



Dr. Michael Surdis Jr, D.C.  
7900 NW. 33rd Street, #104  
Hollywood, FL 33024  
954-443-2420 • Fax 954-443-8422

## Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form completely as you can. If you have any questions, we will be glad to help you. We look forward to working with you in maintaining your health.

## New Patient Information

### Patient Information:

Today's Date \_\_\_\_\_

Name \_\_\_\_\_

I prefer to be called \_\_\_\_\_

Address \_\_\_\_\_

Sex    Male ☐    Female ☐

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Address \_\_\_\_\_

If Minor, name of parent or guardian \_\_\_\_\_

Who should we contact in case of an emergency? \_\_\_\_\_

Relation \_\_\_\_\_

Address \_\_\_\_\_

Primary Care Physician \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

Have you ever been to a chiropractor before? YES ☐ NO ☐

\_\_\_\_\_ If so, whom?

Person responsible for your account \_\_\_\_\_

Cell Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

Email \_\_\_\_\_

Social Security # \_\_\_\_\_

Date of Birth \_\_\_\_\_

Height \_\_\_\_' \_\_\_\_" Weight \_\_\_\_ lbs.

Marital Status \_\_\_\_\_

No. of Children \_\_\_\_\_

Phone \_\_\_\_\_

Phone \_\_\_\_\_

### Health Insurance Information:

Insurance Company \_\_\_\_\_ Policy Number \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_ Relationship to Insured \_\_\_\_\_

Insured Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

Reason for Visit:

\_\_\_\_\_

Please describe your current pain and its location: \_\_\_\_\_

Have you been treated by a medical physician for this condition? \_\_\_\_\_

Is so, when, and where? \_\_\_\_\_

#### **Authorization**

**I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the doctor to help determine appropriate treatment. If there is any change in my medical status, I will inform the doctor. I authorize my insurance company to pay to the doctor or medical group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.**

**I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges or not paid by insurance.**

**Patient/Legal Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_**

## INITIAL EVALUATION

LASTNAME: \_\_\_\_\_ FIRSTNAME: \_\_\_\_\_ MI: \_\_\_\_\_ Date: \_\_\_\_\_

What brings you into our office? ☒ **Not accident related**

Do you feel your condition is:      ☐ Improving      ☐ Staying the same      ☐ Getting worse

Have you lost time from work?      ☐ Yes      ☐ No

Can you perform physical work activities? ☐ Yes      ☐ No

If no, because of:      ☐ Pain      ☐ Weakness      ☐ Stress

Can you go to sleep without problems?      ☐ Yes      ☐ No

Do you awaken because of pain?      ☐ Yes      ☐ No

Did you have sleep problems before?      ☐ Yes      ☐ No

### Activities of Daily Living

Please select all activities which you are currently experiencing problems:

- |                                    |                                        |                                     |                                     |                                    |                                                 |
|------------------------------------|----------------------------------------|-------------------------------------|-------------------------------------|------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> Seeing    | <input type="checkbox"/> Tasting       | <input type="checkbox"/> Smelling   | <input type="checkbox"/> Eating     | <input type="checkbox"/> Hearing   | <input type="checkbox"/> Insomnia               |
| <input type="checkbox"/> Dressing  | <input type="checkbox"/> Reading       | <input type="checkbox"/> Typing     | <input type="checkbox"/> Writing    | <input type="checkbox"/> Grasping  | <input type="checkbox"/> Using the toilet       |
| <input type="checkbox"/> Standing  | <input type="checkbox"/> Leaning       | <input type="checkbox"/> Walking    | <input type="checkbox"/> Stooping   | <input type="checkbox"/> Squatting | <input type="checkbox"/> Loss of sexual drive   |
| <input type="checkbox"/> Bending   | <input type="checkbox"/> Twisting      | <input type="checkbox"/> Carrying   | <input type="checkbox"/> Lifting    | <input type="checkbox"/> Pushing   | <input type="checkbox"/> Restful sleeping       |
| <input type="checkbox"/> Sitting   | <input type="checkbox"/> Driving       | <input type="checkbox"/> Sports     | <input type="checkbox"/> Exercising | <input type="checkbox"/> Reclining | <input type="checkbox"/> Loss of concentration  |
| <input type="checkbox"/> Irritable | <input type="checkbox"/> Riding in car | <input type="checkbox"/> Air travel | <input type="checkbox"/> Climbing   | <input type="checkbox"/> Pulling   | <input type="checkbox"/> Changes in personality |
| <input type="checkbox"/> Grooming  | <input type="checkbox"/> Pinching      | <input type="checkbox"/> Kneeling   | <input type="checkbox"/> Reaching   | <input type="checkbox"/> Nervous   | <input type="checkbox"/> Tactile feeling        |
| <input type="checkbox"/> Bathing   | <input type="checkbox"/> Holding       |                                     |                                     |                                    |                                                 |

