



**Auto Accident Information (If Applicable)**

Date of injury: \_\_\_\_\_ Time: \_\_\_\_\_ AM/PM State: \_\_\_\_\_

Describe in DETAIL how your injury occurred:

---

---

---

Where were you seated?  Driver  Front Passenger  Rear Left  Rear right  Middle

Were you wearing a seatbelt?  Yes  No

Which way were you looking when you were hit?  Forward  Backwards  Right  Left

Did you know you were going to be hit?  Yes  No

Did you brace for impact?  Yes  No

Did the airbag go off?  Yes  No

Did any body part hit the car?  Yes  No

Where on the body? \_\_\_\_\_ What part of the car did you hit? \_\_\_\_\_

Did you lose consciousness?  Yes  No

Make and model of your vehicle? \_\_\_\_\_

Were you stuck from...  Behind  Front  Left side  Right side

Approximate speed of YOUR vehicle was \_\_\_\_\_ mph

The approximate damage to your vehicle...  Minimal  Moderate  Extensive  Totaled

Amount of damage on your vehicle? \$ \_\_\_\_\_

Was your vehicle towed from the scene?  Yes  No

Make and model of the other vehicle? \_\_\_\_\_

What part of the other vehicle did you hit?  Behind  Front  Left side  Right side

Approximate speed of the OTHER vehicle was \_\_\_\_\_ mph

Were police notified?  Yes  No Did the police file a report?  Yes  No

Was EMS notified?  Yes  No Were you transported?  Yes  No

Where did you go for care after the accident? \_\_\_\_\_

Other treatments since the accident? \_\_\_\_\_

Since the accident your symptoms are...  Better  Worse  Same



### **Financial Disclosure Policy**

As a result of the changes to the 2003 Florida No Fault Statute it is a third degree felony for any provider to agree to waive a deductible or to reduce or waive your co-pay (if applicable) as a routine business practice. We therefore require payment of any balances due after all attempts by us (including litigation) to collect from the Florida No Fault coverage whose right to collect, you have assigned to us.

Please speak with our billing manager if you have any questions.

(Two exceptions are allowed by statute involving financial inability in individual cases).

---

Patient's Signature

---

Date

## Automotive Insurance Information

COMPLETING THIS FORM ACCURATELY ALLOWS US TO PROCESS YOUR PIP CLAIM FASTER  
THE PATIENT/GUARDIAN IS RESPONSIBLE FOR PAYMENT IN FULL FOR ALL SERVICES

**Circle what applies:**

Did you inform YOUR insurance carrier of the accident?	Yes	No
Did you inform YOUR insurance carrier of the injuries sustained?	Yes	No
Have you consulted an attorney?	Yes	No

The following information must be made available in order to process your claim immediately on your behalf. Payment will be collected at time of each service until this information has been verified & your insurance sends payment.

**PIP Benefits**

- Deductibles & copays will be collected at the time of each service.
- Any other carrier involved IS NOT RESPONSIBLE to make payments directly to the health care provider.
- Payments are reimbursed to you by the other insurance carrier if & when the case is finalized.

Do you have a PIP deductible?	Amount \$ _____
Your benefits are payable at...	100% or 80%
Do you carry Medpay?	Yes or No

YOUR claim/ file # in this case?

\_\_\_\_\_

Name & Address of YOUR Insurance Company in this case?

\_\_\_\_\_  
\_\_\_\_\_

Name & Phone Number of the adjuster assigned to YOUR INJURY case?

\_\_\_\_\_  
\_\_\_\_\_

Name, Address, Phone # of the Attorney handling your case?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name of Contact Person for your Attorney

\_\_\_\_\_

I HAVE READ & UNDERSTAND MY FINANCIAL RESPONSIBILITY FOR ALL YOUR SERVICES  
RENDERED

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**CHIROPRACTIC**  
restoration health

**Motor Vehicle Insurance (Your PIP information)**

Owner of vehicle in which you were: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Phone: \_\_\_\_\_

Policy # \_\_\_\_\_ Claim # \_\_\_\_\_

Have you retained an attorney?  Yes  No

Name: \_\_\_\_\_

**Third Party information (Other vehicle that struck yours)**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Phone: \_\_\_\_\_

Policy # \_\_\_\_\_ Claim # \_\_\_\_\_

**Authorization for Treatment**

I hereby authorize the Doctor to treat my condition as he/she deems appropriate and furnish any authorized request for information regarding treatment. The patient also agrees that he/she is responsible for all bills incurred at the office. (The Doctor will not be held responsible for any preexisting medically diagnosed conditions, nor for any medical diagnosis). The patient also agrees that statements made in this questionnaire are true and correct.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardians Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**Notice of Initiation of Treatment**

Claim Number: \_\_\_\_\_  
Patient Name: \_\_\_\_\_  
Date of Accident: \_\_\_\_\_  
First Date of Service: \_\_\_\_\_

Practice/ Provider Name: Dr Dan Martingano D.C. PA. dba  
Restoration Health Chiropractic

To Whom It May Concern:

This document shall serve as our formal Notice of Initiation of Treatment pursuant to Fla.Stat. 627.7326(5)(c). This notice is being sent, pursuant to Florida Statutes, within 21 Days after the facility's first examination or treatment of the above referenced claimant. Because this notice has been timely provided, the law allows statements from this provider to include charges for treatment or services rendered up to, but not more than, 75 days before the postmark date of the statement sent.

Please take note and govern yourself accordingly.

Respectfully,

Account Manager



**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 ( <i>PRINT or TYPE</i> )	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 ( <i>PRINT or TYPE</i> )	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.

## **Florida PIP Law in a nutshell: Information You Need to Know**

1. You must seek medical care for injuries resulting from an auto accident within 14 days of the accident, or no PIP benefits will be paid
2. You must be diagnosed with an Emergency Medical Condition or EMC (See definition below) in order to receive the 10,000 of PIP benefits that you are required to carry.
3. If you are not diagnosed with an emergency medical condition, your PIP benefits are reduced to 2,500.
4. Only a medical doctor (MD), osteopathic physician (DO), dentist (DDS) or advanced registered nurse practitioner (RNP), are allowed to make the emergency medical condition (EMC) diagnosis, corroborating that the injury requires immediate medical attention. If you go to the emergency room, you will still have to see your primary care physician or go to an urgent care center to receive the certification as the hospitals are not issuing those.
5. Massage therapy and acupuncture are no longer covered under the new law.

### **What is an EMC?**

"Emergency medical condition" means a medical condition manifesting itself by 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 patient health
- (b) Serious impairment to bodily functions.
- (c) Serious dysfunction of any bodily organ or part.

### **Follow up Care:**

After the initial visit to a medical provider within 14 days. The law provides for follow up care. Follow-up services and care consistent with the underlying medical diagnosis which may be provided, supervised, ordered, or prescribed only by a licensed physician licensed under chapter 458 or chapter 459, a chiropractic physician licensed under chapter 460, a dentist licensed under chapter 466, or, to the extent permitted by applicable law and under the supervision of such physician, osteopathic physician, chiropractic physician, or dentist, by a physician assistant licensed under chapter 458 or chapter 459 or an advanced registered nurse practitioner licensed under chapter 464.