

[REDACTED] DOS: 08/25/2021



[REDACTED]
37 Y old Female, DOB: [REDACTED]
[REDACTED] Account Number: [REDACTED]
APOPKA, FL-32703-5490
Home: [REDACTED]
Guarantor: [REDACTED] Insurance: PROGRESSIVE
CENTRAL PROCESSING UNIT
Referring: - Mauricio Chiropractic West
Appointment Facility: Winter Park-Integrity Medical Group

08/25/2021

Appointment Provider: JACOB PHILLIPS, PA-C

Reason for Appointment

1. Neck pain
2. Low back pain

History of Present Illness

MVA:

Date of Accident: 04/22/2021.
Office Visit: New Patient.
Mechanism of injury: Motor Vehicle Collision.
Position in car: Front seat passenger.
Location of impact: Left front-end collision.
Patient was restrained: Yes.
Was the patient braced for impact: Yes.
Loss of Consciousness: No.
External Signs of Trauma: bruises.
Details of collision: Patient was sitting in the front seat passenger traveling down a two way street when a vehicle on the side road ran a stop sign and impacted the driver side of their vehicle.
Evaluated at Hospital: Patient went to an MD Now the next day.
Did the patient strike anything on the vehicle: airbag.
Previously seen by: Mauricio Chiropractic.
Prior MVA/Slip and Fall Injury no prior motor vehicle accidents.
Additional MVA subsequent to this MVA: No.
Limitations due to the MVA: patient has had to decrease their activities around the house and at work.
History of prior spinal injections done since the accident: No.
Headaches due to the MVA: No.
Neck pain that is: Intermittent, mild pain, localized the cervical region. No numbness or tingling associated with this pain.
Mid back pain that is: Patient currently not experiencing any mid-back pain.
Low back pain that is: Intermittent, moderate pain, localized to the lumbar region. No numbness or tingling associated with this pain .

Current Medications

Taking

- Zinc
- Vitamin D
- Vitamin C
- Ibuprofen

Medication List reviewed and reconciled with the patient

Past Medical History

Patient denies history of major medical illness.

Surgical History

Patient denies surgical history

Social History

Tobacco Use:

Do you use tobacco?: denies.

Drugs/Alcohol:

Do you drink alcohol?: No.
Substance Abuse History?: No.
Patient's Occupation: LPN.
Marital Status: Single.
Number of Children: 2.
Pregnant: No.

Allergies

N.K.D.A.

Hospitalization/Major Diagnostic Procedure

Denies Past Hospitalization

Review of Systems

All Other Systems:

Review of Systems (ROS) See review of 13 systems (Constitutional, Dermatologic, HEENT, Endocrine, Cardiovascular, Pulmonary, GI, GU, Musculoskeletal, Neurologic, Psychiatric, Allergies, Artificial Implants) patient check list on intake form. This was reviewed .

Vital Signs

Ht 66 in, Wt **180 lbs**, BMI **29.05 Index**, BP **111/75 mm Hg**, HR **70 /min**, Ht-cm 167.64 cm, Wt-kg 81.65 kg.

Examination

Neuro Exam:

Soto Hall : Negative.
Cervical Compression test : Negative.
Kemp's Test : Positive.
Straight Leg Raise : Negative.
Cervical spine range of motion : Mildly reduced.
Lumbar spine range of motion : Mildly reduced.
Spinal palpation exam : tenderness to palpation in the lumbar region above the belt line.
Hoffman's Sign Negative.
Clonus Negative.

Imaging:

MRI Cervical Exam Date: 07/28/2021 See report.
MRI Lumbar Exam Date: 07/28/2021 See report.

Neurological:

Cranial nerves including EOM, visual field testing to finger confrontation, facial movement, facial sensation to touch, tongue protrusion, uvular movement, gross hearing, shoulder shrug and speech were without abnormality. Motor examination was within normal limits measuring 5/5 bilaterally in the upper and lower extremities. Deep tendon reflexes were normal 1-2+ at the biceps, triceps, brachioradialis, patellar, ankle jerks bilaterally without pathologic response. Sensory examination to fine touch is intact in all four extremities in all dermatomes. Patient was able to heel and toe stand without problems.

General Examination:

Cardiovascular: The heart has a regular rate and rhythm. No murmurs or rubs were auscultated. Respiratory: Clear to auscultation bilaterally, no wheezes, normal respiratory effort. Gastrointestinal: Abdomen is soft, non-tender and bowel sounds present. Neurologic/Psychiatric: The patient is alert and oriented x 3. Mood and affect appropriate. Speech fluent. Allergic/Immunologic/Lymphatic/Endocrine: No painful or enlarged nodes along the anterior cervical chain.

Assessments

1. Bulging lumbar disc - M51.26 (Primary)
2. Herniated nucleus pulposus, cervical - M50.20
3. Muscle spasms of neck - M62.838
4. Muscle spasm of back - M62.830

* Due to the patient's injuries noted above, which impair their ability to function normally; I believe that their condition met the criteria for an (Emergency Medical Condition) under Florida Statute HB 119.