## INITIAL EVALUATION

### Past Medical History

Please select all conditions that you have had or are currently having:

- |                                                     |                                                    |                                                   |                                                       |                                                    |
|-----------------------------------------------------|----------------------------------------------------|---------------------------------------------------|-------------------------------------------------------|----------------------------------------------------|
| <input type="checkbox"/> None                       | <input type="checkbox"/> Other                     | <input type="checkbox"/> Abdominal pain           | <input type="checkbox"/> Weight gain/loss             | <input type="checkbox"/> Angina                    |
| <input type="checkbox"/> Anorexia                   | <input type="checkbox"/> Anxiety                   | <input type="checkbox"/> Aortic aneurysm          | <input type="checkbox"/> Arthritis                    | <input type="checkbox"/> Asthma                    |
| <input type="checkbox"/> Bladder infection          | <input type="checkbox"/> Blood disorder            | <input type="checkbox"/> Breast lumps             | <input type="checkbox"/> Breast soreness              | <input type="checkbox"/> Bronchitis                |
| <input type="checkbox"/> Cancer                     | <input type="checkbox"/> Cardiovascular Dx         | <input type="checkbox"/> Chest pain               | <input type="checkbox"/> Chronic cough                | <input type="checkbox"/> Chronic sinusitis         |
| <input type="checkbox"/> Colitis                    | <input type="checkbox"/> Constipation              | <input type="checkbox"/> Convulsions              | <input type="checkbox"/> COPD                         | <input type="checkbox"/> Depression                |
| <input type="checkbox"/> Dermatitis, Eczema/Rash    | <input type="checkbox"/> Diabetes                  | <input type="checkbox"/> Difficulty in swallowing | <input type="checkbox"/> Dizziness                    | <input type="checkbox"/> Emphysema                 |
| <input type="checkbox"/> Endometriosis              | <input type="checkbox"/> Epilepsy                  | <input type="checkbox"/> Excessive thirst         | <input type="checkbox"/> Fainting                     | <input type="checkbox"/> Frequent urination        |
| <input type="checkbox"/> General fatigue            | <input type="checkbox"/> Gout                      | <input type="checkbox"/> Hand pain                | <input type="checkbox"/> Headache                     | <input type="checkbox"/> Heart attack              |
| <input type="checkbox"/> Heart disease              | <input type="checkbox"/> Heartburn/Indigestion     | <input type="checkbox"/> Hepatitis                | <input type="checkbox"/> High Blood Pressure          | <input type="checkbox"/> High cholesterol          |
| <input type="checkbox"/> High PSA                   | <input type="checkbox"/> High triglycerides        | <input type="checkbox"/> Hypertension             | <input type="checkbox"/> Irregular menstrual flow     | <input type="checkbox"/> Irritable colon           |
| <input type="checkbox"/> Jaw pain                   | <input type="checkbox"/> Kidney disorders          | <input type="checkbox"/> Kidney stones            | <input type="checkbox"/> Liver / Gallbladder Problems | <input type="checkbox"/> Loss of appetite          |
| <input type="checkbox"/> Loss of bladder control    | <input type="checkbox"/> Low back pain             | <input type="checkbox"/> Lung disease             | <input type="checkbox"/> Mental Disease               | <input type="checkbox"/> Mid back pain             |
| <input type="checkbox"/> Muscular in coordination   | <input type="checkbox"/> Neck pain                 | <input type="checkbox"/> Osteoarthritis           | <input type="checkbox"/> Pain in ankle or foot        | <input type="checkbox"/> Pain in lower leg or knee |
| <input type="checkbox"/> Pain in upper arm or elbow | <input type="checkbox"/> Pain in upper leg and hip | <input type="checkbox"/> Painful urination        | <input type="checkbox"/> PMS                          | <input type="checkbox"/> Pneumonia                 |
| <input type="checkbox"/> Profuse menstrual flow     | <input type="checkbox"/> Prostate problems         | <input type="checkbox"/> Rapid heartbeat          | <input type="checkbox"/> Renal disease                | <input type="checkbox"/> Rheumatoid arthritis      |
| <input type="checkbox"/> Scoliosis                  | <input type="checkbox"/> Shoulder pain             | <input type="checkbox"/> Stroke                   | <input type="checkbox"/> Swelling/stiffness joints    | <input type="checkbox"/> Thyroid disease of        |
| <input type="checkbox"/> Tinnitus/ear noises        | <input type="checkbox"/> Tuberculosis              | <input type="checkbox"/> Tumor                    | <input type="checkbox"/> Ulcer                        | <input type="checkbox"/> Visual disturbances       |
| <input type="checkbox"/> Wrist pain                 |                                                    |                                                   |                                                       |                                                    |

