Name: _____ Date of birth: _____

Address: _____ Phone #: _____

Date of accident: _____ Male Female Right-handed Left-handed

Were you: Driver Passenger: Front Rear-right Rear-left Pedestrian Bicyclist

Impact of the accident? Front Rear Side Other: _____ Wearing seatbelt? No Yes N/A

Injury details: _____

Were you seen in ER or urgent care? No Yes: _____

Have you received other treatment? No Yes: _____

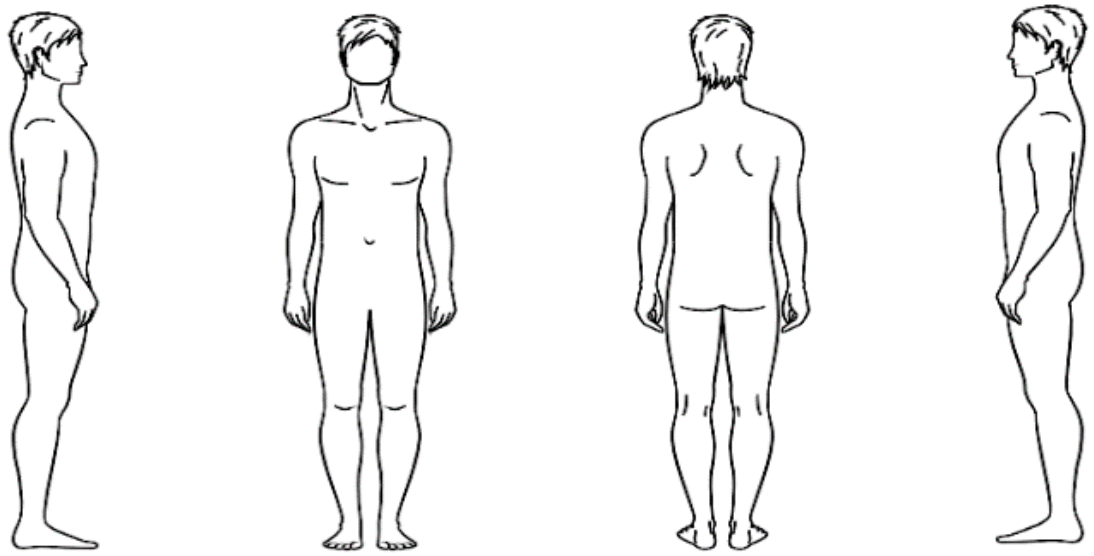
Have you started therapy (DC, PT)? No Yes (Name, Phone #): _____

Have you retained an attorney? No Yes (Name, Phone #): _____

Have you taken time off from work? No Yes

Your main symptoms? Pain Swelling Bruising Numbness Tingling Weakness

Describe and/or draw below:



On a scale of 0-10, how severe is your pain now? 0 1 2 3 4 5 6 7 8 9 10

Pain: Constant Intermittent Wakes you up from sleep Interferes with your daily life

Past medical history: High blood pressure Heart disease Diabetes Arthritis

Past surgeries: _____

Current medications: _____

Drug allergies: _____

PATIENT: _____ "Patient"

HEALTH CARE PROVIDER: _____ "Provider"

ATTORNEY: _____ "Attorney"

PATIENT RECORD RELEASE AND LETTER OF PROTECTION

I hereby authorize Provider to furnish Attorney with full report of any medical records and charges pertaining to my treatment.

I hereby authorize Attorney to pay directly to Provider such sums that may be due and owing for services rendered to me, and to withhold such sums from any settlement, judgement, or verdict which may be paid to me as the result of my injury.

I also agree to promptly inform Provider if any new attorney represents me, and that this release and letter of protection will be immediately executed with my new attorney, if charges occur. If a new release and letter of protection is not immediately executed upon a change of attorney, I agree that my full charges shall become immediately due and payable.

I fully understand that I am directly responsible to Provider for all charges and bills submitted by Provider for services rendered to me. This agreement is made solely for additional protection and consideration of waiting for payment. I also understand that such payment is not contingent on any settlement, judgement or verdict by which I may eventually recover said fee.

