PHYSICAL EVIDENCE

CHIROPRACTIC | CRYOSUITE | CRYOSKIN

Dr. David Lipman
Chiropractic Physician
7035 Beracasa Way Suite 103 Boca Raton FL, 33433
Phone# (561)674-1217 Fax# (561)287-6556

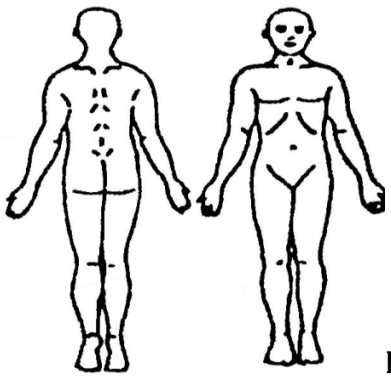
PERSONAL HISTORY

Last Name _____ First Name _____
Address _____City _____State _____ Zip _____
Date of Birth _____ Age _____ Social Security # _____
Circle One: Married Single Widowed Divorced Separated. Sex____ M _____F
Employer: _____ type of work _____
Home Phone _____ Work _____ Cell _____
Spouse Name _____ Spouse Phone _____
Email Address_____

Name & Number of Emergency Contact _____Phone _____
Relationship _____
Who is Responsible for your bill _____ Do you have Health Insurance ___Y ___N
Insurance Company _____ ID # _____

HEALTH CONDITION

What is your major complaint _____ when did this start _____
Other doctors seen for this condition? ___ Y ___N. Who? _____
Is condition ___ job Related ___ Auto Accident ___ Home Injury ___ Slip & fall ___ other ____
_____
Date of Accident _____ Time of accident _____ AM/PM
Have you reported this accident ____Yes ___No. To Whom? _____
Adjusters Name _____ Claim # _____
Have you had any Surgery? Please Describe _____
Previous Chiropractic Care ___ Y ___N Doctors name and Last visit _____



Please outline on the diagram the area of discomfort

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand the doctor's office will prepare any necessary forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to the doctor's office will be credited to my account on receipt. I the undersigned agree that I am responsible for any and all costs associated with the treatment rendered to me by the doctor even if my insurance company fails to pay, or pays a portion thereof if I become delinquent in payment of such fees due the doctor (30 days past due from the date of the original invoice) I am responsible for any and all collection costs attorney fees at the maximum legal rate with the regards to the recovery of such delinquent account I also understand that if I suspend treatment or insurance account is immediately due and payable to doctor .
I hereby authorize the doctor to treat my condition as he or she deems appropriate through the use of manipulation throughout my spine. It is understood and agreed that the amount paid to the doctor is for exam and x-rays, only the x-ray negatives will remain property of this office being on file where they may be seen at any time while a patient is at this office patient also agrees that he/she is responsible for all bills incurred at this office the doctor will not be held responsible for any pre-existing conditions nor for any medical diagnosis.

