SIGNATURE CHIROPRACTIC

Automobile Accident History

Date: _____
Patient # _____

Last _____ First _____ Middle Initial _____ Birth Date _____ Age _____

Address _____ City _____ ST_____ Zip _____

Phone (H) _____ (W) _____ (C) _____

Email _____ May we send you our online newsletter? ☐yes ☐no

Occupation _____ Employer _____

Spouse's Name _____ Business/Employer _____ Spouse Phone: _____

Who may we thank for referring you to our office? _____ ☐Online ☐Advertisement ☐Promotion ☐Walk In

Who is your primary care physician? _____ Address: _____

Phone: _____ Date of last physical/exam? _____ With Whom? _____

Date of Accident: _____ Time of Accident: _____ am / pm ☐Daylight ☐Dawn ☐Dusk ☐Dark

Road conditions at the time of the accident: ☐Wet ☐Dry ☐Snow ☐Ice ☐Other _____

Was the accident on the job? ☐yes ☐no Where you in a company vehicle? ☐yes ☐no Where were you seated in the vehicle?

☐Driver ☐Passenger ☐Rear-seat ☐Other _____

Were you aware of the approaching collision prior to impact, or did it catch you by surprise? ☐Aware ☐Surprise

Did you lose consciousness upon impact? ☐yes ☐no Did you experience a flash of light or explosion in your head? ☐yes ☐no

Did the police come to the accident scene? ☐yes ☐no Is there a police report ☐yes ☐no

Did you go to the hospital? ☐yes ☐no When? ☐Immediately ☐___hours later ☐___days later Which hospital? _____

How did you get to the hospital? _____ How long did you stay in the hospital? _____

What did the hospital do for your injuries? (collars, splints, x-rays, medication etc.)_____

What areas were x-rayed? _____What was their diagnosis? _____

What did they recommend for follow-up care? _____

Was any other doctor consulted after your accident? ☐yes ☐no If yes, please complete information below.

Dr. _____ Specialty?_____ Date first seen:_____

Type of treatment:_____ Treatment frequency:_____ How long did you treat?_____

Dr. _____ Specialty?_____ Date first seen:_____

Type of treatment:_____ Treatment frequency:_____ How long did you treat?_____

Were you wearing a seatbelt? ☐yes ☐no If yes, did you receive any injury or bruise from the seat belt? ☐yes ☐no

Did your head hit the head rest during the accident? ☐yes ☐no If adjustable, was the position of the head rest altered? ☐yes ☐no

Was the seat adjustment altered by the accident? ☐yes ☐no Was the seat broken by the accident? ☐yes ☐no

Did the air-bag deploy? ☐yes ☐no If yes, did it strike you? ☐yes ☐no If yes, where? _____

Which way was your head pointing at the point of impact? ☐Straight ☐Right ☐Left Body? ☐Straight ☐Right ☐Left

Where were your hands? ☐One on the wheel ☐Both on the wheel ☐Not Applicable

Were you wearing a hat or glasses at the time of impact? ☐yes ☐no If so, were they still on after the accident? ☐yes ☐no

YOUR CAR

List the year, make and model of the car you were in: YEAR: _____ MAKE: _____ MODEL: _____

Was your car stopped at the time of impact? ☐yes ☐no If yes, was the driver's foot on the brake? ☐yes ☐no If no, estimate the speed of the vehicle you were in: _____mph

If your vehicle was moving at the time of impact, was it: ☐Slowing down ☐Gaining speed ☐Steady speed

THE OTHER CAR

List the year, make and model of the other car : YEAR: _____ MAKE: _____ MODEL: _____

Was the other car moving at the time of impact? ☐yes ☐no If yes, what was the approximate speed of the vehicle : _____mph

At the time of impact, was the other car: ☐Slowing down ☐Gaining speed ☐Steady speed

Please describe, to the best of your knowledge, what happened during this accident.

