Ultimate Spine & Wellness

Account Number:_____ Date: _____

Name: Birthday:

Address: Sex: ☐ Male ☐ Female

City: Social Security No.:

State: Zip Code: Marital Status: ☐Married ☐Single ☐Divorced ☐Widowed

Spouse Name:

Primary Phone: Name of Emergency Contact:

Do you wish to receive text appt alerts ☐ Primary Care Physician:

Cell Phone: Race: ☐White ☐ A. American ☐ Asian ☐American Indian

Cell Service Provider: Ethnicity: ☐ Hispanic ☐ Non- Hispanic

Email: Preferred Language:

Employer:

How did you hear about us?

Insurance:

Insurance Co.:

Subscribers Name:

Insured: Check One: ☐ Self ☐ Spouse ☐ Parent ☐ Other:

Birthdate: Subscriber No.: Group#:

Effective Date: Deductible:

Is patient covered by additional insurance? ☐ Yes ☐ No Date:

Accident Information:

Is condition due to an accident? ☐ Yes ☐ No Date:

Type of accident: ☐ Auto ☐ Work ☐ Home ☐ Other:

If Disabled From Work Please Give Dates:

Attorney Name (If applicable):

Attorney Address and Phone Number (If applicable):

Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications. The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare". **Other treatment options which could be considered may include the following:**

- Over-the-counter analgesics. The risks of these medications include irritation to stomach, liver and kidneys, and other side effects.
- Medical care, typically anti-inflammatory drugs, tranquilizers, and analgesics.
- Hospitalization in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- Surgery in conjunction with medical care adds the risks of adverse reaction to anesthesia.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual risks: I have had the following unusual risks of my case explained to me.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and herby give my full consent to treatment.

AUDIO / VIDEO CONSENT ☐ YES ☐ NO

I hereby give permission to Ultimate Spine & Wellness to use my image, likeness, and voice as recorded on audio or video without payment or any other consideration. In addition, I give permission to discuss my case and outcomes with anonymity (all names, ages and genders will be changed).

By signing this release, I understand this permission signifies that photographic or video recordings of me may be electronically displayed and posted on a website, published in print, used in documentary video, or shown in the public or private educational setting. My case may be discussed on the Ultimate Spine & Wellness blog, YouTube channel or in office lectures/presentations.

_____ _____ _____

Printed Name (If Minor please indicate parent name) Signature Date

Ultimate Spine & Wellness

Child's Health History

Child's Name:_____DOB:_____ ☐ Male ☐ Female

Current Age:_____ Current Weight:_____lbs. Current Height:_____ft._____in.

Birth Weight:_____Birth Length:_____APGAR Scores: _____

Reason for pursuing care: ☐ Maintenance ☐ Improved Health ☐ Problem: _____

Medical History

Check any of the following conditions that currently apply:

☐ADHD/ADD	☐Autism	☐Colic	☐Headaches	☐Seizures
☐Allergies	☐Bed wetting	☐Digestive problems	☐Recurring Fevers	☐Tantrums
☐Asthma	☐Chronic Colds	☐Growing/ back pains	☐Scoliosis	

☐Car accident (Please include when)_____☐ Other: _____

Previous Chiropractic Care? ☐No ☐Yes If yes, name doctor and last visit:_____

Name of Pediatrician and last visit: _____

Present prescription drugs/ dosage (including over the counter drugs)? _____

Allergies: _____

Surgeries: _____

Family Medical History: _____

Prenatal History

Name of Obstetrician/ Midwife: _____Location of birth: ☐Hospital ☐ Birthing Center ☐ Home

Complications during pregnancy/ delivery? ☐ No ☐ Yes If yes, explain: _____

Medications taken during pregnancy/ delivery? ☐ No ☐ Yes: _____

Cigarette/ Alcohol use during pregnancy? ☐ No ☐ Yes If yes, how often: _____

Genetic disorders/disabilities? ☐ No ☐ Yes: _____

Feeding History

Breast Fed: ☐ No ☐ Yes How long: _____ Formula Fed: ☐ No ☐Yes How long:_____Type: _____

Introduced to: Solid Foods @ _____months Cow's milk @_____months Allergies or food intolerances: ☐ No ☐ Yes: _____

Developmental History

(to the best of your knowledge)

Your child's spine is vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference). Spinal nerve interference can affect the following. At what age was your child able to:

Respond to stimuli:_____Cross Crawl:_____Stand alone: _____

Respond to visual stimuli:_____Hold head up:_____Walk alone: _____

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e. a bed, changing table, down stairs)

Did your child have a fall similar to what was described above? ☐ No ☐ Yes: _____

