SpineX Injury Centers

SpineX Injury Centers
2328 10th Ave N
Ste 200
Lake Worth, FL 33461

Personal Information

First Name: _____ Middle Name: _____

Last Name: _____

Date of birth: _____ Social Security Number: _____

Address: _____ City: _____

State: _____ Zip Code: _____

Best Contact Number: _____ Email: _____

Sex (please circle): ☐ Male ☐ Female

Marital Status (please circle): ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Date of Accident: _____

Type of Accident: ☐ Auto ☐ Slip/Fall ☐ W/C ☐ Self

Name of Car Insurance: _____

Claim Number: _____

Did you go to the Hospital? ☐ Yes ☐ No

Attorney's Name: _____

Attorney's Phone Number: _____

Case Manager Name: _____

Case Manager Number: _____

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Medical history form

Name _____ Date _____

Address _____ State _____ Zip _____

_____ Male or Female _____ Age _____ Height _____ Weight _____

_____ Email _____ Occupation _____

Emergency contact _____ How did you learn about us? _____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Previous chiropractic care? If yes, how long ago? _____

Birth Date

Phone

List your main health concerns	Rate Severity 0 mild & 10 Severe	When did it start?	Did it start with an injury?	Constant pain or intermittent

Health concerns

What makes it worse?

_____

What makes it better?

_____

Have you seen any Doctor/Health Provider for this condition?

_____

If so, what kind of treatments have your received?

_____

List all medications currently taking

_____

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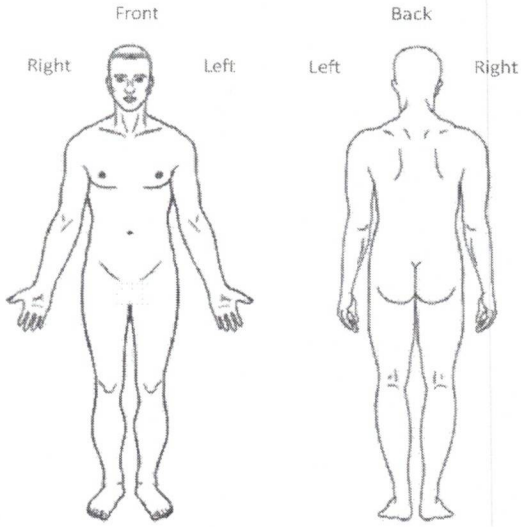
Medical history form

Please mark where you have pain or symptoms.



Please check the symptoms. (Mark all appropriate)

- ☐ Sharp
- ☐ Shooting
- ☐ Numbness
- ☐ Dull
- ☐ Aching
- ☐ Throbbing
- ☐ Stabbing
- ☐ Other _____
- ☐ Stiffness
- ☐ Uncomfortable
- ☐ Tenderness
- ☐ Swelling
- ☐ Nagging
- ☐ Tingling
- ☐ Cramping

Out of 10, mark the severity of your symptoms.

0 1 2 3 4 5 6 7 8 9 10

No Symptoms — Intense Symptoms

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Health and illness History

Please check off any that apply to you:

- ☐ Allergies
- ☐ NeckPain
- ☐ Migraine
- ☐ Arthritis
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ HighBP
- ☐ Fracture
- ☐ Sciatica
- ☐ ADD/ADHD
- ☐ Digestive Issue
- ☐ Immune Issue
- ☐ Chest Pain
- ☐ Stroke
- ☐ Heart Disorder
- ☐ TMJ
- ☐ Blood Clot
- ☐ Surgery
- ☐ Urinary Issue
- ☐ Kidney Issue
- ☐ Bladder Issue
- ☐ Menstrual Issues
- ☐ GRED
- ☐ Surgery
- ☐ Osteoporosis
- ☐ Cardiovascular
- ☐ Asthma
- ☐ Epilepsy
- ☐ Thyroid Issue
- ☐ Varicose Veins
- ☐ Other
- ☐

Please indicate any previous surgeries you have had. If none, please write "None."

_____

Please circle that ones that you have experienced:

Have you experienced any of these? ☐ Auto Crash ☐ Accident ☐ Sport Injury ☐ Hospitalisation

Are you currently pregnant? ☐ Yes or No ☐

Signature:_____ Name:_____ Date:_____

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NOTICE OF PRIVACY PRACTICES-SHORT TERM

Our practice is committed to educating our patients about healthcare issues that affects them. As a result, we are providing you with general information about Privacy Rules, a federal regulation of the Health Insurance Portability and Accountability Act of 1996 (HIPPA) along with a brief overview of our Notice of Privacy. Our practice is complying with HIPAA's regulations.