_____

_____

_____

_____

_____

_____

You may draw the accident here

AUTOMOBILE INSURANCE INFORMATION

Driver of the automobile you were in: _____ **Name of their auto insurance:** _____

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

Auto insurance phone #: _____ **Name of insurance adjuster:** _____

Driver of the other vehicle: _____ **Name of their auto insurance:** _____

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

Auto insurance phone #: _____ **Name of insurance adjuster:** _____

Have you retained an attorney? ☐yes ☐no **Name:** _____ **Phone #:**_____

At the time of the accident, did you become or experience any of the following? ☐Confused ☐Disoriented ☐Light headed ☐Dizzy ☐Nauseated ☐Blurred vision ☐Ringing/Buzzing in ears ☐Loss of balance ☐Other: _____

Do you still have any of those symptoms? ☐yes ☐no **If yes, which ones?** _____

Check symptoms you have noticed since the accident.

☐ Headaches/Migraines	☐ Neck Pain	☐ Upper Back Pain	☐ Shoulder Pain	☐ Midback Pain
☐ Low Back Pain	☐ Depression	☐ Buzzing In Ears	☐ Arm/Leg Pain	☐ Jaw Pain/Clicking
☐ Dizziness	☐ Fatigue	☐ Loss of Memory	☐ Cold Hands/Feet	☐ Numbness/Tingling
☐ Loss of Smell	☐ Irritability	☐ Digestive Problems	☐ Joint Pain/Stiffness	☐ Menstrual Problems
☐ Pinched Nerve	☐ Loss of Sleep	☐ Loss of Balance	☐ Chest Pain	☐ Light Bothers Eyes
☐ Fever	☐ Nervousness	☐ Vision Problems	☐ Urinary Problems	☐ Sleeping Problems
☐ Paralysis	☐ Tension	☐ Fainting	☐ Pins/Needles Feeling	☐ Stomach Upset
☐ Difficulty Swallowing	☐ Sciatica	☐ Sinus Pain	☐ Sore Muscles	☐ Head Feels To Heavy
☐ Other:				

CURRENT COMPLAINTS -List current symptoms separately in order of severity.

1* Body Part:_____

Date symptom first appeared: _____

How often do you experience these symptoms? ☐Constant 100% ☐Frequent 75% ☐Intermittent 50% ☐Occasional 25% ☐Rare 10%

What makes symptom increase? _____

What makes symptom decrease?_____

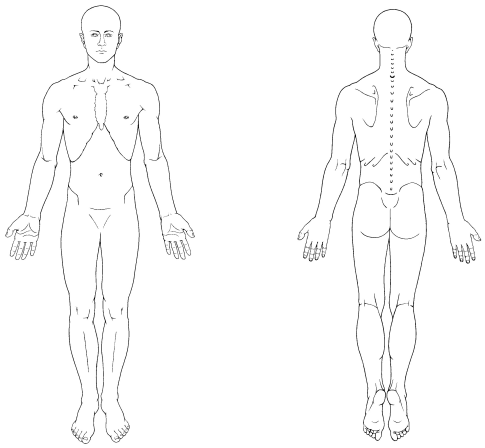
Type of pain? ☐Sharp ☐Dull ☐Aching ☐Burn ☐Throb ☐Numb ☐Other_____

Please rate the intensity of your symptoms (0 being no symptoms, 10 being extreme)

0 ◊◊◊ 1 ◊◊◊ 2 ◊◊◊ 3 ◊◊◊ 4 ◊◊◊ 5 ◊◊◊ 6 ◊◊◊ 7 ◊◊◊ 8 ◊◊◊ 9 ◊◊◊ 10

Where does pain radiate to? _____

Please mark areas of pain on the figures below



2* Body Part: _____

Date symptom first appeared: _____

How often do you experience these symptoms? ☐Constant 100% ☐Frequent 75% ☐Intermittent 50% ☐Occasional 25% ☐Rare 10%