## INITIAL EVALUATION

### Family History

Please select all conditions that run in your family:

- |                                                        |                                                       |                                                   |                                                          |                                                       |
|--------------------------------------------------------|-------------------------------------------------------|---------------------------------------------------|----------------------------------------------------------|-------------------------------------------------------|
| <input type="checkbox"/> None                          | <input type="checkbox"/> Other                        | <input type="checkbox"/> Abdominal pain           | <input type="checkbox"/> Weight Gain/loss                | <input type="checkbox"/> Angina                       |
| <input type="checkbox"/> Anorexia                      | <input type="checkbox"/> Anxiety                      | <input type="checkbox"/> Aortic aneurysm          | <input type="checkbox"/> Arthritis                       | <input type="checkbox"/> Asthma                       |
| <input type="checkbox"/> Bladder infection             | <input type="checkbox"/> Blood disorder               | <input type="checkbox"/> Breast lumps             | <input type="checkbox"/> Breast soreness                 | <input type="checkbox"/> Bronchitis                   |
| <input type="checkbox"/> Cancer                        | <input type="checkbox"/> Cardiovascular Dx            | <input type="checkbox"/> Chest pain               | <input type="checkbox"/> Chronic cough                   | <input type="checkbox"/> Chronic Sinusitis            |
| <input type="checkbox"/> Colitis                       | <input type="checkbox"/> Constipation                 | <input type="checkbox"/> Convulsions              | <input type="checkbox"/> COPD                            | <input type="checkbox"/> Depression                   |
| <input type="checkbox"/> Dermatitis,<br>Eczema/Rash    | <input type="checkbox"/> Diabetes                     | <input type="checkbox"/> Difficulty<br>swallowing | <input type="checkbox"/> Dizziness                       | <input type="checkbox"/> Emphysema                    |
| <input type="checkbox"/> Endometriosis                 | <input type="checkbox"/> Epilepsy                     | <input type="checkbox"/> Excessive thirst         | <input type="checkbox"/> Fainting                        | <input type="checkbox"/> Frequent<br>urination        |
| <input type="checkbox"/> General fatigue               | <input type="checkbox"/> Gout                         | <input type="checkbox"/> Hand pain                | <input type="checkbox"/> Headache                        | <input type="checkbox"/> Heart attack                 |
| <input type="checkbox"/> Heart disease                 | <input type="checkbox"/> Heartburn/Indigestion        | <input type="checkbox"/> Hepatitis                | <input type="checkbox"/> HBP                             | <input type="checkbox"/> High cholesterol             |
| <input type="checkbox"/> High PSA                      | <input type="checkbox"/> High triglycerides           | <input type="checkbox"/> Hypertension             | <input type="checkbox"/> Irregular<br>menstrual flow     | <input type="checkbox"/> Irritable colon              |
| <input type="checkbox"/> Jaw pain                      | <input type="checkbox"/> Kidney disorders             | <input type="checkbox"/> Kidney stones            | <input type="checkbox"/> Liver/Gallbladder<br>problems   | <input type="checkbox"/> Loss of appetite             |
| <input type="checkbox"/> Loss of bladder<br>control    | <input type="checkbox"/> Low back pain                | <input type="checkbox"/> Lung disease             | <input type="checkbox"/> Mental disease                  | <input type="checkbox"/> Mid back pain                |
| <input type="checkbox"/> Muscular<br>coordination      | <input type="checkbox"/> Neck pain                    | <input type="checkbox"/> Osteoarthritis           | <input type="checkbox"/> Pain in ankle or<br>foot        | <input type="checkbox"/> Pain in lower leg<br>or knee |
| <input type="checkbox"/> Pain in upper<br>arm or elbow | <input type="checkbox"/> Pain in upper leg<br>and hip | <input type="checkbox"/> Painful urination        | <input type="checkbox"/> PMS                             | <input type="checkbox"/> Pneumonia                    |
| <input type="checkbox"/> Profuse menstrual<br>flow     | <input type="checkbox"/> Prostate problems            | <input type="checkbox"/> Rapid heartbeat          | <input type="checkbox"/> Renal Dx                        | <input type="checkbox"/> Rheumatoid<br>arthritis      |
| <input type="checkbox"/> Scoliosis                     | <input type="checkbox"/> Shoulder pain                | <input type="checkbox"/> Stroke                   | <input type="checkbox"/> Swelling/stiffness<br>of joints | <input type="checkbox"/> Thyroid disease              |

