Board Certified Chiropractic Physicians:
Dr. Ian Scott, D.C.
Dr. Larisa Scott, D.C.

Email: info@OWRchiro.com
Phone: (407) 901-7704
Fax: (407) 288-8582

1100 Town Plaza Court
Suite 1020-D
Winter Springs, FL 32708

www.OptimalWellnessRedefined.com

COMPREHENSIVE HEALTH HISTORY

Date:_____

First Name: _____ Middle:_____Last: _____

Nickname: _____

Address _____ City _____ State _____ Zip Code _____

Home Phone (____) _____-_____ Work (____) _____-_____ Cell (____) ____-_____

Email _____

Age _____ Date of Birth ____/____/_____ Gender: ☐ Female ☐ Male

Social Security Number _____-_____-_____

Referred by:_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Emergency Contact: _____

Name Relationship Phone

Employment Status: ☐ Employed ☐ Unemployed ☐ FT Student ☐ PT Student ☐ Retired ☐ Other_____

Name of Employer_____ Your Occupation_____

Genetic Background: ☐ African American ☐ Hispanic ☐ Mediterranean ☐ Asian ☐ Native American ☐ Caucasian ☐ Northern European ☐ Other_____

Auto Insurance Information:

Auto Insurance Carrier: _____ Insur. Card ID#_____

Policy Holder's Name: _____ Claim # _____

Policy Holder's Date of Birth _____/_____/_____

Auto Accident Info

Date of Accident_____

Check: ☐ Driver ☐ Passenger

How many people in your vehicle? _____

Car was struck on the: ☐ front ☐ back ☐ side

Air bags deployed: ☐ Yes ☐ No

Did you hit your head? ☐ Yes ☐ No

Unconscious? ☐ Yes ☐ No

Were you wearing your seatbelt? ☐ Yes ☐ No

Did the airbags deploy? ☐ Yes ☐ No

Conditions of Road: ☐ Wet ☐ Dry

How fast were you going? _____ How fast was the other driver going? _____

Was a citation given? ☐ Yes ☐ No

If yes, to whom? ☐ Other driver ☐ Self

Did you go to the hospital? ☐ Yes ☐ No

If yes, which one? _____

Did you get treatment at any other facility? ☐ Yes ☐ No

If yes, where and when? _____

Did you receive any imaging? ☐ Yes ☐ No

Immediately following the accident, did you experience any symptoms? If so, please explain:

_____

How much time have you lost from work or school in the past year due to these conditions?_____

PAIN ASSESSMENT

Are you currently in pain? Yes ☐ No ☐

Is the source of your pain due to an injury? Yes ☐ No ☐

If yes, please describe your injury and the date in which it occurred:_____

_____

If no, please describe how long you have experienced this pain and what you believe it is attributed to:_____

Please use the area(s) and illustration below to describe the severity of your pain.
(0= no pain, 10= severe pain)

