13701 Cypress Terrace Cir
Fort Myers, FL 33907
PH: (239) 277-1655 | FX: (239) 277-1255

PATIENT INTAKE FORM

Multi-Care Medical "Of SW Florida"

PATIENT DEMOGRAPHICS AND HISTORY:

Full Name: _____ **Today's Date**: _____

Date of Birth: _____ **Age:** ____ **Sex**: ☐ Male ☐ Female **SS#:** _____

Address: _____ **City/ST/ZIP**: _____

Phone #: _____ **Email**: _____@_____ ._____

☐ **I authorize to receive email/text messages for appointment and general health reminders from this office.**

Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Spouse Name: _____ **Spouse Phone**: _____

Pharmacy: _____ **Phone #:** _____

Emergency Contact Name: _____ **Relationship**: _____ **Phone #**: _____

☐ **If a family member/friend asks to speak to you, we can tell them you are here**

I am taking: ☐ Blood Pressure Medication ☐ Aspirin ☐ Muscle Relaxers ☐ Blood Thinners

Have you ever had any of the following?

☐ Heart Attack/Stroke	☐ Heart Surgery/Pacemaker	☐ Heart Disease	☐ Alcohol Abuse
☐ Drug Abuse	☐ Shingles	☐ Cancer	☐ Venereal Disease
☐ Sinus Problems	☐ Respiratory Issues	☐ HIV/Aids	☐ Kidney Problems
☐ Diabetes	☐ Glaucoma	☐ Arthritis	☐ Anemia
☐ Asthma	☐ High/Low Blood Pressure	☐Hepatitis	☐ Fainting / Seizures
☐ Ulcer/ Colitis	☐ Psychiatric Problems	☐Other(s):	

Do you have any metal in your body? ☐ No ☐ Yes, I have _____

Medical Condition(s): _____

Allergies: _____

List Previous Surgeries/Treatments With Dates: _____

_____

List Any Past Serious Accidents With Dates:_____

_____

Family Health History (Cancer, High Blood Pressure/Heart Disease/Etc):

_____

Do you take supplements or vitamins? ☐ Yes ☐ No **Do You Exercise?** ☐ Yes ☐ No

Are you on a Special diet? ☐ Yes ☐ No **Do you smoke?** ☐ Yes ☐ No

For Women: Are you pregnant? ☐ Yes ☐ No **Last menstrual cycle:** _____

TODAY'S VISIT REASON:

☐ Auto Accident ☐ Slip/Fall ***If it was an accident, please be sure to complete the Accident Information section below***

☐ Work ☐Sports ☐ Chronic

Are you experiencing pain? ☐ YES ☐ NO **Date the pain began:** _____

Is the pain getting worse? ☐ YES ☐ NO **Is the pain** ☐ Constant ☐ Come & Go

ACCIDENT INFORMATION: **Date of accident: _____ @ ___:___ ☐ AM ☐ PM**

I was the: ☐ Driver ☐ Front Passenger ☐ Rear Passenger

Number of people in the vehicle? _____ **Did the police come to the scene?** ☐ Yes ☐ No

Is there a police report? ☐ Yes ☐ No **Were you wearing your seatbelt?** ☐ Yes ☐ No

Witnesses? ☐ Yes ☐ No **Did airbags deploy?** ☐ Yes ☐ No

Who was cited: ☐ Self ☐ Other

In relation to your skull, the headrest was: ☐ Above ☐ Below ☐ At the base of skull

What did you impact? ☐ Another vehicle ☐ Other: _____

Any body parts struck the vehicle? _____

Make/model of the vehicle you were occupying? _____

Street name on which you were traveling? _____

You were heading: ☐ North ☐ West ☐ South ☐ East - At (speed) _____ MPH.