## INITIAL EVALUATION

☐ Tinnitus/  
ear noises

☐ Tuberculosis

☐ Tumor

☐ Ulcer

☐ Visual  
disturbances

☐ Wrist pain

**Surgical History**

Please select all surgeries that you have had in the past.

- |                                                                             |                                                  |                                                 |                                               |                                                 |
|-----------------------------------------------------------------------------|--------------------------------------------------|-------------------------------------------------|-----------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> None                                               | <input type="checkbox"/> Other                   | <input type="checkbox"/> Abdominal Exploration  | <input type="checkbox"/> Abdominoplasty       | <input type="checkbox"/> Abortion               |
| <input type="checkbox"/> ACL Reconstruction                                 | <input type="checkbox"/> Adenoid Removal         | <input type="checkbox"/> Angioplasty            | <input type="checkbox"/> Appendectomy         | <input type="checkbox"/> Bone Fracture Repair   |
| <input type="checkbox"/> Breast Lump Removal                                | <input type="checkbox"/> Bunion Removal          | <input type="checkbox"/> Carotid Artery Surgery | <input type="checkbox"/> Cataract Surgery     | <input type="checkbox"/> Cervical Spine Surgery |
| <input type="checkbox"/> Cholecystectomy                                    | <input type="checkbox"/> Cosmetic Breast Surgery | <input type="checkbox"/> C-Section              | <input type="checkbox"/> Facelift             | <input type="checkbox"/> Gallbladder Removal    |
| <input type="checkbox"/> Gastric Bypass                                     | <input type="checkbox"/> Heart Bypass Surgery    | <input type="checkbox"/> Heart Surgery          | <input type="checkbox"/> Hemorrhoid Surgery   | <input type="checkbox"/> Hernia Repair          |
| <input type="checkbox"/> Hip Joint Replacement                              | <input type="checkbox"/> Hysterectomy            | <input type="checkbox"/> Kidney Transplant      | <input type="checkbox"/> Knee Arthroscopy     | <input type="checkbox"/> Knee Joint Replacement |
| <input type="checkbox"/> Knee Surgery                                       | <input type="checkbox"/> LASIK Eye Surgery       | <input type="checkbox"/> Liposuction            | <input type="checkbox"/> Lumbar Spine Surgery | <input type="checkbox"/> Mastectomy             |
| <input type="checkbox"/> Prostate Removal                                   | <input type="checkbox"/> Rotator Cuff Surgery    | <input type="checkbox"/> TMJ Surgery            | <input type="checkbox"/> Tonsillectomy        | <input type="checkbox"/> Vasectomy              |
| <input type="checkbox"/> Surgical History was reviewed:<br>Not contributory |                                                  |                                                 |                                               |                                                 |

**Medications**

Please select all medications that you are currently taking:

- |                                         |                                            |                                     |                                          |                                         |
|-----------------------------------------|--------------------------------------------|-------------------------------------|------------------------------------------|-----------------------------------------|
| <input type="checkbox"/> None           | <input type="checkbox"/> Other             | <input type="checkbox"/> Analgesics | <input type="checkbox"/> Antacids        | <input type="checkbox"/> Antibiotics    |
| <input type="checkbox"/> Antihistamines | <input type="checkbox"/> Anti-Inflammatory | <input type="checkbox"/> Arthritis  | <input type="checkbox"/> Aspirin         | <input type="checkbox"/> Birth Control  |
| <input type="checkbox"/> Blood Pressure | <input type="checkbox"/> Bone Density      | <input type="checkbox"/> Cancer     | <input type="checkbox"/> Cholesterol     | <input type="checkbox"/> Daily Vitamins |
| <input type="checkbox"/> Diabetes       | <input type="checkbox"/> Digestion         | <input type="checkbox"/> Heart      | <input type="checkbox"/> Muscle Relaxers |                                         |
| <input type="checkbox"/> OTC            | <input type="checkbox"/> Pain              | <input type="checkbox"/> Steroids   | <input type="checkbox"/> Thyroid         |                                         |