Treatment

1. Bulging lumbar disc

Start Ibuprofen Tablet, 800 MG, 1 tablet with food or milk as needed, Orally, Three times a day, 30, 90, Refills 1
Start Methocarbamol Tablet, 500 MG, 1-2 tablets, Orally, at night, 30 day(s), 60, Refills 1

2. Herniated nucleus pulposus, cervical

Stop Ibuprofen

3. Others

Notes: Patient presents today for a new patient evaluation. She complains of neck and lower back pains that have been present since her accident. She denies any radicular symptoms into the upper or lower extremities. She has been attending a therapy program and using over-the-counter ibuprofen which does provide some short-term relief of her symptoms. We reviewed her cervical and lumbar spine MRI studies in the office today and discussed a course of spinal injections. She is managing her symptoms well at this time and wishes to continue with conservative means of treatment. I will prescribe Robaxin and ibuprofen to use as needed for muscle spasms and inflammation. I encouraged her to continue her therapy program, light stretching/exercise and activities as tolerated. I will see her back in 4-6 weeks. She understands and agrees with the plan. *** Today's visit included the CPT code 99204. 45-59 minutes was used preparing to see the patient (e.g, review of tests); obtaining and/or reviewing separately obtained history; ordering medications, tests or procedures; documenting clinical information in the electronic health record (EHR) or other records; and communicating with the patient, family, and/or caregiver.

Follow Up

* RTC in 4-6 weeks, I have asked the patient to call the office in the interim if they have any problems or changes in their symptoms

Appointment Provider: JACOB PHILLIPS, PA-C



Electronically signed by JACOB PHILLIPS , PA-C on 08/25/2021 at 10:45 AM EDT

Sign off status: Completed

Winter Park-Integrity Medical Group
1801 LEE RD
STE 304
WINTER PARK, FL 32789-2101
Tel: 321-765-4373
Fax: 407-542-0666

Progress Note: JACOB PHILLIPS, PA-C 08/25/2021

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)



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**.

99204

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

AUG 25 2021

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*):

Jacob Phillips, PA-C

Name (PRINT or TYPE)

Signature

AUG 25 2021

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.

Integrity Medical Group, LLC

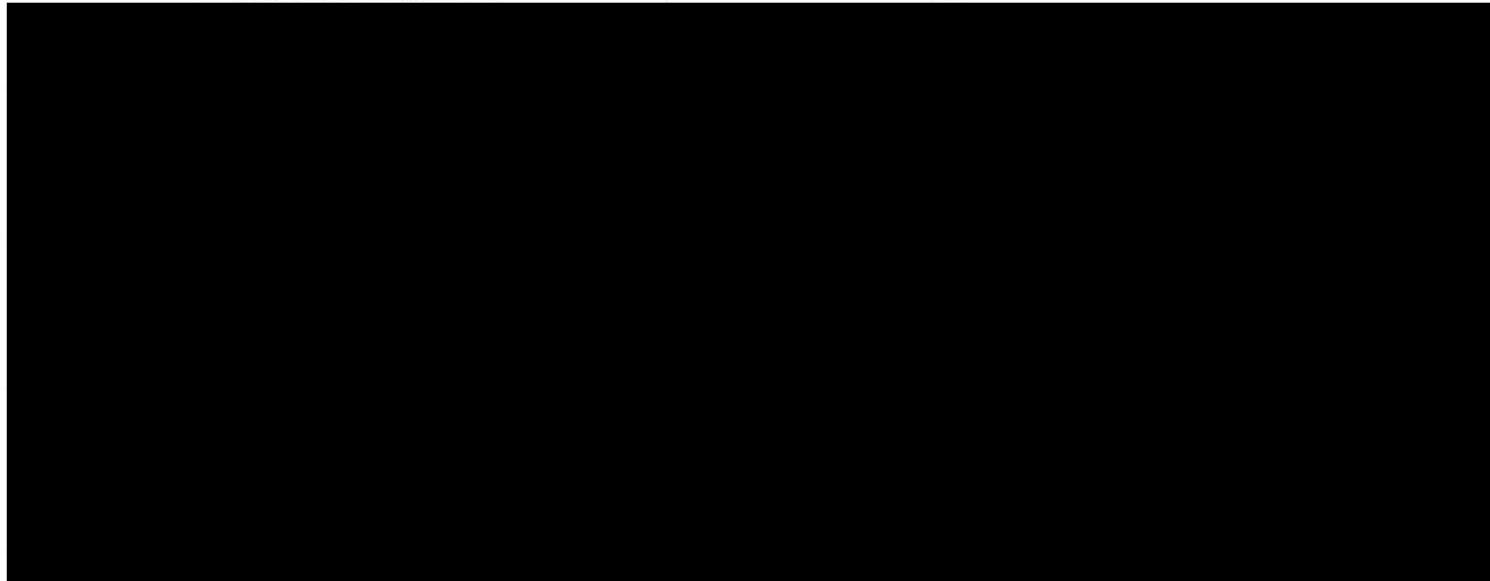
AUTO

Confidential Patient Case History

This questionnaire was designed to provide important facts regarding the history of your pain or condition. The information you provide will assist in reaching a diagnosis and determining the source of your problem. Please take the time and answer each question as completely as possible. Please sign each page.

