



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.

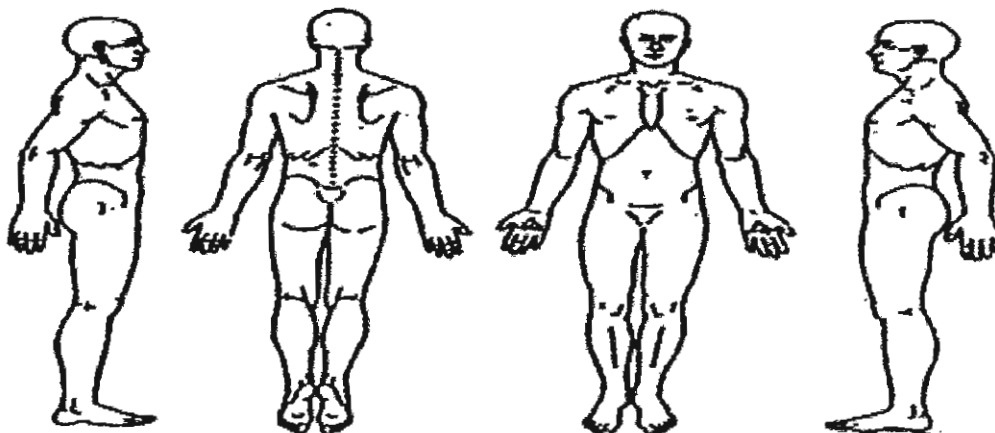
Note: The **original** of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may **not** be electronically furnished. Failure to furnish this form may result in non-payment of the claim.

PATIENT INTAKE FORM

Patient Name: _____ Date: _____

1. Is today's problem caused by: Auto Accident Workman's Compensation

2. Indicate on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?

- Constantly (76-100% of the time) Occasionally (26-50% of the time)
 Frequently (51-75% of the time) Intermittently (1-25% of the time)

4. How would you describe the type of pain?

- Sharp Numb
 Dull Tingly
 Diffuse Sharp with motion
 Achy Shooting with motion
 Burning Stabbing with motion
 Shooting Electric like with motion
 Stiff Other: _____

5. How are your symptoms changing with time?

- Getting Worse Staying the Same Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (Please circle)

7. How much has the problem interfered with your work?

- Not at all A little bit Moderately Quite a bit Extremely

8. How much has the problem interfered with your social activities?

- Not at all A little bit Moderately Quite a bit Extremely

9. Who else have you seen for your problem?

- Chiropractor Neurologist Primary Care Physician
 ER physician Orthopedist Other: _____
 Massage Therapist Physical Therapist No one