What makes symptom increase? _____

What makes symptom decrease?_____

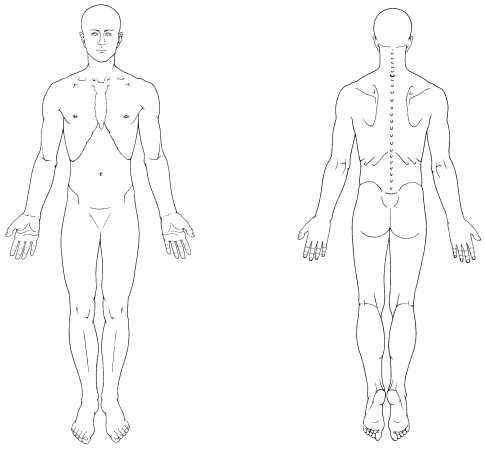
Type of pain? ☐Sharp ☐Dull ☐Aching ☐Burn ☐Throb ☐Numb ☐Other_____

Please rate the intensity of your symptoms (0 being no symptoms, 10 being extreme)

0 ◊◊◊ 1 ◊◊◊ 2 ◊◊◊ 3 ◊◊◊ 4 ◊◊◊ 5 ◊◊◊ 6 ◊◊◊ 7 ◊◊◊ 8 ◊◊◊ 9 ◊◊◊ 10

Where does pain radiate to? _____

Please mark areas of pain on the figures below



3* Body Part: _____

Date symptom first appeared: _____

How often do you experience these symptoms? ☐Constant 100% ☐Frequent 75% ☐Intermittent 50% ☐Occasional 25% ☐Rare 10%

What makes symptom increase? _____

What makes symptom decrease?_____

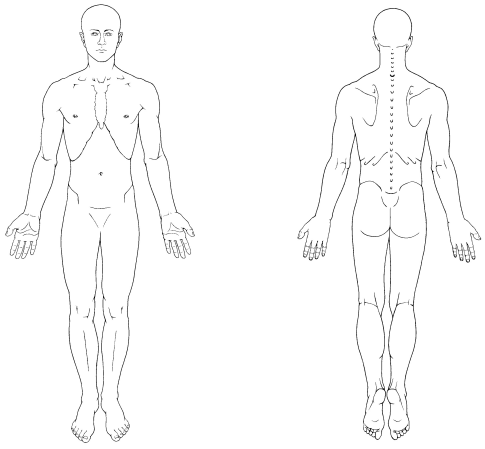
Type of pain? ☐Sharp ☐Dull ☐Aching ☐Burn ☐Throb ☐Numb ☐Other_____

Please rate the intensity of your symptoms (0 being no symptoms, 10 being extreme)

0 ◊◊◊ 1 ◊◊◊ 2 ◊◊◊ 3 ◊◊◊ 4 ◊◊◊ 5 ◊◊◊ 6 ◊◊◊ 7 ◊◊◊ 8 ◊◊◊ 9 ◊◊◊ 10

Where does pain radiate to? _____

Please mark areas of pain on the figures below



OCCUPATIONAL INFORMATION

Job involves: ☐Sitting ☐Standing **How long?** _____ ☐Lifting **How much?** _____ ☐Bending ☐Twisting ☐Turning ☐Stooping

Physical activity at work: ☐Sedentary ☐Light manual labor ☐Manual labor ☐Heavy manual labor

Have you missed any time from work due to the accident? ☐yes ☐no **If yes, how many days?** _____ **Dates:** _____

Are your work activities restricted as a result of this accident? ☐yes ☐no **If yes, please explain.**_____

Do any of your work activities aggravate your present main complaints? ☐yes ☐no **If yes, please explain.** _____

_____

Do you smoke? ☐yes ☐no If yes, how many packs per week?_____**Have you ever smoked in the past?** ☐yes ☐no When did you quit?_____

Do you consume alcohol? ☐yes ☐no If yes, how many drinks per week? _____

Do you consume caffeine? ☐yes ☐no If yes, how many drinks per day? _____

Do you exercise? ☐yes ☐no If yes, how many times per week and what type? _____

Do you have a high stress level? ☐yes ☐no If yes, list reasons:_____

Please list any medications or vitamins you are currently taking (including dosage).

