MOTOR VEHICLE CHECK LIST

PATIENT NAME: _____DOA _____

PATIENT PHONE:_____

MVA INSURANCE:_____CLAIM #_____

ADJUSTOR: _____ PHONE:_____

PATIENT'S ATTORNEY: _____ ATTY PHONE:_____

ATTORNEY'S FAX #:_____CONTACT PERSON:_____

LOP SENT: _____ RECEIVED: _____

EMC RX GIVEN:_____REPORT RECEIVED:_____

MRI RX: CERV___ THORACIC___ LUMBAR___ REPORT RECEIVED:_____

XRAYS TAKEN: CERV_____ THORACIC_____LUMBAR_____

PIP BENEFITS :_____DATE EXHAUSTED:_____

CONTRAINDICATIONS:

_____

_____

IMAGING RESULTS:_____

_____

NOTES:_____

_____

_____

Helping Bodies Perform Better

RUBIN
CHIROPRACTIC
Health Center

NEW PATIENT INFORMATION- AUTO INJURY

Last Name: _____ **First Name:** _____

Date of Birth: _____/_____/_____ **SSN:** _____ **Sex:** Male / Female

Street Address: _____ **Apt/Unit #:** _____ **City/State/Zip Code:** _____

Alternate Address: _____
Street Number **Apt/Unit #** **City** **State** **Zip Code**

Contact Number: _____ **Email Address:** _____

Emergency Contact Name: _____ **Contact Number:** _____

Auto Insurance Information

Auto Insurance Co: _____ **Date of Accident:** _____/_____/_____

Claim #: _____ **Policy #:** _____

Adjustor's Name: _____ **Contact Number:** _____

Attorney: _____ **Contact Number:** _____

Attorney Address: _____

Were you: ( ) Driver ( ) Passenger ( ) Front Seat ( ) Back Seat **Were you wearing a seat belt?** Yes / No

Were you struck from: ( ) Behind ( ) Front ( ) Left Side ( ) Right Side **Were you knocked unconscious?** Yes / No

If yes, how long? _____ **Approximate speed of your car:** _____ MPH **Other car:** _____MPH

Describe how you felt: A) ***During*** the accident: _____

Immediately after the accident: _____

Later that day: _____ **The next day:** _____

In your own words, please describe the accident: _____

_____

_____

Did you have any physical complaints before the accident? Yes / No **If yes, describe:** _____

Are the injuries: ( ) Improving ( ) Getting Worse ( ) Same

Circle any symptoms you have noticed since accident:

Headache	Tension	Numbness in Fingers	Memory Loss	Diarrhea	Fatigue
Neck Pain	Irritability	Numbness in Toes	Ears Ringing/Buzzing	Feet or Hands Cold	Fainting
Neck Still	Chest Pain	Shortness of Breath	Face Flushed	Upset Stomach	Dizziness
Back Pain	Head seems heavy	Loss of Balance	Constipation	Light Sensitivity	Pins & Needles in arms/legs
Nervousness	Depression	Loss of Taste or Smell	Cold Sweats/Fever	Sleeping Problem	Other

Where have you received treatment related to this accident prior to today? List ALL doctors, Emergency Room, physical therapy, x-rays, MRIs, etc.

_____

_____

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**.

__Examination. __X-Ray __Therapeutic Modalities. __Home Exercise Instruction.
__Manipulation. __Home Hot/Cold Pack. __Manual Therapy. __Other:

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 **property 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 (15) and (16), 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.

Helping Bodies Perform Better

RUBIN
CHIROPRACTIC
Health Center

Letter of Protection of Outstanding Charges

Patient Name: _____ **Date of Accident:** _____/_____/_____

Attorney Name: _____ **Attorney Phone #:** _____

Dear Sir or Madam:

Our office has agreed to provide services for the above named patient, related to the above noted date of accident/injury. In exchange for not requiring full payment at the time of service, the patient has agreed to execute this letter of protection and we have agreed to accept this letter of protection.