Example:_____**Neck**_____

1 1 2 3 4 5 6 7 8 9 10

Area 1._____ ☐☐☐☐☐☐☐☐☐☐

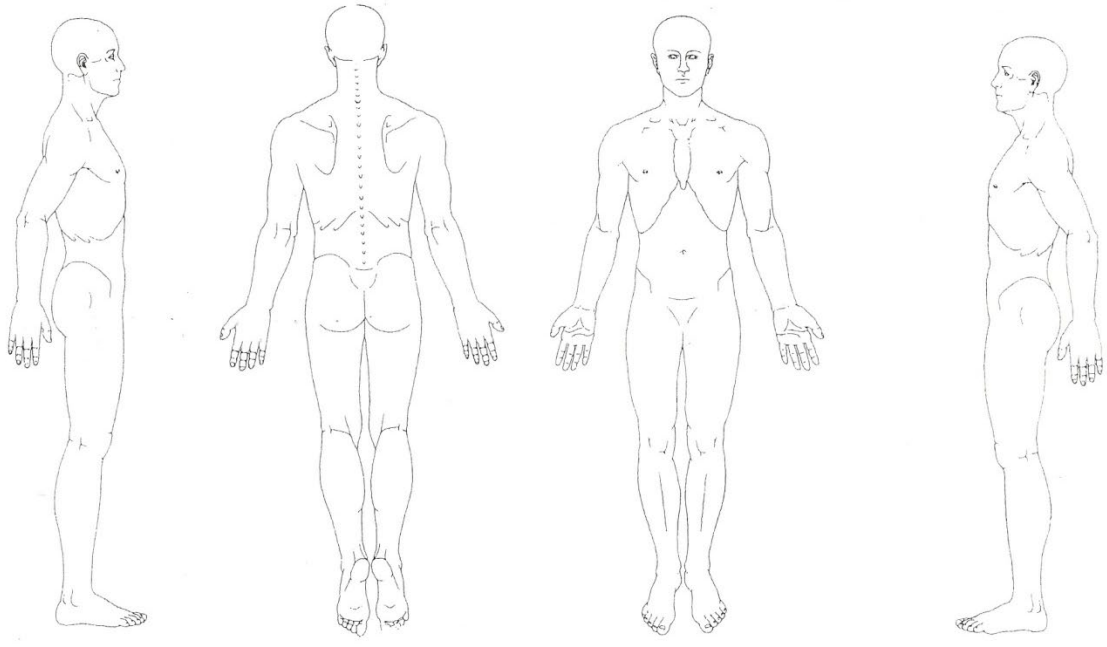
Area 2._____ ☐☐☐☐☐☐☐☐☐☐

Area 3._____ ☐☐☐☐☐☐☐☐☐☐

Area 4._____ ☐☐☐☐☐☐☐☐☐☐

Use the letters provided to mark your area(s) of pain on the illustration.

A = ache **B**= burning **N**=numbness **S**= stiffness **T**=tingling **Z**=sharp/shooting



Right Side Back Front Left side

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PAST MEDICAL AND SURGICAL HISTORY

If you have experienced recurrence of an illness, please indicate when or how often.

ILLNESSES/ SURGERIES	WHEN /ONSET	COMMENTS

HOSPITALIZATIONS

WHERE HOSPITALIZED	WHEN	REASON

MEDICATIONS/ SUPPLEMENTS

Medication Name	Date started	Date stopped	Dosage

List any allergies to any medication, vitamin, mineral, or other nutritional supplement? _____

_____

FAMILY HEALTH HISTORY

Please indicate current and past history to the best of your knowledge

Check Family Members that Apply	Father	Mother	Brother(s)	Sister(s)	Children	Maternal Grand-mother	Maternal Grand-father	Paternal Grand-mother	Paternal Grand-father
Cancer									
ALS or other Motor Neuron Diseases									
Alzheimer's									
Diabetes									
Heart Disease									
High Blood Pressure									
High Cholesterol									
Obesity									
Osteoporosis									
Other									

REVIEW OF SYMPTOMS

Check (√) those items that applied to you in the ***past*** and ***presently***.

GENERAL

- ☐ Fever
- ☐ Chills/Cold all over
- ☐ Aches/Pains
- ☐ General Weakness
- ☐ Swollen Glands
- ☐ Fatigue
- ☐ Difficulty falling asleep/staying asleep

SKIN:

- ☐ Cuts heal slowly
- ☐ Bruise easily
- ☐ Rashes
- ☐ Eczema
- ☐ Psoriasis
- ☐ Dryness/cracking skin
- ☐ Itching
- ☐ Burning on Bottom of Feet
- ☐ Athletes Foot
- ☐ Cellulite
- ☐ Skin cancer

Is your skin sensitive to:

- ☐ Sun
- ☐ Fabrics
- ☐ Detergents
- ☐ Lotions/Creams

HEAD:

- ☐ Poor Concentration
- ☐ Headaches
- ☐ Concussion/Whiplash

EYES:

- ☐ Double vision
- ☐ Blurred vision
- ☐ Halo around lights

EARS:

- ☐ Aches
- ☐ Discharge/Conjunctivitis
- ☐ Pains
- ☐ Ringing
- ☐ Deafness/Hearing loss
- ☐ Pressure
- ☐ Hearing aid
- ☐ Frequent infections

NOSE/SINUSES

- ☐ Bleeding
- ☐ Running/Discharge
- ☐ Congested
- ☐ Infection

MOUTH:

