


## Initial Intake Form

1320 Palm Bay Rd., Palm Bay FL 32905

ABOUT YOU		
First Name:	Middle Name:	Last Name:
Street Address:		
Address Line 2:		
City:	State:	Zip:
Mobile Phone:	Work Phone:	Home Phone:
Email Address:		Date of Birth:
Gender:	Height:	Weight:
Marital Status: <input type="radio"/> Single <input type="radio"/> Married <input type="radio"/> Separated <input type="radio"/> Divorced <input type="radio"/> Widowed <input type="radio"/> Other		
Number of Children:	Spouse's Name:	

EMERGENCY CONTACT AND REFERRAL INFORMATION	
Name:	
Phone:	Relation to You:
Referring Physician:	SSN (for VA patients):
Referring Patient:	Are you working with an Attorney: <input type="radio"/> Yes <input type="radio"/> No
How Did you Hear About Us? <input type="radio"/> Word of Mouth <input type="radio"/> Advertisement <input type="radio"/> Social Media <input type="radio"/> Direct Marketing <input type="radio"/> Internet	

REASON FOR VISIT	
What is the date of your scheduled appointment?    ___ / ___ / ___	
How long have you had this complaint? <input type="radio"/> Less than 5 days (Acute) <input type="radio"/> 5-30 days (Sub Acute) <input type="radio"/> More than 30 days (Chronic)	
What caused this condition?	
What is the date this condition began? (Skip if due to accident)    ___ / ___ / ___	
What terms describe your discomfort best? (aching, burning, tingling, etc):	
<p>On the body diagrams to the right, please indicate your areas of symptoms by drawing in the appropriate symbols.</p> <p><b>P</b> – Pain, <b>N</b> – Numbness, <b>W</b> – Weakness, <b>S</b> – Shooting, <b>A</b> – Aching</p>	
<p>On a scale of 1 to 10, with 10 being the most severe, how would you rate your current level of discomfort?</p> <p>None <span style="float: right;">Unbearable</span></p> <p>0            1            2            3            4            5            6            7            8            9            10</p>	

How often do you feel this discomfort?  Constant  Frequent  Occasional  Intermittent

### REASON FOR VISIT cont.

How has this complaint changed since the onset?  Worsened  Remained the same  Improved

What activity is most significantly affected by this discomfort? (Explain)

What treatment have you received for this condition up to now?

What aggravates this condition?

What improves this condition or gives you relief?

Have other health care provider(s) performed tests related to this condition?

Have you ever had any previous episodes of this condition?

### PERSONAL AND FAMILY HISTORY

Have you had any surgical procedures?  No  Yes Explain:

Are there any past illnesses or conditions we should be aware of?

No  Yes Explain:

Do you have a past history of accidents or trauma?

No  Yes Explain:

Are you presently taking any medications?  No  Yes Explain:

Do you have a past family illness history such as diabetes, cancer, hypertension, or progressive neurological diseases that we should be aware of?  No  Yes Explain:

### WORK AND SOCIAL HABITS

Occupation: \_\_\_\_\_

Current work habits, select all that apply:  Permanently fully disabled  Permanently partially disabled

Cannot work due to current condition  Full-time (20-40+ hours/week)  Part-time (1-19 hours/week)

Retired  Student  Homemaker  Unemployed  Self-employed

Personal social habits, select all that apply:  Smoke or use tobacco products  Drink alcohol  Drink caffeine

Use recreational drugs  Other, to be discussed with doctor

Present exercise habits, select all that apply:  No current exercise  Exercise daily  Exercise 3+ times per week

Cannot return to exercise due to current condition

Diet and nutritional habits, select all that apply:  Vegan or vegetarian  Gluten Free  Lactose Intolerant  Daily supplements

### INFORMED CONSENT TO TREATMENT

I certify that I'm the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

Patient Signature:

Date:



# Restoration Health Chiropractic Pediatric Intake Form

Daniel Martingano, DC

1320 Palm Bay Rd, Palm Bay, FL 32905

## ABOUT YOU

First Name:	Middle Name:	Last Name:
Street Address:		
Address Line 2:		
City:	State:	Zip:
Mobile Phone:	Work Phone:	Home Phone:
Home Email Address:		Date of Birth:
Gender:	Height:	Weight:
Name of Parents/ Guardians:		
Number of Children:		

