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.**

********** INITIAL EVALUATION **********

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):*

Dr. Shane H Silver		
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.

Silver Chiropractic & Wellness

CONFIDENTIAL PATIENT CASE HISTORY

This questionnaire was designed to provide important facts regarding the history of your pain or condition. The information you provide will assist in reaching a diagnosis and determining the source of your problem. Please take the time and answer each question as completely as possible. *Please sign each page.*

PATIENT INFORMATION**

(Underline)DR/ MR/ MRS/ MISS/ MS: TODAYS DATE:___/____/______

FIRST NAME:___________________ LAST NAME:___________________ MIDDLE INIT:_______

ADDRESS:______________________________CITY/STATE:________________ZIP:__________

HOME PHONE:______________AGE:____ BIRTH DATE:___/___/___ SOC. SEC# :____/____/_____

CELL PHONE _____________________ EMAIL ____________________________________

MARITAL STATUS: MARRIED/ SINGLE/ DIVORCE/ WIDOW (*PLEASE CIRCLE*) # OF CHILDREN: _____

OCCUPATION: __________________EMPLOYER: __________________WORK#: __________

SPOUSE'S NAME: _______________SPOUSE'S EMPLOYER: ___________WORK#:__________

FAMILY PHYSICIAN: _______________ ADDRESS: _________________ PHONE#: _________

FAMILY DENTIST: _________________ADDRESS: __________________ PHONE: __________

HEALTH INFORMATION***

WHAT ARE THE CHIEF COMPLAINTS FOR, WHICH YOU ARE SEEKING TREATMENT?
(IN ORDER OF IMPORTANCE WITH 1 BEING MOST IMPORTANT.)

1.________________ 4.________________ 7.________________ 10.________________

2.________________ 5.________________ 8.________________ 11.________________

3.________________ 6.________________ 9.________________ 12.________________

How long have you had this condition(s)? __________________

Have you had this condition in the past? ______________

Is this condition getting progressively worse?
YES [ ] NO [ ] CONSTANT [ ] COMES AND GOES [ ]
Is this condition interfering with your:
WORK[ ] SLEEP[ ] DAILY ROUTINE [ ] OTHER:____________________
How long has it been since you really felt good?_______________________________
Other Doctors who treated this condition____
Date of last physical examination____
List surgical operation and years____

SIGNATURE: X______________________________Date:____________________

Silver Chiropractic & Wellness

List any medications that have caused an allergic reaction_____

List any currently being taken: 1._____ 2._____ 3._____

4._____ 5._____ 6._____

Are you wearing: [ ]Sole lifts [ ]Heel lifts [ ]Inner soles [ ]Arch supports [ ]Pacemaker

Have you ever been in an auto accident? [ ]YES [ ]NO When?_____

Describe: _____

Have you had any other personal injury or accident? [ ] YES [ ] NO When?_____

Describe: _____

Are you pregnant? [ ] YES [ ] NO [ ] MAYBE

List treatments you have had for this problem and all health professionals that you are currently seeing:

PHYSICIANS	SPECIALTY	TREATMENT & APPROX. DATES
1.		
2.		
3.		
4.		
5.		
6.		

PATIENT SIGNATURE: X_____ DATE:_____

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**PLEASE CHECK THE FOLLOWING CONDITIONS THAT APPLY TO YOUR MEDICAL HISTORY*

ALLERGIES:
[ ] Hay Fever
[ ] Food Allergies:_____
[ ] Allergic to:_____

ARTHRITIS:
[ ] Gout
[ ] Osteoarthritis: Specify Joint:_____
[ ] Rheumatoid Disease
[ ] Other:_____

ENDOCRINE DISORDERS:
[ ] Diabetes
[ ] Hypoglycemia
[ ] Parathyroid Disease
[ ] Thyroid Disease
[ ] Other:_____

EYE DISORDERS:
[ ] Glaucoma
[ ] Ocular Herpes
[ ] Other:_____

HIV DISORDERS:
[ ] Tested HIV Positive
[ ] Aids
[ ] Other:_____

KIDNEY/URINARY DISORDERS:
[ ] Bladder Infections
[ ] Blood in urine
[ ] Kidney Disease
[ ] Sugar in Urine
[ ] Other:_____

MUSCLE DISORDERS:
[ ] Muscular Dystrophy
[ ] Muscle Shaking (tremors)
[ ] Muscle Spasms or Cramps
[ ] Other:_____

NERVE DISORDERS:
[ ] Cerebral Palsy
[ ] Epilepsy
[ ] Neuralgia
[ ] Multiple Sclerosis
[ ] Parkinson's Disease
[ ] Stroke
[ ] Other:_____

ARTIFICIAL IMPLANTS:
[ ] Heart pace maker
[ ] Heart Valve
[ ] Joint replacement: specify joint & side:_____
[ ] Other:_____

BLOOD DISORDERS:
[ ] Anemia
[ ] Bleeding Easily
[ ] Hemophilia
[ ] Leukemia
[ ] Sickle Cell Anemia
[ ] Other:_____