- ☐ Bleeding gums
- ☐ Canker sores
- ☐ TMJ
- ☐ Grind teeth when sleeping

CIRCULATION/RESPIRATION:

- ☐ Swollen ankles
- ☐ Sensitive to hot/ cold
- ☐ Extremities cold or clammy
- ☐ Hands/Feet go to sleep/numbness/tingling
- ☐ Dizziness upon standing
- ☐ Wheezing
- ☐ Irregular heartbeat
- ☐ Palpitations
- ☐ Shortness of breath
- ☐ Varicose veins/spider veins
- ☐ Mitral valve prolapse
- ☐ Murmurs
- ☐ Heart enlargement
- ☐ Bronchitis/Pneumonia
- ☐ Emphysema
- ☐ Prior heart attack ? When___/___/_____

GASTROINTESTINAL

- ☐ Peptic/Duodenal Ulcer
- ☐ Gallstones
- ☐ Gallbladder pain
- ☐ Indigestion
- ☐ Heartburn/Acid Reflux
- ☐ Hiatal Hernia
- ☐ Nausea
- ☐ Vomiting
- ☐ Abdominal Pains/Cramps
- ☐ Gas/ Bloating
- ☐ Diarrhea
- ☐ Constipation

KIDNEY/URINARY TRACT:

- ☐ Burning
- ☐ Frequent urination
- ☐ Blood in urine
- ❑ Night time urination
- ❑ Kidney stones
- ❑ Painful urination
- ❑ Bladder infections
- ❑ Kidney infections
- ❑ Loss of bladder control

WOMEN'S HISTORY (for women only)

- ❑ Fibrocystic breasts
- ❑ Lumps in breast
- ❑ Fibroid Tumors/Breast
- ❑ Abnormal periods
- ❑ Fibroid Tumors/Uterus
- ❑ Endometriosis
- ❑ Partial/total hysterectomy
- ❑ Hot flashes
- ❑ Breast cancer
- ❑ Ovarian cysts
- ❑ Pregnant
- ❑ Infertility
- ❑ Decreased libido
- ❑ Weight gain

MEN'S HISTORY (for men only)

Have you had a PSA done?
Yes _____ No _____

PSA Level:

- ❑ 0 – 2
- ❑ 2 – 4
- ❑ 4 – 10
- ❑ >10

- ❑ Prostate enlargement
- ❑ Impotence
- ❑ Genital pain
- ❑ Hernia
- ❑ Prostate cancer

EMOTIONAL:

- ❑ Convulsions
- ❑ Dizziness
- ❑ Fainting Spells
- ❑ Blackouts/Amnesia
- ❑ Anxiety/Feeling of panic
- ❑ Depressed
- ❑ Restless leg syndrome
- ❑ Unable to coordinate muscles
- ❑ Have considered suicide

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LIFESTYLE HISTORY

TOBACCO HISTORY

Have you ever used tobacco? Yes ☐ No ☐

If yes, how much?_____Number of years?____If not a current user, year quit_____

ALCOHOL INTAKE

Have you ever used alcohol? Yes ☐ No ☐

If yes, how often do you now drink alcohol? _____

OTHER SUBSTANCES

Do you currently or have you previously used recreational drugs? Yes ☐ No ☐

If yes, what type(s) and method? (IV, inhaled, smoked, etc) _____

SOCIAL HISTORY

Because stress has a direct effect on your overall health and wellbeing that often leads to illness, immune system dysfunction, and emotional disorders, it is important that your health care provider is aware of any stressful influences that may be impacting your health. Informing your doctor allows him/her to offer you supportive treatment options and optimize the outcome of your health care.

STRESS/PSYCHOSOCIAL HISTORY

Are you overall happy? Yes ☐ No ☐

Do you feel you can easily handle the stress in your life? Yes ☐ No ☐

If no, do you believe that stress is presently reducing the quality of your life? Yes ☐ No ☐

If yes, what do you believe it to be?_____

Informed Consent to Chiropractic Treatment and Medical Photography

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.