The impact came from the: ☐ Front ☐ Rear ☐ Lt Side ☐ Rt side

During the impact you were facing: ☐ North ☐ West ☐ South ☐ East

You were ☐ Aware of the impact before it occurred ☐ Surprised by the impact

What was the make/model of the other vehicle: _____

They were heading: ☐ North ☐ West ☐ South ☐ East At (speed) _____ MPH

Describe the accident in detail: _____

_____

_____

Were you rendered unconscious? ☐ No ☐ Yes, for (how long?) _____

Please describe how you felt after the accident: _____

Hospital? ☐ Yes ☐ No **Ambulance?** ☐ No ☐ Yes (where?) _____

When did you go? ☐ After the accident ☐ Next day ☐ 2+ days

Did you do any imaging? ☐ X-rays ☐ CT scans ☐ MRIs

TELL US ABOUT YOUR PAIN:

☐ **Dizziness**	☐ **Neck Pain / Stiffness**	☐ **Elbow Pain** __ L __ R
☐ **Memory Loss**	☐ **Chest Pain**	☐ **Wrist / Hand Pain** __ L __ R
☐ **Headaches**	☐ **Upper Back Pain**	☐ **Leg Pain** __ L __ R
☐ **Nausea**	☐ **Mid Back Pain**	☐ **Knee Pain** __ L __ R
☐ **Blurred Vision**	☐ **Lower Back Pain**	☐ **Foot / Ankle Pain** __ L __ R
☐ **Buzzing / Ringing in Ear(s)** __L __R		☐ **Numb Arm / Hands / Fingers** __ L __ R
☐ **Shoulder Pain** __ L __ R		☐ **Numb Legs / Feet** __ L __ R

☐ **Other:** _____

Employer: _____ **Occupation:**_____

Does your pain Interfere with: ☐ Work ☐ Sleep ☐ Daily Routine

Have you had a similar condition in the past? ☐ Yes ☐ No

Have you ever been treated by a medical physician before? ☐ Yes ☐ No

Have you ever been treated by a chiropractor before? ☐ Yes ☐ No **Whom?** _____

Have you been able to work? ☐ Yes ☐ No **Number of hours in a workday?** _____

Has your work been affected since the accident? ☐ Yes ☐ No

While in recovery, is there light duty work you can request? ☐ Yes ☐ No

To evaluate the effect that continuing work will have on your recovery please complete:

☐ **Standing**	☐ **Driving**	☐ **Operate equipment**	☐ **Sitting**	☐ **Twisting**
☐ **Walking**	☐ **Crawling**	☐ **Work with arms**	☐ **Lifting**	☐ **Bending**
☐ **Stooping**	☐ **Other** _____			

Indicate your degree of comfort when performing the following activities:

Activity	Comfortable	Uncomfortable	Painful	N/A
Lying on the back	☐	☐	☐	☐
Lying on the side	☐	☐	☐	☐
Lying on the stomach	☐	☐	☐	☐
Sleeping sitting	☐	☐	☐	☐
Standing	☐	☐	☐	☐
Walking	☐	☐	☐	☐
Running	☐	☐	☐	☐
Sports	☐	☐	☐	☐
Working	☐	☐	☐	☐
Lifting	☐	☐	☐	☐

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization to release any information required to process insurance claims. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