Have there been any other traumas? ☐ No ☐ Yes: _____

Has your child been involved in any sports? ☐ No ☐ Yes: _____

Does your child: ☐ Eat healthy food (organic products, etc.) ☐Drink water

☐ Take probiotics ☐Take vitamins Type: _____

Exercise: ☐ none ☐ mild ☐ moderate ☐ heavy ☐ daily

Guardian name: _____Signature: _____Date: _____

Ultimate Spine & Wellness

Patient's Name:_____ Today's Date: _____

Date of Accident: _____

Briefly describe the accident: _____
_____
_____
_____
_____
_____
_____
_____
_____

THE FOLLOWING QUESTIONS PERTAIN TO YOU AND THE VEHICLE YOU WERE IN:

Your Vehicle Type:
☐ Car ☐ Truck
☐ Van ☐ Bus
☐ Motorcycle ☐ Other: _____

Year: _____
Make:_____
Model: _____

Your Position in the vehicle:
Driver
Passenger ------ Location -------- ☐Left ☐Middle ☐Right
Other_____ ☐Front Passenger ☐Rear Passenger ☐Third Row

Speed of Your vehicle:
☐Stopped ☐Moving Moderately
☐Parked ☐Moving Fast
☐Slowing ☐Moving at approx._____MPH

Why Vehicle was slowed or stopped:
☐Traffic Signal ☐Parking
☐Pedestrian ☐Traffic
☐Stop Sign ☐Busy Intersection

Collision Type:
☐Driver Side Impact ☐Head On Collision
☐Passenger Side Impact ☐Rear Impact
☐Front Impact ☐Pedestrian Impact

THE FOLLOWING QUESTIONS CONCERN THE OTHER VEHICLE INVOLVED IN THE ACCIDENT:

Other Vehicle Type:
☐ Car ☐ Truck
☐ Van ☐ Bus
☐ Motorcycle ☐ Other:_____

Year: _____
Make: _____
Model:_____

CONDITIONS AT THE TIME OF THE ACCIDENT:

Time of Day:
☐Full daylight
☐Dawn
☐Dusk
☐Night

Road Conditions:
☐Dry
☐Damp
☐Wet
☐Snow
☐Fair
☐Ice
☐Rain

Visibility:
☐Excellent
☐Good
☐Fair
☐Poor

THE FOLLOWING QUESTIONS CONCERN THE MOMENT OF IMPACT OF THE ACCIDENT:

Were you……
☐Totally unaware that the accident was impending
☐Aware that the accident was impending
☐Aware that the accident was impending and braced for it

Restraints:
☐Seat belt
☐Shoulder harness
☐No Restraints

THE FOLLOWING QUESTIONS CONCERN THE TIME PERIOD IMMEDIATELY FOLLOWING THE ACCIDENT

Did you lose consciousness?
☐Yes
☐No

Were you able to walk unaided?
☐Yes
☐No

Did you feel?
☐Dizzy ☐Weak
☐Dazed ☐Nervous
☐Disorientated ☐Nauseated

Where did you go?
☐Drove home ☐Drove to work
☐Was driven home ☐Was driven to work
☐Drove to hospital ☐Drove to school
☐Was driven to hospital ☐Was driven to school
☐Taken to hospital via ambulance
Name of hospital: _____

In what areas did you feel pain?

☐Head	Shoulder	☐Left	☐Right	Hip	☐Left	☐Right
☐Neck	Arm	☐Left	☐Right	Thigh	☐Left	☐Right
☐Upper back	Elbow	☐Left	☐Right	Knee	☐Left	☐Right
☐Mid back	Wrist	☐Left	☐Right	Calf	☐Left	☐Right
☐Ribs	Hand	☐Left	☐Right	Ankle	☐Left	☐Right
☐Chest	Fingers	☐Left	☐Right	Foot	☐Left	☐Right
☐Abdomen	Buttock	☐Left	☐Right	Toes	☐Left	☐Right
☐Low back	Pelvis					

In what areas did you experience lacerations (cuts) or bruises?

☐Head	Shoulder	☐Left	☐Right	Hip	☐Left	☐Right
☐Neck	Arm	☐Left	☐Right	Thigh	☐Left	☐Right
☐Upper back	Elbow	☐Left	☐Right	Knee	☐Left	☐Right
☐Mid back	Wrist	☐Left	☐Right	Calf	☐Left	☐Right
☐Ribs	Hand	☐Left	☐Right	Ankle	☐Left	☐Right
☐Chest	Fingers	☐Left	☐Right	Foot	☐Left	☐Right
☐Abdomen	Buttock	☐Left	☐Right	Toes	☐Left	☐Right
☐Low back	Pelvis					

At the hospital, what areas were x-rayed?