CONSENT AND AUTHORIZATION

I hereby authorize Provider to release medical information to my insurance company to secure payment of benefit. I also authorize the use of my signature on all insurance submissions and as authorization for payment to be sent to Provider.

I understand that I am financially responsible for all charges whether or not paid by my insurance. I further acknowledge that in the event Provider is forced to retain the services of a collection agency and/or attorney, I will be responsible for the collection and/or legal fees.

I hereby consent to the following treatments: administration and performance of therapeutic procedures/treatments, prescription/administration of medication, performance of diagnostic/laboratory procedures/tests as may be deemed advisable based on the judgement of Provider. I fully understand that this is given in advance of any specific diagnosis or treatment. I intend this consent to be continuing in nature even after a specific diagnosis or treatment. The consent will remain in full force until revoked in writing.

I certify that I have read, have fully understood and agree to this Consent and Authorization.

ASSIGNMENTS OF BENEFITS

I, Patient, knowingly, voluntarily and intentionally assign the rights and benefits of my automobile insurance (a/k/a Personal Injury Protect and Medical payments) payable for services to Provider.

I understand it is the intention of the Provider to accept this assignment of benefits in lieu of demanding payments at the time services are rendered. I understand this Assignment of Benefits will allow Provider to file a claim against the insurer for payment of the insurance benefits and to seek damages from the insurer per Florida statute 627.428.

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, the undersigned, acknowledge that Provider will use and disclose my protected health information for the purpose of treatment, payment, and healthcare operations as described in the notice of privacy practices available online. I acknowledge that I have access to Provider's notice of privacy practices and have been offered a copy for review.

PATIENT 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(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**):*

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.

Elias Lu, APRN
5753 Hwy 85 N 6386
Crestview, FL 32536
PH: 888-354-2758 FX: 866-271-1923

Patient Name: _____ Date:_____

OFFICE VISITS: ___ 99205 HIGH COMPLEXITY ___99204 MODERATE COMPLEXITY ___97535 HOME MANAGEMENT TRAINING

DIAGNOSIS

__M53.82 Cervical Spine Disorder
__M54.2 Cervicalgia
__M54.12 Cervical Radiculopathy
__M50.90 Cervical Disc Disorder
__M50.00 Cervical Disc Disorder w/ Myelopathy
__M50.10 Cervical Disc Disorder w/ Radiculopathy
__S13.4XXA Cervical Sprain/Strain
__M43.6 Torticollis
__M50.30 Cervical Disc Tear
__S13.4XXS Cervical Vertigo
__M99.19 Subluxation of Antlanto-Occipital Joint
__M99.01 Cervicothoracic Segmental Dysfunction
__M48.8X9 Retrolisthesis
__M50.20 Cervical Herniation

__M53.9 Thoracic Spine Disorder
__M54.6 Thoracic Pain
__M51.14 Thoracic Disc Prolapse w/ Radiculopathy
__M51.9 Disc Disorder of Thoracic Spine
__S23.3XXA Thoracic Sprain/Strain
__M51.24 Thoracic Herniation
__M99.02 Thoracic Segmental Dysfunction
__S24.2XXA Thoracic Nerve Injury
__M51.34 Thoracic Disc Tear

__M53.9 Lumbar Spine Disorder
__M54.5 Acute Lower Back Pain
__M54.40 Lumbago w/ Sciatica
__M54.42 Lt Sided Lumbago w/ Sciatica
__M54.41 Rt Sided Lumbago w/ Sciatica
__M54.16 Lumbar Radiculopathy
__M51.16 Lumbar Disc Prolapsew/ Radiculopathy
__M51.9 Lumbar Disc Disorder
__M51.06 Lumbar Disc Disorder w/ Myelopathy
__S33.9XXA Lumbar Sprain/Strain
__M51.26 Lumbar Herniation
__M51.36 Lumbar Disc Tear
__M40.40 Acquired Lordosis
__M40.30 Flattened Lordosis
__S34.21XA Lumbar Nerve Injury
__M99.03 Lumbar Segmental Dysfunction
__M54.32 Lt Sided Piriformis Syndrome
__M54.31 Rt Sided Piriformis Syndrome
__M53.3 Coccyx Pain