_____ **Frequency:**_____ **Dosage:** _____ **What is this for?** _____

_____ **Frequency:**_____ **Dosage:** _____ **What is this for?** _____

_____ **Frequency:**_____ **Dosage:** _____ **What is this for?** _____

_____ **Frequency:**_____ **Dosage:** _____ **What is this for?** _____

X-RAY CONFIRMATION - FEMALES

At this time, to the best of my knowledge, I am not pregnant, and I consent to radiographic pictures if necessary.

_____ _____

Patient Signature **Date**

I understand the information contained within this form and guarantee this form was completed correctly and to the best of my knowledge.

_____ _____

Patient Signature **Date**

AUTHORIZATION FOR CARE OF MINOR

CONSENT TO TREAT A MINOR: I hearby authorize the doctor(s) at *Signature Chiropractic* and whom ever they designate as assistants to administer care to child.

Name of Child / Minor (please print)_____

Name of Parent / Guardian (please print) _____

Parent / Guardian signature: _____ **Date:** _____

SIGNATURE CHIROPRACTIC

CONSENT FORM

Full Name: _____

HIPAA

I acknowledge that I have received a copy of this office's Notice of Privacy Practices Pursuant to HIPAA and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I hereby consent to the use of my health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State Law and Federal law. I understand that this form will be placed in my patient chart and maintained for six (6) years. A full copy is available upon request.

INFORMED CONSENT

I hereby request and consent to the performance of chiropractic examinations, adjustments and any other associated chiropractic procedures on me, including various modes of therapy modalities and diagnostic x-rays on myself (or on the individual named below, for whom I am legally responsible) by Dr. Tiffany Le at Signature Chiropractic. I understand and am informed that, as in the practice of chiropractic there are some risks and certain complications, which may arise during chiropractic treatment. Those risks and complications include but not limited to: physical burns, fractures, disc injuries, strokes, dislocations, muscle strain, cervical myelopathy, and costovertebral strains and separations. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor of exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest.

I have had an opportunity to discuss the nature, purpose, and risks of chiropractic care and other recommended procedures. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed. If there is any dispute about my care, I agree to a resolution by binding arbitration according to the American Arbitration Association guidelines. I have read (or have had read to me) the above explanation of the chiropractic treatments. I state that I have been informed and weighed the risks involved in chiropractic treatment at this health care office. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

X-RAY CONSENT

X-rays are utilized in the office to help locate and analyze vertebral subluxations. These x-rays are not to be used to investigate for medical pathology. Dr. Tiffany Le does not diagnose or treat medical conditions; however, if any abnormalities are found, Dr. Le will bring it to your attention so that you can seek proper medical advice.

By my signature below I am acknowledging that the doctor has discussed with me the hazardous effects of ionization and I have conveyed my understanding of the risks associated with exposure to x-rays. *Female*: I have been provided a full explanation of the hazardous effects of radiation to an unborn child. After careful consideration, I hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____ _____

SIGNATURE **DATE**

To be completed by patient's representative if patient is a minor, physically or legally incapacitated.

Parent/Guardian Name (print): _____

Signature of Parent/Guardian: _____

Relationship to Patient: _____

OFFICE POLICIES

We want to thank you for choosing Dr. Tiffany Le as your chiropractic health provider. Our goal is to serve you with exceptionally friendly and prompt service, and provide the best family health care available. In return, you will receive restored health. It is our experience that our patients who follow these simple guidelines obtain the best results and greatest benefits to their health.

Late, Cancelation & No Show Policy
When you schedule an appointment, it is your responsibility to keep it. We will make every attempt to remind you via phone, text or email, but we cannot guarantee that you will receive a reminder.

For chiropractic appointments, if you miss or cancel with less than 24-hours' notice, you have 24-hours from the time of the missed visit to schedule another visit within 2 business days to make up that appointment, or you will be charged a $35 late fee.

At times, there may be a need for Dr. Tiffany Le to cancel or reschedule an appointment. We will make every effort to notify you promptly and offer alternative appointment times as soon as possible. Please be sure you have updated your contact information so that we may reach you if necessary.

