

New Patient Health History Form # _____

In order to provide you the best possible wellness care, please complete this form and bring it to your first appointment. All information is strictly CONFIDENTIAL.

Patient Data

Name _____ Date _____ Email _____
Your email will NOT be shared with any 3d parties, and is used for general office announcements and promotions.

Mailing address

Address _____ City _____ State _____ Zip _____
Telephone #'s Hm _____ Wk _____ Cell _____
Preferred method of contact: _____ Email _____ Text _____ Phone/Home/Work/Cell _____
Age _____ Birth date _____ SS # _____ Ref By _____
Occupation _____ Employer _____
Marital Status _____ Spouse's name _____ Spouse's Occupation _____
Spouse's Health Status _____ Emergency contact _____ Phone _____

Current Complaints

Nature of injury: Automobile* Work Other

Please describe _____

Date of injury _____ Date symptoms appeared _____

Have you ever had same condition? No Yes If yes, when? _____

List other practioners seen for this injury/condition _____

Have you ever been under chiropractic care? No Yes

If yes, please describe _____

Insurance Information

Name of party responsible for payment _____ Phone _____

Do you have health insurance? No Yes Name of company _____

** If an auto accident please provide:*

Insurance company name _____ Contact person _____

Phone _____ Claim # _____

Billing Address

Name of the insured _____

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's signature _____ Date _____

Spouse's or guardian's signature _____ Date _____

Medical History

Have you been treated for any conditions in the last year? No Yes Height _____ Weight _____

If yes, please describe _____

Date of last physical exam _____ Is there a chance that you are pregnant? No Yes

Have you had X-rays taken? No Yes If yes, where? _____

What medications are you taking and for what conditions (Please list dosage and amounts, etc). _____

What vitamins, minerals, or herbs do you currently take? (Please list for what condition, dosage, and frequency).

| Have you ever: | No | Yes | Briefly Explain |
|---------------------------|--------------------------|--------------------------|-----------------|
| Broken bones? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Been hospitalized? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Been in an auto accident? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Had Sprains/Strains? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Been struck unconscious? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Had surgery? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

Family History

| Family Member | Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc.) |
|---------------|--|
| | |
| | |
| | |
| | |

| Habits: | None | Light | Moderate | Heavy | | Yes | No |
|-----------------------|--------------------------|--------------------------|--------------------------|--------------------------|--|--------------------------|--------------------------|
| Alcohol | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Do you experience pain every day? | <input type="checkbox"/> | <input type="checkbox"/> |
| Coffee | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Do your symptoms interfere with daily life? | <input type="checkbox"/> | <input type="checkbox"/> |
| Tobacco | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Does pain wake you up at night? | <input type="checkbox"/> | <input type="checkbox"/> |
| Drugs | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Are your symptoms worse during certain times of the day? | <input type="checkbox"/> | <input type="checkbox"/> |
| Exercise | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Do changes in weather affect your symptoms? | <input type="checkbox"/> | <input type="checkbox"/> |
| Sleep | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Do you wear orthotics? | <input type="checkbox"/> | <input type="checkbox"/> |
| Appetite | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Do you take vitamin supplements? | <input type="checkbox"/> | <input type="checkbox"/> |
| Soft Drinks | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | What activities aggravate your symptoms? | | |
| Water | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | What gives relief of your symptoms? | | |
| Salty Foods | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | |
| Sugary Foods | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | |
| Artificial Sweeteners | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | |

Have you ever suffered from:

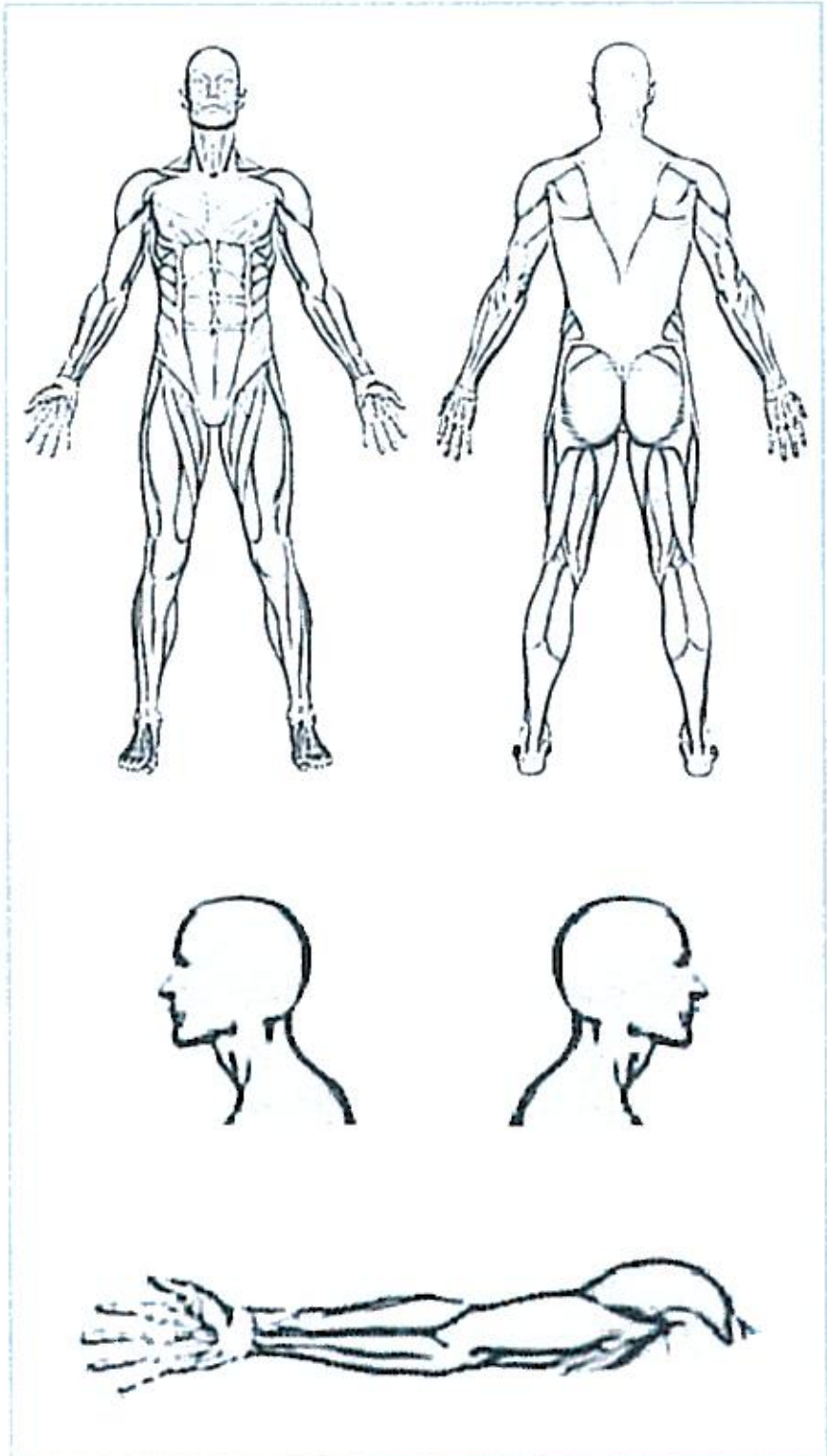
- Alcoholism
- Allergies
- Anemia
- Arteriosclerosis
- Arthritis
- Asthma
- Back Pain
- Breast lump
- Bronchitis
- Bruise Easily
- Cancer
- Chest Pain/Conditions
- Cold extremities
- Constipation
- Cramps
- Depression
- Diabetes
- Digestion Problems
- Dizziness
- Ears Ring
- Excessive Menstruation
- Eye Pain/Difficulties
- Fatigue
- Frequent Urination
- Headache
- Hemorrhoids
- High Blood Pressure
- Hot Flashes
- Irregular Heart Beat
- Irregular Cycle
- Kidney Infection
- Kidney Stones
- Loss of memory
- Loss of balance
- Loss of smell
- Loss of taste
- Lumps In Breast
- Neck Pain or Stiffness
- Nervousness
- Nosebleeds
- Pacemaker
- Polio
- Poor Posture
- Prostate Trouble
- Sciatica
- Shortness of breath
- Sinus Infection
- Sleep problems/insomnia
- Spinal Curvatures
- Stroke
- Swelling of ankles
- Swollen Joints
- Thyroid Condition
- Tuberculosis
- Ulcers
- Varicose Veins
- Venereal Disease
- Other:

Current Complaints (Continued)

Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing.