10. How long have you had this problem? _____

11. How do you think your problem began?

12. Do you consider this problem to be severe?

- Yes Yes, at times No

13. What aggravates your problem?

14. What concerns you the most about your problem; what does it prevent you from doing?

15. What is your: Height _____ Weight _____ Date of Birth _____

Occupation _____

16. How would you rate your overall Health?

- Excellent Very Good Good Fair Poor

17. What type of exercise do you do?

- Strenuous Moderate Light None

18. Indicate if you have any immediate family members with any of the following:

- Rheumatoid Arthritis Diabetes Lupus
 Heart Problems Cancer ALS

19. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

- | Past | Present | Past | Present | Past | Present |
|--------------------------|---|--------------------------|--|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> Headaches | <input type="checkbox"/> | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> | <input type="checkbox"/> Excessive Thirst |
| <input type="checkbox"/> | <input type="checkbox"/> Upper Back Pain | <input type="checkbox"/> | <input type="checkbox"/> Chest Pains | <input type="checkbox"/> | <input type="checkbox"/> Frequent Urination |
| <input type="checkbox"/> | <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> | <input type="checkbox"/> Stroke | <input type="checkbox"/> | <input type="checkbox"/> Smoking/Tobacco Use |
| <input type="checkbox"/> | <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> | <input type="checkbox"/> Angina | <input type="checkbox"/> | <input type="checkbox"/> Drug/Alcohol Dependence |
| <input type="checkbox"/> | <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> | <input type="checkbox"/> Elbow/Upper Arm Pain | <input type="checkbox"/> | <input type="checkbox"/> Kidney Disorders | <input type="checkbox"/> | <input type="checkbox"/> Depression |
| <input type="checkbox"/> | <input type="checkbox"/> Wrist Pain | <input type="checkbox"/> | <input type="checkbox"/> Bladder Infection | <input type="checkbox"/> | <input type="checkbox"/> Systemic Lupus |
| <input type="checkbox"/> | <input type="checkbox"/> Hand Pain | <input type="checkbox"/> | <input type="checkbox"/> Painful Urination | <input type="checkbox"/> | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> | <input type="checkbox"/> Hip Pain | <input type="checkbox"/> | <input type="checkbox"/> Loss of Bladder Control | <input type="checkbox"/> | <input type="checkbox"/> Dermatitis/Eczema/Rash |
| <input type="checkbox"/> | <input type="checkbox"/> Upper Leg Pain | <input type="checkbox"/> | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> | <input type="checkbox"/> Knee Pain | <input type="checkbox"/> | <input type="checkbox"/> Abnormal Weight Gain/Loss | | |
| <input type="checkbox"/> | <input type="checkbox"/> Ankle/Foot Pain | <input type="checkbox"/> | <input type="checkbox"/> Loss of Appetite | | |
| <input type="checkbox"/> | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> | <input type="checkbox"/> Abdominal Pain | | For Females Only |
| <input type="checkbox"/> | <input type="checkbox"/> Joint Pain/Stiffness | <input type="checkbox"/> | <input type="checkbox"/> Ulcer | <input type="checkbox"/> | <input type="checkbox"/> Birth Control Pills |
| <input type="checkbox"/> | <input type="checkbox"/> Arthritis | <input type="checkbox"/> | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> | <input type="checkbox"/> Hormonal Replacement |
| <input type="checkbox"/> | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> | <input type="checkbox"/> Liver/Gall Bladder Disorder | <input type="checkbox"/> | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> | <input type="checkbox"/> Cancer | <input type="checkbox"/> | <input type="checkbox"/> General Fatigue | | |
| <input type="checkbox"/> | <input type="checkbox"/> Tumor | <input type="checkbox"/> | <input type="checkbox"/> Muscular Incoordination | | |
| <input type="checkbox"/> | <input type="checkbox"/> Asthma | <input type="checkbox"/> | <input type="checkbox"/> Visual Disturbances | | |
| <input type="checkbox"/> | <input type="checkbox"/> Chronic Sinusitis | <input type="checkbox"/> | <input type="checkbox"/> Dizziness | | |
| <input type="checkbox"/> | <input type="checkbox"/> Other: _____ | | | | |

20. List all prescription medications you are currently taking:

21. List all of the over-the-counter medications you are currently taking:

22. List all surgical procedures you have had:

23. What activities do you do at work?

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Sit: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> Stand: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> Computer work: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> On the phone: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half of the day | <input type="checkbox"/> A little of the day |

24. What activities do you do outside of work?

25. Have you ever been hospitalized? No Yes

if yes, why _____

26. Have you had significant past trauma? No Yes

27. Anything else pertinent to your visit today? _____

Patient Signature _____ Date: _____

1. What was the date of the accident? _____
2. What time did the accident occur? _____
3. How many vehicles were involved in the accident? _____
4. What was the estimated damage to the vehicle you were in? _____
5. What state did the accident occur in? _____
6. What city did the accident occur in? _____
7. What street or intersection were you on when the accident occurred? _____
8. What direction were you traveling in? _____
9. What type of impact was the auto accident? _____
10. Did your vehicle hit anything after the accident? if yes, please describe