Payment Policy
All payments and cost of treatments are due at the time of your visit. There is a $30 fee for returned checks. Payments can be made by cash, check, or credit card.

Personal Responsibility Policy
Signature Chiropractic is in no way responsible for the safekeeping of your personal belongings while you are in an appointment or session.

Returns Policy
We cannot accept returns on purchased items, unless an item is defective. In this case please contact us to let us know, bring in the item, and we will exchange it for the same or similar item.

Photo Policy
We are PROUD of our patients and the progress they make while under our care! We love to celebrate our patients' successes along with them. And when something good is happening in our lives, we feel inclined to share it with others. If the moment arises, we would love to share your photo, story, or progress on our Signature Chiropractic's Website and Social Media (i.e. Facebook, Instagram, etc.) pages in the interest of showing others that "real people" visit our office and are smiling while they're here – and most importantly, getting results!

Please check the box that applies to you:

☐ Sure! You can use my picture on the Signature Chiropractic's Website and Social Media pages.

☐ No thanks! I'll pass for now.

Thank you for understanding our Office Policies. Please let us know if you have questions or concerns.

I have read the Policy. I understand and agree to this Policy.

Signature _____

FINANCIAL POLICY

We ask that you read and understand our policy as it applies to your particular situation.

"ON THE JOB" INJURY (Worker's Compensation)

1. We file your worker's compensation claims to the appropriate insurance carrier to collect payment for services rendered in the office. When you are under care for worker's compensation, you are authorize us to send your records and bills to the appropriate companies (i.e. insurance company or attorney). Please note, if claims are denied for any reason, you are ultimately responsible for any final outstanding balance.
2. In the event that legal representation is acquired by the patient, Signature Chiropractic accepts Letter of Protection (LOP) or Doctor's Lien from an attorney and agrees to allow the outstanding amount to remain owing until the case settles. Once the case is settled, the outstanding balance must be paid in full by the patient, unless your attorney has been authorized to pay the balance on your behalf. Please note, if LOP or Doctor's Lien is not signed by your attorney within 7 days after initial visit, you will be fully responsible for the total charge. Outstanding balance must be paid immediately.
3. In the event that a lawsuit or settlement attempt is lost or dropped by the patient or the attorney, the patient agrees to pay the outstanding balance in full within 14 days of the date the lawsuit or settlement is lost or dropped.
4. Furthermore, the patient agrees to have on file with Signature Chiropractic a valid credit/debit card, and authorizes Signature Chiropractic to automatically process any payment if the amount owing is not paid in full at the agreed upon time.

PERSONAL INJURY OR AUTOMOBILE ACCIDENTS

1. We file your claim with the appropriate insurance carrier and your auto Med-pay to collect payment for services rendered in the office. When you are under care for personal injury, you are authorize us to send your records and bills to the appropriate companies (i.e. auto insurance company or attorney). Please note, you are ultimately responsible for any final outstanding balance.
2. In the event that legal representation is acquired by the patient, and if there is no insurance coverage, auto Med-pay that will pay the outstanding bill, Signature Chiropractic accepts Letter of Protection (LOP) or Doctor's Lien from an attorney and agrees to allow the outstanding amount to remain owing until the case settles. Once the case is settled, the outstanding balance must be paid in full by the patient, unless your attorney has been authorized to pay the balance on your behalf. Please note, if LOP or Doctor's Lien is not signed by your attorney within 7 days after initial visit, you will be fully responsible for the total charge. Outstanding balance must be paid immediately.
3. In the event that a lawsuit or settlement attempt is lost or dropped by the patient or the attorney, the patient agrees to pay the outstanding balance in full within 14 days of the date the lawsuit or settlement is lost or dropped.
4. Furthermore, the patient agrees to have on file with Signature Chiropractic a valid credit/debit card, and authorizes Signature Chiropractic to automatically process any payment if the amount owing is not paid in full at the agreed upon time.

