**Health-Fit Chiropractic & Sports Medicine**
**2900 N. Military Trail, Suite 230 Boca Raton, FL 33431**

## ASSIGNMENT OF INSURANCE BENEFITS, RELEASE, AND DEMAND

**Insurer and Patient, Please Read the Following in Its Entirety Carefully!**

I, the undersigned patient/insured, knowingly, voluntarily and intentionally assign the rights and benefits of my automobile insurance, also known as Personal Injury Protection (hereinafter PIP), and Medical Payments policy of Insurance to the above health care provider. I understand it is the intention of the provider to accept this assignment of benefits in lieu of demanding payment at the time services are rendered. I understand this document will allow the provider to file suit against an insurance company for payment of the insurance benefits or an explanation of benefits. If the provider's bills are applied to a deductible, I agree this will serve as a benefit to me and I authorize and request such litigation. This assignment of benefits includes the cost of transportation, medications, supplies, overdue interest and any potential claim for common law or statutory bad faith/unfair claims handling. If the insurer disputes the validity of this assignment of benefits, then the insurer is instructed to notify the provider in writing within five days of receipt of this document. Failure to inform the provider shall result in a waiver by the insurer to contest the validity of this document. The undersigned directs the insurer to pay the health care provider the maximum amount directly without any reductions and without including the patient's name on the check. To the extent the PIP insurer contends there is a material misrepresentation on the application for insurance resulting in the policy of insurance being declared voided, rescinded, or canceled, I, as the named insured under said policy of insurance, hereby assign the right to receive the premiums paid for my PIP insurance to this provider and to file suit for recovery of the premiums. The insurer is directed to issue such a refund check payable to this provider only. Should the medical bills not exceed the premium refunded, then the provider is directed to mail the patient/named insured a check which represents the difference between the medical bills and the premiums paid.

The insurer is directed by the provider and the undersigned to not issue any checks or drafts in partial settlement of a claim that contain or are accompanied by language releasing the insurer or its insured/patient from liability unless there has been a prior written settlement agreed to by the health provider and the insurer as to the amount payable under the insurance policy. The insured and the provider hereby contest and object to any reductions or partial payments. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by the provider shall be done so under protest, at the risk of the insurer, and the deposit shall not be deemed a waiver, accord, satisfaction, discharge, settlement or agreement by the provider to accept a reduced amount as payment in full. The insurer is hereby placed on notice that this provider reserves the right to seek the full amount of the bills submitted.

If the insurer schedules a defense examination or examination under oath (hereinafter "EUO") the insurer is hereby INSTRUCTED to send a copy of said notification to this provider. The provider or the provider's attorney is expressly authorized to appear at any EUO or IME set by the insurer. The health care provider is not the agent of the insurer or the patient for any purpose.

This assignment applies to both past and future medical expenses and is valid even if undated. A photocopy of this assignment is to be considered as valid as the original. I agree to pay any applicable deductible, co-payments, for services rendered after the policy of insurance exhausts and for any other services unrelated to the automobile accident. The health care provider is given the power of attorney to endorse my name on any check for services rendered by the above provider, and to request and obtain a copy of any statements or examinations under oath given by patient.

**Release of Information**: I hereby authorize this provider to: furnish an insurer, an insurer's intermediary, the patient's other medical providers, and the patient's attorney via mail, fax, or e-mail, with any and all information that may be contained in the medical records; to obtain insurance coverage information (declaration sheet and policy of insurance) in writing and telephonically from the insurer; request from any insurer all explanation of benefits (EOBs) for all providers and non-redacted PIP payout sheets; obtain any written and verbal statements the patient or anyone else provided to the insurer; obtain copies of the entire claim file and all medical records, including but not limited to, documents, reports, scans, notes, bills, opinions, X-rays, IMEs, and MRIs, from any other medical provider or any insurer. The provider is permitted to produce my medical records to its attorney in connection with any pending lawsuits. The insurer is directed to keep the patient's medical records from this provider private and confidential and the insurer is not authorized to provide these medical records to anyone without the patient's and the provider's prior express written permission.

**Demand**: Demand is hereby made for the insurer to pay all bills within 30 days without reductions and to mail the latest non-redacted PIP payout sheet and the insurance coverage declaration sheet to the above provider within 15 days. The insurer is directed to pay the bills in the order they are received. However, if a bill from this provider and a claim from anyone else are received by the insurer on the same day, the insurer is directed to not apply this provider's bill to the deductible. If a bill from this provider and claim from anyone else is received by the insurer on the same day, then the insurer is directed to pay this provider first before the policy is exhausted. In the event the provider's medical bills are disputed or reduced by the insurer for any reason or amount, the insurer is to: set aside the entire amount disputed or reduced; escrow the full amount at issue; and not pay the disputed amount to anyone or any entity, including myself, until the dispute is resolved by a Court. Do not exhaust the policy. The insurer is instructed to inform, in writing, the provider of any dispute.