SIGNATURE: _____ DATE: _____

WITNESS: _____

First Party Assignment of Benefits [excluding] UM

I, the undersigned patient/insured knowingly, voluntarily and intentionally assign the rights and benefits of my personal injury protection and medical payments provisions of my automobile insurance to **Multi-Care Medical of SW Florida, PLLC**. I understand it is the intention of the provider to accept this assignment of benefits in lieu of demanding payment at the time services are rendered. I understand this document will allow **Multi-Care Medical of SW Florida, PLLC** to file suit against an insurer for payment of the insurance benefits or an explanation of benefits and to seek 627.428 damages from the insurer. If the provider's bills are applied to a deductible, I agree this will serve as a benefit to me. If the insurer disputes the validity of this assignment of benefits, then the insurer is instructed to notify **Multi-Care Medical of SW Florida, PLLC** in writing within five days of receipt of this document. Failure to inform **Multi-Care Medical of SW Florida, PLLC** shall result in a waiver by the insurer to contest the validity of this document. The undersigned directs the insurer to pay the health care provider the maximum amount directly without any reductions & without including the patient's name on the check. To the extent the PIP insurer contends there is a material misrepresentation on the application for insurance resulting in the policy of insurance is declared void, rescinded, or canceled, I, as the named insured under said policy of insurance, hereby assign the right to receive the premiums paid for my PIP insurance to **Multi-Care Medical of SW Florida, PLLC** and to file suit for recovery of the premiums. The insurer is directed to issue such a refund checks payable to this provider only. Should the medical bills not exceed the premium refunded, then **Multi-Care Medical of SW Florida, PLLC** is directed to mail the patient/named insured a check, which represents the difference between the medical bills and the premiums paid. I understand that I am directly, individually, and personally responsible to **Multi-Care Medical of SW Florida, PLLC** for all medical bills for services rendered to me by **Multi-Care Medical of SW Florida, PLLC**. I also understand that my obligation to pay **Multi-Care Medical of SW Florida, PLLC** is not contingent on any recovery, settlement, or judgment.

DISPUTES: The insurer is directed by **Multi-Care Medical of SW Florida, PLLC** and the undersigned to not issue any checks or drafts in partial settlement of a claim that contain or are accompanied by language releasing the insurer or its insured/patient from liability unless there has been a prior written settlement agreed to by the health provider (specifically the office manager) and the insurer as to the amount payable under the insurance policy. The insured and **Multi-Care Medical of SW Florida, PLLC** hereby contests and objects to any reductions or partial payments. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by **Multi-Care Medical of SW Florida, PLLC** shall be done so under protest, at the risk of the insurer, and the deposit shall not be deemed a waiver, accords, satisfaction, discharge, settlement or agreement by the provider to accept a reduced amount as payment in full. If the insurer pays claims at 200% of the Medicare rate then the insurer is instructed & directed to provide **Multi-Care Medical of SW Florida, PLLC** with a copy of the policy of insurance within 10 days**. Any effort by the insurer to pay a disputed debt as full satisfaction must be mailed to the address above, after speaking with the office manager, and mailed to the specific attention of the Office Manager. See Fla. Stat. 673.3111.**

EUOs and CMEs: If the insurer schedules a defense examination r examination under oath (hereinafter "EUO") the insurer is hereby INSTRUCTED to send a copy of said notification to **Multi-Care Medical of SW Florida, PLLC**. The provider or the provider's attorney is expressly authorized to appear at any EUO or CME set by the insurer. The health care provider is not the agent of the insurer or the patient for any purpose. This assignment applies to both past and future medical expenses and is valid even if undated. A photocopy of this assignment is to be considered as valid as the original. I agree to pay any applicable deductible, co-payments, for services rendered after the policy of insurance exhausts and for any other services unrelated to the automobile accident. **Multi-Care Medical of SW Florida, PLLC** is given the power of attorney to: endorse my name on any check for services rendered by the above provider; and to request and obtain a copy of any statements or examinations under oath given by patient.

Release of Information: I authorize **Multi-Care Medical of SW Florida, PLLC** to: furnish an insurer, an insurer's intermediary, the patient's other medical providers and the patient's attorney via mail, fax, or email, with any and all information that may be contained in the medical records; to obtain insurance coverage information (declaration sheet & policy of insurance) in writing and telephonically from the insurer; request from any insurer all explanation of benefits (EOBs) for all providers and non-redacted PIP payout sheets; obtain any written and verbal statements the patient or anyone else provided to the insurer; obtain copies of the entire claim file, the property damage file, and all medical records, including but not limited to, documents, reports, scans, notes, bills, opinions, X-rays, CMEs, and MRIs, from any other medical provider or any insurer. **Multi-Care Medical of SW Florida, PLLC** is permitted to produce my medical records to its attorney in connection with any pending lawsuits. The insurer is directed to keep the patient's medical records from this provider private and confidential. The insurer is not authorized to provide these medical records to anyone without the patient's and provider's prior express written permission.