ACCOUNT BALANCES: Any charges you incur after your insurance has been billed, including co-insurance, deductibles, and any unauthorized or out of network services are your responsibility. Payment for these balances is expected within 60 days. If you are unable to pay within this timeframe, please contact the office. We are willing to negotiate payment arrangements to enable you to avoid additional action. Additional fees for payment letters will be added to the account balance. Account balances that older than 60 days will be charged 10% interest. Balances that reach 90 days will be charged to the debit/credit card on file. Remaining balances will be sent to collections.

By my signature below, I hereby authorize and direct my insurance company to issue payment directly to Signature Chiropractic for medical services rendered on my behalf. If I receive payment for these services from my insurance company in error, I understand I am obligated to forward the money immediately to Signature Chiropractic. I understand that services rendered by Signature Chiropractic and Dr. Tiffany Le are a necessary part of the medical care for which I have been referred to this office to receive. I hereby consent to and authorize the administration of the recommended services. I authorize Signature Chiropractic to obtain or secure any medical records as may be required for continuity of care on my behalf.

By my signature below, I confirm I have read and fully understand financial policy of Signature Chiropractic. I have been given an opportunity to ask questions and receive a copy of this document. I also understand that if my insurance does not respond within 60 days, or if my attorney no longer represent my lawsuit, or if I suspend or terminate my schedule of care as prescribed by Dr. Tiffany Le at Signature Chiropractic that fees will be due and payable immediately. My account balance will be charged to the debit/credit card on file.

Patient or Responsible Party Name: _____ Patient DOB: _____

Patient or Responsible Signature: _____ Date: _____

Letter of Protection

I,_____, do hereby authorize and direct my attorney's, to pay **Signature Chiropractic LLC and Dr. Tiffany Le** directly out of the proceeds of any settlement or recovery, such sums as may be due and owing the Clinic for services rendered to me, both by reason of this accident on _____ (DOA), and by reason of any other bills that are due to the Clinic and to withhold such sums from settlement, judgement, or recovery as may be necessary to adequately protect said doctor. And I hereby further give a lien on my case to said doctor against any and all proceeds of any settlement, judgment, or recovery which may be paid to me as the result of the injuries for which I have been treated or injuries in connection herewith.

Signature Chiropractic LLC and Dr. Tiffany Le have relied on these promises in providing medical services to me. I fully understand that in the event that I do not receive a settlement or recovery in my personal injury case, or if the amount is not enough to pay all fees, costs and outstanding bills, I am still personally responsible to pay the Clinic for all medical bills and for all amount I still owe. I understand and agree that this lien and agreement is made solely for said doctor's additional protection and in consideration of her 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 do hereby authorize the above doctor to furnish you, my attorney, with a full report of the evaluation, diagnosis, treatment, prognosis, etc., of me in regard to the accident in which I was involved.

I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but may demand payment from me immediately for the entire balance due.

Patient's Name: _____

Patient's Signature: _____ Date: _____

As the Attorney of record for the above patient, I agree to observe the terms of this agreement and to act in accordance with the agreement between the Clinic and my client by paying directly from the proceeds of any settlement, judgment or recovery that patient is entitled to receive after attorney fees and costs and any valid hospital liens are paid.

Attorney's Name: _____

Attorney's Signature: _____ Date: _____

ATTORNEY: Please date, sign and return original copy to:

Signature Chiropractic
9420 Balm Riverview Road
Riverview, FL 33569
Phone: 813-672-1818 | Fax: 813-642-7145

SIGNATURE CHIROPRACTIC

ASSIGNMENT OF INSURANCE BENEFITS, RELEASE, & DEMAND

Insurer and Patient, please read the following in its entirety carefully!