☐Head	Shoulder	☐Left	☐Right	Hip	☐Left	☐Right
☐Neck	Arm	☐Left	☐Right	Thigh	☐Left	☐Right
☐Upper back	Elbow	☐Left	☐Right	Knee	☐Left	☐Right
☐Mid back	Wrist	☐Left	☐Right	Calf	☐Left	☐Right
☐Ribs	Hand	☐Left	☐Right	Ankle	☐Left	☐Right
☐Chest	Fingers	☐Left	☐Right	Foot	☐Left	☐Right
☐Abdomen	Buttock	☐Left	☐Right	Toes	☐Left	☐Right
☐Low back	Pelvis					

Where did you experience pain on the day FOLLOWING the accident?

☐Head	Shoulder	☐Left	☐Right	Hip	☐Left	☐Right
☐Neck	Arm	☐Left	☐Right	Thigh	☐Left	☐Right
☐Upper back	Elbow	☐Left	☐Right	Knee	☐Left	☐Right
☐Mid back	Wrist	☐Left	☐Right	Calf	☐Left	☐Right
☐Ribs	Hand	☐Left	☐Right	Ankle	☐Left	☐Right
☐Chest	Fingers	☐Left	☐Right	Foot	☐Left	☐Right
☐Abdomen	Buttock	☐Left	☐Right	Toes	☐Left	☐Right
☐Low back	Pelvis					

Was the air bag deployed?
☐Car not equipped with air bag
☐Air bag deployed
☐Air bag not deployed

What position was YOUR headrest in?
☐Above head, high position
☐Even with head, middle position
☐Below head, low position

Position of YOUR head at time of impact?
☐Facing straight ahead
☐Tilted forward
☐Rotated to the left
☐Rotated to the right

Position of YOUR body at time of impact?
☐Straight
☐Tilted forward
☐Rotated to the left
☐Rotated to the right

Damage to vehicle YOU were in:
☐Incurred minimal damage
☐Incurred moderate damage
☐Incurred severe damage
☐Was totaled

AS A RESULT OF THE FORCE OF THE COLLISION, WHICH OBJECTS IN THE VEHICLE DID YOU BODY STRIKE?

Head
☐Steering wheel
☐Dashboard
☐Windshield
☐Armrest
☐Headrest
☐Rear view mirror
☐Right door
☐Left door
☐Right window
☐Left window
☐Console
☐Front seat

Torso
☐Steering wheel
☐Dashboard
☐Windshield
☐Armrest
☐Headrest
☐Rear view mirror
☐Right door
☐Left door
☐Right window
☐Left window
☐Console
☐Front seat

Left Arm
☐Steering wheel
☐Dashboard
☐Windshield
☐Armrest
☐Headrest
☐Rear view mirror
☐Right door
☐Left door
☐Right window
☐Left window
☐Console
☐Front seat

Right Arm
☐Steering wheel
☐Dashboard
☐Windshield
☐Armrest
☐Headrest
☐Rear view mirror
☐Right door
☐Left door
☐Right window
☐Left window
☐Console
☐Front seat

Left Leg
☐Steering wheel
☐Dashboard
☐Windshield
☐Armrest
☐Headrest
☐Rear view mirror
☐Right door
☐Left door
☐Right window
☐Left window
☐Console
☐Front seat

Right Leg
☐Steering wheel
☐Dashboard
☐Windshield
☐Armrest
☐Headrest
☐Rear view mirror
☐Right door
☐Left door
☐Right window
☐Left window
☐Console
☐Front seat

Patient Signature:_____**Date:** _____

Ultimate Spine & Wellness

Jamie A. Grainger, D.C.
1251 S Volusia Ave
Orange City, FL 32763
Phone: 386-668-6321
Fax: 386-775-1452