Demand: Demand is hereby made for the insurer to pay all bills within 30 days without reductions and to mail the latest non-redacted PIP payout sheet and the insurance coverage declaration sheet to the above provider within 15 days. The insurer is directed to pay the bills in the order they are received. However, if a bill from **Multi-Care Medical of SW Florida, PLLC** and a claim from anyone else are received by the insurer on the same day the insurer is directed to not apply this provider's bill to the deductible. If the insurer receives a bill from this provider and claim from anyone else on the same day, then the insurer is direct to pay this provider first before the policy is exhausted. In the event the provider's medical bills are disputed or reduced by the insurer for any reason, or amount, the insurer is to: set aside the entire amount disputed or reduced; escrow the full amount at issue; and not pay the disputed amount to anyone or any entity, including myself, until the dispute is resolved by a Court. Do not exhaust the policy. The insurer is instructed to inform, in writing **Multi-Care Medical of SW Florida, PLLC** of any dispute.

I authorize **Multi-Care Medical of SW Florida, PLLC** to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under this Assignment of Benefits and Release. I agree that **Multi-Care Medical of SW Florida, PLLC** be given a Special Power of Attorney to endorse/sign my name on any and all checks and claim forms for payment of my bill.

Certification: I certify that: I have read and agree to the above; I have not been solicited or promised anything in exchange for receiving health care; I have not received any promises or guarantees from anyone as to results that may be obtained by any treatment or service; and I agree the provider's treatment and supplies are medically necessary and pertaining to my injuries. **Caution: Please read before signing. If you do not completely understand this document, please ask us to explain it to you. If you sign below, we will assume you understand and agree to the above**

Patient Name: _____ Signature: _____ Date: _____

Authorization For Medical Treatment

I, the undersigned, patient in this office hereby authorize **MULTI-CARE MEDICAL OF SW FLORIDA** and/or the physicians of **MULTI-CARE MEDICAL OF SW FLORIDA**(and whomever they designate as their assistants) to administer such treatments as is necessary and to perform the following therapy and manipulation and such additional therapy or procedures as are considered therapeutically necessary on the basis of findings during the course of said treatment.
I hereby certify that I have read and fully understand the above Authorization of Medical Treatment, the reason why the above named treatment is considered necessary, its advantages and possible complications, if any as well as possible alternative modes of treatment which are explained to me by **MULTI-CARE MEDICAL OF SW FLORIDA** and/or the physicians of **MULTI-CARE MEDICAL OF SW FLORIDA** .
I also certify that no guarantee or assurance has been made as to the result that may be obtained.

Patient Signature: _____ Date: _____

Patient Name: _____ Witness: _____

Authorization For Medical Information

The authorization or photocopy hereof, will authorize you to furnish all information you may have regarding my condition while under your observation or treatment, including the history obtained, X-Ray and physical findings, diagnosis and prognosis. You are authorized to provide this information in accordance with the Florida “NO FAULT” auto insurance.

Patient Signature: _____ Date: _____

Authorization For Wage And Salary Information

The authorization or photocopy hereof, will authorize you to furnish all information you may have regarding my wages or salary. You are authorized to provide this information in accordance with the Florida “NO FAULT” auto insurance law (Chapter 71.252F.5)

Patient Signature: _____ Date: _____

Social Security #: _____

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURANCE COMPANY OR FILES A STATEMENT OR CLAIM CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

Notice Of Privacy Practices Acknowledgment

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.
I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Signature: _____ Date: _____
Patient Name: _____ Witness: _____

IRREVOCABLE DEFERRED PAYMENT AGREEMENT

I _____, hereby authorize **Multi-Care Medical Of SW Florida, PLLC.** ("Provider") to defer, at its sole discretion. The demand for payment for services rendered. I understand that such a deferral may be granted, modified, or revoked at any time and for any reason. Notwithstanding any deferral, I acknowledge and agree that I remain **personally and fully responsible** for all charges and fees for services rendered to me by **Multi-Care Medical Of SW Florida, PLLC**. and/or its providers. This agreement is made solely to extend courtesy and flexibility in payment timing and does **NOT** release me from financial responsibility for said services. I further agree that, in the event of failure to pay the demanded amount when due, I shall be responsible for all reasonable attorney's fees, collection costs, and expenses incurred by **Multi-Care Medical Of SW Florida, PLLC.** in the enforcement of this agreement or collection of my outstanding balance. By signing below, I confirm that I have **read, understood, and voluntarily agreed** to the terms contained in this document.