**Allergies**

Please select all items that you are allergic to:

- |                               |                                     |                                   |                                        |
|-------------------------------|-------------------------------------|-----------------------------------|----------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Other      | <input type="checkbox"/> Chemical | <input type="checkbox"/> Environmental |
| <input type="checkbox"/> Food | <input type="checkbox"/> Medication | <input type="checkbox"/> Seasonal |                                        |

**Social History**

Please answer the following questions:

- ☐ Married    ☐ Single    ☐ Widowed    ☐ Divorced    ☐ Separated
- Do you have any children?    ☐ Yes    ☐ No    If yes, how many? \_\_\_\_\_
- Do you use:    ☐ Tobacco    ☐ Alcohol    ☐ Coffee



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## **Consent to Treat**

I, \_\_\_\_\_ authorize the performance upon myself of the following procedures(s): Ultrasound, electric muscle stimulation, traction, massage and stretching to be performed by or under the direction of All Broward Chiropractic/Dr. Michael Surdis, Jr.

I also consent to the performance of other diagnostic and therapeutic procedures in addition to or different from those stated above, whether arising from present or unforeseen conditions, that the above-named doctor, physical therapist, associates, or assistants, may consider necessary or advisable in the course of my healthcare.

The above-named doctor and/or his associates/assistants have explained the nature and have explained the nature and purpose of the procedures, possible alternatives, the risks involved, and the possibility of complications to me. I acknowledge that no guarantee or assurance have been given as to the results that may be obtained from the procedures given by the above-named doctor and/or physical therapist and/or his associates or assistants. I accept the risks and benefits and consent to treatment.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_





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**PAYMENT RESPONSIBILITY-PLEASE READ CAREFULLY!**

Dear Patient:

Please be advised that your insurance company, \_\_\_\_\_, may automatically send payments directly to your home for services rendered by our office. It is your responsibility to forward these payments to our office as soon as possible so that we may properly credit your account.

If your check is made payable to you directly, please copy that check and explanation of benefits. Please deposit that check into your account, bring in a personal check or money order for the amount you were paid along with the copies of the correspondence and the copy of the check. If we do not receive these payments within fifteen (15) days, your account will be referred to our collections department. Thank you in advance for your cooperation.

Sincerely,

Dr. Michael Surdis, Jr.  
All Broward Chiropractic and Pain Rehabilitation Center, Inc.

X \_\_\_\_\_  
Patient Signature

X \_\_\_\_\_  
Print Patient Name

**Please sign above to acknowledge that you have read the above statement and that you agree to comply with our request.**

**DR. MICHAEL SURDIS, JR., P.A. d/b/a ALL BROWARD CHIROPRACTIC & PAIN REHABILITATION CENTERS**

7900 N.W. 33<sup>rd</sup> Street Suite 104 Hollywood, FL 33024

954-443-2420 Fax 954-443-8422

**ASSIGNMENT OF INSURANCE BENEFITS, RELEASE, & DEMAND**

***Insurer and Patient Please Carefully Read the Following in its Entirety!***

I, the undersigned patient/insured knowingly, voluntarily and intentionally assign the rights and benefits of my automobile Insurance, a/k/a Personal Injury Protection (hereinafter PIP), Uninsured Motorist, 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. I understand this document will allow the provider to file suit against an insurer for payment of the insurance benefits or an explanation of benefits and to seek \$627,428 damages from the insurer. If the provider's bills are applied to a deductible, I agree this will serve as a benefit to me. This assignment of benefits includes the cost of transportation, medications, supplies, overdue interest, any premium reimbursement 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 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 the maximum amount directly without any 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 being 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.

**Disputes:** 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 signed settlement agreed to by the health provider (specifically the office manager) 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 PIP insurer states it can pay claims at the optional permissive fee schedule then the insurer is instructed & directed to provide this provider with a copy of the policy of insurance within 10 days. Any effort by the insurer to pay a disputed debt as full satisfaction must be mailed to the address above, after speaking with the office manager, and mailed to the attention of **Office Manager** per \$673.3111.