11. Where were you sitting in the vehicle during the accident?

12. Did you know the accident was coming? _____
13. What type of vehicle were you in? _____
14. What type of vehicle impacted yours? _____
15. At the time of the impact, how fast was your vehicle moving? _____
16. At the time of impact, how fast was the other vehicle moving? _____
17. During and after the crash what happened to your vehicle? (circle all that apply)

- kept going straight	- spun around
- kept going straight hitting a car in front	- spun around and hit a stationary object
- was hit by another vehicle	- hit a stationary object
18. Did you lose consciousness during the accident? -yes - no
19. How was your head positioned during the accident? _____
20. How was your torso positioned during the accident? _____
21. How were your hands positioned during the accident? _____
22. Did your head hit anything during the accident? -no - yes, please describe _____
23. Did your face hit anything during the accident? -no - yes, please describe _____
24. Did your shoulders hit anything during the accident? -no - yes, please describe _____
25. Did your neck hit anything during the accident? -no - yes, please describe _____
26. Did your chest hit anything during the accident? -no - yes, please describe _____
27. Did your hips hit anything during the accident? -no - yes, please describe _____

28. Did your knees hit anything during the accident? -no - yes, please describe _____

29. Did your feet hit anything during the accident? -no - yes, please describe _____

30. What kind of headrest was in your vehicle?

- movable fixed headrest
- nonmovable fixed headrest
- no headrest

31. Where was the headrest positioned on your head? _____

32. Did you have your seatbelt on during the accident? - yes -no

33. Did you slide out of your seatbelt during the accident? _____

34. What was damaged in your vehicle? (Circle all that apply)

- windshield
- steering wheel
- dashboard
- seat frame
- side window
- rear window
- rear bumper
- front bumper
- trunk
- front left door
- front right door
- back left door
- mirror
- knee bolster
- back right door
- completely totalled

35. Choose the items that dented inward

- floorboards
- side door
- dashboard

36. Choose the doors that would not open as a result of the accident

- front left
- front right
- rear left
- rear right

37. Did you go to the hospital? If no, why and do not answer 38-43

38. How did get to the hospital? _____

39. What was the name of the hospital? _____

40. Were you hospitalized over night? _____

41. Circle what you were prescribed at the hospital

- pain medication
- muscle relaxors
- neck brace

42. Did you recieve any stitches for any cuts at the hospital? _____

43. Were x rays taken at the hosiptal? If yes, which area was taken?

GENERATION CHIROPRACTIC

an art, a science, a philosophy

Informed Consent Form

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 same 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 print name _____ Date _____

Patient signature _____ Date _____

Witness print name _____ Date _____

Witness signature _____ Date _____

Generation Chiropractic

Receipt of Notice of Privacy Practices

Written Acknowledgement Form

I, _____ have read a copy of Generation Chiropractic's Notice of Patient Privacy Practices.

Signature of Patient or legal Guardian: _____ Date: _____

Assignment of Benefits and Direction to Pay Benefits Owed

I, the undersigned insured or beneficiary of an insurance policy, irrevocably assign to Dr. Nathalie Blum, Dr. David Blum, Generation Chiropractic, and Blum Health LLC., whatever rights I have under any policy of insurance and under Florida law, including, without limitation, any and all attorney's fees, costs, interest and/or damages pursuant to Florida Statute 624.155. The Assignment of Benefits (AOB) includes an assignment of any potential claim for common law or statutory bad faith. If the Insurer disputes the validity of this AOB, then the insurer is instructed to notify the provider in writing within 10 days of receipt of this document. Failure to do so shall result in the provider relying on this AOB for direct payment and could constitute a waiver by the insurer to contest the validity of this document. I do hereby confirm that this AOB is irrevocable and instruct any insurance company or other collateral source for which I am entitled to benefits to pay for monies owed as a result of medical services rendered by Dr. Nathalie Blum, Dr. David Blum, Generation Chiropractic, and Blum Health LLC., to promptly make a payment in the name of and directly to Dr. Nathalie Blum, Dr. David Blum, Generation Chiropractic, Blum Health LLC., or its chosen billing service.