A=Ache
B=Burning
N=Numbness

O=Other
P=Pins & Needles
S=Stabbing



**AUTHORIZATION TO USE OR DISCLOSE
PROTECTED HEALTH INFORMATION**

Patient Name: _____

Address: _____

Date of Birth: _____ **Date of Request:** _____

As required by the **Privacy Regulations**, this practice may not use or disclose your protected health information except as provided in our **Notice of Privacy Practices** without your authorization.

I hereby authorize this office and any of its employees to use or disclose my **Patient Health Information** to the following person(s), entity(s), or business associates:

Patient Health Information authorized to be disclosed:

For the specific purpose of (describe in detail)

Effective Dates for this authorization ____/____/____ through ____/____/____

This authorization will expire at the end of the above period.

(You may leave dates blank if authorization to the person(s) named above is for **the entire length of your treatment**)

I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond our control.

I understand I have the right to:

1. Revoke this authorization by sending written notice to this office and that revocation will not have any effect on disclosures prior to the executions.
2. Inspect a copy of Patient Health Information being used or disclosed under federal law.
3. Refuse to sign this authorization.
4. Receive a copy of this authorization if needed.
5. Restrict what is disclosed with this authorization.

(Signature of Patient/Guardian) _____
(Date)

(Authorized Signature of Facility) _____
(Date)

VEHICLE ACCIDENT REPORT

Name _____

1) Date of Accident ____ / ____ / ____ 2) Time of Accident ____ : ____ (AM / PM)

3) Were you: A) Driver B) Passenger (Front) C) Passenger (Rear) D) Pedestrian

4) Were you wearing seatbelts? (Y/N) 4a) Make/Model of car: _____

5) Type of Vehicle: A) Auto B) Truck C) Van D) Motorcycle E) Motorhome F) Bicycle

6) How accident occurred: A) Struck by another vehicle B) Struck another vehicle C) Struck a stationary object D) Other

7) Where was your vehicle hit? A) Front B) Rear C) Rt. Side D) Lt. Side E) Rt. Front F) Lt. Front G) Rt. Rear H) Lt. Rear

8) Where was other vehicle hit? A) Front B) Rear C) Rt. Side D) Lt. Side E) Rt. Front F) Lt. Front G) Rt. Rear H) Lt. Rear

9) Your approximate speed ____ MPH 10) Other vehicle approximate speed ____ MPH

11) What occurred at the moment of impact? (Circle as many as apply)

A) Tensed body for impact B) Neck whipped forward & back C) Spine torqued and twisted D) Thrown over seat

E) Thrown from vehicle F) Pinned in vehicle G) Thrown from side to side H) Cut and bruised

12) Did you strike your: (Circle as many as apply)

A) Head Against the: 1) Dashboard 2) Windshield 3) Steering Wheel 4) Rt. Door 5) Lt. Door 6) Seat Frame 7) Unknown Object

B) Shoulder (Lt./Rt.) - Against the: 1) Dashboard 2) Windshield 3) Steering Wheel 4) Rt. Door 5) Lt. Door 6) Seat Frame 7) Unknown Object

C) Arm (Lt./Rt.) - Against the: 1) Dashboard 2) Windshield 3) Steering Wheel 4) Rt. Door 5) Lt. Door 6) Seat Frame 7) Unknown Object

D) Elbow (Lt./Rt.) - Against the: 1) Dashboard 2) Windshield 3) Steering Wheel 4) Rt. Door 5) Lt. Door 6) Seat Frame 7) Unknown Object