The patient hereby agrees to pay the billing for our services from any recovery obtained by the patient due to the above noted accident/injury. This letter of protection is intended to be a legally enforceable agreement requiring the attorney(s) and/or law firm representing the patient to pay the billing for our services from any recovery obtained for the patient. Accordingly, this letter of protection includes both the signature of the patient and the authorized signatory for the patient's attorney(s), agreeing to pay the billing for our services from any recovery obtained for the patient.

At the time of any recovery on behalf of the patient for the above noted accident/injury, the attorney(s) agree to request in writing the balance due from our office and we agree to respond in writing stating the balance owed for services related to the above noted accident/injury. Rubin Health Center, P.A. agrees to refrain from collection efforts during the prosecution of the claim related to the above named accident/injury, which is the consideration for offer of protection.

The attorney(s) for the patient agree that any outstanding bill for services owed to us by the patient due to the above noted accident/injury shall be paid directly to us from the amount recovered and collected.

It is intended the patient's signature on this agreement is an irrevocable letter of protection directing payment of our bill by any subsequent attorney of the patient for the above noted accident/injury. If the patient obtains a recovery and has no attorney at the time of such recovery, it is intended this agreement by the patient is a direction to any party paying such recovery to honor this letter or protection. This letter or protection does not eliminate or compromise the obligation of the patient to pay the billing for our services if there is no recovery obtained by the patient.

_____ _____/_____/_____

Patient Signature **Date**

_____ _____/_____/_____

Attorney Signature **Date**

1700 Dr. MLK Jr. St. N. St. Petersburg, FL 33704
727-822-1555 - (Fax) 727-822-1777 – www.rubinhealthcenter.com

Medical History Information

Last Name: First Name:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Widow
Email:		Birth date:	Age:	Sex:
Address:	City:		State:	
ZIP Code:	Social Security No.:	Home Phone:		
Occupation:	Employer:		Employer phone:	

Medical Care Information

Do You Have a Family Doctor?: ☐ No ☐ Yes, Name of Doctor:			
Address:	City:	State:	ZIP Code:
Date of last Visit: / /	Date of last exam: / /		
Do You Have a Family Chiropractor?: ☐ No ☐ Yes, Name of Chiropractor:			
Address:	City:	State:	ZIP Code:
Date of last Visit: / /	Date of last exam: / /		
Have you had surgeries in the last 5 Years: ☐ Yes ☐ No	If yes, Last Surgery Date:		
Reason for Surgery:			

Present illness /Conditions:

☐ AIDS	☐ Cancer	☐ Heart Problem	☐ Multiple Sclerosis	☐ Spinal Disc Disease	
☐ Allergies	☐ Cirrhosis/hepatitis	☐ High blood pressure	☐ Pacemaker	☐ Thyroid trouble	☐ Epilepsy
☐ Anemia	☐ Diabetes	☐ HIV/ARC	☐ Prostate trouble	☐ Tuberculosis	
☐ Arthritis	☐ Dislocated joints	☐ Kidney trouble	☐ Rheumatic fever	☐ Ulcer	
☐ Asthma	☐ Diverticulitis	☐ Low Blood Pressure	☐ Scoliosis	☐ Polio	
☐ Bone fracture	☐ Hay Fever	☐ Mental/ Emotional Difficulty	☐ Sinus trouble	☐ STD'S	

Other:

Family History of illness:

☐ AIDS	☐ Cancer	☐ Multiple Sclerosis	☐ Spinal Disc Disease	☐ STD'S	☐ Ulcer
☐ Allergies	☐ Bone fracture	☐ Heart Problem	☐ Low Blood Pressure	☐ Sinus trouble	☐ Polio
☐ Anemia	☐ Cirrhosis/hepatitis	☐ HIV/ARC	☐ Mental/ Emotional Difficulty	☐ Epilepsy	☐ Scoliosis
☐ Arthritis	☐ Diabetes	☐ High blood pressure	☐ Prostate trouble	☐ Thyroid trouble	☐ Diverticulitis
☐ Asthma	☐ Dislocated joints	☐ Kidney trouble	☐ Rheumatic fever	☐ Tuberculosis	

Other:

Type of Cancer: ☐ Breast ☐ Lung ☐ Other:

Social History:

Alcohol? ☐ No ☐ Yes Drinks per week?	Cigarettes? ☐ No ☐ Yes If yes, please see pg. 2. Packs per day?	Caffeine? ☐ No ☐ Yes Drinks per day?	Exercise? ☐ No ☐ Yes Hours per week? (circle one) Light / Moderate / Strenuous

Misc.:

Smoking

❑ Current every day smoker ❑Current some day smoker ❑Former smoker ❑ Never

Medication Allergies

☐ ACE Inhibitors	☐ Cephalosporin's	☐ HMG-COA Reductase Inhibitors	☐ Macrolides	☐ Paxil	☐Sertraline Derivatives
☐ Amoxicillin	☐ Cipro	☐ Ibuprofen	☐ Mepridine	☐ Penicillin	☐ Sulfa
☐ Aspirin	☐ Codeine	☐ Iodine	☐ Metronidazole	☐ Percocet	☐ Tetracycline
☐ Bactrim	☐ Darvon	☐ Keflex	☐ Morphine	☐ Pravachol	☐ Ultram
☐ Benadryl	☐ Demerol	☐ Levaquin	☐ NSAIDS	☐ Propoxyphene	☐ Zestril
☐ Biaxin	☐Erythromycin	☐ Lipitor	☐ Opioid Analgesics	☐ Quinolones	☐ Zocor
☐ Cefaclor	☐Flagyl	☐Lisinopril	☐ Peroxitine Derivatives	☐ Salicylates	☐ Zoloft

Other:
What are the reactions you face? (i.e. - Hives, Rash, etc.)

Medications

Medication Name	Dose	Form	Route	Frequency	Date Started
E.G. Zyrtec	10 mg	Tablet	By mouth	once per day	10/24/2008

Race: ❑ White ❑African American ❑Asian ❑ Am Indian or AK Native ❑Native Hawaiian or other Pacific Islander ❑Decline

Ethnicity: ❑Non-Hispanic or Latino ❑Hispanic or Latino ❑Decline

Preferred Language: ❑English ❑Spanish ❑Portuguese ❑Italian ❑French ❑Chinese ❑Russian ❑Japanese

Preferred Contact: ❑Phone ❑Email ❑Text ❑Fax ❑Postal Mail ❑Other: _____

Signature: _____ Date: _____

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

1700 Dr. MLK Jr. St. N.
St. Petersburg, FL 33704
(727) 822-1555 – Fax (727) 822-1777

Informed Consent / Assignment of Benefits / Financial Agreement

Patient Name: _____

Authorization for Treatment

I hereby authorize the staff of Rubin Health Center, P.A. to render chiropractic and/or massage services as deemed necessary. I also certify that no guarantee or assurance has been made as to the results that may be obtained. I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also certify that all insurance information give to Rubin Health Center, P.A. is correct and complete; I understand that every attempt will be made by this office to verify my insurance benefits. I understand that it is my responsibility to be aware of what services are covered and what my insurance benefits are for the services rendered. _____ **(initial)**

Provider/Supplier Notice to Beneficiary and Agreement to Pay

Medicare will only pay for services that it determines to be "reasonable and necessary" under the section 1862 (a) (1) of the Federal Medicare statutes. If Medicare determines that a particular service, although it would otherwise be covered is "not reasonable and necessary" under the Medicare program standards, then Medicare would deny payment for that service. It is our understanding that Medicare only covers chiropractic manipulation and will deny payment for any Therapy service(s). If Medicare denies payment, I agree to be personally and fully responsible for payment. ____ **(initial)**

Financial Agreement

I understand that I am financially responsible for services rendered by Rubin Health Center, P.A. Payment is to be made by insurance assignment, by myself and/or authorized guarantor. I understand and agree, regardless of my insurance, I am ultimately and fully responsible for my account for any professional services rendered. I also agree to pay all collection, attorney and court fees that may be incurred for the collection of delinquent accounts. _____ **(initial)**