PHYSICAL EVIDENCE CHIROPRACTIC
7035 BERACASA WAY SUITE 103 BOCA RATON FL, 33433
PHONE# (561)361-4888 FAX# (561)361-4999

PERSONAL INJURY PATIENT HISTORY

NAME: _____ **DATE:** _____ **FILE#**_____

HISTORY OF OCCURANCE

DATE OF ACCIDENT _____TIME _____AM __PM __DRIVER OF CAR_____

WHERE WERE YOU SEATED? DRIVER'S SEAT ____FRONT RIGHT PASSENGER _____FRONT MIDDLE PASSENGER_____

RIGHT REAR PASSENGER _____REAR MIDDLE PASSENGER _____ REAR MIDDLE PASSENGER _____

WHO OWNS THE CAR? _____ YEAR & MODEL OF CAR _____

WHAT WAS THE DAMAGE DONE TO THE CAR YOU WERE IN? MILD___ MODERATE___ SEVERE____ TOTAL ___ UNKNOWN___

VISIBILITY AT TIME OF ACCIDENT: POOR___ FAIR___ GOOD___

ROAD CONDITIONS AT TIME OF ACCIDENT: SNOW/ICY____ WET___ CLEAR___ DARK____

TYPE OF ACCIDENT: WAS HIT IN THE __ HIT ANOTHER CAR __ REAR__ RIGHT SIDE __ LEFT SIDE __ FRONT___

NON-COLLISION (DESCRIBE) _____

IMPACT/ SEAT BELT /HEADREST/ SPEED

DESCRIBE IN YOUR OWN WORDS WHAT HAPPENED TO YOU UPON IMPACT: _____

_____

WERE YOU AWARE THE ACCIDENT WAS ABOUT TO HAPPEN? YES ___ NO___

DID YOU BRACE FOR THE IMPACT YES ___ NO___?

WERE YOU WEARING A SEATBELT / SHOULDER HARNESS YES ___ NO___?

DID THE CAR YOU WERE IN HAVE A HEADREST? YES ___ NO___

IF YES WHAT WAS THE POSITION OF THE HEADREST COMPARED TO YOUR HEAD BEFORE THE IMPACT

TOP OF HEAD REST EVEN WITH BOTTOM OF HEAD __ TOP OF HEAD REST EVEN WITH TOP OF HEAD___

TOP OF HEAD REST EVEN WITH MIDDLE OF NECK ____

Was the car equipped with an airbag where you were seated? Yes ___ No___

If yes did the airbag inflate? Yes ___ No___

Were you injured by the inflated air bag Yes ___ No___?

If yes what were the injuries? _____

Was your foot on the brake pedal? Yes ___ No___

Was your car moving at the time of the accident? Yes ___ No___

If yes how fast would you estimate you were going ____ MPH (estimate)

How fast was the other car traveling _____MPH (estimate?)

HEAD/BODY POSITION/ ABLE TO MOVE BODY

Head/Body position at time of impact: Head Turned ___ Right ___Left ___ Head Looking back ___

Head Straight forward ___ Body Straight sitting position ____Body Rotated Left ___ Right ___

At the time of the accident, Recall what parts of your head or body hit what parts on the inside of the car: _____

As a Result of the accident you were: Rendered unconscious ____ Dazed, Circumstances Vague __ Shaken Up but could think clearly and function____

Could you move all parts of your body? Yes ___ No___

If no what part could you not move and why? _____

Were you able to get out of the car and walk unaided? _____

Did you receive any medical assistance at the scene of the accident Yes ___ No___

Did you have any bleeding cuts form this accident? _____

Did you get any Bruises from this Accident? _____

Please describe how you felt Please be specific:

Immediately after accident _____

The next Day _____

Check the symptoms apparent since the accident:

___Headaches __Dizziness ___Loss of memory __ sleeping problems __ Constipation

___Neck Pain/ Stiffness __Fainting __Fatigue __Numb Toes ___Chest Pain ___Midback pain

___Ringing in ears __Loss of balance ___Numb Fingers __Nervousness ___ Low back Pain

___Tension ___Shortness of breath ___Cold hands ___ Cold Sweats ___Los s of smell

___Irritability ___Cold Feet ___Eyes sensitive to light ___Anxious ___Pain Behind Eyes

___loss of taste ___Depression ___Diarrhea

WORK STATUS HISTORY

OCCUPATION: _____ EMPLOYER: _____

HAVE YOU MISSED TIME FROM WORK? ___YES ___NO

IF YES, FULL TIME OFF OF WORK: _____

IF YES, PART TIME OFF OF WORK: _____

___BEEN ABLE TO WORK SINCE ACCIDENT.

FIRST DOCTOR/ HOSPITAL / CLINIC SEEN

DID YOU GO SEEK MEDICAL HELP IMMEDIATELY / SOON AFTER ACCIDENT? ___YES ___NO

IF YES, WHO DID YOU FIRST GET TREATMENT FROM? DOCTOR/ HOSPITAL/ CLINIC SEEN:
_____

DATE OF FIRST VISIT: _____ WERE YOU EXAMINED ___YES ___NO WERE X-RAYS TAKEN ___YES ___ NO

WERE YOU GIVEN TREATMENT___ YES ___NO IF YES WHAT TREATMENT WAS GIVEN TO YOU?
_____

WHAT BENEFITS DID YOU RECEIVE FROM TREATMENT? _____

DATE OF LAST TREATMENT? _____

PRIOR SIMILAR SYMPTOMS

DID YOU HAVE ANY PHYSICAL COMPLAINTS JUST BEFORE THE ACCIDENT ____ YES ____NO?

