CONSENT FOR TREATMENT

I, THE UNDERSIGNED, HEREBY AUTHORIZE PLANTATION SPINE & SPORTS REHAB AND WHOMEVER THEY MAY DESIGNATE AS THEIR ASSISTANTS TO PERFORM AND ADMINISTER THERAPY AND TREATMENT AS IS NECESSARY. I ALSO CERTIFY THAT NO GUARANTEE OR ASSURANCE HAD BEEN MADE TO THE RESULTS THAT MAY BE OBTAINED.

I UNDERSTAND AND AGREE THAT HEALTH AND ACCIDENT INSURANCE POLICIES ARE AN ARRANGEMENT BETWEEN AN INSURANCE CARRIER AND MYSELF. FURTHERMORE, I UNDERSTAND THAT THIS OFFICE WILL PREPARE ANY NECESSARY REPORTS AND FORMS TO ASSIST ME IN MAKING COLLECTION FROM THE INSURANCE COMPANY AND THAT ANY AMOUNT AUTHORIZED TO BE PAID DIRECTLY TO THIS OFFICE WILL BE CREDITED TO MY ACCOUNT UPON REQUEST. I PERMIT THIS OFFICE TO ENDORSE REMITTANCES FOR THE CONVEYANCE OF CREDIT TO MY ACCOUNT. HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT.

PATIENT SIGNATURE______________________________ DATE____________

CIRCLE ANY OF THE FOLLOWING SURGERIES YOU HAVE HAD:

Appendix	Tonsils	Gall Bladder	Hernia	Heart	Back
Neck	Legs	Colon	Cancer	C-Section	Eyes

Other: ______________________________

CIRCLE ANY OF THE FOLLOWING CONDITIONS YOU HAVE BEEN DIAGNOSED WITH:

Appendicitis	Malaria	Chicken Pox	Alcoholism	Scarlet Fever	Tuberculosis
Diabetes	Pneumonia	Diphtheria	Cancer	Arthritis	Fibromyalgia
Whooping	Typhoid	Rheumatic	Heart	Mental	Venereal
Cough	Fever	Fever	Disease	Disorder	Infection
Measles	Mumps	Pleurisy	Small Pox	Polio	Epilepsy
Hepatitis	Anemia	Goiter	Flu	Eczema	Lumbago
Diverticulitis	Acid Reflux	Herpes	AIDS	Bronchitis	

Other: ______________________________

CIRCLE ANY OF THE FOLLOWING YOU HAVE EXPERIENCED IN THE PAST 6 MONTHS:

Musculo-skeletal:
Low Back Pain
Pain Between Shoulders
Neck Pain
Arm Pain
Joint Pain/Stiffness
Walking Problems
Clicking Jaw/Difficulty Chewing

Nervous System:
Numbness
Paralysis
Dizziness
Forgetfulness
Confusion/Depression
Fainting
Convulsions
Cold/Tingling Extremities

General:
Allergies
Loss of Sleep
Fever
Headaches/Migraines
Sore Throat
Ear Aches
Stuffy Nose
Varicose Veins
Ankle Swelling
Lung Problems/Congestion
Chest Pain
Shortness of Breath
Irregular Heartbeat
Heart Problems
Blood Pressure Problems

Gastro-Intestinal:
Poor/Excessive Appetite
Excessive Thirst
Frequent Nausea
Vomiting
Diarrhea
Constipation
Hemorrhoids
Liver Trouble
Gall Bladder Problems
Weight Trouble
Abdominal Cramps
Gas/Bloating After Meals
Heartburn
Black/Bloody Stool
Colitis

Genito-Urinary:
Bladder Trouble
Painful/Excessive Urination
Discolored Urine

Male/Female:
Menstrual Irregularity
Menstrual Cramping
Vaginal Pain/Infection/Discharge
Breast Pain/Lumps
Prostate/Sexual Dysfunction
Genital Herpes

Other:
Vision Problems
Hearing Difficulties
Dental Problems

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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 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. This means that no person has initiated contact with me and/or persuaded me to use the doctor or licensed professional, clinic, or medical institution that provided the services.
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.

The undersigned licensed medical professional 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. I have **explained** the services rendered 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.

Insured Person (patient receiving treatment) or Guardian of Insured Person:

Name *(PRINT or TYPE)*	Signature	Date

Licensed Medical Professional Rendering Treatment *(Signature by his or 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.

OIR-B1-1571
10/03