Attorney Representation and Protection of Balance

I, the undersigned patient, am directing my Attorney _____ to pay any outstanding bills out of my settlement, and in effect, protecting any such balance. I fully understand that I am directly responsible for all medical bills and this agreement is made solely for Rubin Health Center P.A's additional protection and consideration of 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 have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, Rubin Health Center, P.A. will not await payment, but will require me to make payment on a current basis. _____ **(initial)**

Consent for Treatment of Minor

I hereby authorize Rubin Health Center, P.A. to administer chiropractic care as necessary to my child _____ (name). I further attest that I am the parent/legal guardian of said child and legally eligible to approve such authorization. _____**(initial)**

_____ _____/_____/_____

Patient/Legal Guardian Signature **Date**

HIPAA PRIVACY & RELEASE
OF MEDICAL RECORDS AUTHORIZATION

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et.seq., and regulations promulgated there under, as amended from time to time (collectively) referred to as "HIPPA".

This authorization affects your rights in the privacy of your personal healthcare information. Please read it carefully before signing.

Rubin Health Center, P.A. will not condition treatment, payment, enrollment in a health plan or eligibility for benefits, as applicable, on your providing authorization for the requested use or disclosure. *YOU MAY REFUSE TO SIGN THIS AUTHORIZATION.*

By signing this authorization you acknowledge and agree that Rubin Health Center, P.A. may use, disclose or obtain protected health information for the purpose(s) of treatment, payment or health care operations.

By signing this authorization you agree that Rubin Health Center, P.A. may disclose your personal health care information to other medical professionals relating to your treatment, payment or health care operations.

Further, by signing this authorization you acknowledge that you have been provided a copy of and have read and understand Rubin Health Center's HIPAA Privacy Notice containing a complete description of your rights, and the permitted uses and disclosures, under HIPAA. While Rubin Health Center, P.A. has reserved the right to change the terms of its Privacy Notice, copies of the Privacy Notice as amended are available from Rubin Health Center, P.A's office or by sending a written request with return address to 1500 Dr. MLK Jr. St. N. St. Petersburg, FL 33704.

In accordance with your rights under, and subject to certain restrictions imposed by HIPAA, you may inspect or copy your Personal Health Information (PHI) in the designated record set maintained by Rubin Health Center, P.A. for as long as the Personal Health Information (PHI) is maintained in the designated record set.

You have the right to revoke this authorization, in writing, at any time, except to the extent that Rubin Health Center, P.A. has taken action in reliance on it. A revocation is effective upon receipt by Rubin Health Center, P.A. of a written request to revoke this authorization at the address listed above.

This authorization shall expire upon the earlier occurrence of: (a) revocation of the authorization, (b) a finding by the Secretary of the U.S. Department of Health and Human Services, Offices of Civil Rights that this authorization in not in compliance with requirements of HIPAA, (c) complete satisfaction of the purpose for which this authorization was originally obtained, to be determined in the reasonable discretion of Rubin Health Center, P.A. or (d) six years from the date this authorization was executed.

By signing this authorization you acknowledge and agree that any information used, disclosed or obtained pursuant to this authorization could be at risk for re-disclosure by the recipient and no longer protected under HIPAA. Rubin Health Center, P.A. will provide you with a copy of this signed authorization if requested.

By signing this authorization you further agree and acknowledge that Rubin Health Center, P.A. will obtain your medical records as they pertain to your treatment with Rubin Health Center. The records will be obtained for continuity of care purposes only and may include reports, notes, dictation, x-rays, MRIs, lab work

_____ _____

Patient Name **Patient or Parent/Guardian Signature**

_____/_____/_____ _____-_____-_____

Date of Birth **Social Security number**

Records to be disclosed:

_____

_____

_____/_____/_____

Today's Date

Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other treatment options which could be considered may include the following:

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual risks: I have had the following unusual risks of my case explained to me.
I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and herby give my full consent to treatment.

Printed Name	Signature	Date

WITNESS:

Printed Name	Signature	Date

Massage Appointment Cancellation and No Show Policy

NOTICE TO ALL MASSAGE PATIENTS/CLIENTS

AS OF AUGUST 1, 2018

ALL NO SHOW'S FOR MASSAGES WILL BE CHARGED A $45.00 NO SHOW FEE UNLESS A PHONE CALL IS MADE TO THE OFFICE NO LESS THAN (1) ONE HOUR PRIOR TO THE MASSAGE.

