www.RHChiropracTOR.com
321-729-9430

RH CHIROPRACTIC
restoration health

1320 Palm Bay Rd
Palm Bay, FL 32905

Demographics

Full Name: _____ Date of Birth: _____/_____/_____

Address: _____

City: _____ State: _____ Zip Code: _____

Email: _____ Best Phone #: _____

VA patients and Auto patients only - Social Security # _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Other

Spouse's Name: _____ Number of Children: _____

It is our mission to keep our community healthy and thriving by empowering you to achieve your greatest health potential! Who can we thank for referring you to our office?

Name: _____ or Event Location: _____

☐ Word of Mouth ☐ Google ☐ Facebook ☐ RHC Website ☐ Workshop ☐ Outside Talk

Current Health Concern

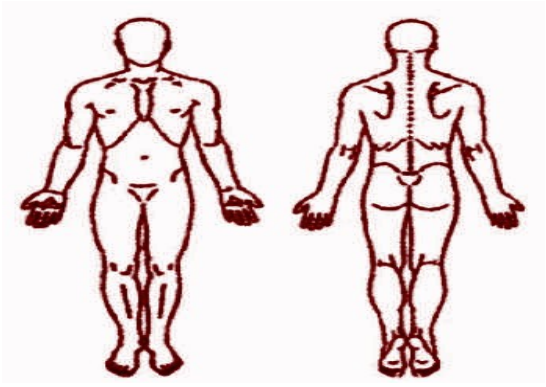
Main Complaint: _____

How Long have you had this complaint?

☐ Less than 5 days (Acute) ☐ 5-30 days (Sub Acute) ☐ More than 30 days (Chronic)

Have you recently been in a car accident? Yes or No If so, when? _____

On the body diagrams below, please indicate your areas of concern by labeling with the appropriate descriptions:



P - Pain

N - Numbness

T - Tingling

S - Shooting

On a Scale of 1 to 10 with 10 being the most severe, how would you rate your current level of discomfort?_____

Body Measurements

Health challenges always have root causes. In this section, we will be gathering basic lifestyle and health history information so we can understand how best to help you heal.

Height (in): _____ Weight (lbs): _____ Gender: _____

Health History Review

Have you been diagnosed with, or currently taking medication for any of the following:

- □ Arthritis
- □ Asthma
- □ Cancer
- □ Diabetes
- □ Digestive Disorder
- □ Heart Disease
- □ Herniated Disc
- □ High Blood Pressure
- □ High Cholesterol
- □ Liver Disease
- □ Migraine/Headaches
- □ Neurodegenerative
- □ Osteoporosis
- □ Thyroid Problems
- □ Other _____

Current Medications:

- □ Blood Pressure
- □ Cholesterol
- □ Insulin/Diabetes
- □ Pain Killers
- □ Muscle Relaxers
- □ Advil/Tylenol
- □ Anxiety/Depression
- □ ADD/ADHD
- □ Sleep Aids
- □ Other _____

Lifestyle Habits

On a scale 1-10 with 1 being poor and 10 being excellent, how would you rate your:

Exercise _____ Sleep _____ Diet _____ Stress Level _____ Water _____ General Health _____

How many days a week do you do use: Alcohol _____ Smoking _____ Sodas _____ Energy Drinks _____

Occupation : _____

Employer : _____

Describe Your Typical Day at Work:

- □ Sitting
- □ Standing
- □ Light Duty
- □ Heavy Duty

The following supplements are what we call the "Core 4" because they are critical to your health, and because the research shows most Americans are deficient in them. Do you take the following daily:

Omega-3 Fish Oils	Vitamin D3	Probiotics	Multi Vit/Mineral
Yes / No	Yes / No	Yes / No	Yes / No

HIPPA and Insurance / Payment Policies

This office conforms to the current HIPAA guidelines. You can request a copy of your HIPAA policy at the front desk. 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. I authorize this office and its staff to examine and treat my condition as the doctor sees fit. I hereby authorize the doctor to release all information necessary to insurance company, attorney or adjustor 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 submission. 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 any 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. My signature indicates I have been made aware of these policies.

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? O No O Yes Explain:

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

O No O Yes Explain:

Do you have a past history of accidents or trauma?

O No O Yes Explain:

Is your child presently taking any medications? O No O 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? O No O 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:

Terms for Acceptance of Care at Restoration Health Chiropractic

When a person seeks chiropractic and rehabilitation health care and is accepted for such care, it is essential for both parties to be working towards the same objective. As a chiropractic & rehab facility we have one main goal, to detect and correct/reduce the vertebral subluxation complex. It is important that each person understand both the objective and the method that will be used to attain this goal. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat a disease or condition other than vertebral subluxation. Regardless of what a disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **Our Only Practice Objective** is to eliminate a major interference to the expression of the body's innate wisdom and ability to heal. Our only method is specific adjusting to correct vertebral subluxations combined with rehabilitation procedures.

NOTE: It is understood and agreed the amount paid to Restoration Health Chiropractic for x-ray, is for examination only and they will remain the property of this office, being on file where they may be seen at any time while a patient of this office.

CONSENT TO CARE

I do hereby authorize the doctors of Restoration Health Chiropractic to administer such care that is necessary for my particular case. This may include consultation, examination, spinal adjustments and other chiropractic procedures, various modes of physical and diagnostic x-rays or any other procedure that is advisable, and necessary for my condition.

Furthermore, I authorize and agree to allow the doctor of chiropractic and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic, including those working at the clinic or office or any other office or clinic, to work with my spine through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration to allow for normal biomechanical motion and neurological function.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures related to my health care. I understand that I am responsible for all fees incurred for the services provided and agree to ensure full payment of all charges. I further understand that a fee for services rendered will be charged and that I am responsible for this fee whether results are obtained or not.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to fractures, disk injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests. The doctor will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another health care practitioner, or are not related to the spinal structural conditions treated at this clinic.

I also clearly understand that if I do not follow the doctor's specific recommendations at this clinic that I will not receive the full benefit from the programs offered and that if I terminate my care prematurely that all fees incurred will be due and payable at that time. I authorize the assignment of all insurance benefits be directed to the doctor for all services rendered. I also understand any sum of money paid under assignment by any insurance company shall be credited to my account, and I shall be personally liable for any and all of the unpaid balance to the doctor.

I, _____, have read or have had read to me, the above consent. I have also had the opportunity to ask questions about this consent, and by signing below I agree to the above named procedures. I intend this consent form to cover

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

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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 or 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

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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? ☐ Foward ☐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

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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

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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: _____

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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 *(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.

OIR-B1-1571
Pub. 1/2004

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 dysfunc-tion 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.