IF YES, WHAT PHYSICAL SYMPTOMS JUST BEFORE THE ACCIDENT? _____

PRIOR TO THIS ACCIDENT HAVE YOU EVER HAD SYMPTOMS SIMILAR TO WHAT YOU'RE EXPERIENCING NOW ___YES ___NO IF YES PLEASE EXPLAIN (BRIEFLY INCLUDE PAST FALLS, INJURIES, ACCIDENTS OPERATIONS ETC.)

_____

ACTIVITES OF DAILY LIVING

DO YOU NOTICE ANY OF YOUR HOME ACTIVITIES THAT ARE DIFFERENT NOW THAN BEFORE THE ACCIDENT __YES __ NO?

IF YES, LIST THEM AS:

THOSE ACTIVITIES THAT YOU ARE NOW UNABLE TO DO ARE (BE SPECIFIC) _____

THOSE ACTIVITIES THAT ARE NOW PAINFUL TO DO ARE (BE SPECIFIC) _____

THOSE ACTIVITIES THAT ARE NOW DIFFICULT TO DO ARE (BE SPECIFIC) _____

ATTORNEY ON CASE

DO YOU HAVE AN ATTORNEY ON THIS CASE ____YES ____ NO

IF YES WHO? NAME _____ PHONE _____

ADDRESS: _____CITY:_____ STATE: _____ ZIP: _____

PATIENT SIGNATURE: _____ DATE: _____

AUTOMOBILE ACCIDENT- INSURANCE DATA

PATIENT'S INSURANCE COMPANY INFORMATION (YOU)

COMPANY NAME: _____ POLICY # _____

CLAIM # _____ ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

ADJUSTERS NAME: _____ PHONE# _____FAX#_____

INSURED'S INSURANCE COMPANY INFORMATION (DRIVER OF CAR YOU WERE IN IF NOT YOU)

COMPANY NAME: _____ POLICY # _____

CLAIM # _____ ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

ADJUSTERS NAME: _____ PHONE# _____FAX#_____

OTHER DRIVERS INSURANCE COMPANY INFORMATION (OTHER CAR'S DRIVER)

COMPANY NAME: _____ POLICY # _____

CLAIM # _____ ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

ADJUSTERS NAME: _____ PHONE# _____FAX#_____

PHYSICAL EVIDENCE CHIROPRACTIC
DR. DAVID LIPMAN

HIPPA FORM

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT & HEALTH CARE OPERATIONS (3/03)

IN THIS DOCUMENT, "I" AND "MY" REFERS TO THE PATIENT.
AND "CHIROPRACTOR" REFERS TO DR. DAVID LIPMAN DC.

I CONSENT TO THE USE OR DISCLOSURE OF MY PROTECTED HEALTH INFORMATION BY THE CHIROPRACTOR FOR THE PURPOSE OF ANALYZING, DIAGNOSING OR PROVIDING TREATMENT TO ME, OBTAINING PAYMENT FOR MY HEALTH CARE BILLS OR TO CONDUCT HEALTH CARE OPERATIONS OF CHIROPRACTOR. I UNDERSTAND THAT ANALYSIS, DIAGNOSIS OR TREATMENT OF ME BY CHIROPRACTOR MAY BE CONDITIONED UPON MY CONSENT AS EVIDENCED BY MY SIGNATURE BELOW

I UNDERSTAND I HAVE THE RIGHT TO REQUEST A RESTRICTION AS TO HOW MY PROTECTED HEALTH INFORMATION IS USED OR DISCLOSED TO CARRY OUT TREATMENT, PAYMENT OF HEALTH CARE OPERATIONS OF THE PRACTICE. CHIROPRACTOR IS NOT REQUIRED TO AGREE TO THE RESTRICTIONS THAT I MAY REQUEST. HOWEVER, IF CHIROPRACTOR AGREES TO A RESTRICTION THAT I REQUEST, THE RESTRICTION IS BINDING ON CHIROPRACTOR.

