Dr. John Madlener, M.D.
Dr. Richard Helton, D.C.
903 Jordan Blass Dr. Site 102
Melbourne, FL. 32940
P: 321-751-5351 F: 321-751-5370

Motor Vehicle Accident Form

Confidential Patient Information

Last Name: _____ MI: _____ First Name: _____
Date of Birth: _____ Address: _____ City: _____
State: _____ Zip: _____ Phone #: _____ Email: _____
Emergency Contact: _____ Relationship: _____ Phone #: _____
Auto Insurance: _____ Policy ID: _____ Date of Accident: _____
Claim Number: _____ Were you the driver? YES [ ] NO [ ]
If you do not have insurance, do you live with someone who does? YES [ ] NO [ ]
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: _____

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RELEASE OF MEDICAL RECORDS FROM OTHER FACILITES

This section is for office use only:

I request and authorize:_____

to release healthcare information to:

Brevard Therapy & Physical Medicine, Dr. Madlener, and/or Dr. Helton.

This request and authorization applies to:

Full medical records held by this office: _____

A specific portion/section of the record: _____

Radiology Reports: _____

Medical record for the period: _____ to _____

Other diagnostic studies: _____

Purpose of the requested disclosure: [ ] At patient's request [ ] Continuing care

I understand that I have the right to revoke this authorization at any time. My revocation must be in writing in a letter provided to the privacy officer. I am aware that my revocation is not effective to the extent that the person I have authorized to use and/or disclose my Protected Health Information have acted in reliance upon the authorization. I understand that I do not have to sign the authorization and that Brevard Therapy & Physical Medicine may not condition treatment on whether I sign this authorization. I further understand that if the person(s) or organization(s) authorized to receive the information is not a health plan or health care provider, the release of information may be re-disclosed and would no longer be protected by federal privacy regulations.

I agree that a copy of this release of fax of this release shall be as valid as the original release. If I authorize Brevard Therapy & Physical Medicine to fax information, I realize there are inherent risks in faxing Protected Health Information released to anyone other than the health care provider. I understand I will get a copy of this form after I sign it if I wish to have one.

Print Name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____