**Certification**: I certify that: I have read and agree to the above; I have not been solicited or promised anything in exchange for receiving health care; I have not received any promises or guarantees from anyone as to the results that may be obtained by any treatment or service; and I agree the provider's prices for medical services, treatment and supplies are reasonable, usual and customary.

**Caution**: **Please read before signing. Please ask to view a copy of our charges. If you do not completely understand this document please ask us to explain it to you. If you sign below, we will assume you understand and agree to the above.**

Patient's Name_____ Patient's Signature_____
(Please Print) (If patient is a minor, signature of parent/guardian)

Date_____

# HEALTH-FIT CHIROPRACTIC & SPORTS MEDICINE

Medical Report and Doctor's Lien

I hereby authorize Health-Fit Chiropractic & Sports Medicine to furnish you, my attorney, with a full report of my examination, diagnosis, treatment, prognosis, etc.

I hereby authorize and direct you, my attorney, to pay directly to said Doctor and/or Health-Fit Chiropractic & Sports Medicine such sums as may be due and owing for services rendered both by reason of other bills that are due, and to withhold and forward immediately to Health-Fit Chiropractic & Sports Medicine such sums from any insurance reimbursement, settlement, judgment, or verdict which may be paid to you, my attorney, or myself as a result of the injuries in connection herewith.

I completely understand that I am fully and directly responsible to Health-Fit Chiropractic & Sports Medicine for all medical bills submitted by both parties for any and all services rendered and that I will pay bills no later than three months from the time such services have been provided, and forward immediately to said Doctor and Health-Fit Chiropractic & Sports Medicine reimbursement received from my insurance carriers. This agreement is made solely for said Doctors and Health-Fit Chiropractic & Sports Medicine additional protection and, in consideration of their payment to said Doctor and Florida Chiropractic & Rehabilitation Center, is unconditional and is not congruent on my receiving any insurance reimbursement, settlement, judgment, or verdict.

In the event my insurance carrier fails to pay Health-Fit Chiropractic & Sports Medicine/Doctor for services rendered within thirty days as described by the Florida Statutes, I HEREBY AUTHORIZE HEALTH-FIT CHIROPRACTIC & SPORTS MEDICINE TO RETAIN THEIR OWN CORPORATE ATTORNEY(S) TO REPRESENT ME ON MY OWN BEHALF IN ORDER TO COLLECT FROM SAID INSURANCE CARRIER THE REASONABLE MONIES OWED TO HEALTH-FIT CHIROPRACTIC & SPORTS MEDICINE. I hereby acknowledge and understand that I shall incur no attorney's fees or costs as a result of Health-Fit Chiropractic & Sports Medicine retaining their own corporate attorney(s) on my behalf. Representation by Health-Fit Chiropractic & Sports Medicine attorney(s) shall solely be for collection of overdue and/or unpaid medical bills owed to Health-Fit Chiropractic & Sports Medicine for services previously rendered on my patient's behalf. Furthermore, if it becomes necessary for Health-Fit Chiropractic & Sports Medicine to institute a lawsuit against patient/client to recover any monies due to a result of services rendered by Health-Fit Chiropractic & Sports Medicine to patient/client, the prevailing party in any such cause of action shall be entitled to recover from the other it's reasonable costs, including any and all attorney's fees at all levels.

It is the intent of the undersigned that this agreement is irrevocable and shall apply to the previously described cause of action whether or not the undersigned should engage co-counsel or substitute attorneys at any future time. In the event this should occur, the undersigned further agrees to immediately advise the doctor's office in writing of said substitution or engagement of co-counsel.

Patient's attorney agrees to forward immediately to Health-Fit Chiropractic & Sports Medicine payment received as reimbursement for services rendered to the above patient by Health-Fit Chiropractic & Sports Medicine. The attorney agrees to provide the doctor's office with a brief report on the status of the patient's case.

PATIENT_____ DATE_____

WITNESS_____ DATE_____

The undersigned, being attorney of record for the above patient, hereby agrees to comply with all of the terms of the above and consents to withhold sufficient sums from any reimbursement, settlement, judgment, or verdict to pay said Doctor and Health-Fit Chiropractic & Sports Medicine who shall have a priority lien and charge against any such sums, to which attorney's lien and charges shall be subject and subordinated.

Furthermore, attorney agrees to immediately notify doctor's office in writing should there occur a substitution of counsel, referral to attorney, retention of co-counsel or termination or modification in any manner of attorney/client relationship. The attorney further agrees to immediately notify the doctor's office in writing should there occur any insurance reimbursement, settlement, judgment, or verdict in said patient's case.