I, the undersigned patient/insured knowingly, voluntarily and intentionally assign the rights and benefits of my automobile Insurance, also known as Personal Injury Protection (hereinafter PIP), Uninsured Motorist 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. I understand this document will allow the provider to file suit against an insurer for payment of the insurance benefits or an explanation of benefits and to seek §627.428 damages from the insurer. If the provider's bills are applied to a deductible, I agree this will serve as a benefit to me. This assignment of benefits includes transportation, medications, supplies, overdue interest and any potential claim for common law or statutory bad faith/unfair claims handling. If the insurer disputes the validity of this assignment of benefits then the insurer is instructed to notify the provider in writing within five 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. 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 the maximum amount directly without any reductions & without including the patient's name on the check. To the extent the PIP insurer contends there is a material misrepresentation on the application for insurance resulting in the policy of insurance is declared voided, rescinded, or canceled, I as he named insured under said policy of insurance, hereby assign the right to receive the premiums paid for my PIP insurance to this provider and to file suit for recovery of the premiums. The insurer is directed to issue such a refund check payable to this provider only. Should the medical bills not exceed the premium refunded, then the provider is directed to mail the patient/named insured a check which represents the difference between the medical bills and the premiums paid.

Disputes: 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 (specifically the office manager) and the insurer as to the amount payable under the insurance policy. The insured and provider hereby contests and 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 PIP insurer states it can pay claims at 200% of Medicare then the insurer is instructed & directed to provide this provider with a copy of the policy of insurance within 10 days. Any effort by the insurer to pay a disputed debt as full satisfaction must be mailed to the address above, after speaking with the office manager and mailed to the attention of the Office Manager. See Fla. Stat. §673.3111.

EUOs and IMEs: If the insurer schedules a defense examination or examination under oath (hereinafter "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 and obtain a copy of any statements or examinations under oath given by patient.

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 (declaration sheet & policy of insurance) in writing 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 written and verbal statements the patient or anyone else provided to the insurer; obtain copies of the entire claim file and 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. 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 is 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 the provider's medical bills are disputed or reduced by the insurer for any reason, or amount, the insurer is to: set aside the entire amount disputed or reduced; escrow the full amount at issue; and not pay the disputed amount to anyone or any entity, including myself, until the dispute is resolved by a Court. Do not exhaust the policy. The insurer is instructed to inform, in writing, the 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.

_____ _____

Patient's Name Date

_____

Patient's Signature

(If patient is a minor, signature of parent/guardian is required.)

_____ _____

Parent's Name Date

_____

Parent's Signature

SIGNATURE CHIROPRACTIC

AUTHORIZATION TO SETTLE CLAIM, DIRECTION TO PAY PROVIDER DIRECTLY &

AUTHORIZATION TO RELEASE RECORDS

In consideration of your undertaking to care for me, I agree to the following:

1. You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred.

2. You are authorized to negotiate, collect, and settle any claim with any insurance carrier or other third party payer with regard to any services rendered by you.

3. I authorize the direct payment to you at the billing address contained on your medical bills of any sums I now or hereafter owe you, by my attorney out of proceeds of any settlement of my case, and/or by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.

4. In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services refuses to make such payment upon demand by you. I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent date) and authorize you to prosecute an action in my name as you see fit and further authorize you to compromise, settle or otherwise receive and claim as you see fit. However, it is understood that until a reasonable effort has been made to collect the sums due from the insurance company or companies contractually obligated, you will refrain from collecting the amounts owed, directly from me. I understand that whatever amounts you do not collect from insurance company's proceeds, whether it be all or part of what is due, I personally owe and agree to pay you.

5. I also acknowledge that any medical expenses not covered under my insurance policy will be my personal responsibility.

6. I further agree that this Authorization and Assignment is irrevocable and ongoing until all monies owed are paid in full.

7. This Authorization and Assignment will be in continual effect until revoked by both parties. A photocopy of this form shall be considered as effective and valid as the original.

8. I hereby request and authorize **my other medical providers** to furnish and disclose to **Dr. Tiffany Le** or anyone designated in writing by her, all records and reports, including x-rays, advanced imaging and photostatic copies, abstracts or excerpts of all records and any other information she may request relating to any examination, treatment or opinion concerning any condition that I may have had in the past or now have.

_____ _____

Patient's Name Date

_____

Patient/Insured's Signature

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.**

Chiropractic evaluation, diagnostic testing, manipulative therapy, and therapeutic modalities.

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**):*

Dr. TIFFANY LE		
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.