PATIENTS WILL BE RESPONSIBLE TO PAY THIS FEE ON THEIR NEXT SCHEDULED VISIT.

_____ _____

Printed Name **Signature**

Today's Date: _____/_____/_____

WAIVER AND RELEASE OF LIABILITY

In consideration of the risk of injury while participating in Massage/Chiropractic Adjustment, and as consideration for the right to participate in the Activity, I hereby, for myself, my heirs, executors, administrators, assigns, or personal representatives, knowingly and voluntarily enter into this waiver and release of liability and hereby waive any and all rights, claims or causes of action of any kind whatsoever arising out of my participation in the Activity, and do hereby release and forever discharge Dr. Scott Rubin / Rubin Health Center, located at 1700 Dr. Martin Luther King Junior Street North, Saint Petersburg, Florida 33704, their affiliates, managers, members, agents, attorneys, staff, volunteers, heirs, representatives, predecessors, successors and assigns, for any physical or psychological injury, including but not limited to illness, paralysis, death, damages, economical or emotional loss, that I may suffer as a direct result of my participation in the aforementioned Activity, including traveling to and from an event related to this Activity.

I AM VOLUNTARILY PARTICIPATING IN THE AFOREMENTIONED ACTIVITY AND I AM PARTICIPATING IN THE ACTIVITY ENTIRELY AT MY OWN RISK. I AM AWARE OF THE RISKS ASSOCIATED WITH TRAVELING TO AND FROM AS WELL AS PARTICIPATING IN THIS ACTIVITY, WHICH MAY INCLUDE, BUT ARE NOT LIMITED TO, PHYSICAL OR PSYCHOLOGICAL INJURY, PAIN, SUFFERING, ILLNESS, DISFIGUREMENT, TEMPORARY OR PERMANENT DISABILITY (INCLUDING PARALYSIS), ECONOMIC OR EMOTIONAL LOSS, AND DEATH. I UNDERSTAND THAT THESE INJURIES OR OUTCOMES MAY ARISE FROM MY OWN OR OTHERS' NEGLIGENCE, CONDITIONS RELATED TO TRAVEL, OR THE CONDITION OF THE ACTIVITY LOCATION(S). NONETHELESS, I ASSUME ALL RELATED RISKS, BOTH KNOWN OR UNKNOWN TO ME, OF MY PARTICIPATION IN THIS ACTIVITY, INCLUDING TRAVEL TO, FROM AND DURING THIS ACTIVITY.

I agree to indemnify and hold harmless Dr. Scott Rubin / Rubin Health Center against any and all claims, suits or actions of any kind whatsoever for liability, damages, compensation or otherwise brought by me or anyone on my behalf, including attorney's fees and any related costs, if litigation arises pursuant to any claims made by me or by anyone else acting on my behalf. If Dr. Scott Rubin / Rubin Health Center incurs any of these types of expenses, I agree to reimburse Dr. Scott Rubin / Rubin Health Center.

I acknowledge that Dr. Scott Rubin / Rubin Health Center and their directors, officers, volunteers, representatives and agents are not responsible for errors, omissions, acts or failures to act of any party or entity conducting a specific event or activity on behalf of Dr. Scott Rubin / Rubin Health Center.

I ACKNOWLEDGE THAT THIS ACTIVITY MAY INVOLVE A TEST OF A PERSON'S PHYSICAL AND MENTAL LIMITS AND MAY CARRY WITH IT THE POTENTIAL FOR DEATH, SERIOUS INJURY, AND PROPERTY LOSS. The risks may include, but are not limited to, those caused by terrain, facilities, temperature, weather, lack of hydration, condition of participants, equipment, vehicular traffic and actions of others, including but not limited to, participants, volunteers, spectators, coaches, event officials and event monitors, and/or producers of the event.