ATTORNEY'S SIGNATURE_____ DATE_____

# INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

### Health-Fit Chiropractic & Sports Medicine

I hereby request and consent to the performance of chiropractic treatments (also known as chiropractic adjustments or chiropractic manipulative treatments) and any other associated procedures: physical examination, tests, diagnostic x-rays, physio therapy, physical medicine, physical therapy procedures, etc.on me by the doctor of chiropractic named above and/or other assistants and/or licensed practitioners.

I understand, as with any health care procedures, that there are certain complications, which may arise during chiropractic treatments. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Homers' syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke.

I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest.

I have had an opportunity to discuss the nature, purpose and risks of chiropractic treatments and other recommended procedures. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed.

If there is any dispute about my care, I agree to a resolution by binding arbitration according to the American Arbitration Association guidelines.

I have read (or have had read to me) the above explanation of the chiropractic treatments. I state that I have been informed and weighed the risks involved in chiropractic treatment at this health care office. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future conditions(s) for which I seek treatment.

**SIGN ONLY AFTER YOU UNDERSTAND AND AGREE TO THE ABOVE**

_____
Printed name of Patient

x_____ _____
Signature of Patient Date

x_____ _____
Signature of Representative Date
(if patient is a minor or is handicapped)

x_____ _____
Witness to Patient's Signature Date

**HEALTH-FIT CHIROPRACTIC & SPORTS MEDICINE**
**2900 N. MILITARY TRAIL SUITE 230 BOCA RATON, FL 33431**
**561-859-3109**

**NON SOLICITATION AFFIDAVIT**

I HEREBY ACKNOWLEDGE AND AFFIRM THAT NO PERSON NOR ENTITY, IN AN INDIVIDUAL CAPACITY OR IN THE CAPACITY AS REPRESENTATIVE OF THE ABOVE-REFERENCED MEDICAL FACILITY, CORPORATION, PARTNERSHIP, OR ASSOCIATION, INCLUDING BUT NOT LIMITED TO THE ABOVE-REFERENCED MEDICAL FACILITY, SOLICITED ME FOR THE PURPOSE OF MAKING A CLAIM FOR PERSONAL INJURY/PERSONAL INJURY PROTECTION OR ANY OTHER BENEFITS UNDER ANY POLICY OF INSURANCE INCLUDING BUT NOT LIMITED TO AUTOMOBILE INSURANCE AS A RESULT OF MY MOTOR VEHICLE ACCIDENT ON _____.

FURTHER, I HEREBY ACKNOWLEDGE AND AFFIRM THAT I SUSTAINED INJURIES AS A RESULT OF AN ACCIDENT ON _____, AND THAT THE ABOVE-REFERENCED MEDICAL FACILITY HAS NOT OFFERED MONEY OR ANY OTHER REMUNERATION FOR THE PURPOSE OF TREATING AT THE ABOVE MEDICAL FACILITY AND THAT I CHOSE THE ABOVE MEDICAL FACILITY OF MY OWN FREE WILL.

_____ _____
PATIENT'S NAME (PRINT) DATE

_____ _____
PATIENT'S SIGNATURE DATE

STATE OF FLORIDA
COUNTY OF _____

THE FOREGOING INSTRUMENT was acknowledged before me this _____ day of _____ 2009, by _____who is personally known to me or who has produced_____as identification and who did take an oath acknowledging that all of the foregoing interrogatories were answered truthfully and completely to the best of his/her knowledge and ability.

NOTARY PUBLIC

_____
PRINT NAME

Commission Expiration Date:_____

Commission Numer:_____

# HEALTH-FIT CHIROPRACTIC & SPORTS MEDICINE

**2900 N. MILITARY TRAIL**
**SUITE 230**
**BOCA RATON, FL 33431**

# PIP INTAKE FORM

Date & country of accident: _____

Patient's name & address: _____

Patient's #: Home: _____ Work: _____ Cell: _____

**A. Did patient own an automobile at the time of the accident? Yes __ No __**

If Yes:

Name of Ins. Co.: _____

Adjuster's name & phone #: _____

Claim # or Policy #: _____

If No:

**B. Did patient reside with any resident relatives (rr)? Yes___ No ___**

Name of resident relatives: _____

RR Ins. Co: _____

Adjuster's Name & Phone #: _____

Claim # or Policy #: _____

**C. If patient does not own a vehicle and does not reside with any relative:**

Name of vehicle owner: _____

Name of Ins. Co: _____

Adjuster's name & phone#: _____

Claim # or policy #: _____

# HEALTH-FIT CHIROPRACTIC & SPORTS MEDICINE

**2900 N. MILITARY TRAIL**
**SUITE 230**
**BOCA RATON, FL 33431**

Receipt of Notice of Privacy Practices
Written Acknowledgement Form

I,_____, have read a copy of Health-Fit Chiropractic & Sports Medicine's Notice of Patient Privacy Practices.

_____ _____

Signature of Patient or Legal Guardian 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.**

_____

_____

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.