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**Major Medical Form**  
**Confidential Patient Information**

Last Name: \_\_\_\_\_ MI: \_\_\_\_\_ First Name: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Address: \_\_\_\_\_ City: \_\_\_\_\_  
 State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone #: \_\_\_\_\_ Email: \_\_\_\_\_  
 Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_  
 Insurance: \_\_\_\_\_ Policy ID: \_\_\_\_\_  
 Secondary Insurance: \_\_\_\_\_ Policy ID: \_\_\_\_\_  
 Name of Policy Holder: \_\_\_\_\_ Relationship: \_\_\_\_\_

➤ **PERMISSION TO DISCUSS MEDICAL RECORDS**

I, \_\_\_\_\_ give **Brevard Therapy and Physical Medicine** permission to discuss my condition and share my medical records with the following people:

	NAME	RELATION	PHONE NUMBER
1.			
2.			
3.			
4.			

**Initial:** \_\_\_\_\_

➤ **NOTICE OF PRIVACY HIPPA CONSENT**

I acknowledge that I have read the HIPPA Notice of Privacy and that I will be provided with a copy if I wish to have one.

**Initial:** \_\_\_\_\_

➤ **ASSIGNMENT AND RELEASE**

I, the undersigned certify that I (or my dependent) have insurance coverage with \_\_\_\_\_ and assign directly to **Brevard Therapy and Physical Medicine** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of the signature on all submissions.

**Initial:** \_\_\_\_\_

➤ **24 HOUR CANCELLATION POLICY**

If you are unable to keep your appointment, you are obligated to notify our office. Please be advised, a **\$25 cancellation fee** will be charged to your account for any appointments that are missed or **canceled without 24 hours prior notice**. Three missed appointments with less than 24 hours' notice will result in automatic discharge from this practice. All cancellation fees must be current before another appointment can be made.

**Initial:** \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_