I ACKNOWLEDGE THAT I HAVE CAREFULLY READ THIS "WAIVER AND RELEASE" AND FULLY UNDERSTAND THAT IT IS A RELEASE OF LIABILITY. I EXPRESSLY AGREE TO RELEASE AND DISCHARGE Dr. Scott Rubin / Rubin Health Center AND ALL OF ITS AFFILIATES, MANAGERS, MEMBERS, AGENTS, ATTORNEYS, STAFF, VOLUNTEERS, HEIRS, REPRESENTATIVES, PREDECESSORS, SUCCESSORS AND ASSIGNS, FROM ANY AND ALL CLAIMS OR CAUSES OF ACTION AND I AGREE TO VOLUNTARILY GIVE UP OR WAIVE ANY RIGHT THAT I OTHERWISE HAVE TO BRING A LEGAL ACTION AGAINST Dr. Scott Rubin / Rubin Health Center FOR PERSONAL INJURY OR PROPERTY DAMAGE.

To the extent that statute or case law does not prohibit releases for negligence, this release is also for negligence on the part of Dr. Scott Rubin / Rubin Health Center, its agents, and employees.

In the event that I should require medical care or treatment, I agree to be financially responsible for any costs incurred as a result of such treatment. I am aware and understand that I should carry my own health insurance.

In the event that any damage to equipment or facilities occurs as a result of my or my family's willful actions, neglect or recklessness, I acknowledge and agree to be held liable for any and all costs associated with any actions of neglect or recklessness.

This agreement was entered into at arm's-length, without duress or coercion, and is to be interpreted as an agreement between two parties of equal bargaining strength. Both and Dr. Scott Rubin / Rubin Health Center agree that this agreement is clear and unambiguous as to its terms, and that no other evidence will be used or admitted to alter or explain the terms of this agreement, but that it will be interpreted based on the language in accordance with the purposes for which it is entered into.

In the event that any provision contained within this Release of Liability shall be deemed to be severable or invalid, or if any term, condition, phrase or portion of this agreement shall be determined to be unlawful or otherwise unenforceable, the remainder of this agreement shall remain in full force and effect, so long as the clause severed does not affect the intent of the parties. If a court should find that any provision of this agreement to be invalid or unenforceable, but that by limiting said provision it would become valid and enforceable, then said provision shall be deemed to be written, construed and enforced as so limited.

In the event of an emergency, please contact the following person(s) in the order presented:

Emergency Contact	Contact Relationship	Contact Telephone

Patient Signature _____

Helping Bodies Perform Better

RUBIN
CHIROPRACTIC
Health Center

DISCLOSURE OF NON COVERED CHARGES:

EFFECTICE IMMEDIATELY (11/19/2014)

THIS SHALL SERVE AS WRITTEN NOTIFICATION: SHOULD YOUR INSURANCE COMPANY NOT COVER CERTAIN SERVICES SUCH AS:

**** THE FIRST INITIAL EXAM - CPT CODE 99202**

**** X-RAYS – CPT CODE - 72020, (ALL CPT CODES AND ALL VIEWS OF X-RAYS)**

**** THERAPEUTIC ACTIVITY - CPT CODE 97530**

**** ACUPUNTURE – CPT CODE 97810**

YOU ARE RESPONSIBLE FOR THESE SERVICES. PAYMENT IS REQUIRED UP FRONT. WE WILL BE HAPPY TO BILL IT TO YOUR INSURANCE COMPANY FOR YOU. YOU WILL RECEIVE AN EXPLANATION FROM YOUR INSURANCE COMPANY AS TO WHETHER THEY PAID THE SERVICE. IF THEY SHOULD PAY IT WE WILL BE HAPPY TO REIMBURSE YOU FOR THIS. IF PAYMENT IS NOT COLLECTED UP FRONT AND IT IS DENIED THEN YOU WILL BE BALANCED BILLED FOR THE SERVICE.

_____ _____

PATIENT'S SIGNATURE DATE SIGNED

1700 Dr. MLK Jr. Street N. , St. Petersburg, FL 33704
Ph: 727-822-1555, Fax: 727-822-1777 www.rubinhealthcenter.com