Pursuant to this AOB, Dr. Nathalie Blum, Dr. David Blum, Generation Chiropractic, and Blum Health LLC., is authorized to file suit on my behalf against any insurance company that reduces or denies benefits for medical services rendered to me and to collect any damages awarded or settlement monies for services rendered plus interest, costs, reasonable attorney's fees and a contingency fee multiplier. I understand that in any such lawsuit, my name or other identifying information will need to be included in and/or portions of my medical file attached to pleadings and/or formal discovery. I waive any confidentiality of my records and/or information but only to the extent necessary to prosecute a claim for unpaid or owed medical expenses against the insurance company or any other responsible party.

I acknowledge that Dr. Nathalie Blum, Dr. David Blum, Generation Chiropractic, and Blum Health LLC., objects to any reductions or partial payments by the Insurer. Any partial or reduced payment, regardless of the accompanying language, issued by the Insurer and deposited by Dr. Nathalie Blum, Dr. David Blum, Generation Chiropractic, and Blum Health LLC., shall be done 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. Dr. Nathalie Blum, Dr. David Blum, Generation Chiropractic, and Blum Health LLC., reserves the right to seek full amount of the bill submitted from the insurance company (ies) or me. Accordingly, the insurer is hereby instructed to set aside (escrow) any and all reduced or denied benefit payments for medical services rendered by this provider and not pay the disputed amount to anyone until the dispute is resolved.

I further instruct my insurance company to cooperate with the above-captioned Dr. Nathalie Blum, Dr. David Blum, Generation Chiropractic, and Blum Health LLC., in resolving all medical billing disputes. Cooperation includes, but is not limited to, providing any and all declaration pages, PIP logs, payout ledgers, explanations of benefits, copies of checks, and all other documents or information to Dr. Nathalie Blum, Dr. David, Generation Chiropractic, and Blum Health LLC., or its attorneys, employees or other representatives acting on behalf of Dr. Nathalie Blum, Dr. David Blum, Generation Chiropractic, and Blum Health LLC.. If the insurer schedules a defense examination, examination under oath (EUO) or Independent Medical Examination (IME) of the patient, the insurer is hereby instructed to send a copy of said notification to this provider and the provider's attorneys. The provider and/or the provider's attorneys are authorized to appear at any patient EUO or IME set by the insurer. **THIS ASSIGNMENT OF BENEFITS DOES NOT ASSIGN ANY RIGHTS OR OBLIGATIONS UNDER THE POLICY OF INSURANCE, TO**

SUBMIT TO AN EUO OR RECORDED STATEMENT. I further direct and authorize you to speak to an attorney, employee or any other representative of Dr. Nathalie Blum, Dr. David Blum, Generation Chiropractic, and Blum Health LLC., or anyone acting on their behalf over the phone and provide them with any and all information you may have or documentation not previously mentioned above that they may request.

I, as the patient, agree to remain personally liable for the amounts billed by Dr. Nathalie Blum, Dr. David Blum, Generation Chiropractic, and Blum Health LLC., regardless of the amount paid by the insurance company, unless ordered by a court of law. I fully understand that said health care services were provided to me in consideration for an unconditional promise to pay and for me providing these instructions to my insurance company. I, as the patient, further agree to be liable for reasonable attorney's fees and costs incurred in collecting any delinquent accounts or unpaid balances. By executing this document, I am placing my insurance company (ies) on notice that the claims for medical treatment rendered by Dr. Nathalie Blum, Dr. David Blum, Generation Chiropractic, and Blum Health LLC., are related to my accident (or my covered conditions) and should be paid directly to Dr. Nathalie Blum, Dr. David Blum, Generation Chiropractic, and Blum Health LLC., pursuant to this AOB and Florida law. Any delay in paying benefits owed under the insurance policy could adversely affect me.