Consent for Medical Imaging

I consent for medical imaging (photo, video, and/or audio) to be made of me or my child (or for person whom I am legal guardian). I understand that the information may be used in my medical record, for purposes of medical teaching at Optimal Wellness Redefined. By consenting to this medical photography I understand that I will not receive payment from any party. Refusal to consent to photographs, video, and/or audio recording will in no way affect the medical care I will receive. If I have any questions or wish to withdraw my consent in the future I may contact the staff at Optimal Wellness Redefined.

HIPAA Privacy Practices

I acknowledge that I have received and /or have been given the opportunity to review this Chiropractic Office's Notice of HIPAA Privacy Practices for protected health information.

Print Patient's Name _____

Patient's Signature _____ Date_____

Consent to Treat a Minor: (Minor's Printed Name) _____

Guardian / Spouse's Signature Authorizing Care _____ Date_____

Office Financial Policy

CASH

1. All patients are on a cash basis until their respective insurance coverage and deductible may be verified by our staff.
2. This office may make payment plan arrangements on an individual basis. Any such plan or arrangement will be discussed with you during your consultation.

INSURANCE

1. If you have insurance, we will gladly accept assignment with the following exceptions and regulations provided that we have prior certification from your insurance company.
2. We accept assignment for the initial treatment plan only. Any follow up visits will be payable when services are rendered. Once you have been discharged from active care and placed on maintenance care, we will continue to file your insurance but require full payment each visit.
3. We accept assignment as a courtesy to you. You are responsible for your entire bill should your insurance company not pay any of the anticipated charges for any reason. We are not a mediator between you and your insurance company and will not enter into any dispute with the same, as your contract is between you and your insurance company.
4. Whenever you receive any worksheets from your insurance company or explanation of benefits, please bring this information into this office as soon as possible. We must have a copy of this to determine whether proper payment has been made. If you should receive a check from your insurance company during our billing, you must bring it into this office. If any over payment exists after all insurance billing has been done, we will issue you an over payment check. It will not come from your insurance company. All insurance payments, regardless of which company issues a check first, are applied to your account as long as any balance is due.
5. Any services not covered or coverage reductions by your insurance will be the patient's responsibility.
6. This office will resubmit a claim ONE TIME. We will not enter into any dispute with your insurance company. If coverage problems arise, you will be expected to assist directly in dealing with your insurance company, adjuster or agent. Any denied or disputed claims will be treated as uncovered services and you will be expected to pay such charges on a timely basis.
7. If the patient is referred to another specialist or discontinues care for any reason other than a discharge by the doctor, the bill is due and payment in full expected immediately regardless of any claims submitted.
8. If you have questions concerning this or any other matter, please speak with the office manager or our insurance department prior to seeing the doctor.

Thank you.

I have read and understand the Office Financial Policy and agree to abide by these terms.

_____ _____

Patient/Guardian Signature | Printed Name of Patient

_____ _____

Date | Guardian Relationship *(if applicable)*

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Requesting records from Dr. _____

Address _____ City _____ State _____ Zip Code _____

Telephone number ( ) ___ - _____ Fax number ( ) ___ - _____

THE PURPOSE FOR THIS RELEASE

You are hereby authorized to furnish and release to Optimal Wellness Redefined,LLC all information from my medical, psychological, and other health records, with no limitation placed on history of illness or diagnostic or therapeutic information, including the furnishing of photocopies of all written documents pertinent thereto.

In addition to the above general authorization to release my protected health information, I further authorize release of the following information if it is contained in those records:

Alcohol or Drug Abuse: ☐ Yes ☐ No

Communicable disease related information, including AIDS or ARC diagnosis and/or HIT or HTLA-III test results or treatment: ☐ Yes ☐ No

Genetic Testing ☐ Yes ☐ No

Please note: With respect to drug and alcohol abuse treatment information, or records regarding communicable disease information, the information is from confidential records which are protected by State and Federal laws that prohibit disclosure with the specific written consent of the person to who they pertain, or as otherwise permitted by law. A general authorization for the release of the protected health information is not sufficient for this purpose.

This authorization can be revoked in writing at any time except to the extent that disclosure made in good faith has already occurred in reliance on this authorization.