What is HIPAA and how does the Privacy Rule affect you?

When the Health Insurance Portability and Accountability Act (HIPAA) was passed in August of 1996, this gave the federal government the ability to mandate how healthcare plans, providers, and clearing houses store and send a patient's personal information as it releases to healthcare. The Privacy Rule was created to protect your rights as a patient of our practice, and we are required by law to be compliant with this regulation. Under the Privacy Rule you are guaranteed access to your medical records and allowed control over how your protected health information is used and disclosed and allowed to take action if your privacy is compromised by following the practice's policy. Our practice is dedicated to maintaining the privacy of your personal information.

What is Individuality Identifiable Health Information (IIHI)?

Any health information you provide our practice, including your mailing address. IIHI is any information that is created and retained by our practice or received by another healthcare provider that relates to treatment, payment, and/or that identifies you as an individual.

What is the Notice of Privacy Practice?

Our practice has an official Notice of Privacy Practice posted in our waiting room informing our patients about their rights surrounding the protection of your IIHI and our obligations concerning the use and disclosure of your IIHI. This notice applies to all records created or retained by our practice. We can update our Notice of Privacy Practices at any time. It will be posted, and a copy is provided in our waiting room, and you can take a copy of the current notice at any time.

The following categories describe the different ways in which we may use and disclose your IIHI:

Treatment	Appointment Reminders	Release of Information to Family/Friends
Payment	Treatment Options	Disclosure Required by Law
Health-Related Benefits and Services		HealthCare Operations

The following categories describe unique situations in which we may use or disclose your Identifiable Health Information:

Public Health Risk	Health Oversight Activities	Lawsuits and Similar Proceedings
Law Enforcement	Deceased Patients	Organ and Tissue Donation
Military	National Security Inmates	Workers' Compensation
Serious Threats to Health & Safety	Research	

What are your rights concerning your individuality Identifiable Health Information (IIHI)?

We have rights regarding the IIHI that we maintain about you. In our Notice of Privacy, you can view the policies and procedures you will need to follow for the areas listed below.

1. Confidential Communications
2. Requesting Restrictions
3. Inspection and Copies
4. Amendment
5. Accounting of Disclosures
6. Right to a Paper Copy of this Notice
7. Right to file a complaint
8. Right to provide an Authorization for other uses and disclosures.

If you have any questions about this notice, please ask the receptionist to speak to our Privacy Officer.

I have read the short notice provided by SpineX Injury Centers and have been informed of how to obtain more information of our Notice of Privacy.

Print Name: _____ Patient Signature: _____

Date: _____

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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 Doctor 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 be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgement 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 Name_____ Date_____

Patient Signature_____ Date_____

Witness Print Name_____ Date_____

Witness Signature_____ Date_____

Emergency Contact Name_____ Date_____

Emergency Contact Phone Number:_____

Relationship to Emergency Contact:_____

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Receipt of Notice of Privacy Policy

Written Acknowledgement Form

I, _____ have read a copy of SpineX's Injury Notice of Patient Privacy Practices.

Signature of Patient or Legal Guardian: _____ Date: _____

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Date: _____

Patient Name: _____

Insured Name: _____

Claim Number: _____

Insurance Company: _____

Date of Onset: _____

Notice of Initiation of Treatment

To whom it may concern:

This document shall serve as our formal Notice of Initiation of treatment pursuant to the Florida Statute § 627,736 (5)(c). This notice is being sent pursuant to the Florida Statute within 21 days after this facility's first examination or treatment of the above referenced claimant.

Because this notice has been timely provided. The law allows statements from this provider to Include charges for treatment or services rendered up to, but not more than. 75 days before the postmarked date of the statement sent. Please take note and govern yourself accordingly.

Respectfully,

Billing Manager

APPLICATION FOR FLORIDA "NO FAULT" BENEFITS

NAME OF AUTO INSURANCE COMPANY	POLICY NUMBER	CLAIM NUMBER
NAME OF AUTO ADJUSTER	PHONE NUMBER FOR AUTO ADJUSTER	

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.

