with numerous insurance companies. In the event Waden E. Emery III M.D., P.A. contracts with your insurance company, Waden E. Emery III, M.D., P.A.'s contract with your insurance company will supersede this contract.

I/We have read, understood and agree to the above.

Print: Patient's Legal Name	Print: Agent or Guardian's Legal Name
<hr style="width: 80%; margin: 0 auto;"/> Patient's Signature	<hr style="width: 80%; margin: 0 auto;"/> Agent or Guardian's Signature
Date	Date