I hereby release_____

(Name of physician, clinic name, or health organization)

employees of or agents managing members, and the attending physician(s) from legal responsibility or liability for the release of the above information to the extent authorized. A copy of this authorization shall be as valid as the original.

I understand the there may be a fee for this service depending on the number of pages photocopied. However; no such fee will be charged if these records are requested for continuing medical care.

Patient's Name:_____ D.O.B._____

Please Print

Signature: _____ Date_____

Records Requested by:

Doctor's Name: _____

Signature:_____

HIPAA NOTICE OF PRIVACY PRACTICES
As required by the Privacy Regulations Promulgated Pursuant to the
Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by our organization, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the organization, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for equipment or supplies coverage may require that your relevant protected health information be disclosed to the health plan to obtain approval for coverage.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of our organization. These activities include, but are not limited to, quality assessment activities, employee review activities, accreditation activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to accrediting agencies as part of an accreditation survey. We may also call you by name while you are at our facility. We may use or disclose your protected health information, as necessary, to contact you to check the status of your equipment.

We may use or disclose your protected health information in the following situations without your authorization: as Required By Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Criminal Activity, Inmates, Military Activity, National Security, and Workers' Compensation. Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to Object, unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or this organization has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Our organization is not required to agree to a restriction that you may request. If our organization believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, e.g., electronically.

You may have the right to have our organization amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information, if you have any questions concerning or objections to this form, please ask to speak with our President in person or by phone at 407-901-7704.

Associated companies with whom we may do business, such as an answering service or delivery service, are given only enough information to provide the necessary service to you. No medical information is provided.

We welcome your comments: Please feel free to call us if you have any questions about how we protect your privacy. Our goal is always to provide you with the highest quality services.

Authorization for Direct Payment, Authorization to Release Insurance Information, and Request for PIP Payout Log

Personal Automobile Insurer: _____

Policy Number: _____

Claim Number: _____

Date of Loss: _____

I hereby irrevocably assign all rights and benefits to Optimal Wellness Redefined, LLC for Personal Injury Protection benefits, extended Personal Injury Protection benefits, Medical Payment Coverage, and other benefits, which I may be entitled to recover pursuant to Florida Statute 627.736 as well as my personal automobile policy. THis includes any benefits form my insurance company as well as any other entity which may be responsible for my medical expenses incurred and or services rendered to me by Optimal Wellness Redefined, LLC.

I direct my personal automobile insurer to provide Optimal Wellness Redefined, LLC any coverage information, documents, PIP payout sheet/PIP log, declaration page, all applicable endorsements, transcripts and /r copies of any recorded statements, examinations under oath, independent medical evaluations and a listing of all PIP benefits paid to date which shall include when claims were made, when the claims were received, the payment or denial of each claim, the amount of the deductible and the claims applied thereto, and whether benefits have been exhausted and the amount of PIP benefit.

_____ _____

Patient Signature Date

_____ _____

Patient Name/Printed Dated

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Request For Letter of Protection From Attorney

Attorney's Name:

I hereby authorize and direct you, my attorney, to pay Optimal Wellness Redefined, LLC any unpaid balances due from any settlement, judgement, or verdict, for services rendered to me in my care and treatment for injuries sustained by me on _____

This letter of protections is irrevocable and being entered into with knowledge of and on behalf of _____, the patient. In return for this letter, Optimal wellness Redefined, LLC agrees it will not pursue its claims against the patient until settlement, at which payment is due.

I understand that this does not relieve me of my personal responsibility for all such charges in the event there is no recovery.

The undersigned patient agrees to observe all of the above terms, and requests that his/her attorney withhold such sums from any settlement, judgment, verdict, ro rotherer sources that may become available to protect the patient's outstanding bills from this office.