HEART/CIRCULATORY DISORDERS:
[ ] Arteriosclerosis
[ ] Congenital Heart Disorders (at birth)
[ ] Coronary Artery Disease
[ ] Heart Murmur
[ ] Heart Palpitations
[ ] High Blood Pressure
[ ] Low Blood Pressure
[ ] Poor Circulation
[ ] Rheumatic Fever
[ ] Other:_____

LIVER DISEASE:
[ ] Cirrhosis of the Liver
[ ] Hepatitis A (infectious)
[ ] Hepatitis B (serum)
[ ] Other:_____

LUNG/RESPIRATORY DISORDERS:
[ ] Asthma
[ ] Chronic Colds
[ ] Emphysema
[ ] Frequent Cough
[ ] Lung Cancer
[ ] Shortness of Breath
[ ] Tuberculosis
[ ] Other:_____

STOMACH/INTESTINAL DISORDER:
[ ] Bloating
[ ] Colitis
[ ] Constipation
[ ] Frequent Diarrhea
[ ] Frequent Gas
[ ] Gallbladder Problems
[ ] Heartburn
[ ] Ulcers [ ] Other:_____

SIGNATURE: X_____ DATE:_____

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ACCIDENT INFORMATION**********

If you were involved in an accident or a traumatic incident, complete this section.

Date / Time of Accident: _____

What makes your pain worse? _____

When did your condition first occur?_____

What do you believe is the cause of your pain or condition?
[ ] A motor vehicle accident (Date:_____)
[ ] A motorcycle accident (Date:_____)
[ ] A work related accident (Date:_____)
[ ] A play ground accident (Date:_____)
[ ] Athletic endeavor [ ] Fight [ ] Fall (Date:_____)
[ ] Unknown (Date:_____)
[ ] Other:_____

WHAT OTHER INFORMATION IS IMPORTANT TO YOUR CONDITION?

_____

_____

_____

_____

Briefly describe the accident: _____

_____

_____

_____

DESTINATION AFTER ACCIDENT / INJURY

When did you go to the hospital? _____
Hospital Name: _____
Who drove you the Hospital?_____ Were you admitted:_____
Date Discharged: _____ Were X-rays taken? _____
Has a doctor or dentist ever diagnosed a TMJ disorder prior to the accident? _____

_____

SIGNATURE: X_____ **DATE:** _____

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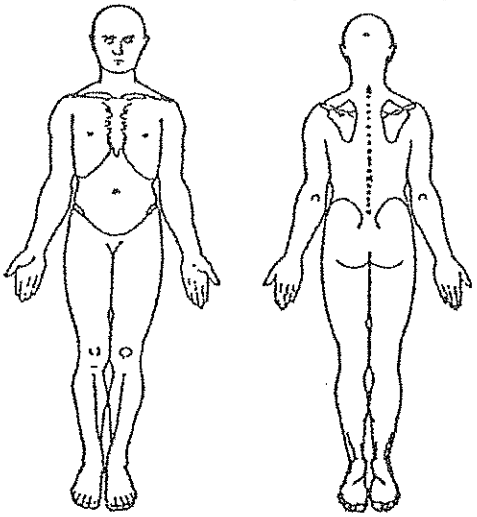
Please mark your areas of pain on the figures below.



Have you ever suffered from:

[ ] Dizziness_____
[ ] Backaches_____
[ ] Heart Trouble_____
[ ] Diabetes_____
[ ] Arthritis_____
[ ] Headaches_____
[ ] Asthma_____
[ ] Neuritis_____
[ ] Digestive Disorders_____
[ ] Nervousness_____
[ ] Sinus Trouble_____
[ ] Neck Pain_____
[ ] Other:_____

****

FAMILY HEALTH INFORMATION

(Many health problems are the result of hereditary spinal weakness; thus information about your family members will give us a better picture of your total health picture.)

Father:_____

_____

Mother: _____

_____

Sister: _____

_____

Brother: _____

_____

Other: _____

_____

PLEASE THINK...Is there anything else the doctor should know about you? _____

_____

_____

SIGNATURE: X_____ **DATE:** _____

Silver Chiropractic & Wellness

INSURANCE INFORMATION:**********

Health Insurance:_____
Subscriber
Name / Number:_____ Group #_____

Secondary Health Insurance: _____
Subscriber
Name / Number:_____Group#_____

Automobile
Insurance:_____
Date & Time of Accident:_____
Name of the insured: _____ Insured's Date of Birth: _____
Policy #:_____ Claim #:_____
Name of Adjuster:_____

If you do not have your own insurance, do you live with anybody who does?_____
Name of the Insured:_____ How are you related?_____
Policy #:_____ Claim #:_____

ATTORNEY INFORMATION:**********

Name of Attorney_____ Phone #:_____
Attorney's Address:_____

I authorize the release of a full report of examination findings, diagnosis, treatment program, etc., to any referring or treating dentist or physician. I additionally authorize the release of any medical information to insurance companies or for legal documentation to process claims. I understand that I am responsible for all charges for the treatment rendered to me regardless of insurance coverage.