I HAVE THE RIGHT TO REVOKE THIS CONSENT, IN WRITING, AT ANY TIME, EXCEPT TO THE EXTENT THAT CHIROPRACTOR HAS TAKEN ACTION IN RELIANCE ON THIS CONSENT.

MY "PROTECTED HEALTH INFORMATION" MEANS HEALTH INFORMATION, INCLUDING ME DEMOGRAPHIC INFORMATION, COLLECTED FORM ME AND CREATED OR RECEIVED BY MY PHYSICIAN, ANOTHER HEALTH CARE PROVIDER, A HEALTH PLAN, MY EMPLOYER OR HEALTH CARE CLEARING HOUSE. THIS PROTECTED HEALTH INFORMATION RELATES TO MY PAST, PRESENT OF FUTURE PHYSICAL OR MENTAL HEALTH OR CONDITION AND IDENTIFIES OR THERE IS A REASONABLE BASIS TO BELIEVE THE INFORMATION MY IDENTIFY ME.

I HAVE BEEN PROVIDED WITH A COPY OF THE NOTICE OF PRIVACY PRACTICES OF CHIROPRACTOR AND UNDERSTAND THAT I HAVE A RIGHT TO REVIEW THE NOTICE OF PRIVACY PRACTICES PRIOR TO SIGNING THIS DOCUMENT. THE NOTICE OF PRIVACY PRACTICES DESCRIBES THE TYPES OF USES AND DISCLOSURES OF MY PROTECTED HEALTH INFORMATION THAT WILL OCCUR IN MY TREATMENT, PAYMENT OF MY BILLS OR IN THE PERFORMANCE OF HEALTH CARE OPERATIONS OF CHIROPRACTOR. THE NOTICE OF PRIVACY PRACTICES FOR CHIROPRACTOR IS ALSO POSTED IN THE OFFICE OF DR. DAVID LIPMAN'S OFFICE. THE NOTICE OF PRIVACY PRACTICES ALSO DESCRIBES MY RIGHTS AND DUTIES OF THE CHIROPRACTOR WITH RESPECT TO MY PROTECTED HEALTH INFORMATION.

CHIROPRACTOR RESERVES THE RIGHT TO CHANGE THE PRIVACY PRACTICES THAT ARE DESCRIBED IN THE NOTICE OF PRIVACY PRACTICES. I MAY OBTAIN A REVISED NOTICE OF PRIVACY PRACTICES BY CALLING THE OFFICE OF CHIROPRACTOR AND REQUESTING A REVISED COPY TO BE SENT IN THE MAIL OR ASKING FOR ONE AT THE TIME OF MY NEXT APPOINTMENT.

NAME: _____ SIGNATURE: _____

DATE: _____ WITNESS SIGNATURE: _____

DAVID LIPMAN D.C.

INFORMED CONSENT FOR CHIROPRACTIC CARE

WHEN A PATIENT SEEKS CHIROPRACTIC HEALTH CARE AND WE ACCEPT A PATIENT FOR SUCH CARE, IT IS ESSENTIAL FOR BOTH TO BE WORKING FOR THE SAME OBJECTIVE. IT IS IMPORTANT THAT EACH PATIENT UNDERSTANDS BOTH THE OBJECTIVE AND THE METHOD THAT WILL BE USED TO OBTAIN IT. THIS WILL PREVENT ANY CONFUSION OR DISAPPOINTMENT. YOU HAVE THE RIGHT, AS A PATIENT, TO BE INFORMED ABOUT THE CONDITION OF YOUR HEALTH AND THE RECOMMENDED CARE AND TREATMENT TO BE PROVIDED SO THAT YOU MAY MAKE THE DECISION WHETHER OR NOT TO UNDERGO CHIROPRACTIC CARE AFTER BEING ADVISED OF THE KNOWN BENEFITS, RISKS AND, ALTERNATIVES.

