NEW PATIENT REFERRAL INFORMATION
Please complete *ALL* fields. Use "N/A" if not applicable.

General Information

Name: _____ Date of Birth: _____

Street Address: _____ City: _____

State: _____ Zip: _____ Gender: Male or Female

Home Phone: _____ Cell Phone: _____

Email Address: _____

Emergency Contact Information

Emergency Contact Name: _____ Relationship to Patient: _____

Emergency Contact's Home Phone: _____ Cell Phone: _____

Emergency Contact's Email: _____

*Date of Accident: _____ Date of First Treatment: _____

*Law Firm Name: _____ Law Firm Contact #: _____

Insurance Information – **THE BELOW MUST BE FILLED OUT COMPLETELY**

*Were You at Fault? _____

*Your Car Insurance Carrier: _____

*Policy Number: _____ *Claim Number: _____

*Adjuster's Name: _____ *Adjuster's Phone Number: _____

*At Fault Insurance Carrier for Other Party: _____

Policy Number: _____ *Claim Number: _____

*Adjuster's Name: _____ *Adjuster's Phone Number: _____

IRREVOCABLE ASSIGNMENT OF PROCEEDS

Patient's Name:_____ Patient's Date of Birth:_____

Date of Incident _____

I, the undersigned Patient (or legal guardian of a minor Patient), of_____ (the SyndeoCare Provider), forever and irrevocably assign any and all proceeds that I receive from any insurance company(ies), to be paid directly to SyndeoCare LLC ("SyndeoCare") for professional medical services rendered to me by a provider within SyndeoCare's contracted network of providers ("SyndeoCare Provider") in connection with the Date of Incident noted above. I also acknowledge that I have executed a HIPAA Authorization directing SyndeoCare to provide certain information to the insurance company(ies).

As consideration for my execution of this Irrevocable Assignment of Proceeds, I represent that the SyndeoCare Provider has provided me medical services upon my request, that I am aware of the nature and expense of all such services so provided and that as consideration for its forbearance of its legal right to require payment by me at the time such services were rendered, said SyndeoCare Provider relied upon my express declaration and intention to execute and instruct that this Irrevocable Assignment of Proceeds shall apply to the insurance proceeds to which I am entitled, and direct that the amount of such proceeds be paid to SydeoCare, at such time as I receive an insurance settlement or other monetary settlement/award.

In the event there is no recovery or insufficient recovery from the insurance company(ies) or other source to reimburse SyndeoCare for the amounts it has paid to the SyndeoCare Provider for my care, I understand that I am directly and fully responsible for reimbursing SyndeoCare for such unrecovered amounts of my medical bills. If I do not have an attorney and later decide to retain one, then I agree to promptly (1) furnish SyndeoCare with contact information concerning that attorney; and (2) notify that attorney concerning existence of this Irrevocable Assignment of Proceeds. I acknowledge that the SyndeoCare Provider will be paid by SyndeoCare for all medical bills associated with the services rendered to me; and therefore, I agree to allow SyndeoCare to file a Uniform Commercial Code-1 (UCC-1) Financing Statement and/or Hospital/Emergency Services/Healthcare Provider Lien, as applicable, as a security instrument to ensure payment of professional medical services rendered during my recovery and specifically agree and affirm that the insurance company(ies) should pay SyndeoCare one hundred percent (100%) of the invoice amount submitted by SyndeoCare for any care that I receive during my treatment. If, for any reason whatsoever, I, rather than SyndeoCare, am paid by way of settlement, judgment or verdict, I agree not to accept any money from either the insurance company(ies) or attorney from any of the proceeds that I have herein assigned to SyndeoCare, and will instruct the insurance company(ies) or attorney to deliver such payment, settlement, judgment or verdict's proceeds to SyndeoCare to ensure that SyndeoCare shall be paid in full out of the first proceeds received or paid by insurance company(ies) or attorney.

*Print Name of Patient:_____ Date: _____

*SIGNATURE OF PATIENT/LEGAL REP: _____

(If signed by other than patient, state relationship with signature)

NOTE: IF INSURANCE COMPANY POLICY REQUIRES A RECORDED/FILED LIEN FOR DIRECT PAYMENT, PLEASE CONTACT THE SYNDEOCARE OFFICE PRIOR TO SETTLING YOUR CASE. SYNDEOCARE WILL PROVIDE YOU WITH THE NECESSARY PAPERWORK.

Authorization for Disclosure of Protected Health Information

I,_____, authorize the disclosure of my protected health information[1] as described herein. I understand that this authorization is voluntary and made to confirm my direction. I understand that, if the person(s) or organization(s) that I authorize to receive my protected health information are not subject to federal and state health information privacy laws[2], subsequent disclosure by such person(s) or organization(s) may not be protected by those laws.

1. I authorize the following person(s) and/or organization(s) to disclose my protected health information (as specified below):

Name(s): _____

Organization(s): _____

Address: _____

2. I authorize the following person(s) and/or organizations to receive my protected health information as disclosed by the person(s) and/or organizations(s) above from the date of injury to 3 years after the date of injury. **Syndeocare LLC/MoveDocs**
4670 S Fort Apache Rd Ste 200
Las Vegas, NV 89147
3. Specific description of the protected health information that I authorize for disclosure:
Treatment notes, diagnostic test results, history/physical notes, narrative reports, and billing data.

4. Specific description of the purpose for each use or disclosure:

5. I understand that I may revoke this authorization in writing at any time, except to the extent that the person(s) and/or organization(s) named above have taken action in reliance on this authorization.

6. I understand the information released may include information that may indicate the presence of communicable or venereal diseases which may include but are not limited to, diseases such as hepatitis, syphilis, gonorrhea, and the Human Immune Deficiency Virus also known as Acquired Immune Deficiency Syndrome("AIDS").

I have had the opportunity to read and consider the contents of this authorization. I confirm that the contents are consistent with my direction.

Signed _____ Date _____

Name: _____

Address: _____

Telephone: _____

Relationship or Authority of Personal Representative (if applicable) _____

This Authorization to disclose PHI constitutes a waiver of privilege per 76 O.S. §19. Photostatic copies of this Authorization carry the same authority as the original.

[1] Protected health information ("PHI") is health information that is created or received by a health care provider, health plan, or health care clearing house which relates to: 1) the past, present or future physical or mental health of an individual; 2) the provision of heath care to an individual; or 3) the past, present, or future payment for the provision of heath care to an individual. To be protected, the information must be such that it identifies the individual or provides a reasonable basis to believe that the information can identify the individual. 45C.F.R.164.508

[2] These laws apply to health plans, health care providers, and health care clearinghouses.