Patient Information

TODAY'S DATE: 8/25/21



NAME OF YOUR INSURANCE COMPANY: Progressive

DATE OF ACCIDENT: 4/22/21 Name on the Policy: [REDACTED]

POLICY #: [REDACTED] CLAIM #: don't have it today

ADJUSTER'S NAME: _____ PHONE #: (____) _____

IF YOU DO NOT HAVE YOUR OWN INSURANCE, DO YOU LIVE WITH SOMEONE WHO DOES? YES / NO

NAME OF THE POLICY HOLDER: _____ RELATIONSHIP: _____

POLICY #: _____ CLAIM #: _____

ARE YOU BEING REPRESENTED BY AN ATTORNEY? Y / N

ATTORNEY'S NAME: _____ PHONE #: (____) _____

ADDRESS: [REDACTED] CITY: _____ STATE: _____ ZIP: _____

SIGNATURE: [REDACTED] DATE: 8/25/21

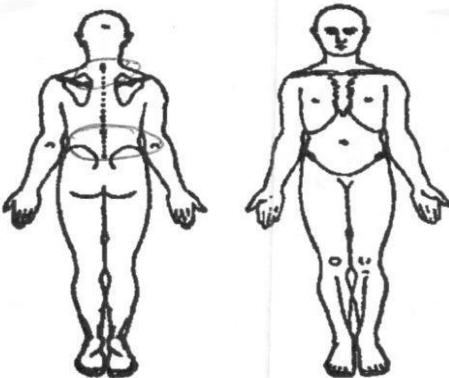
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Revised 04.27.2021

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CURRENT CONDITION

USING THE FOLLOWING DRAWINGS, PLEASE INDICATE AREAS OF CHIEF COMPLAINTS FOR WHICH YOU ARE SEEKING TREATMENT.



For how long have you had this condition? Since April 22 Have you had this condition in the past? YES / NO

PROGRESS: WORSE SAME CONSTANT COMES AND GOES

Is this condition interfering with your daily routine? WORK SLEEP DAILY ROUTINE OTHER: _____

List treatments you have had for this problem and all health professionals that you are currently seeing:

PHYSICIANS	SPECIALTY	TREATMENT DURATION

BRIEFLY DESCRIBE THE ACCIDENT:

riding down one way someone hit us on side
after running stop sign.

Destination after the accident/injury:

When did you go to the hospital? _____ / _____ / _____ Hospital Name: _____

Who drove you to the hospital? _____ Were you admitted? _____

Date discharged: _____ / _____ / _____ Were X-rays taken? YES / NO Describe: _____

Has a doctor or dentist ever diagnosed a TMJ disorder prior to the accident? _____

SIGNATURE: Hope Williams **DATE:** 8/25/21

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Revised 07/01/2019

Integrity Medical Group, LLC

MEDICAL HISTORY

PLEASE INDICATE WHICH OF THE FOLLOWING CONDITIONS APPLY TO YOU OR YOUR FAMILY MEDICAL HISTORY

YOU	FAM.	Condition	YOU	FAM.	Condition
		Allergies			Artificial Implants
		Arthritis			Blood Disorders
		Endocrine disorders: diabetes, osteoporosis, thyroid, etc.			Heart/Circulatory Disorders
		Eyes/Vision Disorders			HIV Disorders
		Liver Disease			Kidney/Urinary Disorder
		Lung/Respiratory Disorders			Muscle Disorders
		Nervous Disorders: multiple sclerosis, Alzheimer's, epilepsy, etc.			Stomach/Intestinal Disorders

HEIGHT: 5'10 WEIGHT: 180 CHILDREN: 2

SMOKER: YES / NO ALCOHOL CONSUMPTION: YES / NO

RECREATIONAL DRUGS: YES / NO

Allergies to any medications: none

Surgical History: none

Occupation: _____

MARITAL STATUS: Married/Single/Divorced/Widow

Have you had to reduce work related activities due to injuries sustained from this accident? YES / NO

LIST ALL OVER THE COUNTER AND PRESCRIPTION MEDICATIONS YOU ARE CURRENTLY TAKING:

Ibuprofen, Tylenol

Prior to this occurrence, have you been in an auto accident? YES / NO WHEN? _____

DESCRIBE: _____

Have you had any other personal injury or incident? YES / NO WHEN? _____

DESCRIBE: _____

Is there any possibility that you may be pregnant? YES / NO / MAYBE

How far along? _____ Due date: _____ / _____ / _____

PATIENT'S SIGNATURE: _____

Date: 8/25/21

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Revised 07/02/2019

Integrity Medical Group, LLC

Donald Behrmann, M.D.
Thomas Cooper, M.D.
Pedro Ramirez, M.D.
Paul Shuler, M.D.
Debra Eriksen, D.O.
Thomas Koehne, P.A.-C
Jacob Phillips, P.A.-C
Rafael Romero, P.A.-C
Patricia McFadden, P.A.-C
Kurt Wood, P.A.-C
Shahed Hmeidan PA-C