CHIROPRACTIC IS A SCIENCE AND ART WHICH CONCERNS ITSELF WITH THE RELATIONSHIP BETWEEN STRUCTURE (PRIMARILY THE SPINE) AND FUNCTION (PRIMARILY THE NERVOUS SYSTEM) AS THE RELATIONSHIP MAY EFFECT THE RESTORATION AND PRESERVATION OF HEALTH. **HEALTH** IS A STATE OF PHYSICAL, MENTAL AND SOCIAL WELL-BEING, NOT MERELY THE ABSENCE OF DISEASE OR INFIRMITY.

ONE DISTURBANCE TO THE NERVOUS SYSTEM IS CALLED **VERTEBRAL SUBLUXATION**. THIS OCCURS WHEN ONE OR MORE OF THE 24 VERTEBRA IN THE SPINAL COLUMN BECOMES MISALIGNED AND/OR DO NOT MOVE PROPERLY. THIS CAUSES ALTERATION OF NERVE FUNCTION AND INTERFERENCE TO THE NERVOUS SYSTEM. THIS MAY RESULT IN PAIN DYSFUNCTION OR MAY BE ENTIRELY ASYMPTOMATIC.

SUBLUXATIONS ARE CORRECTED AND/OR REDUCED BY AN **ADJUSTMENT**. AN ADJUSTMENT IS THE SPECIFIC APPLICATION OF FORCES TO CORRECT AND/OR REDUCE VERTEBRAL SUBLUXATION. OUR CHIROPRACTIC METHOD OF CORRECTION IS BY SPECIFIC ADJUSTMENTS OF THE SPINE. ADJUSTMENTS ARE USUALLY PERFORMED BY HAND BUT MAYBE PERFORMED BY HANDHELD INSTRUMENTS. IN ADDITION, ANCILLARY PROCEDURES SUCH AS PHYSIOTHERAPY AND/OR REHABILITATIVE PROCEDURES MAY BE INCLUDED.

ALL HEALTH CARE PROCEDURES CARRY SOME RISK. RISKS ASSOCIATED WITH CHIROPRACTIC CARE MAY INCLUDE, BUT ARE NOT LIMITED TO, MUSCLE OR LIGAMENT INJURIES, NERVE INJURIES, VASCULAR INJURIES, AND FRACTURES. ALTERNATIVES TO CHIROPRACTIC CARE MAY INCLUDE MEDICATIONS, SURGERY AND OTHER ALTERNATIVE TREATMENTS.

IF DURING THE COURSE OF CARE WE ENCOUNTER NON-CHIROPRACTIC OR UNUSUAL FINDINGS, WE WILL ADVISE YOU OF THOSE FINDINGS AND RECOMMEND THAT YOU SEEK THE SERVICES OF ANOTHER HEALTH CARE PROVIDER.

ALL QUESTIONS REGARDING THE DOCTOR'S OBJECTIVE PERTAINING TO MY CARE IN THIS OFFICE HAVE BEEN ANSWERED TO MY COMPLETE SATISFACTION. THE BENEFITS, RISKS AND ALTERNATIVES OF CHIROPRACTIC CARE HAVE BEEN EXPLAINED TO ME TO MY SATISFACTION. I HAVE READ AND FULLY UNDERSTAND THE ABOVE STATEMENTS AND THEREFORE ACCEPT CHIROPRACTIC CARE ON THIS BASIS.

PRINT NAME_____ SIGNATURE _____ DATE _____

CONSENT TO EVALUATE AND ADJUST A MINOR CHILD:

I, _____BEING THE PATIENT OR LEGAL GUARDIAN OF_____

HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT AND HEREBY GRANT PERMISSION FOR MY CHILD TO RECEIVE CHIROPRACTIC CARE.

PREGNANCY RELEASE: THIS IS TO CERTIFY THAT TO THE BEST OF MY KNOWLEDGE I AM NOT PREGNANT AND THE ABOVE DOCTOR AND HIS/HER 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: _____

Physical Evidence Chiropractic

Informed Consent for Active Release Technique

What is Active Release Technique?

It is a hands-on touch and case-management system that allows a practitioner to diagnose and treat soft-tissue injuries. Soft tissue refers primarily to muscle, tendons, fascia and nerves. Specific injuries that apply are repetitive strains, traumas, adhesions, tissue hypoxia and joint dysfunction.

