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

APPLICATION FOR FLORIDA "NO FAULT" BENEFITS

NAME OF INSURANCE COMPANY

DATE	OUR POLICY HOLDER	DATE OF ACCIDENT	FILE NUMBER

TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE FLORIDA PERSONAL INJURY PROTECTION LAW. PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURANCE COMPANY MAKES A STATEMENT OF CLAIM CONTAINING ANY FALSE INCOMPLETE OR MISLEADING INFORMATION, IS GUILTY OF A FELONY OF THE THIRD DEGREE.

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

BRIEF DESCRIPTION OF ACCIDENT AND VEHICLES INVOLVED:

DESCRIBE MOTOR VEHICLE YOU OWN -	DESCRIBE MOTOR VEHICLE OWNED BY ANY MEMBER OF YOUR FAMILY-

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

SIGNATURE: DATE:

DESCRIBE YOUR INJURY

WERE YOU TREATED BY A DOCTOR?		DOCTOR'S NAME AND ADDRESS
IF YOU WERE TREATED IN A HOSPITAL, WERE YOU AN IN PATIENT ____ OUT PATIENT ____		HOSPITAL'S NAME AND ADDRESS
AMOUNT OF MEDICAL BILLS TO DATE	WILL YOU HAVE MORE MEDICAL EXPENSE?	AT THE TIME OF YOUR ACCIDENT, WERE YOU IN THE COURSE OF YOUR EMPLOYMENT?
DID YOU LOSE WAGES OR SALARY AS A RESULT OF YOUR INJURY?	IF YES, AMOUNT OF LOSS TO DATE	WHAT IS YOUR AVERAGE WEEKLY WAGE OR SALARY?
IF YOU LOST WAGES:	DATE DISABILITY FROM WORK BEGAN	DATE YOU RETURNED TO WORK
HAVE YOU RECEIVED, OR ARE YOU ELIGIBLE FOR, PAYMENTS UNDER ANY WORKMEN'S COMPENSATION OR EMPLOYMENT LAW?	IF YES, AMOUNT PER WEEK	PER MONTH

LIST NAMES AND ADDRESSES OF YOUR PRESENT EMPLOYER(S) AND GIVE YOUR OCCUPATION AND DATES OF EMPLOYMENT FOR EACH

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 OTHER EXPENSES? IF YES, EXPLAIN ON REVERSE SIDE

SIGNATURE: DATE:

IMPORTANT: 1. TO BE ELIGIBLE FOR BENEFITS COMPLETE AND SIGN THIS APPLICATION
2. SIGN AND ATTACH AUTHORIZATION(S)
3. RETURN PROMPTLY WITH ANY MEDICAL BILLS YOU HAVE RECEIVED TO DATE

DO NOT DETACH

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

DO NOT DETACH

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 NO.

Assignment of Insurance Benefits

Client/Insured ______________________

Policy Number ______________________

Claim Number ______________________

Insurer ______________________

Date of Loss ______________________

I hereby assign any and all insurance rights, benefits, and proceeds under the above referenced policy to my medical facility, Countryside Chiropractic. I hereby authorize direct payment of any benefits of proceeds to my medical facility, Countryside Chiropractic, as consideration for any medically necessary charges made by Countryside Chiropractic. I hereby direct my insurance carrier ______________________ to release any and all information requested by my medical facility, Countryside Chiropractic, its representative, or it's Attorney for the direct purpose of obtaining actual benefits to be paid by my insurance carrier to my medical facility for services rendered or to be rendered for my appropriate medical injuries. *In this regard, I waive my privacy rights.*

DATED THIS __________ DAY OF ______________________, 20__, in Clearwater, Florida

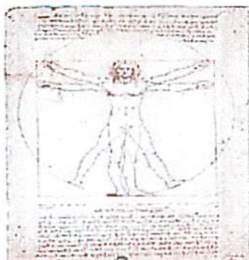
CLIENT/INSURED

____

(Print Name)

____

(Signature)



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