Patient signature _____ Date _____

Doctor signature _____ Date _____

Attorney signature _____ Date_____

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APPLICATION FOR FLORIDA "NO FAULT" BENEFITS

DATE	OUR POLICYHOLDER	DATE OF ACCIDENT	FILE NUMBER

(Pursuant to Florida Statute 817.234 any person who knowingly and with intent to injure, defraud or deceive any insurance company by filing a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree.)
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

YOUR NAME		PHONE NUMBER: Home: Business:
YOUR ADDRESS:	DATE OF BIRTH:	SOCIAL SECURITY NUMBER:
PERMANENT ADDRESS, IF DIFFERENT:		HOW LONG HAVE YOU LIVED IN FLORIDA:
DATE AND TIME OF ACCIDENT:		PLACE OF ACCIDENT (STREET, CITY/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 RESIDING IN SAME HOUSEHOLD:
AS A RESULT OF THIS ACCIDENT WERE YOU INJURED: ☐ YES ☐ NO. IF YOUR ANSWER IS YES, COMPLETE THE REST OF THIS FORM. IF NO, SIGN HERE AND RETURN FORM TO US. SIGNATURE: DATE:		
DESCRIBE YOUR INJURY:		
WERE YOU TREATED BY A DOCTOR? ☐ YES ☐ NO		DOCTOR'S NAME AND ADDRESS:
IF YOU WERE TREATED IN A HOSPITAL, WERE YOU AN IN-PATIENT ☐ OUT-PATIENT ☐		HOSPITAL'S NAME AND ADDRESS:
AMOUNT OF MEDICAL BILLS TO DATE: $	WILL YOU HAVE MORE MEDICAL EXPENSES ☐ YES ☐ NO	AT THE TIME OF THE ACCIDENT WERE YOU IN THE COURSE OF YOUR EMPLOYMENT ☐ YES ☐ NO
DID YOU LOSE WAGES OR SALARY AS A RESULT OF YOUR INJURY? ☐ YES ☐ NO	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 WORKERS' COMPENSATION OR UNEMPLOYMENT LAW? ☐ YES ☐ NO / IF YES, AMOUNT: PER WEEK _____ PER MONTH _____		
HAVE YOU RECEIVED, OR ARE YOU ELIGIBLE FOR, PAYMENTS UNDER MEDICAID? ☐ YES ☐ NO		
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		

AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES? ☐ YES ☐ NO IF YES, EXPLAIN ON REVERSE SIDE.

[SEE REVERSE SIDE FOR SIGNATURES]

(As to information on reverse side)

SIGNATURE: _____ **DATE:** _____

AUTHORIZATION FOR MEDICAL INFORMATION

THIS AUTHORTIZATION OR PHOTOCOPY HEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY CONDITION WHILE UNDER YOUR OBSERVATION OR TREATMENT, INCLUDING THE HISTORY OBTAINED, X-RAY AND PHYSICAL FINDINGS DIAGNOSIS AND PROGNOSIS. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE FLORIDA "NO FAULT" AUTO INSURANCE LAW (CHAPTER 71-252 F.S.).

SIGNATURE: _____ **DATE:** _____

AUTHORIZATION FOR WAGE AND SALARY INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY HEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY WAGES OR SALARY WHILE EMPLOYED BY YOU. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE FLORIDA "NO FAULT" AUTO INSURANCE LAW (CHAPTER 71-252 F.S.).

SIGNATURE: _____ **DATE:** _____

OFFICE OF INSURANCE REGULATION
Bureau of Property & Casualty Forms and Rates

Standard Disclosure and Acknowledgement Form
Personal Injury Protection - Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

1. The services or treatment set forth below were **actually rendered.** This means that those services have **already been provided.**

_____

_____

2. I have the right and the **duty to confirm** that the services have already been provided.

3. I was **not solicited** by any person to seek any services from the medical provider of the services described above.

4. The medical provider has **explained** the services to me for which payment is being claimed.

5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to $500.

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

Name *(PRINT or TYPE)*	Signature	Date

The undersigned licensed medical professional or medical director, if applicable, affirms the statement numbered 1 above and also:

A. I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.

B. The treatment or services rendered were explained to the insured person, or his or her guardian, **sufficiently** for that person to sign this form with informed consent.

C. The accompanying statement or bill is **properly completed** in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to **truthfully, accurately**, and in a **substantially complete** manner.

D. The coding of procedures on the accompanying statement or bill is proper. This means that **no service has been upcoded, unbundled**, or constitutes an invalid **or not medically necessary diagnostic test** as defined by Section 627.732 (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.

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