

Genesis Medical Clinic
11351 N 56th Street
Temple Terrace, FL 33617
Tel 813-549-7465 Fax 813-549-7399

TO ALL NEW PATIENTS

Please provide us with the following document:

- 1. Drivers License***
- 2. Your Auto Insurance Card & Claim # from your insurance for this accident***
- 3. Adjuster Name and Phone #***
- 4. Medical Insurance Card (if you have any)***
- 5. Accident Report***
- 6. Attorney's address & Phone #***
- 7. Minor must have guardian present***

If you have an attorney please give us the name, address and telephone number of your attorney.

If you have been to the hospital or had any testing as a result of this accident we will need to have you obtain copies of those records.

Thank You

Genesis Medical Clinic
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Insurance Verification Form

Patient Name: _____ Date: ___ / ___ / ___

Auto Insurance:

Insurance Company: _____

Phone: _____ ext: _____ Fax: _____

Address: _____

City: _____ State: _____ Zip: _____

Insured: _____ Ins Soc Sec: _____

Attorney: yes _____ no _____ Attorney Name: _____

Date of accident: _____ Type of Insurance: _____

Passenger / Driver:

Policy #: _____ Claim#: _____

Adjuster: _____ Phone #: _____

Ded: _____ Met: _____ Cov: _____ Med Pay: _____

Verified on: ___/___/___ By: _____

Patient Information:

Name: _____

Phone: _____ ext: _____ Cell: _____

Address: _____

City: _____ State: _____ Zip: _____

DOB: _____ SS#: _____

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Explanation of Financial Responsibility, according to Florida PIP Laws

1) *If you have a policy with a deductible:*

You, the patient are responsible to pay your deductible.

Should you have an attorney to represent you with your case the deductible share will be part of the settlement at the end of your case, providing your lawyer issues us a Letter of Protection.

2) *If you have chosen a policy that pays a percentage of the medical charges:*

You, the patient, are responsible to pay the percentage not paid by your insurance.

Should you have an attorney to represent you with your case the percentage share will be part of the settlement at the end of your case.

3) *Should you not be represented by an attorney and are faced with financial hardship please notify a staff member*

I have read and understand the above information

Patient's Signature

Date

Genesis Medical Clinic
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Patient Name: _____

Authorization to obtain PIP Payouts / Payment EOB's
Request under section S.627.736(7)

Policy#

Claim#

I, _____ authorize my PIP Insurance carrier to immediately provide a PIP Payout explanation to Superior Medical Clinic, LLC, dba **Genesis Medical Clinic**. I also authorize an Explanation Of Benefits (EOB) be included with each payment to this physicians office.

Patient's signature

Date

Patient's Assignment of Benefits is attached

Genesis Medical Clinic
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Patient Name: _____
Address: _____
City: _____ Stet: _____ Zip: _____
DOI: _____ Claim # _____

ASSIGNMENT OF BENEFITS/POLICY RIGHTS/DIRECT PAYMENT AUTHORIZATION

I hereby assign from any and all automobile policies which provide medical benefits or no-fault benefits, all rights, title and interest to Superior Medical Clinic, LLC; dba GenesisMedical Clinic ("Assignee") for payment for services rendered unto me both by reason of accident or illness. In the event my insurance company fails to pay Assignee the full amount owing to Assignee after proper statutory notice, I hereby also assign by this instrument, all rights and causes of action in tort, in contract and the laws of Florida, against the personal injury protection carrier for the above named insured/patient for it's failure to pay for services rendered unto me by assignee in relation to any accident or illness. This assignment may only be rescinded/reassigned by the mutual consent of the patient/insured/assignor and health care provider/assignee.

RESERVATION OF BENEFITS

Please be advised that I am hereby placing you on notice pursuant to Florida case law that should you deny, reduce or fail to pay either a part or an entire bill, which was submitted on my behalf from this healthcare provider. I am requesting you reserve, or hold aside, that same amount until the dispute is resolved. Additionally, should the remaining amount of any benefits approach an amount where there would be insufficient funds to pay the amount you reduced, denied or failed to pay, or if my benefits should become exhausted, please notify me and this health care provider of this fact immediately.

DIRECTION OF PAYMENT/RELEASE OF INFORMATION

I hereby authorize any insurance company or attorney to pay direct to Assignee the amount of this and/or any future bills for services rendered unto me. I also agree to pay in a current manner any difference between the total charges and the amount paid by the insurance company directly to the Assignee. I hereby authorize Assignee to release any information requested that is pertinent to my case to any insurance company or attorney involved in this case. Pursuant to FS 627.4137, I hereby request a copy of the PIP payment log and any available policy of Insurance or declaration sheet, to be provided by the insurance company to the Assignee. I hereby authorize Assignee permission to request and receive a current copy of my PIP payment log periodically as they deem necessary. A photocopy of this assignment shall be considered as valid and effective as the original.