NAME OF MEDICAL INSURANCE	INSURANCE MEMBER ID/SUBSCRIBER NUMBER

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

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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IRREVOCABLE ASSIGNMENT OF BENEFITS, AUTHORIZATION AND LIEN

To Whom It May Concern:

This Irrevocable Assignment of Benefits, Authorization and Lien (this "Assignment") is made by and between _____ ("Patient") and SpineX. With this Assignment, and in consideration of treatment without having to render concurrent payment, Patient, hereby irrevocably transfers sets over and assigns to Health Care Provider all insurance and/or litigation proceeds to which Patient is now or may hereafter become entitled, including those listed below, up to the total amount due and owing the Health Care Provider for services rendered to the Patient by reason of accident or illness, including interest thereon, as well as any other charges that are due or may become due the Health Care Provider, including, without limitation, requested reports, collection costs and expenses and attorney's fees, and Patient further hereby irrevocably authorizes and directs any insurance company and/or attorney to whom an original or copy of this Assignment is provided to withhold from Patient and pay directly to such Health Care Provider such amount(s) from (1) any insurance benefits payable to Patient or on Patients behalf, including, but not limited to, medical payments benefits, No Fault benefits, health and accident benefits, personal injury protection benefits, third-party liability coverage, foundation grants, governmental or agency benefits, worker's compensation benefits or any other insurance proceeds or benefits of any kind which are payable to or on behalf of the Patient, and (2) any litigation proceeds (which may include insurance proceeds) from any settlement, judgment or verdict in Patients favor as may be necessary to fully pay any and all financial obligations owed to the Health Care Provider by the Patient. This Assignment is to be a complete and current transfer of Patients right, title, and interest, separate from any statutory or contractual lien or claim to which the Health care Provider may also be entitled. Patient acknowledges that Health Care Provider has a substantial pecuniary interest in the enforcement of this Assignment.

The Patient further agrees that, in the event the insurance company and/or attorney obligated hereunder to make payments to the Health Care Provider fails or refuses to make payment for the full amount due as set forth above, this Assignment is a full, immediate and complete assignment of all the Patient's rights, title, interest, remedies and benefits in and to the assigned property to the extent of the Health Care Providers total claim amount; therefore, Patient hereby irrevocably and fully assigns and transfers to the Health Care Provider any and all causes of action that Patient might have or that might exist in Patients favor against such insurance company and/or attorney with respect to the assigned property. In addition to the foregoing assignment, Patient hereby authorizes, nominates and appoints as Patients attorney-in-fact any officer of Health Care Provider, to prosecute said causes(s) of action either in Patients name or in the Health Care Providers name and Patient further authorizes the Health Care Provider to compromise, settle or otherwise resolve said claim(s) or cause(s) of action as it sees fit.

In further consideration of the services provided by the Health Care Provider, Patient hereby grants a lien to said Health Care Provider against any and all insurance benefits and litigation proceeds outlined in the first paragraph above which may be payable to or on behalf of the Patient as a result of the injuries or illness for which Patient has been treated by said Health Care Provider. The Patient further agrees that the statute of limitations applicable to Health care Providers right to demand payment from the patient shall be tolled for all reasonable times that negotiations or litigation between third parties and the Patient are ongoing. Patient hereby acknowledges that Florida law imposes a lien in the amount of $750.00 upon patients claim against the individual or entity whose negligence is alleged to have caused Patients injuries.

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Notwithstanding the foregoing, the Patient agrees that until the Health Care Provider is paid in full, the Patient shall remain personally and fully responsible for and promises to pay the total amount due the Health Care Provider (including principal, interest, collection costs and attorney's fees of 35%) until fully paid. The Patient further understands and agrees that this Assignment does not constitute any agreement of or consideration for the Health Care Provider to await payments from any source, and in the event the Health Care Provider deems itself in its sole discretion insecure as to the prospect payment, it may demand payments from Patient immediately upon rendering services at its option and proceed to collect same through legal means if necessary. Patient authorizes the Health Care Provider to release this Assignment and any information pertinent to Patients case to any insurance company, adjuster or attorney to facilitate collection under this Assignment. Patient hereby nominates and appoints any officer of the Health Care Provider as Patient's attorney-in-fact to endorse/sign Patient's name on any and all checks for payment of the services provided to Patient by said Health Care Provider. In the event that any part or provision of this Assignment shall be determined to be invalid or unenforceable, the remaining parts and provisions of this Assignment which can be separated from the invalid, unenforceable provision shall continue in full force and effect.