INITIATION OF TREATMENT

To Whom It May Concern:

This is to inform you that I was injured in a motor vehicle accident. This letter is to confirm that I intend to initiate treatment therapy as outlined by the doctors at **Integrity Medical Group, LLC**

CONSENT FOR TREATMENT

I hereby authorize your practice and whomever the doctor may designate as assistant to perform examination, physiotherapy, physical therapy and perform non-invasive diagnostic tests and, if any unforeseen condition arises in the course of the procedures calling for judgment, procedures in addition to or different from those contemplated. I further request and authorize this office to perform whatever my treating doctor deems advisable. The nature and purpose of these procedures have risks involved and the possibility of complications has been fully explained to me. I acknowledge that no guarantee has been made to me as to the result that may be obtained. I have the right to refuse additional treatment aside from a consultation.

DATE: 8/25/21

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Integrity Medical Group, LLC

NOTICE of EMERGENCY MEDICAL CONDITION

The undersigned licensed medical provider, hereby affirms:

1. The below injured patient, has in the opinion of this medical provider, suffered an **Emergency Medical Condition**, as a result of the patient's injuries sustained in an _____
2. Automobile accident that occurred on 4-22-21
3. The Basis for the findings of an **Emergency Medical Condition** is that the patient Has sustained acute symptoms of sufficient severity, which may include severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following a) Serious jeopardy to the patient health; b) Serious impairment to body functions; or c) Serious dysfunction of a body system or part.

I hereby attest than I am a licensed physician under chapter 458 chapter 459, an advanced registered nurse practitioner under chapter 464 or a physician's assistant licensed under chapter 458, ad that the above facts are true and correct.

x_____

Provider Signature

Jacob Phillips, PA-C

AUG 25 2021
Date

The undersigned person or legal guardian of such person affirms:

1. The symptoms I reported to the medical provider are true and correct.
2. I understand that the medical provider has determined that I sustained an **Emergency Medical Condition** as a result of the injuries I sustained in the automobile accident.
3. The medical provider has explained to my satisfaction the need for future medical attention and harmful consequences to my heath which may occur if I do not receive future treatment.

Injured patient receiving this diagnosis or legal guardian of said injured patient

AUG 25 2021
Date

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KISSIMMEE
206 West Oak Street, Suite B, Kissimmee, FL 34741
Phone: 407-930-0838 Fax: 407-930-0841

Revised 10/29/18

Integrity Medical Group, LLC

ASSIGNMENT OF INSURANCE BENEFITS, RELEASE, & DEMAND

Insurer and Patient Please Read the Following in its Entirety

I, the undersigned patient/insured knowingly, voluntarily and intentionally assign the rights and benefits of my automobile Insurance, also known as Personal Injury Protection (P.I.P.), and Medical Payments policy of insurance to the above health care provider. 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 and that this document will allow the provider to file suit against an insurance company for payment of the insurance benefits. This assignment of benefits includes overdue interest payments and any potential claim for common law or statutory bad faith. If the insurer disputes the validity of this assignment of benefits then the insurer is instructed to notify the provider in writing within five (5) days of receipt of this document. Failure to inform the provider 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 directly without including the patient's name on the check.

The insurer is directed by the provider 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 and the insurer as to the amount payable under the insurance policy or contract. The provider hereby objects to any reductions or partial payments. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by the provider shall be done so under protest, at the risk of the insurer, and the deposit shall not be deemed a waiver, accord, satisfaction, discharge, settlement or agreement by the provider to accept a reduced amount as payment in full. The insurer is hereby placed on notice that this provider reserves the right to seek the full amount of the bills submitted.

If the insurer schedules a defense examination or examination under oath (herein after "EUO") the insurer is hereby INSTRUCTED to send a copy of said notification to this provider. The provider or the provider's attorney is expressly authorized to appear at any EUO or IME 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. The health care provider is given the power of attorney to endorse my name on any check for services rendered by the above provider and to request any statements or examinations under oath the patient provided to any insurer.

Release of information: I hereby authorize this provider 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 in writing (declaration sheet) 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 statements the patient provided to the insurer; obtain copies of all medical records, including but not limited to, documents, reports, scans, notes, bills, opinions, X-rays, IMEs, and MRIs, from any other medical provider or any insurer. The provider 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 and the insurer is not authorized to provide these medical records to anyone without the patient's and the 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 this provider 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 a bill from this provider and claim from anyone else is received by the insurer on the same day then the insurer is directed to pay this provider first before the policy is exhausted. In the event this provider's medical bills are disputed by the insurer for any reason the undersigned hereby instructs the insurer to set aside any amount disputed (i.e., to escrow the money) and not pay the disputed amount to anyone, including myself, or any entity until the dispute is resolved. The insurer is instructed to immediately explain in writing to the above provider of any dispute.

