APPLICATION FOR BENEFITS - PERSONAL INJURY PROTECTION

FILE NUMBER	OUR POLICYHOLDER	DATE OF ACCIDENT

TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE FLORIDA AUTO MOBILE REPARATIONS REFORM ACT, PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY.

"Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree."

YOUR NAME	DATE OF BIRTH	SOCIAL SECURITY NO.
YOUR FLORIDA ADDRESS: STREET, CITY OR TOWN, STATE, ZIP CODE	HOME PHONE	BUSINESS PHONE
YOUR PERMANENT ADDRESS IF DIFFERENT	HOW LONG HAVE YOU LIVED IN FLORIDA?	

DATE AND TIME OF ACCIDENT	PLACE OF ACCIDENT: STREET, CITY OR TOWN, STATE

BRIEF DESCRIPTION OF ACCIDENT AND VEHICLES INVOLVED

DESCRIBE ALL MOTOR VEHICLES YOU OWN

DESCRIBE ALL MOTOR VEHICLES OWNED BY ALL RELATIVES IN YOUR HOUSEHOLD

AS A RESULT OF THIS ACCIDENT, WERE YOU INJURED? ☐ YES ☐ NO IF YOUR ANSWER IS YES, COMPLETE THE REST OF THIS FORM.
IF YOUR ANSWER IS NO, SIGN HERE AND RETURN THIS FORM TO US.

SIGNATURE: DATE:

DESCRIBE YOUR INJURY

WERE YOU TREATED BY A DOCTOR? ☐ YES ☐ NO
IF YES, DOCTOR'S NAME & ADDRESS:

IF YOU WERE TREATED IN A HOSPITAL, WERE YOU AN: ☐ INPATIENT ☐ OUTPATIENT
HOSPITAL'S NAME & ADDRESS:

AMOUNT OF MEDICAL BILLS TO DATE: $	WILL YOU HAVE MORE MEDICAL EXPENSES? ☐ YES ☐ NO IF YES, EXPLAIN

AT THE TIME OF YOUR ACCIDENT, WERE YOU IN THE COURSE OF YOUR EMPLOYMENT? ☐ YES ☐ NO	DID YOU LOSE WAGES AS A RESULT OF INJURY? ☐ YES ☐ NO IF YES, AMOUNT OF WAGES LOST TO DATE: $	WHAT IS YOUR AVERAGE WEEKLY WAGE? $

IF YOU LOST WAGES, DATE DISABILITY FROM WORK BEGAN	DATE YOU RETURNED TO WORK

HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR PAYMENT UNDER ANY WORKMEN'S COMPENSATION OR UNEMPLOYMENT LAW? ☐ YES ☐ NO
IF YES, AMOUNT PER WEEK: $ AMOUNT PER MONTH: $

LIST NAMES AND ADDRESSES OF YOUR EMPLOYER AND OTHER EMPLOYERS FOR ONE YEAR PRIOR TO ACCIDENT DATE

EMPLOYER AND ADDRESS	YOUR OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	YOUR OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	YOUR OCCUPATION	FROM	TO

AS A RESULT OF YOUR INJURY, HAVE YOU HAD ANY EXPENSES? ☐ YES ☐ NO IF YES, EXPLAIN ON REVERSE SIDE

SIGNATURE: X DATE:

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 FLORIDA "NO FAULT" AUTO INSURANCE LAW (CHAPTER 71-252.F.S.)

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 FLORIDA "NO FAULT" AUTO INSURANCE LAW (CHAPTER 71-252.F.S.)

SIGNATURE: DATE:

SOCIAL SECURITY NUMBER

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 (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**)*:

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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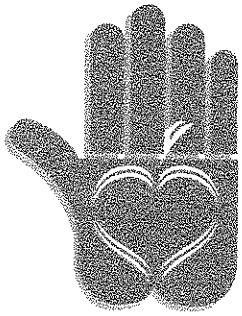

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be there healthy.

ALL CARE HEALTH & WELLNESS CENTERS, PA

Informed Consent

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature_____ Date _____

Witness Signature _____ Date_____

Dr. Brad A. Kern

Chiropractic Physician

2875 N.E. 191st Street, Suite 303 • Aventura, Florida 33180
Office: **305.466.HELP (4357)** • Fax: 305.466.4358 • www.drbradkern.com • bak111@aol.com

ALL CARE HEALTH & WELLNESS CENTERS, PA

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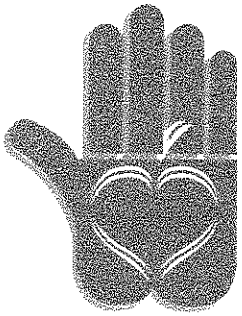
RELEASE OF RECORDS AND X-RAYS