## PURPOSE OF VISIT

**Purpose for this visit?** \_\_\_\_\_

**Other Doctors Seen for this Condition:** \_\_\_\_\_ N \_\_\_\_\_ Y

**Doctor(s) name and prior Treatments:** \_\_\_\_\_

\_\_\_\_\_

**Other Health Problems?** \_\_\_\_\_

\_\_\_\_\_

**Check any of the following conditions that your child has suffered from during the past six (6) months:**

Ear Infections     Headaches     Colic     Chronic Colds     Recurring Fevers     Car Accident   
 Asthma/ Allergies     Growing/ Back Pains     Temper Tantrums     Scoliosis   
 Digestive Problems     Car Accident     Seizures     ADHD     Bed Wetting     Other   
 \_\_\_\_\_

## PERTINENT HISTORY

Previous Chiropractor? \_\_\_\_\_

Name of Pediatrician: \_\_\_\_\_

Date of last visit: \_\_\_\_/\_\_\_\_/\_\_\_\_ Reason \_\_\_\_\_

Number of doses of antibiotics your child has taken - during the last six months: \_\_\_\_\_ In his/her lifetime: \_\_\_\_\_

Vaccine History: \_\_\_\_\_

Complications/Medication Usage/Alcohol or Cigarettes during Pregnancy or Delivery? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Birth Location? Home Birth? \_\_\_\_\_

### DEVELOPMENTAL HISTORY

Has your child been involved in high impact or contact type sports (i.e. Soccer, Football, Gymnastics, Baseball, Cheerleading, Martial Arts, etc.)? No  Yes  List: \_\_\_\_\_

Has your child been involved in a Car Accident? No  Yes  List: \_\_\_\_\_

Has your child been seen on an Emergency basis? No  Yes  List: \_\_\_\_\_

Other traumas not described above? No  Yes  List: \_\_\_\_\_

What improves this condition or gives you relief?

Have other health care provider(s) performed tests related to this condition?

Have you ever had any previous episodes of this condition?

### PERSONAL AND FAMILY HISTORY

Have you had any surgical procedures?  No  Yes Explain:

Are there any past illnesses or conditions we should be aware of?

No  Yes Explain:

Do you have a past history of accidents or trauma?

No  Yes Explain:

Is your child presently taking any medications?  No  Yes Explain:

Do you have a past family illness history such as diabetes, cancer, hypertension, or progressive neurological diseases that we should be aware of?  No  Yes Explain:

### INFORMED CONSENT TO TREATMENT

I certify that I'm the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

Patient/Parent Signature:

Date:



the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Signature \_\_\_\_\_ (If under 18 parent's signature) Date \_\_\_\_\_

**Pregnancy Release:**

This is to certify that to the best of my knowledge I am not pregnant and the doctor and his associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: \_\_\_\_\_

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

**Consent to X-ray:**

I hereby grant Restoration Health Chiropractic permission to perform an x-ray evaluation if needed. I understand that x-rays are being performed to locate vertebral subluxation and not to diagnose or treat any other disease or condition.

Signature (parent of minor): \_\_\_\_\_ Date: \_\_\_\_\_

**Consent to Evaluate and Adjust a minor child:**

I, \_\_\_\_\_, being the parent or legal guardian of \_\_\_\_\_ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

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

**INSURANCE INFORMATION**

I clearly understand that all insurance coverage is an arrangement between my insurance carrier and me. If this office chooses to bill any services to my insurance carrier that they are performing these services strictly as a convenience for me. The doctor's office will provide any necessary report or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny any claim and that I am ultimately held responsible for any unpaid balances. Any monies received will be credited to my account. I certify that this office visit is not related to any personal injury or workers compensation case that is active or that has not been closed and finalized.

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

# Health Insurance Portability and Accountability Act (HIPAA) and Patient Consent Form



I understand and have been provided with the opportunity to review a **Notice of Privacy Practices** that provides a more complete description of information of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing consent
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be disclosed to carry out treatment, payment or health care operations.

## Florida Insurance Commissioner

Your chiropractor and members of the practice staff may need to disclose your name, address, phone number, billing information and your clinical records to the FL Insurance Commissioner (FLIC). This disclosure will be made if we need the FLIC's assistance to receive reimbursement for your services or, we need the FLIC's assistance because the party responsible for reimbursing your services has improperly processed your claim.

By signing this form, you are giving us authorization to send the FLIC this information. You are also giving the FLIC authorization to re-disclose your information to the party responsible for the payment of your services, the FLIC counsel, and state or federal agencies that may be asked to intercede on your behalf. I hereby give my consent for Restoration Health Chiropractic to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

## Appointment Reminders and Health Care Information Authorization

Dr. Martingano and members of the staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your voicemail.