OFFICE FEE SCHEDULE

Billed Services			Non-Covered Services		Supplies	
Initial Visit and Exam		*$130*	Medicare Initial Visit and Exam	*$35*	Hot / Cold Pack	*$35*
Re -Activation Exam		*$100*	Medicare Re-Exam	*$25*	Muscle Relaxer Formula 303	*$20*
Re – Exam		*$70*	Initial Medical Nutrition Assess.	*$70*	Cryoderm	*$ 20*
Manipulation 1-2		*$60*	Follow Up Nutrition Assessment	*$35*	Ciroflow Water Pillow	*$60*
Manipulation 3-4		*$85*	Infrared / Laser	*$35*	Cervical Pillow	*$50*
Manipulation 5		*$115*	Kinesiology Tape	*$7*	Home Traction Cervical	*$45*
Manipulation of Extremity		*$60*	Cupping Therapy	*$45*	Calming Magnesium Cream	*$28*
Electrical Stimulation		*$76*	Decompression Therapy	*$200*	MCHC	*$18*
Massage Therapy	15 mins	*$20*	School Physical	*$25*	Turmeric	*$40*
Massage Therapy	30 mins	$40	X-Ray Cervical – 3 views	*$225*	Support Adrenals	*$40*
Massage Therapy	60 mins	*$75*	X-Ray Thoracic	*$250*	BioActive Nutritional	*$14*
Manual Therapy		*$119*	X-Ray Lumbar – 3 Views	*$250*	CW Oil	*$60*
Ultrasound Therapy	15 Mins	*$25*...	X-Ray Extremities	*$150*	TrueEase	*$89*
Other: _____			Additional X-Ray View	*$100*	Nano Greens	*$40*
Other: _____			Other: _____		Vitamin Med Weight Loss	*$200*

OFFICE FINANCIAL POLICY

CASH
We accept cash, check, Visa, Master Card, Discover and American Express.

INSURANCE
As a courtesy we will bill your insurance company for you. All co-pay amounts and deductibles are due at the time of service. We encourage you to call your insurance company to confirm your coverage percentage and limits. Knowing your insurance benefits is your responsibility. We will call your insurance company to verify coverage. What we are told on the phone is not always the same as what they end up paying. You are responsible for any difference between the billed allowable amount and what we receive from your insurance company.

MEDICARE
I am a Medicare provider. Medicare covers the chiropractic adjustment at 80%. Most supplemental plans pay the remaining 20%. Medicare and the supplement do not cover the initial exam, re-exams and x-ray fee, this is the patient's responsibility.

AUTO ACCIDENT INSURANCE (PIP)
Your auto insurance covers your injuries at 100% up to the limits of your policy. Some policies cover 80%. The remaining 20% will be collected from the patient.

WORKERS' COMP
Work related injuries must be pre-approved by your employer and insurance carrier. Most new cases need a referral from the PCP.

CANCELLATIONS
We do not double book. Your appointment time is reserved for you. We appreciate a 24-hour notice on all canceled appointments. We reserve the right to charge you $20 for all missed appointments.

Patient Signature:_____ Date: _____

Authorization to Release Medical Information

ULTIMATE SPINE & WELLNESS

MEDICAL RECORD NUMBER: _____

Patient Name_____

Alternate Name _____

Birthdate_____

Current Address_____

Daytime Phone #_____

Email address _____

PREFERRED METHOD OF DELIVERY

- ❑ Mail
- ❑ Fax (386) 775-1452
- ❑ Pick-up
- ❑ Secure Message*

**Email address required*

REASON FOR RECORD

- ❑ Medical Care
- ❑ Benefits
- ❑ Litigation
- ❑ Workers' Comp
- ❑ Individual Request
- ❑ Other _____

I AUTHORIZE INFORMATION RELEASED FROM:

Name of Office

Telephone Fax

Address

City, State, Zip

PLEASE SEND MY RECORDS TO:

Ultimate Spine & Wellness
Facility to Receive Information

(386) 668-6321
Telephone

1251 S. Volusia Ave
Address

Orange City, FL 32763
City, State, Zip

Type of Information to be Released *There may be fees for providing copies.*

❑ **SPECIFIC INFORMATION ONLY, INCLUDING:**

___Pap Results	___Radiology Reports	___Immunizations	___Operative Report	Dates:_____
___Mammogram Reports	___History and Physical	___OB / GYN Records	___Pathology Report	Dates:_____
___Medications/Therapy	___Genetics/Amniocentesis	___Other: _____	___Ultrasound Report	Dates:_____
___Lab	___Office Visits			

❑ **GENERAL MEDICAL RECORDS (FROM THE PAST TWO YEARS ONLY)**

PROTECTED OR SENSITIVE INFORMATION. Certain information cannot be released without specific authorization. Please initial below **if you agree to release the following:**

___I recognize that the information disclosed may contain DRUG/ALCOHOL information that is protected by federal and state law. I specifically consent to disclosure of such information.

___I recognize that the information disclosed may contain MENTAL HEALTH information that is protected by federal and state law. I specifically consent to disclosure of such information.

___I recognize that the information disclosed may contain data regarding HIV/AIDS testing. I specifically consent to disclosure of such information.

___I recognize that the information disclosed may contain data regarding GENETIC TESTING. I specifically consent to disclosure of such information.

