Dr. John Madlener, M.D.
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1715 Berglund Ln, #104
Viera, FL 32940
P: 321-751-5351 F: 321-751-5370

MVA Intake 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 TEXT

I give permission to **Brevard Therapy and Physical Medicine** to communicate via text message on the following phone number:

Initial: _____ _____

➢ 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.			

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: _____

➢ 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: _____

Patient Signature: _____ Date: _____