Patient's signature or patient/guardian

Date



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**.

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.

Genesis Medical Clinic

NOTICE OF INITIATION OF TREATMENT

Name of Insured Patient: _____

Name of PIP Insurer _____

Policy Number: _____

Claim Number: _____

Pursuant to Florida statute 627.736(5)(c)1., you are hereby notified that treatment on your insured, _____ was initiated on ____/____/____ for injuries sustained in an automobile crash on ____/____/____.

**Genesis Medical Clinic
11531 N 56th Street
Temple Terrace, Florida 33617
Phone: 813-386-0685
Fax:813-549-7399**

Patient Authorization for release of protected Health Information

To: _____
Physician of Facility Name

Street Address

City/State/Zip

I hereby request that my medical records be released to

**Genesis Medical Clinic
11531 N 56th Street
Temple Terrace, Florida 33617**

Records requested:

_____ Complete chart including HIV results and psychiatric records
_____ Lab reports
_____ X-ray reports
_____ consult reports
_____ Medication Log
_____ Others _____

Please Fax medical records to: 813-549-7399

Date of request _____
Patient Name _____
Patient's DOB _____ Patient's SS# _____

Patients Signature: _____

Witness Signature: _____



Please safeguard
your medication
against theft !

Please keep your medication
in a secure lockable place!
Don't leave your medication in
unsecure luggage during
travel!



**LOST, STOLEN OR
MISPLACED NARCOTICS
WILL NOT BE REPLACED !!**

Patient name (Print) _____

Patient Signature _____ Date _____



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Patient Name: _____

Date of Exam: _____

Date of Injury: _____

The Cervical Spine:

- 739.0 Occipital Subluxation
- 739.1 Cervical Subluxation
- 739.2 Thoracic Subluxation
- 739.3 Lumbar Subluxation
- 739.4 Sacrum, Coccyx Subluxation
- 739.5 Pelvic (Iliac or SI) Subluxation

- 839 series:
- 839.01 Subluxation of First Cervical Vertebra
- 839.02 Subluxation of First Second Vertebra (.03 = third, ect)
- 839.08 Multiple Cervical Subluxation
- 722.0 Cervical Disc Disorder w/o Myelopathy
- 722.71 Cervical Disc Disorder with Myelopathy
- 723.0 Cervical Spinal Stenosis (usually Disc-related)
- 723.1 Neck Pain
- 729.4 Ligament laxity (observed on flexion/extension films)
- 723.2 Cervicocranial Syndrome (Barre-Lieou syndrome; Posterior cervical sympathetic sync)
- 723.3 Cervicobrachial Syndrome (diffuse)
- 723.4 Brachial Neuritis; Cervical Radiculitis; Radicular Syndrome of Upper Extremity
- 723.5 Torticollis; Contracture of Neck
- 722.4 Degeneration of Cervical Disc(s)
- 353.2 Cervical Nerve Root Lesion
- 724.9 Foraminal Encroachment (Compression) of Nerve Root, Cervical
- 722.81 Post laminectomy Syndrome Of Cervical Region
- 354.1 Median Nerve Neuritis
- 354.2 Ulnar Nerve Lesion
- 354.3 Radial Nerve Lesion
- 719.08 Edema of Cervical Facet Joint
- 719.48 Arthralgia of Cervical Spine
- 719.58 Stiffness of Cervical Spine
- 847.0 Cervical Sprain/Strain
- 723.2 Cervicocranial Syndrome
- 351.0 Bell's Palsy
- 723.8 Occipital Neuralgia
- 353.0 Thoracic Outlet Syndrome

- 726.1 Rotator Cuff Syndrome
- 726.10 Supraspinatus Syndrome
- 354.0 Carpal Tunnel Syndrome
- 524.6 TMJ Dysfunction Syndrome
- 847.0 Acute post-traumatic torticollis

The Thoracic Spine:

- 839.21 Subluxation of the Thoracic Vertebrae
- 722.11 Thoracic Disc Disorder w/o Myelopathy
- 722.72 Thoracic Disc Disorder with Myelopathy
- 722.51 Degeneration of Thoracic Disc(s)
- 724.9 Foraminal Encroachment (Compression) of Nerve Root, Thoracic
- 722.82 Postlaminectomy Syndrome of Thoracic Region
- 353.3 Thoracic Nerve Root Lesion
- 724.4 Thoracic Or Lumbosacral Neuritis Or Radiculitis
- 719.08 Edema of Thoracic Facet Joint
- 847.1 Thoracic Sprain/Strain
- 719.48 Arthralgia of Thoracic Spine
- 719.58 Stiffness of Thoracic Spine

The lumbar Spine:

- 839.20 Subluxation of the Lumbar Vertebrae
- 722.10 Lumbar Disc Disorder w/o Myelopathy
- 722.73 Lumbar Disc Disorder with Myelopathy
- 722.52 Degeneration of Lumbar Disc(s)
- 738.4 Spondylolysis/Spondylolisthesis (Acquired)
- 756.12 Spondylolysis (Congenital)
- 756.11 Prespondylolisthesis (Congenital)
- 724.3 Sciatica; Neuralgia of Sciatic Nerve
- 724.9 Foraminal Encroachment (Compression) of Nerve Root, Lumbar
- 722.83 Postlaminectomy Syndrome Of Lumbar Region
- 724.4 Thoracic Or Lumbosacral Neuritis Or Radiculitis

The lumbar Spine:

- 353.4 Lumbosacral Nerve Root Lesion
- 719.08 Edema of Lumbar Facet Joint
- 847.2 Lumbar Sprain/Strain
- 719.48 Arthralgia of Lumbar Spine
- 719.58 Stiffness of Lumbar Spine
- 724.2 Lower Back Pain

The Pelvis:

- 839.42 Subluxation of the Sacroiliac Joint
- 847.3 Sacroiliac (SI) Sprain/Strain
- 353.1 Lumbosacral Plexus Lesion
- 720.2 Sacroilitis
- 719.08 Edema of Sacroiliac Joint
- 719.48 Arthralgia of Sacroiliac Joint
- 719.58 Stiffness of Sacroiliac Joint
- 839.41 Subluxation of the Coccyx
- 724.71 Hypermobility Of Coccyx
- 847.4 Coccyx Sprain/Strain
- 353.1 Lumbosacral Plexus Lesion

The Peripheral Joint Codes:

- 831.01 Anterior Subluxation of Humerus
- 831.02 Posterior Subluxation of Humerus
- 832.12 Subluxation of Elbow
- 833.03 Subluxation of Carpal Bone
- 836.53 Medial Subluxation of Tibia
- 836.54 Lateral Subluxation of Tibia
- 838.01 Subluxation of Tarsal Bone

Sprains and Strains of Shoulder and Upper Arm:

- 840.0 Acromioclavicular (joint) (ligament)
- 840.1 Coracoclavicular (ligament)
- 840.2 Coracohumeral (ligament)
- 840.3 Infraspinatus (muscle) (tendon)
- 840.4 Rotator cuff (capsule)
- 840.5 Subscapularis (muscle)
- 840.6 Supraspinatus (muscle) (tendon)

Various Other Codes:

- 733.1 Collapsed Vertebra
- 805.2 Compression Fracture
- 805.4 Compression Fracture Lumbar
- 381.00 Acute Nonsuppurative Otitis Media
- 381.10 Chronic Serous Otitis Media, Simple Or Unspecified Acute Suppurative
- 382.00 Otitis Media W/O Spontaneous Rupture of Eardrum
- 724.9 Ankylosing Sponylitis (Ankylosis of Spine)
- 736.81 Acquired Unequal Leg Length
- 755.30 Congenital Unequal Leg Length
- Abnormality of Gait (Ataxic, Paralytic, Spastic, Staggering)
- 781.2 Difficulty in Walking

- 719.7 Lack of Coordination
- 781.3 Abnormal Posture
- 781.9 Kyphosis (Acquired)
- 737.10 Lordosis (Acquired)
- 737.20 Hypolordosis of the Cervical/Lumbar Spine (Acquired)
- 738.2 Reversal of the Cervical Curve
- 737.30 Scoliosis (Idiopathic)

- 715.9 Degenerative Joint Disease (Osteoarthritis)
- 715.95 Degenerative Joint Disease of the Hip
- 715.96 Degenerative Joint Disease of the Knee
- 715.09 Osteoarthrosis of Multiple Sites
- 716.9 Chronic Arthritis
- 734 Pes Planus, Acquired
- 754.61 Pes Planus, Congenital
- 736.41 Genu Valgus
- 733.0 Osteoporosis
- 733.01 Osteoporosis Senile
- 733.02 Osteoporosis Idiopathic

SYMPTOMS:

- 723.1 Cervicalgia
- 724.1 Thoracic Spine Pain
- 724.2 Lumbalgia
- 648.70 Pregnancy Backache
- 724.5 Vertebrogenic Pain Syndrome
- 726.90 Tendinitis/Capsulitis
- 727.00 Synovitis/Tenosynovitis
- 727.3 Bursitis
- 729.1 Myofascitis of Upper or Extremity Musculature
- 728.87 Muscle Weakness
- 728.85 Muscle Spasm
- 780.4 Dizziness
- 438.85 Vertigo
- 780.4 Dizzinedd and Giddiness ?Light-headedness/Vertigo
- 780.5 Sleep Disturbance
- 780.7 Fatigue
- 787.2 Dysphagia
- 784.5 Dysathria/Dysphasia/Slurred speech
- 784.9 Choking Sensation
- 784.49 Hoarseness of Speech
- 787.0 Nausea

Other: _____