E) Wrist (Lt./Rt.) - Against the: 1) Dashboard 2) Windshield 3) Steering Wheel 4) Rt. Door 5) Lt. Door 6) Seat Frame 7) Unknown Object

F) Hip (Lt./Rt.) - Against the: 1) Dashboard 2) Windshield 3) Steering Wheel 4) Rt. Door 5) Lt. Door 6) Seat Frame 7) Unknown Object

G) Knee (Lt./Rt.) - Against the: 1) Dashboard 2) Windshield 3) Steering Wheel 4) Rt. Door 5) Lt. Door 6) Seat Frame 7) Unknown Object

H) Ankle (Lt./Rt.) - Against the: 1) Dashboard 2) Windshield 3) Steering Wheel 4) Rt. Door 5) Lt. Door 6) Seat Frame 7) Unknown Object

13) Were you rendered unconscious? (Y/N) 14) Did you receive medical attention at the scene of the accident? (Y/N)

15) Where did you go immediately following the accident? A) Hospital B) Home C) Personal Doctor D) To this office E) Resumed activities

16) Were you: (Circle as many as apply) A) Shaken B) Disoriented

Did you have any physical complaints before the accident? (Y/N) If "YES" please describe: _____

In your own words, please describe accident and where it occurred: _____

How did you feel immediately after the accident? _____

Important: This form may be used in the determination of insurance benefits and/or litigation for compensation. It is imperative that this form be filled out completely to protect your rights of compensation.

DIAGNOSTIC IMAGING CONSULTANTS, P.A.
A. SCOTT THORPE, DC, DACBR
RICHARD A. LEVERONE, DC, DACBR
TERRY D. SANDMAN, DC, DACBR, MPH
Diplomate's American Chiropractic Board of Radiology

5136 Central Ave., St. Petersburg, FL 33707
Phone (727)579-2500 Fax(727)579-1060
Toll Free (877)579-8800

**ATTENTION: IT IS VERY IMPORTANT THAT YOUR PATIENT SIGNS THIS AGREEMENT
TO COMPLY WITH THE HIPAA COMPLIANCE. WE ALSO NEED THE PATIENTS SIGNATURE TO FILE THE
PROPER INSURANCE FORMS**

**ASSIGNMENT, LIEN AND AUTHORIZATION
INSURANCE BENEFITS**

For and in consideration of receiving services by "Assignee" and for other good and valuable consideration, I hereby agree to the following:

I authorize assignee to release any information pertinent to my case to any insurance company, adjuster, or attorney to facilitate collection under this Assignment, Lien, Reservation of Benefits and Authorization.

ASSIGNMENT OF BENEFITS, RESERVATION AND REQUEST TO ESCROW ANY DISPUTED BENEFITS: I hereby assign my insurance benefits and any and all causes of action available under my policy of automobile insurance to SCOTT THORPE, DC, DACBR, RICHARD A. LEVERONE, DC, DACBR, TERRY D. SANDMAN, DC, DACBR, MPH a/k/a DIAGNOSTIC IMAGING CONSULTANTS, P.A. hereinafter, collectively referred to as the Assignee. Additionally, both the assignee and the undersigned patient acknowledge they are foregoing or assuming certain rights under this agreement that they would not otherwise have under normal circumstances, and as such, agree the same serves as additional consideration for this assignment of benefits to the provider/assignees. In the event my insurance company, obligated to make payments to me upon charges made by assignee for services, refuses to make or reduces such payments and in order to maximize the benefits available under my policy coverage, I hereby request the insurance company (assuming there is coverage remaining at the time the company receives the Assignees' bill and if the company fails to pay Assignee the full amount of the bill(s) submitted), to avoid exhaustion of coverage while Assignee pursues its rights under this Agreement, both parties to this agreement (the Assignee and I) further authorize, direct, notice and request the Insurance Company to set aside and place in escrow an amount equal to the full amount of any such denial or reduction, and to hold that amount in escrow until the dispute is resolved in the appropriate forum.