What do you expect from an Active Release Technique treatment?

Every session is actually a combination of examination and treatment. Dr. Lipman uses his hands to evaluate the texture, tension, movement and function of muscles, fascia, tendons, ligaments and nerves. Abnormal tissues are treated by combining precisely directed tension and pressure with very specific patient movements.

How Long Are Treatments?

Treatments take about 8-15 minutes for each area being treated. A condition may require two to ten Visits before full functionality is restored. Manipulation of the spine and extremity joints is almost always carried out in conjunction with Active Release Therapy to increase treatment effectiveness. Whenever possible we have our patients perform active movements during the treatment process. Active motions stimulate neurological pathways in the spinal cord that help to reduce pain during treatment. Motion also helps to reproduce the stresses the patient will actually be under during normal active motion.

Is it safe?

Yes it is.

Are there any side effects?

Active Release Therapy is a non-invasive, safe and virtually no side effects and comes with a record of very good results. In a small percentage of patients, symptoms can become worse before improving. This is generally a sign that healing has begun. In some cases Active Release Therapy can cause bruising and tenderness in the region that is being treated. If during the treatment session you find it to be too uncomfortable, please bring it to Dr. Lipman's attention immediately so the treatment can be modified. If worsening of symptoms or the bruising that may ensue is concerning you or lasts more than a few days, contact Dr. Lipman to discuss.

I _____ (Full name) Have read and understood the above information. I consent to receive Active Release Technique treatment within this practice. I agree to

This consent remaining valid until such time as I withdraw that consent.

Signed _____ Date _____

PHYSICAL EVIDENCE CHIROPRACTIC
DR. DAVID LIPMAN
7035 BERACASA WAY SUITE 103
BOCA RATON, FL 33433

(P) 561-674-1217

ASSIGNMENT OF INSURANCE BENEFITS, RELEASE, & 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, a/k/a Personal Injury Protection (hereinafter PIP), Uninsured Motorist, 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 insurer for payment of the insurance benefits or an explanation of benefits and to seek §627.428 damages from the insurer. If the provider's bills are applied to a deductible, I agree this will serve as a benefit to me. 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 & 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 is 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.

Disputes: 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 (specifically the office manager) and the insurer as to the amount payable under the insurance policy. The insured and the provider hereby contests and objects 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 PIP insurer states it can pay claims at 200% of Medicare then the insurer is instructed & directed to provide this provider with a copy of the policy of insurance within 10 days. **Any effort by the insurer to pay a disputed debt as full satisfaction must be mailed to the address above, after speaking with the office manager, and mailed to the specific attention of the Office Manager. See Fla. Stat. §673.3111.**

EUOs and IMEs: 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 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 email, with any and all information that may be contained in the medical records; to obtain insurance coverage information (declaration sheet & 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, the property damage 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. 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 is 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. 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 _____ (Please Print) Patient's Signature _____ (If patient is a minor, signature of parent/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**)*:

DR. David Lipman DC 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.

Physical Evidence Chiropractic, LLC
Dr. David Lipman

Financial Policy

I personally strive to provide the highest quality health care, all the while maintaining Affordability for you, the patient. By agreeing to receive treatment in my office, you acknowledge that there is no guarantee that your condition will resolve or that you will have 100% results. There are many factors that affect the success of the treatment administered. No reimbursements are provided if results aren't obtained.

Participating Insurances

Our office will accept your insurance on assignment and do participate as preferred Providers for many insurance plans. However, it must be fully understood that your Insurance policy is a contract between you and your insurance company. Our office will not enter into a dispute with your insurance company over policy limitations or Issues. This is your responsibility and obligation. **ALL CHARGES INCURRED ARE YOUR RESPONSIBILITY.** If you have a question or concern with your reimbursement, you will Need to contact your employer or insurance company. Our office will file your claims for you and assist you in every way possible to ensure benefit recovery. We cannot be certain if your insurance covers chiropractic care, although most policies do provide coverage. The amount they pay varies from one policy to another. We will call to verify benefits on your insurance; however, the benefits quoted to us by your insurance company are not a guarantee of payment. It is our policy and agreed that any services rendered are charged to you directly and you are responsible for payment of any non-covered services, deductibles or co-pays.