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 the results that may be obtained by any treatment or service; I agree the provider's prices for medical services, treatment and supplies are reasonable and customary.

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.

Printed Name (Signature)

Date

8/25/21

Facility Signature:

WINTER PARK, 1801 Lee Road, Suite 304, Winter Park, FL 32789
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Revised 07/01/2019

Integrity Medical Group, LLC

HEALTH INSURANCE DETAIL

TODAYS DATE: 8/25/21

DO YOU HAVE HEALTH INSURANCE: YES NO ✓

If you answered YES, please fill out below.

LAST NAME: _____

FIRST NAME: _____

DOB: _____

HEALTH INSURANCE
COMPANY: _____

ID# _____ GROUP# _____

ADDRESS: _____

PHONE#: _____

NAME OF PRIMARY HOLDER: _____

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Revised 07/02/2019

Integrity Medical Group, LLC

Consent to Obtain Prescription History

This consent form authorizes Integrity Medical Group, LLC to obtain and review my prescription history. Detailed prescription history provides your physician with information about medications being prescribed by other providers involved in your medical care. This information will improve the accuracy of our medication list in your medical chart and decrease any adverse drug reactions or inaccurate medication information such as medication names or dosages.

By signing this consent form you agree that Integrity Medical Group, LLC can request and use your prescription medication history from other healthcare providers, pharmacies, and benefit payors (such as your insurance company) for treatment purposes.

Understanding all of the above, I hereby provide informed consent to Integrity Medical Group, LLC to request, view, and use my external prescription history for treatment purposes. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Patient Name (Printed): _____
 Patient Signature: _____
 Patient Date of Birth: _____
 Date of Signing Consent Form: _____ 8/24/21

Primary Pharmacy Information:

Pharmacy Name: Walgreens
 City: _____ State: FL Zip Code: 32703
 Nearest Cross Street: _____
 Pharmacy Phone Number: _____

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Integrity Medical Group, LLC

POWER OF ATTORNEY TO ENDORSE CHECKS

KNOW ALL MEN BY THESE PRESENT: That the undersigned has made constituted and appointed, and by these presents does hereby make, constitute and appoint the *Integrity Medical Group, LLC* any and all of its duly authorized agents and employees as and to be the undersigned's true and lawful attorney for and in the undersigned's name, place and stead to endorse any and all checks, drafts, or money orders which are made payable to the undersigned alone or is the undersigned and the said *Integrity Medical Group, LLC* which checks, drafts, or money orders are to pay for the services of the like which have been made by _____ (Ins. Co.) at the request or with the knowledge and approval of the undersigned and/or the maker of the check, draft or money order.

The undersigned by these presents does give and grant unto the said *Integrity Medical Group, LLC* as attorney the full power and authority to do and perform all and every act and thing what so ever requisite and necessary to be done in and about the premises as fully to all intents and purposes as the undersigned might or could do to personally present in so far as the endorsing and cashing of said checks are concerned.

The undersigned does hereby ratify and confirm any and all actions taken by the said attorney in accordance with this special power of attorney and which they said attorney shall do or cause to be done by virtue of these presents.

IN WITNESS WHEREOF the undersigned have hereunto set their hands, thus
25 Day of August, 2021.
 (Day) (Month) (Year)

PATRON

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KISSIMMEE
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 Phone: 407-930-0838 Fax: 407-930-0841

Revised 05.29.2019

INTEGRITY MEDICAL GROUP, LLC

Patient Acknowledgement and Waiver

To the extent that, I [REDACTED], have health insurance benefits for which my medical service provider may have a provider agreement ("Provider Agreement") in effect with such health insurance provider, I acknowledge that:

Despite any requirements in the "Provider Agreement" for provider to submit claims for services and treatments (collectively Services) to my health insurance plan within a particular timeframe, and despite any statement in the provider agreement notifying the medical services provider that failure to submit claims for services within a specific timeframe will preclude payment to the provider and prohibit the medical services provider from charging me (or anyone else related to me) for said services, medical service provider will not be submitting claims to my health insurance plan for any services he/she has rendered to me; and

I have certain third-party beneficiary rights under the provider agreement and I hereby relinquish those rights voluntarily, knowledgeably, and intentionally.

I, [REDACTED] further acknowledge that:

I will be responsible for the payment for all services rendered to me by the medical services provider;

In lieu of the medical services provider billing me or my health insurance plan for my services, health insurance provider, health insurance provider will enter into a medical lien with myself whereby medical services provider will be compensated for all services he/she provides to me, as a direct or indirect result of my personal injury case, from the proceeds of my settlement of said personal injury case; and

The compensation that medical services provider will receive under the medical lien will likely exceed the compensation that medical services provider would have received if the medical services provider would have submitted claims to my health insurance plan for my services, and I believe that such additional compensation is equitable in light of the nature of the services that medical services provider will be furnishing to me.