In the event my insurance company obligated to make payments to me upon the charges made be Assignee for their services refused to make such payments, upon demand by me or Assignee, I hereby assign and transfer to Assignee any and all caused of action that I might have or that might exist in my favor against such company and authorize Assignee to prosecute said cause of action either in my name or in Assignee name and further I authorize Assignee to compromise, settle or otherwise resolve said claim or cause of action as they see fit.

I authorize Assignee to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under this Assignment, Lien and Authorization. I agree that the above mentioned Assignee be given Special Power of Attorney to endorse/sign my name on and all checks and claim forms for payment of my bill.

I understand that I remain personally responsible for the total amounts due the Assignee for their services as insurance coverage may only pay a certain percentage of the bill; as, I may have an insurance deductible or my insurance benefits may exhaust or otherwise be limited. I further understand and agree that this Assignment, Lien and Authorization does not require Assignee to await payments and they may demand payments from me immediately upon rendering services at their option, although the Assignee agrees to first demand immediate payment from the insurance company as their first means of pursuing payment for services rendered. Also, I understand that if this account is assigned to an attorney for collection and/or suit, the assignee shall be entitled to reasonable attorney fees and costs of collection. I also understand that, if any bad check is written, I agree to pay for those added costs.

Dated this _____ day of _____, 20 ____.

Patient's signature

Witness

Patient's printed name

Witness #2

APPLICATION FOR FLORIDA "NO FAULT" BENEFITS

NAME OF
INSURANCE
COMPANY:

Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of third degree.

| | | | |
|------|------------------|------------------|-------------|
| DATE | OUR POLICYHOLDER | 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

TO: CLAIM DEPARTMENT

FOLD HERE

| | | | | |
|---|--|--|-------------------------------------|------------------------------------|
| 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 | A.M. P.M. | 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? YES <input type="checkbox"/> NO <input type="checkbox"/> 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? YES <input type="checkbox"/> NO <input type="checkbox"/> | | DOCTOR'S NAME AND ADDRESS | | |
| IF YOU WERE TREATED IN A HOSPITAL, WERE YOU AN IN-PATIENT? <input type="checkbox"/> OUT-PATIENT? <input type="checkbox"/> | | HOSPITAL'S NAME AND ADDRESS | | |
| AMOUNT OF MEDICAL BILLS TO DATE \$ | WILL YOU HAVE MORE MEDICAL EXPENSE? YES <input type="checkbox"/> NO <input type="checkbox"/> | AT THE TIME OF YOUR ACCIDENT WERE YOU IN THE COURSE OF YOUR EMPLOYMENT? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| DID YOU LOSE WAGES OR SALARY AS A RESULT OF YOUR INJURY? YES <input type="checkbox"/> NO <input type="checkbox"/> | IF YES, AMOUNT LOST 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 UNEMPLOYMENT LAW? YES <input type="checkbox"/> NO <input type="checkbox"/> | | IF YES, AMOUNT \$ | PER WEEK <input type="checkbox"/> | PER MONTH <input type="checkbox"/> |
| 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? YES <input type="checkbox"/> NO <input type="checkbox"/> IF YES, EXPLAIN ON REVERSE SIDE. | | | | |
| I HEREBY AUTHORIZE RELEASE OF MEDICAL INFORMATION INCLUDING, BUT NOT LIMITED TO, MEDICAL BILLS AND REPORTS TO SUCH PERSONS AS THE COMPANY MAY DEEM NECESSARY TO PERFECT ITS RIGHTS OF RECOVERY UNDER THE "NO-FAULT" AUTO INSURANCE LAW. | | | | |
| SIGNATURE: _____ | | | | DATE: _____ |

RECORDING REQUESTED BY:

WHEN RECORDED MAIL TO:

IRREVOCABLE HEALTHCARE POWER OF ATTORNEY

BY THIS POWER OF ATTORNEY:

I, _____ (hereinafter, "Principal") of _____ County, state of _____, do appoint my healthcare provider Dr. Paul A. Raveling (hereinafter, "Attorney"), as my true and lawful attorney in fact. In Principal's name, and for Principal's use and benefit, said Attorney is hereby authorized to:

1. Endorse any and all checks or other forms of reimbursement made payable to Principal (or members of Principal's family) by any auto insurance, health insurance, or 3rd party liability insurance companies which relate to medical treatment provided by Attorney to Principal (or members of Principal's family) over to Attorney.