By signing this form, you are giving us authorization to contact you with these reminders and information.

\_\_\_\_\_ **Patient Signature**

\_\_\_\_\_ **Date**

If not signed by the patient, please indicate relationship:

- Parent/Guardian
- Guardian or conservator of an incompetent patient
- Beneficiary or personal representative of deceased patient

Name of Patient: \_\_\_\_\_

**Health Information Notification/Communication Form:**

The goal of our office is to enable patients to gain control of their health. To attain this we believe communication is the key. Please read the below and if you have any questions, please feel free to ask one of our staff members.

In order to assist you in receiving or sharing your protected health information from Restoration Health Chiropractic (RHC), please complete this form. I authorize the person(s) listed below to have access to any & all of my health information relative to my chiropractic care at "RHC". "RHC" is permitted to share any chiropractic & medical information from my treatment files including test results & information disclosed during my visits. In the event that we would need to communicate your healthcare information, to whom may we do so?

NAME	RELATIONSHIP	PHONE NUMBER
_____	_____	_____
_____	_____	_____
_____	_____	_____

May we mail postcards or leave messages on any answering device, i.e. home answering machines or voicemails? **Yes [ ] No [ ]**

May we use your name on our Thank-You Referral board in acknowledgement of your trust in referring relatives & friends? **Yes [ ] No [ ]**

May we use your name & pictures on our social media accounts & our website pages in acknowledgement of your trust in our services and in sharing highlights of our practice events? **Yes [ ] No [ ]**

May we send email appointment reminders, birthday & holiday greetings and notices of special offers, events, articles of health interests and our monthly newsletter to the email you have provided. You will have the option to opt out at any time? **Yes [ ] No [ ]**

I, \_\_\_\_\_, have read and fully understand the above statements.

**Acknowledgement**

I have been given the option to review the notice of privacy practices (HIPAA) for "RHC" and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy. I understand and direct that this authorization remain in effect until revoked by me in writing.

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# *Restoration Health Chiropractic Payment Policy*

RHC is NOT an insurance based service provider  
SERVICE IS RENDERED AND FEE IS COLLECTED EACH VISIT

## **If you have health insurance:**

Because of the diversity in plan policies and benefits, we recommend that you call your carrier to question your plan's policy on benefits for chiropractic care "in network" or "out of network", whichever applies. As a courtesy for your payment as service is rendered, this office will generate and mail insurance claims for you; however, payment for services will be collected as rendered until your carrier responds to our claims.

## **If you have Medicare:**

You will be responsible for the annual Medicare deductible as well as the exam & x-ray fee which Medicare will not pay. RHC is a participating provider and WILL ACCEPT ASSIGNMENT direct from the TRADITIONAL Medicare program only. If your secondary carrier is a Medigap policy, we will submit the information directly to them. If you have a supplemental policy, we will make copies of your "Explanation of Benefits" forms for treatment in this office only for reimbursement. Your copay will be collected.

If you are enrolled in one of Medicare's HMO Plans (Health First), we cannot process a claim for you.

**If you had an auto (or other) accident:** We will bill the responsible insurance company only AFTER we verify your policy benefits and have guarantee of payment. If an attorney is involved, we will request a "Letter of Protection". You MUST supply an Accident Report, Insurance company name, Address and Phone #, PIP Claim #, Adjuster's name, & Attorney's name, (if handling this case).

**If you were hurt at work:** Your insurance carrier MUST AUTHORIZE care rendered by FCC. We will bill the liable insurance company directly. You will be responsible to bring in the necessary information. (Copy of Injury Report, signed Authorization to Treat form, Insurance company name, address and phone #)

I HAVE READ & AGREE TO THE ABOVE TERMS OF PAYMENT

Print Name

Signature

Date

## **FOR ALL INSURANCE PROCESSING BELOW MUST BE SIGNED**

### **LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS**

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee healthcare benefits coverage and hereby assign at clinic's request, and directly convey to Restoration Health Chiropractic all medical benefits and/or insurance reimbursements, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of an applicable insurance or benefits payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize my plan administrator or fiduciary, insurer and, my attorney to release to such doctor and clinic any and all plan documents, insurance policy and /or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claims submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expense. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

Signature of Insured / Guardian

Date

**IF YOU ARE SELF-PAY PLEASE ADVISE FRONT DESK FOR ADDITIONAL PAYMENT OPTIONS**



**Auto Accident Information (If Applicable)**

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

Describe in DETAIL how your injury occurred:

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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).

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Patient's Signature

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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
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**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
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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
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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.