Patient Name : _____

Signature: _____

Date: _____

Multi-Care Medical Of SW Florida
13701 Cypress Terrace Cir.
Fort Myers, FL 33907
Ph : (239)277-1655
Fx : (239)277-1255
Email: admin@multi-caremedical.com

APPLICATION FOR FLORIDA "NO FAULT" BENEFITS

NAME OF INSURANCE COMPANY

DATE	OUR POLICY HOLDER	DATE OF ACCIDENT	FILE NUMBER

TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE FLORIDA PERSONAL INJURY PROTECTION LAW, PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURANCE COMPANY MAKES A STATEMENT OF CLAIM CONTAINING ANY FALSE INCOMPLETE OR MISLEADING INFORMATION, IS GUILTY OF A FELONY OF THE THIRD DEGREE.

YOUR NAME	PHONE NO.	HOME	BUSINESS

YOUR ADDRESS (NO, STREET, CITY OR TOWN, STATE AND ZIP CODE)	DATE OF BIRTH	SOCIAL SECURITY NO.

PERMANENT ADDRESS, IF DIFFERENT	HOW LONG HAVE YOU LIVED IN FLORIDA?

DATE AND TIME OF ACCIDENT	PLACE OF ACCIDENT (STREET, CITY OR TOWN AND STATE)

BRIEF DESCRIPTION OF ACCIDENT AND VEHICLES INVOLVED:

DESCRIBE MOTOR VEHICLE YOU OWN -	DESCRIBE MOTOR VEHICLE OWNED BY ANY MEMBER OF YOUR FAMILY-

AS A RESULT OF THIS ACCIDENT, WERE YOU INJURED? IF YOUR ANSWER IS YES, COMPLETE THE REST OF THIS FORM. IF NO, SIGN HERE AND RETURN THIS FORM TO US.

SIGNATURE: **DATE:**

DESCRIBE YOUR INJURY

WERE YOU TREATED BY A DOCTOR?		DOCTOR'S NAME AND ADDRESS
IF YOU WERE TREATED IN A HOSPITAL, WERE YOU AN IN PATIENT ____ OUT PATIENT _____		HOSPITAL'S NAME AND ADDRESS

AMOUNT OF MEDICAL BILLS TO DATE	WILL YOU HAVE MORE MEDICAL EXPENSE?	AT THE TIME OF YOUR ACCIDENT, WERE YOU IN THE COURSE OF YOUR EMPLOYMENT?

DID YOU LOSE WAGES OR SALARY AS A RESULT OF YOUR INJURY?	IF YES, AMOUNT OF LOSS TO DATE	WHAT IS YOUR AVERAGE WEEKLY WAGE OR SALARY?

IF YOU LOST WAGES:	DATE DISABILITY FROM WORK BEGAN	DATE YOU RETURNED TO WORK

HAVE YOU RECEIVED, OR ARE YOU ELIGIBLE FOR, PAYMENTS UNDER ANY WORKMEN'S COMPENSATION OR EMPLOYMENT LAW?	IF YES, AMOUNT PER WEEK PER MONTH

LIST NAMES AND ADDRESSES OF YOUR PRESENT EMPLOYER(S) AND GIVE YOUR OCCUPATION AND DATES OF EMPLOYMENT FOR EACH

EMPLOYER AND ADDRESS	YOUR OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	YOUR OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	YOUR OCCUPATION	FROM	TO

AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES?	IF YES, EXPLAIN ON REVERSE SIDE
SIGNATURE: DATE:	

IMPORTANT: 1. TO BE ELIGIBLE FOR BENEFITS COMPLETE AND SIGN THIS APPLICATION
2. SIGN AND ATTACH AUTHORIZATION(S)
3. RETURN PROMPTLY WITH ANY MEDICAL BILLS YOU HAVE RECEIVED TO 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 or treatment 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.