2. Demand and direct any and all auto, health, or liability insurance companies, during the course of Principal's (or members of Principal's family) medical treatment with Attorney on personal injury cases or major medical matters, to make all reimbursement checks for such treatment payable to Attorney and to send such checks directly to Attorney.

This Special Power of Attorney is created for Attorney's benefit to secure Attorney's right to payment for healthcare services provided and shall be irrevocable throughout the duration of the healthcare services provided by Attorney to Principal arising from any injury or major medical conditions sustained either by Principal or members of Principal's family.

GIVING AND GRANTING to said attorney full power and authority to do all and every act and thing whatsoever requisite and necessary to be done relative to any of the foregoing as fully to all intents and purposes as Principal might or could do if personally present.

All that said attorney shall lawfully do or cause to be done under the authority of this power of attorney is expressly approved.

Dated: _____, 20__

(Signature of Principle)

(Printed Name of Principle)

STATE OF _____ }
COUNTY OF _____ } ss.

On _____, 20__, before me, _____, personally appeared _____, personally known to me (or proved to me on the basis of satisfactory evidence) to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s) or the entity upon behalf of which the person(s) acted, executed the instrument.

WITNESS my hand and official seal.
Signature

(This area for official notary seal)



Raveling Chiropractic Center, P.A.

Dr. Paul A. Raveling, D.C., P.A.
1116 Belcher Road
Dunedin, Florida 34698

Telephone
(727) 733-0433
Fax
(727) 738-6187

NOTICE OF DOCTOR'S LEIN

Patient: _____

Date of Accident: _____

I do hereby authorize Dr. Paul A. Raveling to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was recently involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due the owing him for medical service rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate said doctor.. And I hereby further give a lien on my case to said doctor against any and all proceeds of my settlement, judgment or verdict which may be paid to you, my attorney, or myself, as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

I agree to promptly notify said doctor of any change or addition of attorney(s) used by me in connection with this accident, and I instruct my attorney to do the same and promptly deliver a copy of this lien to any substituted or added attorney(s).

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but may declare the entire balance due and payable. I further direct my attorney to pay said doctor one hundred percent of all chiropractic costs associated with my treatment. I understand all costs associated with my care and believe them to be necessary, reasonable and customary.

Dated _____
Patient's Signature

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict, as may be necessary to adequately protect and fully compensate said doctor above-named. Attorney further agrees that in the event this lien is litigated that the prevailing party will be awarded attorney fees and costs.

Dated _____
Attorney's Signature

Please date, sign and return one copy to doctor's office. Also keep one copy for your records.

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO
DOCTOR PRIVATE AND GROUP ACCIDENT AND HEALTH
INSURANCE

I hereby instruct and direct the _____
Insurance Company to pay by check made out and mailed directly to:

Raveling Chiropractic Center
1116 Belcher Rd.
Dunedin, FL 34698

If my current policy prohibits direct payment to doctor, then I hereby also instruct
and direct you to make out the check to me and mail it as follows:

See Above Address

for the professional or chiropractic expense benefits allowable, and otherwise
payable to me under my current insurance policy as payment toward the total
charges for professional services rendered.

**THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS
UNDER THIS POLICY.** This payment will not exceed my indebtedness to the
above mentioned assignee, and I have agreed to pay, in a current manner, any
balance of said professional service charges over and above this insurance
payment.

A photocopy of this Assignment shall be considered as effective and valid as the
original.

I also authorize the release of any information pertinent to my case to any
Insurance company, adjuster, or attorney involved in this case.

Dated at _____ this _____ day of _____ 20__.

Signature of policyholder

Signature of Claimant, if other than Policyholder