PERMISSION TO FAX INFORMATION: I specifically consent to the faxing of my medical records. All faxed material will contain a confidentiality statement, however, I understand confidentiality at the receiving end cannot be guaranteed. Initial: _____

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain health care services or reimbursement for services. The only circumstance when refusal to sign means I will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else, and the authorization is necessary to make that disclosure. My refusal to sign this authorization will not adversely affect my enrollment in a health plan or eligibility for health benefits unless the authorized information is necessary to determine if I am eligible to enroll in the health plan.

I understand that I may revoke this authorization at any time (except to the extent that action has been taken relying upon it) by writing to the HIPAA Privacy Officer at the Administrative office (see reverse). Once information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient without my knowledge or consent. However, federal or state law may restrict the re-disclosure of HIV/AIDS information, mental health information, drug/alcohol conditions, or genetic information. If I revoke my authorization, the information described above may no longer be used or disclosed for the purposes described in this authorization. Unless revoked earlier, this authorization will expire 180 days from the date of signing or on_____(insert applicable date or event).

Signature of Patient or Patient's Legal Representative Date

Print Patient's Name or Name of Patient's Legal Representative (if applicable) Relationship to Patient

ULTIMATE
SPINE & WELLNESS

ASSIGNMENT OF BENEFITS

I hereby assign from any and all automobile insurance policies which provide medical benefits or no-fault benefits, all benefits, rights, title and interest to "Ultimate Spine & Wellness" as Assignee, for services rendered unto me both by reason of accident and illness. This document is to act as a limited assignment of my rights and benefits to the extent of the services provided by the Assignee and in no way should be construed as a delegation of any duties or obligations under said automobile insurance policy by the Assignor to Assignee, or a delegation of any conditions precedent under the above-referenced insurance policies.

ASSIGNMENT OF CAUSE OF ACTION

In the event my insurance company fails to pay Assignee the full amount due and owing to Assignee after notice is given, I hereby assign and transfer to Assignee any and all causes of action in tort or contract and proceeds from such causes of action, that I might have or that might exist in my favor against such insurance company and authorize Assignee to prosecute said cause of action either in my name or Assignee's name and further I authorize Assignee to compromise, settle or otherwise resolve said claim or cause of action as they see fit.

DIRECTION OF PAYMENT

I hereby authorize said insurance company or attorney to pay directly to Assignee the amount of this and/or any future bills for services rendered to me. I also agree to pay in a current manner any difference between the total charges and the amount paid by the insurance company directly to Assignee. I further agree to pay any applicable deductible or co-payment not covered by my insurance. In the event that I do not have insurance coverage, I understand that I remain personally responsible for payment of services rendered. I hereby further give an irrevocable lien to said Assignee against any and all insurance benefits named herein and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by the Assignee.

PIP LOG REQUEST

I hereby authorize my insurance company to release any information requested that is pertinent to my case to Assignee. Pursuant to the applicable Florida Statutes, Florida case law, the subject policy of insurance and in conjunction with this document. I hereby request a copy of the PIP log, Declaration Sheet and a copy of the insurance policy, which reflects the policy limits available at the time of the accident to be provided to Assignee.

RESERVATION OF BENEFITS

Please be advised that I am here by placing you on notice that, pursuant to Florida law, should you deny, reduce or fail to pay either a portion of or an entire bill submitted on my behalf from this Assignee. I am requesting that you reserve, or hold aside, that same amount until this dispute is resolved.

RELEASE OF INFORMATION

I hereby authorize Assignee and / or her office to disclose / release any information concerning my injuries protection by the Health Insurance Portability and Accountability Act to a requesting party with a properly executed medical records release.

If any term of the Assignment of document or the application thereof to any person or circumstances shall be determined invalid or unenforceable, the remainder of this Assignment shall not be affected thereby, and each term and provision of this Assignment shall be valid and enforced to the fullest extent of the law.

PATIENT NAME _____SIGNATURE_____DATE _____

GUARDIAN NAME_____SIGNATURE_____DATE_____

DOCTOR NAME_____ _SIGNATURE_____DATE_____

OFFICE OF INSURANCE REGULATION
Bureau of Property & Casualty Forms and Rates

Standard Disclosure and Acknowledgement Form
Personal Injury Protection - Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

1. The services or treatment set forth below were **actually rendered.** This means that those services have **already been provided.**

New Patient Consultation, examination, manual therapy, electrical stimulation, laser therapy and mechanical traction, physical exercise, x-ray

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 (15) and (16), 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**):*

Jamie A. Grainger, D.C.		
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.

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Pub. 1/2004