**EUOs and CMEs:** If the insurer schedules a compulsory medical examination or examination under oath (hereinafter "EUO") the insurer is hereby INSTRUCTED to send a copy of said notification to this provider in advance of the notice being sent to the insured/patient. The provider or the provider's attorney is expressly authorized to appear at any EUO or CME set by the insurer. It is hereby demanded that at least 10 days prior to any CME that the insurer provide this healthcare provider with a list of exactly what exams and tests the CME doctor will perform. See Schagrin v. Nacht, 683 So.2d 1173 (Fla. 4th DCA 1996).

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, or 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, examinations under oath given by patient, or to obtain medical records from other health care providers treating me for injuries connected with or related to the event which gave rise to my need for medical treatment with the above provider.

**Release of information:** I authorize this provider to: furnish an insurer, an insurer's intermediary, the patient's other medical providers, and 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, the property damage 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. The insurer is not authorized to provide these medical records to anyone without the patient's and the provider's prior express written permission. This medical records authorization is intended to comply with HIPAA and shall remain in effect for the duration of any lawsuits which may be filed to collect PIP benefits.

**Demand:** Demand is hereby made for the insurer to pay all bills within 30 days without reductions and to mail the latest non-redacted PIP payout sheet, the insurance coverage declaration sheet and the policy of insurance to the above provider within 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.

**Certification:** I certify that: I have read and agree to the above and have asked questions regarding any provisions I did not understand; 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 that I shall review all medical records to insure that all treatments reflected on said records were provided and I also agree that the provider's prices are reasonable, usual and customary.

Patient's Name \_\_\_\_\_ Patient's Signature \_\_\_\_\_  
(Please Print) (If patient is a minor, signature of parent/guardian)

Date \_\_\_\_\_



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## **PREGNANCY WAIVER**

**ON THIS DAY, IT HAS BEEN EXPLAINED TO ME THAT X-RAYS CAN BE DANGEROUS TO A PREGNANT WOMAN. TO THE BEST OF MY KNOWLEDGE, I DECREE THAT I AM NOT PREGNANT AT THIS TIME AND THAT DIAGNOSTIC X-RAYS CAN BE TAKEN AT THIS TIME.**

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



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### **Appointment/Cancellation/No Show Policy**

#### **Appointments**

Office visits are by appointment only please call (954-443-2420). The receptionist may ask about the reason for your visit. This helps us schedule the doctors time more efficiently. Please arrive 10 minutes early for your appointment. Patients who are running late for any appointment, please call our office to let us know.

#### **Cancellations**

We would like to thank you for being a patient in our office. We value all our patients and strive to provide the best care possible in the most comfortable setting. Please understand that when we schedule your appointment, we are reserving time for your needs. We kindly ask that if you must change an appointment, please give us at least 24 hours' notice. This courtesy makes it possible to give your reserved time to another patient who would like it. We know that your time is valuable. When your appointment is made, a room is reserved, your records are prepared, and special instruments are readied for your visit. Except in the case of emergency treatment for another patient, you can expect us to be running on schedule. If you are unable to keep an appointment, we ask that you cancel at least 24 hours in advance. If this is not possible, call us as soon as you can so that another patient can be given your appointment time.

#### **Missed Appointments (Non-Cancelled)**

We understand that occasion missed appointments can occur for a variety of reasons. When you miss an appointment without canceling, someone else who could have been seen in your place is delayed unnecessarily. We track missed (non-cancelled) appointments. A "No Show/Late Cancellation" is defined as missing an appointment without cancelling at least 24 hours before scheduled time. There will be a charge for a missed or non-cancelled appointment, insurance will not cover charges for no show/late or cancellation fees. The \$25.00 charge is in addition to any other charges you may have incurred. No refunds will be given.

#### **Payment**

Payment is due in full at the time of service, no exceptions.

---

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_

**ALL BROWARD CHIROPRACTIC AND PAIN REHAB.  
DR. MICHAEL SURDIS, JR., P.A.  
RECEIPT OF NOTICE OF PRIVACY PRACTICES  
WRITTEN ACKNOWLEDGEMENT FORM**

I, \_\_\_\_\_, have reviewed/received a copy of  
Patient Name

**DR. MICHAEL SURDIS, JR., P.A.** \_\_\_\_\_'s Notice of Privacy Practices.  
Practice Name

\_\_\_\_\_  
Signature of Patient / Guardian

\_\_\_\_\_  
Date

**OFFICE USE ONLY**

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

Date:	Initials:	Reason:
-------	-----------	---------

HIPAA04P

WHITE COPY - OFFICE / YELLOW COPY - PATIENT

Reorder 6/11 OBS 1-800-634-1876