I have read and I understand all of the statements above. I acknowledge and understand that I have a right to consult with legal counsel before signing this Patient Acknowledgement and Waiver. I hereby execute this Patient Acknowledgement and Waiver voluntarily, knowledgeably and intentionally

Patient: [REDACTED]

Signature: [REDACTED]

Date: 8-25-21

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INTEGRITY MEDICAL GROUP, LLC

NOTICE OF PHYSICIAN'S FINANCIAL INTEREST

A physician must notify a patient that the owner of the medical practice has a direct financial interest in a separate diagnostic facility where the patient has been referred for services. (Florida statutes 456.052). We will support these laws in order to help patients make informed and reasoned decisions concerning their medical care

In compliance with the requirements of these laws, Donald L Behrman M.D. PhD. The owner of Integrity Medical Group, has ownership interest in Orlando Surgery Center located at 3435 Pinehurst Ave., Orlando, FL. 32804.

In compliance with the requirements of these laws, Paul Shuler M.D. and employee of Integrity Medical Group has ownership interest in Sand Lake Surgical Center located at 7477 Sand Lake Commons Blvd., Orlando, FL. 32819

The surgical services recommended by your treating physician are available elsewhere on a competitive basis by Millennia Surgery Center located at 4901 Vineland Rd. Orlando Florida. 32811 and Park Place Surgery Center located at 2450 Maitland Center Pkwy., Unit 100, Maitland, Florida. 32751

The law requires your acknowledgment that you have read and understood this disclosure by signing and dating this form in the space provided below. We will keep the signed original and your patient file and you may receive a copy upon request.

ACKNOWLEDGEMENT: I have read this "Notice of Physician's Financial Interest" form, and I understand by signing this form that the treating physician at Integrity Medical Group has recommended services at a facility where the owner of Integrity Medical Group has a direct financial interest.

Dated this 25 date of Aug 21

Signature of Patient or Guardian

WINTER PARK: 1801 Lee Road. #304. Winter Park, FL. 32789
KISSIMMEE • 206 W. Oak St. Ste B Kissimmee, FL. 34741.
LAKE MARY: 978 International pkwy, Suite 1440. Lake Mary, FL 32746
THE VILLAGES: 17820 SE 109th Avenue. STE 104. Summerfield, FL. 34491

INTEGRITY MEDICAL GROUP, LLC

LIEN LETTER

Date:

RE:

I do hereby authorize you, my attorney, to pay directly to Integrity Medical Group, LLC, such sums as may be due and owing it for medical services rendered me by reason of the accident on _____ and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect Integrity Medical Group, LLC.

I understand that Integrity Medical Group, LLC, will not be filing a claim to my health insurance company, if one exists, for services rendered as a result of this accident. In the event that I am a third-party beneficiary under a contract between Integrity Medical Group, LLC and my health insurance carrier, I hereby voluntarily and intentionally waive and relinquish my rights privileges and advantages as a third-party beneficiary under that contract.

I understand that the provider has the right to assign the collection rights for medical expenses related to the medical care I received to an "assignee" or "third party". Lastly, I understand that I will not be liable for any amount of other than the actual amount listed in the "Services Bill" from the medical provider

I agree never to rescind this document and that rescission will not be honored by my attorney. I also agree and understand this document to be valid upon my signature. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney honor this lien as inherent to the settlement and enforceable upon the cases as if it were executed by him.

I fully understand that I am directly and fully responsible to Integrity Medical Group, LLC for all medical bills and services rendered to me and that this agreement is made solely for the additional protection of Integrity Medical Group, LLC and in consideration of the Integrity Medical Group's awaiting payment. I further understand that as the recipient of the medical services, I remain personally responsible for the payment of these services even if unsuccessful in my liability claim and that payment for these medical services is not contingent on any settlement, judgment or verdict I may receive. I hereby further state and agree that a photocopy of this document is deemed as valid and binding on all parties involved as the original. I further understand that this provider lien is assignable and transferable.

Dated: 8/25/21

Patient's Signature: 

Attorney/Law Firm Name:

Morgan and Morgan

This facility holds an assignment/lien on this case for medical services rendered. Any settlement of this claim without honoring this assignment/lien will cause you to be responsible to this facility for payment.

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INTEGRITY MEDICAL GROUP, LLC

SURGERY CANCELLATION POLICY

Integrity Medical Group requires at least 48 business hours cancellation notice for surgical procedures. Please be aware that time is immediately blocked upon scheduling your procedure. If adequate notice is not given, we are unable to utilize this time for another patient.

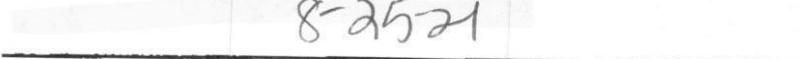
If you fail to notify our office of your cancellation at least 48 business hours prior to the procedure you will be charged a \$5000 cancellation fee. This fee will not be paid by your insurance company. This will be a fee that you must pay personally or through your medical Lien if one is on file.

We do understand that there may be extenuating circumstances such as cancellations secondary to medical problems or abnormal labs. In these cases a fee will not be charged to your count.