__M25.519 Shoulder Pain
__M25.619 Shoulder Stiffness
__M75.00 Shoulder Adhesive Capsulitis
__S43.90XA Shoulder Sprain/Strain
__S46.812A Trapezius Strain
__S46.019A Supraspinatus/Infraspinatus Strain
__M75.80 Infraspinatus Tendonitis
__M75.92 Lt Shoulder Tendonitis
__M75.91 Rt Shoulder Tendonitis
__M65.819 Shoulder Synovitis/Tenosynovitis
__M67.412 Lt Shoulder Ganglion
__M67.411 Rt Shoulder Ganglion
__M75.110 Supraspinatus Tear
__M19.112 Lt Rotator Cuff Tear w/ Arthropathy
__M19.111 Rt Rotator Cuff Tear w/ Arthropathy
__M75.100 Rotator Cuff Partial Thickness Tear
__S46.001 Rt Rotator Cuff Tendon Injury
__S46.002 Lt Rotator Cuff Tendon Injury
__M75.50 Shoulder Bursitis
__M25.419 Shoulder Joint Swelling

__M25.522 Left Elbow Pain
__M25.521 Right Elbow Pain
__S53.499A Elbow Sprain/Strain
__M25.9 Disorder of Elbow
__M25.429 Elbow Swelling
__M70.20 Olecranon Bursitis
__M99.07 Upper Extremity Somatic Dysfunction

__M25.552 Left Hip Pain
__M25.551 Right Hip Pain
__M24.1529 Pelvic Cartilage Disorder
__M79.652 Left Thigh Pain
__M79.651 Right Thigh Pain
__S73.192A Left Hip & Thigh Sprain/Strain
__S73.191A Right Hip & Thigh Sprain/Strain
__S76.3995 Hamstring Tendon Division

__M25.562 Left Knee Pain
__M25.561 Right Knee Pain
__M23.90 Derangement of Knee
__S83.90XA Knee Sprain/Strain
__M25.9 Knee/Ankle Disorder
__M25.469 Knee Swelling
__M70.50 Knee Bursitis

__M79.604 Rt Leg Pain
__M79.605 Lt Leg Pain
__M79.671 Rt Foot Pain
__M79.672 Lt Foot Pain
__S93.609A Foot Sprain
__M99.06 LE Somatic Dysfunction

__R51 Headache
__R41.3 Short Term Memory Loss
__G44.319 Acute Posttraumatic HA
__F44.89 Confusional State
__V43.52 Car Driver Injured In Collision
__G47.9 Sleep Disorder
__R29.3 Antalgic Posture
__R53.2 Immobile
__G82.50 Tetraplegia/Quadriplegia
__Z73.89 Difficulty Coping w/ Pain
__M53.80 Intervertebral Disc Rupture
__M51.35 Intervertebral Disc Tear
__G95.20 Spinal Cord Compression
__M62.9 Myopathy
__R60.0 UE/LE Edema
__M65.9 Synovitis/Tenosynovitis
__M62.838 Smooth Muscle Spasm
__M25.60 Joint Stiffness (ROM)
__M71.50 Bursitis
__M60.9 Myostitis
__G99.0 Peripheral Neuropathy
__R20.2 Parasthesa
__M26.609 TMJ
__S06.9X0A Traumatic Brain Injury
__F07.81 Post Concussion Syndrome
__H93.19 Tinnitus
__F43.10 PTSD

__S20.00XA Breast Contusion
__S20.20XA Thorax Contusion
__S30.1XXA Abdominal Wall Contusion
__S30.0XXA Low Back/Pelvis Contusion
__S20.229 Scapular Region Contusion

Provider Signature: _____ Date:_____

The undersigned insured person or guardian of such person affirms: The service(s) set forth above were actually and fully explained to me. I was not solicited by any person to seek services from the medical provider of the services provided above.

Patient/Guardian Signature: _____ Date: _____