Signature: X_____**DATE:**_____

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that *Silver Chiropractic & Wellness will* prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to *Silver Chiropractic & Wellness will* be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

PATIENT SIGNATURE: X_____

GUARDIAN or SPOUSE'S SIGNATURE: X_____

Silver Chiropractic & Wellness

AUTHORIZATION for MEDICAL INFORMATION

This authorization or photocopy hereof, will authorize you to furnish all information you may have regarding my condition while under your observation or treatment, including the history obtained, x-ray and physical findings diagnosis and prognosis. You are authorized to provide this information in accordance with the automobile personal injury protection law (Chapter 71-252F.S.).

X_____ _____

SIGNATURE DATE

AUTHORIZATION for WAGE and SALARY INFORMATION

This authorization or photocopy hereof, will authorize you to furnish all information you may have regarding my wages or salary while employed by you. You are authorized to provide this information in accordance with the automobile personal injury protection law (Chapter 71-252F.S.).

X_____ _____

SIGNATURE DATE

Silver Chiropractic & Wellness

CLAIM # _____

ASSIGNMENT OF BENEFITS

The undersigned patient hereby assigns the benefits of insurance under the automobile insurance with _____ to:
(Insurance Company)
Silver Chiropractic & Wellness and its physician *Dr. Shane H. Silver* for services rendered to the undersigned patient and covered by Personal Injury Protection (PIP) coverage under _____ policy with
(Insured's Name)
_____ and in accordance with Florida Statute Article
(Insurance Company Name)
627.736 (5). The undersigned further agrees to pay any applicable deductible or co-payment not covered by the PIP insurance coverage.

PATIENT SIGNATURE: X_____**DATE:**_____

The undersigned hereby accepts assignment of insurance benefits for services rendered to

_____ and to be paid directly to me under
(Patient's Name)
_____ Personal Injury Protection (PIP)
(Insured's Name)
coverage with _____ and in accordance with Florida
(Insurance Company Name)
Statute Article 627.736 (5).

_____ _____
(Doctor's Signature) (Date)

_____
(Witness)

Silver Chiropractic & Wellness

INITIATION OF TREATMENT

Date:_____

RE:_____

To Whom It May Concern:

This is to inform you that I _____, was injured in a motor vehicle accident on _____. This letter is to confirm that I intend to initiate treatment therapy as outlined by Dr. Shane H. Silver at his *Silver Chiropractic & Wellness* facility.

X_____

(Patient Signature)

Silver Chiropractic & Wellness

Shane H. Silver, D.C.

CONSENT FOR TREATMENT

I hereby authorize your practice and whomever the doctor may designate as her assistant to perform examination, physiotherapy, physical therapy and perform non-invasive diagnostic tests and, if any unforeseen condition arises in the course of the procedures calling for judgment, procedures in addition to or different from those non complicated. I further request and authorize this office to perform whatever my treating doctor deems advisable. The nature and purpose of these procedures have risks involved and the possibility of complications has been fully explained to me. I acknowledge that no guarantee has been made to me as the result that may be obtained.

DATE: _____

SIGNATURE: X_____

Medical Information Release Form

(HIPAA Release Form)

Name: _____ Date of Birth: ____/____/_____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other_____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number:_____

If unable to reach me:

[ ] you may leave a detailed message

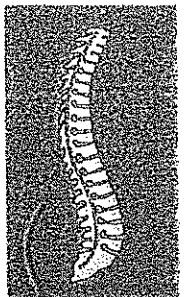
[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is (*day*)_____ between (*time*)_____

Signed: _____ Date: ____/____/_____

Witness:_____ Date: ___/____/_____



STAT...PLEASE!

WE APPRECIATE YOUR HELP AND THANK YOU...SCW

TO: _____

FAX#: _____

RELEASE OF MEDICAL AUTHORIZATION

I hereby authorize _____ to release a copy of all my patient records, reports, or X-rays containing protected health information to SILVER CHIROPRACTIC & WELLNESS. This authorization is given pursuant to Florida Statute 456.057 and HIPPA regulations. I understand that Florida Statute 456.057 (10) makes clear that any third party to who records are disclosed is prohibited from further disclosing any information in the medical record without the expressed written consent of the patient or the patient's legal representative.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Records Department where my information is maintained. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that once the above information is disclosed, it may be re-disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

_____

Print Patient Name **Social Security Number**

_____

Patient's or Patient's Legal Representative's Signature **Patient's Date of Birth**

_____ **Date Signed**

(1) Please provide final diagnosis and doctor's report...including Emergency Medical Condition designation if applicable...
(2) Other specific information to be disclosed ...

_____

_____

PLEASE FAX REPORTS TO (904) 634-0950

1050 Riverside Avenue, Suite B • Jacksonville, Florida 32204 • Office 904.634:0805 • Fax 904.634.0950