By signing below you indicate that you understand the above policy and agree to said charges if adequate notice is not given.


Patient Signature


Patient Name


Date

WINTER PARK: 1801 Lee Road, #304, Winter Park, FL 32789
KISSIMMEE • 206 W. Oak St. Ste B Kissimmee, FL 34741.
LAKE MARY: 978 International pkwy, Suite 1440, Lake Mary, FL 32746
THE VILLAGES: 17820 SE 109th Avenue, STE 104, Summerfield, FL 34491

Integrity Medical Group, LLC

RELEASE OF PATIENT RECORDS AUTHORIZATION

I authorize the release of a full report of examination findings, diagnosis, treatment program, etc., to any referring or treating dentist or physician. I additionally authorize the release of any medical information to insurance companies or for legal documentation to process claims. I understand that I am responsible for all charges for the treatment rendered to me regardless of insurance coverage.

I understand and agree that health and accident policies are an arrangement between an insurance carrier and me. Furthermore, I understand that Integrity Medical Group, LLC 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 Integrity Medical Group, LLC will be credited to my account on receipt. 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 understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

I hereby authorize Integrity Medical Group, LLC to release a copy of my patient records or x-rays containing protected health information to my insurance company and/or attorney representing me in this case. This authorization is given pursuant to Florida Statute 456.057 and HIPAA regulations. I understand that Florida Statute 456.057 (12) makes clear that any third party to whom records are disclosed is prohibited from further disclosing any information in the medical records without the expressed written consent of the patient or his/her representatives.

8/25/21 *5/2/82*

Patient's Date of Birth

8/25/21

Date Signed

Specific description of information to be disclosed: _____

PATIENT SIGNATURE: _____ DATE: _____

WINTER PARK, 1801 Lee Road, Suite 304, Winter Park, FL 32789
 KISSIMMEE, 206 W. Oak Street, Suite B, Kissimmee, FL 34741
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 THE VILLAGES, 17820 SE 109th Avenue, Ste. 104 Sunnenfield, FL 34491

Revised 07/02/2019

Integrity Medical Group, LLC

Patient's Name: [REDACTED] DOB: [REDACTED]
 Social Security #: [REDACTED] D/A: [REDACTED]

I request and authorize: _____

To release healthcare information of the patient named above to: **Integrity Medical Group, LLC**

- 1801 Lee Road, Ste. 304, Winter Park, FL 32789 ♦ Ph: (321) 765-4373 / Fax: (407) 542-0666
- 206 W. Oak St.; Ste. B Kissimmee, FL 34741 ♦ Ph: (407) 930-0838 / Fax: (407) 930-0841
- 978 International Pkwy, Ste. 1440, Lake Mary, FL 32746 ♦ Ph: (321) 765-4373 / Fax: (407) 542-0666
- 17820 SE 109th Ave., Suite 104, Summerfield, FL 34491 ♦ Ph: (352) 320-3200 / Fax: (352) 320-3210

This request and authorization applies to:

- Full medical records held by this office
- A specific portion/section of the record as follows: _____
- Radiology reports
- Medical record for the period _____ through _____
- Other diagnostic studies: _____

Purpose of the requested disclosure: _____ At patient's request. _____ Continuing Care

I understand that I have the right to revoke this authorization at any time. My revocation must be in writing in a letter provided to the privacy officer. I am aware that my revocation is not effective to the extent that the person I have authorized to use and/or disclose my Protected Health Information have acted in reliance upon this authorization. I understand that I do not have to sign this authorization and that **Integrity Medical Group, LLC** may not condition treatment on whether I sign this authorization. I further understand that if the person(s) or organization(s) authorized to receive the information is not a health plan or health care provider, the release information may be re-disclosed and would no longer be protected by federal privacy regulations.

I agree that a copy of this release or fax of this release shall be as valid as the original release.

If I authorize **Integrity Medical Group, LLC** to fax information, I realize there are inherent risks in faxing Protected Health Information; I understand a fee will be charged to cover the cost of copying, including the cost of supplies and labor of copying and mailing Protected Health Information released to anyone other than another health care provider. I understand I will get a copy of this form after I sign it.

[REDACTED]

[REDACTED]

Date
Signed: _____

8/25/21

THIS AUTHORIZATION EXPIRES 365 DAYS FROM THE DATE IT IS SIGNED

WINTER PARK, 1801 Lee Road, Suite 304, Winter Park, FL 32789
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 THE VILLAGES, 17820 SE 109th Avenue, Ste. 104 Summerfield, FL 34491

Revised 07/02/2019

Integrity Medical Group, LLC

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

Patient Name (please print)

8/25/21

Date

Parent, Guardian or Patient's legal representative

Signature

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.

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Revised 07/02/2019

Integrity Medical Group, LLC

COMMUNICATION PREFERENCE FORM

Patient Name (please print): [REDACTED]

Date of Birth: [REDACTED]

Please indicate which of the following numbers you would like for us to use:

- Home Phone: (____) - [REDACTED] Work Phone: (____) - [REDACTED]
 Cell Phone: [REDACTED]

E-mail: _____

Please note, if you supply a cell phone number and/or an email address, you will receive appointment reminders through these methods. You may later opt-out of them if you wish.

