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

Major Medical Intake Form (Confidential Patient Information)

Last Name: _____ MI: _____ First Name: _____

Date of Birth: _____ Address: _____ City: _____

State: _____ Zip: _____ Phone #: _____Email: _____

SSN: _____ Emergency Contact: _____ Relationship: _____

EC Phone #: _____ Insurance: _____ Policy ID: _____

Secondary Insurance: _____ Policy ID: _____

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: _____

➢ 24 HOUR CANCELLATION POLICY

If I am unable to keep my appointment, I am obligated to notify BTPM. I am aware that a **$75 cancellation fee** will be charged to my 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: _____

➢ 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: _____