BY EXECUTING THIS DOCUMENT, I AM PLACING MY INSURANCE COMPANY ON NOTICE THAT THIS IS A DIRECT ASSIGNMENT OF BENEFITS PURSUANT TO FLORIDA LAW. AS THE INSURED OR BENEFICIARY OF SAID INSURANCE POLICY, I AM IRREVOCABLY ASSIGNING WHATEVER RIGHTS I HAVE UNDER MY POLICY OF INSURANCE (LESS THE DUTY TO ATTEND AN EUO) AND UNDER FLORIDA LAW TO THIS HEALTH CARE PROVIDER. A photocopy of this assignment shall be considered as effective and valid as the original.

Name of patient / DOB

Signature/Date

Name of Policy Holder or Claimant

**Acceptance of Dr.
Nathalie Blum, Dr.
David Blum,
Generation
Chiropractic, and
Blum Health LLC.**

Notice of initiation of Treatment

Name of Insured Patient: _____

Name of PIP Insurer: _____

Policy Number: _____

Pursuant to Florida Statute **627.736(5)(c)1.**, you are hereby notified that treatment on your insured, _____, was initiated on _____ for injuries sustained in an automobile crash on _____.

Dr. Nathalie Blum

Authorization to Obtain PIP Benefits Payout Information

Name of Insurer: _____

PIP Policy #: _____

Name of insured: _____

Date of the Accident: _____

I, _____, hereby authorize and direct _____
To send to Dr. Nathalie Blum, Generation Chiropractic 6850-2 103rd St.
Jacksonville, FL 32210 (904)317-6628 fax (904)317-6625 an accounting of
payouts made under all claims submitted for payment under the above
referenced policy relating to the automobile accident occurring on the
above referenced date as those payouts occur.

Signature of insured

Date

Address of the insured:

Generation Chiropractic
5851 Timuquana Rd. Ste. 304
Jacksonville, FL 32210
PH: 904-317-6628 FX: 904-317-6625

ASSIGNMENT OF NET SETTLEMENT OR JUDGEMENT PROCEEDS

Attorney _____

Re: Assignment of Net Settlement or Judge Proceeds

I hereby grant, convey, transfer, assign and set over unto Generation Chiropractic all of my rights, title and interests to any proceeds from any settlement, judgment or verdict arising from this accident, as may be necessary to fully compensate Generation Chiropractic for any medical services rendered to me, both by reason of this accident and by reason of any other bills that are due to Generation Chiropractic.

I hereby authorize and direct you, my attorney, to withhold from any settlement, judgment, or verdict, such as sums as may be necessary to fully compensate Generation Chiropractic for any medical services rendered to me, both by reason of this accident and by reason of any other bills that are due to Generation Chiropractic. Such sums shall be paid directly to Generation Chiropractic by you, my attorney, from the proceeds of any settlement, judgment, or verdict arising from this accident.

It is expressly acknowledge, understood and agreed that this assignment is conditioned and subject only to the claims of you, my attorney, for fees and services arising from this accident. Presentation of a signed copy of this assignment to you, my attorney, shall constitute sufficient authority by Generation Chiropractic to obtain said payment.

Irrespective of the above, I fully understand that I am directly and fully responsible to Generation Chiropractic for all medical bills submitted by Generation Chiropractic for services rendered to me that this agreement is made solely for Generation Chiropractic's additional protection and in consideration of Generation Chiropractic's willingness to forego payment for services rendered to me for a period of 120 days. I further fully understand that such payment is not contingent on any settlement, judgment, or verdict that I may eventually recover. Accordingly, in the event payment in full is not made to Generation Chiropractic within 120 days from the date of the last medical services by Generation Chiropractic are rendered to me; I shall be responsible for making such payment in full.

Dated: _____ Patient's Signature _____

The undersigned attorney of record for the above patient does hereby acknowledge receipt of this assignment, agrees to all the terms of this assignment, and agrees to withhold and pay directly to Generation Chiropractic such sums from any settlement, judgment or verdict as may be necessary to fully compensate Generation Chiropractic for any and all medical services rendered to said parent.

Dated: _____ Attorney's Signature _____