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.

Insured Person (patient receiving treatment or services) or Guardian of Insured Person:

Name *(PRINT or TYPE)*	Signature	Date

The undersigned licensed medical professional or medical director, if applicable, 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. The treatment or services rendered were explained 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(14) and (15), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Licensed Medical Professional Rendering Treatment/Services or Medical Director, if applicable *(Signature by his/ her **own hand**):*

Name *(PRINT or TYPE)*	Signature	Date

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.

OIR-B1-1571
Pub. 1/2004

AFFIDAVIT OF HEALTH INSURANCE

I acknowledge the following by initialing my selection:
PLEASE MAKE A SELECTION BELOW

_____I certify that I was not covered by any form of health insurance at the time of the accident that occurred on _____.

_____ I do have health insurance and Multi-Care Medical (MCM) is authorized to submit a claim on my behalf, however they are not in network providers for my health insurance.

_____I do have health insurance and elect not to use my health insurance for the following reason:

(CHECK ALL REASONS THAT APPLY TO YOU BELOW)

_____ The out-of-pocket, co-insurance, deductible and copays are a financial hardship for me.
_____ I have been unable to obtain the referrals/authorizations necessary for me to use my insurance plan and receive care in a timely manner
_____ I have not been able to find a doctor in my insurance network that will see me in a timely manner.
_____ Other:_____

I understand that I am financially responsible for medical services provided to me. I further understand that MCM is not contracted with any health insurance carriers and is under no obligation to bill or accept any form of insurance payment. The patient agrees that our rates are reasonable and customary based on the geographic location where the treatment was rendered. If requested, MCM may submit a claim to my insurance as a courtesy, but such submission does not create any agreement to accept the insurance rate as full payment.

SUBSCRIBED AND SWORN TO UNDER THE PAINS AND PENALTIES OF PERJURY ON THIS_____DAY _____OF _____ 2026.

Signed:_____ Date:_____
Multi-Care Medical is not in network, but we will bill for out of network when applicable. *

PRINTED NAME:_____

FORT MYERS
13701 Cypress Terrace Cir.
Fort Myers, FL 33907
239-277-1655

CAPE CORAL
1425 Viscaya Parkway, Suite 203
Cape Coral, FL 33990
239-236-5570

NAPLES
860 111th Ave North
Naples, FL 34108
239-228-3221

STAT REQUEST!

Date: _____

DISCLOSURE OF PROTECTED HEALTH INFORMATION

Information may be disclosed by: _____

Tel: _____ Fax: _____

Information to be disclosed to : **MULTI-CARE MEDICAL OF SW FLORIDA**

13701 CYPRESS TERRRACE CIRCLE. FORT MYERS, FL 33907

TEL: (239) 277-1655 FAX: (239) 277-1255

PATIENT WHOSE PROTECTED HEALTH INFORMATION IS TO BE DISCLOSED

Patient Name: _____ Date of Birth: _____

Social Security: _____ Date of Accident: _____

INFORMATION TO BE DISCLOSED

- ☐ ALL MEDICAL RECORDS
- ☐ Final Narrative Dictated Report
- ☐ Patient was involved in a prior MVA on or approximately: _____
- ☐ X-RAYS / MRI / CT / ULTRASOUND
- ☐ Progress Notes / Consultation
- ☐ Other: _____

Expiration Date – This authorization will expire (_____) 2 years from the above referenced date. I understand that if I fail to specify an expiration or event, this authorization will expire six (6) months from the date on which I signed.

Re-Disclosure: I understand that once the above information is disclosed. It may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

Conditioning: I understand that completing the authorization form is voluntary. I realize that treatment will not be denied if I refuse to sign this form.

Revocation: I understand that I have the right to revoke this authorization at any time by giving a written/verbal notice to the office listed above.

_____ _____

Patient Signature Date