What is your preferred communication method? Email Phone Text

In an effort to guard your privacy, please answer the following questions on how best to contact you regarding communication from Integrity Medical Group, LLC. In regards to messages left on voicemail or an answering machine, you authorize your doctor or staff (please choose one):

- To leave messages regarding your medical condition(s), as well as appointment reminders, billing/financial questions, and requests to call the office.
 To leave only messages regarding appointment reminders and requests to call the office. Do not reference your medical condition(s) in the message.

If you wish to allow IMG staff to discuss your protected health information (PHI) with a person(s) you appoint, please fill out the sections below.

- IMG may share medical, billing, and appointment information with the following individuals:
 Spouse or significant other: _____
 Son(s) or daughter(s): _____
 Any relative: _____
 Other (nursing home, friend, caregiver, etc.): _____

Authorization

I understand I may notify the doctor's office at any time of changes to this request, which would require a new form and authorization to be completed.

[REDACTED]
Signature

8/25/21
Date

WINTER PARK, 1801 Lee Road, Suite 304, Winter Park, FL 32789
 KISSIMMEE, 206 w. Oak Street, Suite B, Kissimmee, FL 34741
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Revised 07/02/2019

Your ID Cards

Keep these cards handy--in your glove compartment or wallet. And contact us anytime you have a question or need to report a claim.

If you have a claim, we'll get you back on the road as soon as possible. And while you'll always have a choice where to repair your vehicle, when you use a shop in our preapproved network, we'll guarantee your repair for as long as you own or lease your vehicle.

Thank you for choosing Progressive.

  Silver Level  Form A022 FL (10/20)	<p>Florida Automobile Insurance Identification Card</p> <p>Insurer: Progressive Select Insurance Co - 02960 Effective Date: 07/21/2021 Policy Number: [REDACTED] Expiration Date: 01/21/2022</p> <p><input checked="" type="checkbox"/> Personal Injury Protection <input checked="" type="checkbox"/> Bodily Injury Liability Benefits/Property Damage Liability See policy and outline of coverage; Named Insured(s): [REDACTED] damage to a rental vehicle is covered to the extent shown therein. ®</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;">Year</th> <th style="text-align: left;">Make</th> <th style="text-align: left;">Model</th> <th style="text-align: left;">VIN</th> </tr> </thead> <tbody> <tr> <td>[REDACTED]</td> <td>[REDACTED]</td> <td>[REDACTED]</td> <td>[REDACTED]</td> </tr> </tbody> </table> <p>NAIC Number: 10192 NOT VALID FOR MORE THAN ONE YEAR FROM EFFECTIVE DATE.</p> <p>IF YOU'RE IN AN ACCIDENT 1. Remain at the scene. Don't admit fault. 2. Find a safe location, call the police, and exchange driver information. 3. Call Progressive right away.</p> <p>TO REPORT A CLAIM Call 1-800-274-4499 or go to claims.progressive.com.</p> <p>PROGRESSIVE®</p> <p>KEEP THIS CARD IN YOUR VEHICLE WHILE IN OPERATION.</p>	Year	Make	Model	VIN	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
Year	Make	Model	VIN						
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]						

INTEGRITY MEDICAL GROUP, LLC

Donald L Behrmann, MD, PhD

Thomas Cooper, MD

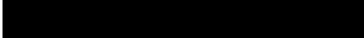
Pedro Ramirez, MD

Paul Shuler, MD

FAX / EMAIL REFERRAL

Fax: (407) 542-1072

Email: referrals

Patient Name 

Date: 8-10-2021

Insurance: Progressive

Claim# 

Phone: 

Cell:

Chief Complaint: Post traumatic cervical + lumbar injury

DOB 

Referring Physician: Carlos H. Osuna

Office# 407 814 0985

Office Fax# 407 814 0119

Email: mauriciorecords@live.com

PLEASE COMPLETE FORM AND FAX TO OFFICE WITH MOST RECENT OFFICE NOTES, DIAGNOSTIC REPORTS, PATIENT DEMOGRAPHICS AND INSURANCE INFORMATION

-Neurosurgery (Spine) Orthopedic (second opinion)

Cervical

Thoracic

Lumbar

Other _____

Orthopedic (Extremity)

Shoulder R L Knee R L Hip R L Ankle R L

Hand/Wrist R L Other _____

Pain Management

Cervical

Thoracic

Lumbar

Other _____

- 1801 Lee Rd., Ste 304, Winter Park, FL 32789. T: (321) 765-4373 F: (407) 542-0666
- 206 W. Oak St., Ste B. Kissimmee, FL 34741. T: (407) 930-0838 F: (407) 930-0841
- 978 International Parkway, Ste 1440, Lake Mary, FL 32746. T: (407) 624-5028 F: (407) 624-5040

Patient must bring MRI CD to office visit. Thank You for choosing Integrity Medical Group, LLC