I, _____hereby authorize you to release any and all information including x-rays, diagnostic scans and records pertaining to the examination, diagnosis and treatment rendered to me and acknowledge receipt of this information to transferred to:

ALL CARE HEALTH & WELLNESS CENTER, PA
2875 NE 191 Street, Suite 303
Aventura, FL. 33180
305-466-4357
Fax: 305-466-4358

_____
DATE SIGNATURE

_____
DATE WITNESS



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ASSIGNMENT OF BENEFITS, DIRECTION TO PAY, RELEASE OF RECORDS, AUTHORITY TO SIGN

The undersigned patient/insured_____assigns all of my rights and all of my benefits of insurance and any over due interest payment under the No-Fault Policy of Automobile Insurance, also known as Personal Injury Protection with my insurance carrier or the responsible insurer to ALL CARE HEALTH & WELLNESS CENTER for services rendered to the undersigned patient. DIRECTION TO PAY: The undersigned patient directs the insurer to pay the medical provider directly (i.e. payments to be mailed to and made payable to the medical provider) for services rendered.

The undersigned agrees to comply with all the terms and conditions of the policy of insurance at issue, including but not limited to appearing for an independent medical examination and/or sworn statement at the request of the insurance. In the event the medical provider is required to file a lawsuit against the insurer for payment, the undersigned patient agrees to cooperate with the medical provider's attorney and the insurer. In the event the subject medical benefits are disputed or reduced for any reason, including but not limited to medical reasonableness and/or necessity; the undersigned patient hereby instructs the insurer to set aside any amount disputed and not pay the disputed amount to anyone including myself or any entity until the dispute is resolved. Further, I hereby instruct the insurer to notify the provider immediately of any dispute as to payment so the medical provider can exercise its legal rights.

I hereby authorize ALL CARE HEALTH & WELLNESS CENTER to sign on my behalf, any and all documents including but not limited to HICFA forms and furtherance of obtaining payment for services rendered by the facility. ALL CARE HEALTH & WELLNESS CENTER.

I hereby assign to ALL CARE HEALTH & WELLNESS CENTER. any benefits under any policy of insurance for service and or charges provided by ALL CARE HEALTH & WELLNESS CENTER. Regardless of whether an insurance company is listed or the incorrect insurance company is listed herein. I am assigning benefits from any policy that would owe me insurance benefits for treatment rendered herein.

I have understood and agreed to all the above.

Patient's signature_____ Date_____
(If patient is a minor, signature of parent/guardian)

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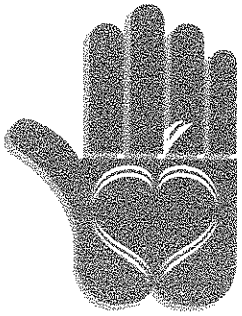
Receipt of Notice Privacy Practices
Written Acknowledgement Form

ALL CARE HEALTH & WELLNESS CENTER

I ,_____ have read a copy of ALL CARE HEALTH & WELLNESS CENTER'S Notice of Patient Privacy Practices.

_____
Signature of Patient or
Parent or Legal Guardian



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ALL CARE HEALTH & WELLNESS CENTERS, PA

RE:_____

I hereby authorize the above doctor to furnish you, my attorney, with a full report of his examination, diagnoses, treatment, prognosis, etc., of myself in regard to the accident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him for professional services rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment or verdict as may be necessary adequately to protect said doctor. I hereby further give a lien on my case to said doctor against any and all proceeds of any settlement, judgment or verdict which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly responsible to said doctor for all professional bills submitted by him for services rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

Dated:_____ Patient Signature:_____

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary adequately to protect the said doctor named above.

Date:_____ Attorney Signature:_____

Attorney: please date, sign, and return one copy to doctor's office

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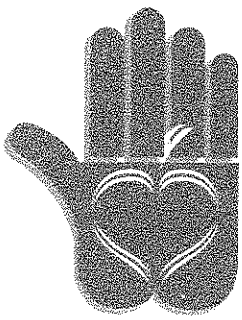

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Date:

Patient:
Date of Loss:
File #:

RE: Deductible and co-payment

Dear Patient:

We greatly appreciate the opportunity to treat you for your injuries caused by the automobile accident that occurred on the above captioned date. As you are aware, your PIP insurance company is responsible to pay 80% of all services performed to you. You are ultimately responsible for any outstanding balances that may remain after the insurance company's payment including 20% portion of your bill and any applicable deductible.

This office will provide you and/or you appointed attorney with a statement of your outstanding balance. You then can make arrangements for payment options of your outstanding balance.

Please feel free to contact us with any questions. Thank you for the opportunity to provide your chiropractic care.

Sincerely,

Brad A. Kern, DC

I have read and understand the above statements and acknowledge this my signature.

_____ Date: _____

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