Non Participating Insurances

We will gladly bill your insurance company for you, and will call to determine your chiropractic benefits... Payment is due at the time of service for all deductibles, copays, and non-covered therapies unless arrangements are with the office staff.

Patients without Insurance

We request that 100% of the examination and x-ray exam be paid at the time of The visit, unless other arrangements have been made. To qualify for our Time of Service Reduction in fees you must pay on the day the service was performed. We are happy to accept cash, check, Master Card, Visa, Discover or American Express. No insurance will be billed.

Medicare

Our office accepts assignment from Medicare. Reimbursement is sent directly to our office in payment for chiropractic services that Medicare will cover. Medicare will **ONLY** cover manipulation of the spine. Medicare pays 80% of the allowable fee once the deductible has been met. You are required to pay the deductible and the remaining fees for services Medicare does not reimburse. These non-covered services include, but are not limited to, x-rays, examinations, therapies, orthotics, Supports, and/or nutritional supplements. Medicare patients are fully responsible for Charges of non-covered services. Secondary insurance may or may not pay for These non-covered services. Our office completes and files the forms for Medicare at No charge.

Secondary Insurance

Please inform us of any secondary insurance you may have. We will file and collect from your secondary insurance for services covered by the secondary payer.

Flex Plans/Medical Savings Accounts

Please inform us if you have a medical savings account, or a 'flex spending plan'. We will be happy to provide you with a statement of your charges for reimbursement.

Health Saving Accounts (HSA)/High Deductible Health Plan

Please inform us if you have an H.S.A. As Chiropractic is a qualified expense and can Be paid for through your H.S.A. and billed to your high deductible health plan.

Please read the following office policy regarding assignments:

1. At the beginning of your treatment in our office we will verify your policy Benefits. However, phone or fax verification of coverage is never a guarantee of Payment.
2. Returned checks and balances over 90 days may be subject to additional Collection fees and interest charges of 2% per month. Charges may also be made For missed appointments and those canceled without 24 hours notice.
3. Your insurance will be filed as a courtesy to you. We file insurance claims on A weekly basis.
4. You will be responsible for your full deductible and co-payment or coinsurance. Payment is due when services are rendered. If your insurance company does not pay something that was anticipated, you will be responsible for the amount as soon as we/you are of aware of the denial.
5. If you pay the full amount for services rendered each visit, you may qualifying For our Time of Service (TOS) discount. You may then submit the bill to your Insurance company for reimbursement.
6. If your insurance company has not paid a claim within sixty (60) days of Submission, you agree to take an active part in the resolution of your claim. If your insurance company has not paid within ninety (90) days of submission, you are responsible for payment of any outstanding balance.
7. Our fees are considered usual and customary by most insurance companies, And therefore are covered up to the maximum allowance determined by each insurance company. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard of care in this area.

Personal Injury (PI) or Automobile Accidents

Please present your auto insurance card, your health insurance card, and inform us If you have retained an attorney.

There are four options available to the PI patient:

1. Pay cash for your care and we will submit reports whenever necessary.
2. We will bill and accept assignment from the Med Pay portion of your auto insurance.
3. We will accept a Letter of Protection or Doctor's Lien from an attorney. Account balances 90 days past the release date of treatment will incur a 2% Monthly charge.
4. We will bill your standard health insurance plan and you will be responsible for all co-pays and deductibles as they are incurred.

Although you are ultimately responsible for your bill, we will wait for settlement of Your claim for up to 6 (six) months after your care is completed. Once the claim is Settled or if you suspend or terminate care, any fees for services are due immediately.

I have read and understand this financial policy. I realize that I am responsible for all Charges incurred by me at Columbia Family Chiropractic. I agree to the above terms And authorize Columbia Family Chiropractic to collect from me payment if it is not Received within ninety (90) days after the time of service.

Print Patient Name: _____ Guardian name: _____

Patient or Guardian's Signature: _____ Date: _____