Notice: Automobile Accident Patients. If you have been in an automobile accident, you may be entitled to payment from your automobile insurance if you have medical expense benefits coverage. By signing this assignment of benefits form you are giving to your health care Provider the right to receive some or all of that payment directly from your automobile insurance company. If you have health insurance and your healthcare Provider is in-network: as long as you provide information necessary to verify your health insurance coverage the healthcare provider may only bill the amount you owe for any co-payment, coinsurance, or deductible to your automobile insurance and you may be entitled to any remainder of your automobile insurance benefit. If you do not provide information necessary to verify your health insurance coverage, do not have health insurance, or your healthcare Provider is not in your health insurer's provider network: your healthcare Provider may bill their full charges to your automobile insurance. You may want to consult your insurance agent or attorney before signing or initialing this form. You are not required to sign/initial this form to

receive care. By initialing here, I acknowledge that I have read or had the opportunity to read this notice. Patient acknowledges that as a courtesy Provider may choose to bill Patient's insurance, including but not limited to Patient secondary insurance and Patient's automobile insurance, but that Provider is not required to do so.

YOU ARE NOT REQUIRED TO EXECUTE THIS ASSIGNMENT IN ORDER TO RECEIVE CARE.

However, if you do not sign this form, you will be required to (I) pay any applicable co-pays and deductibles at the time of services are provided and allow us to bill your health insurance company or (I) pay for all care at the time of service.

Witness the following signatures and seal as of the indicated date:

Patient Signature: _____ Printed Name: _____

SS#: _____ Date: _____

Witness: _____

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PIP Benefit Exhaustion Explanation

Patient Name: _____

Your insurance has a policy limit of _____. This is the money that can be used for you to get the services you need for your injuries from the accident. All services you receive for treatment of this accident are paid from this amount of money. We are no longer reimbursed from that point on until the end of the case. At the end of your case when a settlement or jury award is received, we expect to get reimbursed for the services rendered. There is a common misconception that once the benefits are exhausted you should stop treatment. This can only harm you and the case if you are not yet finished with your treatments. If you choose to not get care above and beyond your policy limits, please notify your attorney and he can explain your options. Signature below states that you have read and understand the above paragraph and any and all questions have been answered and explained to your satisfaction.

Patient Signature: _____ Date: _____

Witness: _____

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PRIVATE CONTRACT
AGREEMENT TO PAY
REGARDLESS OF ANY INSURANCE COVERAGE

AUTHORIZATION TO ATTORNEY TO PAY BILLS FROM SETTLEMENT PROCEEDS AND MEDICAL RELEASE AGREEMENT

I understand that I may have health Insurance, PIP or Med Pay Insurance and that I may have a third-party beneficiary of an agreement which could set a specified rate of reimbursement for medical care for a reduced amount, and I understand and acknowledge that SpineX Injury reserves the right to bill or not bill available health Insurance, PIP or Med Pay Carriers. Notwithstanding any such prior agreements or PIP Fee Schedule in consideration of SpineX Injury or Proving me medical care for other valuable consideration. I agree to release SPineX Injury from any such contractual agreement and/or fee schedule and pay the full amount of the medical bill and further agree that this document shall constitute an Irrevocable letter of protection against the proceeds of any settlement or verdict related to my injury/loss claim.

I authorize SpineX Injury to endorse any check Witten in both our names where such check is in payment for services regarding my Injury. I forbid you, my attorney, for paying my doctor any sums less than the full amount owed to the Doctor without his prior written consent. I further authorize and direct you, my attorney, to pay directly to the Doctor any such sums as may be due and owing for professional services rendered to me, both by reason of Injury/Ulness and by reason of any other outstanding bills that are due to the Doctor and any disbursement to myself, as may be necessary to adequately protect the Doctor. I further agree and direct the amounts owed to the Doctor, or SpineX Injury shall be paid in fail prior to any disbursement to me by my attorney and direct my attorney to comply.

I understand that I am directly and folly responsible to the Doctor for all professional bills, for medical services rendered to me. And that this agreement is made solely for the Doctor's additional protection and in consideration of him awaiting payment. I farther understand that such payment is dependent upon any settlement, judgment or verdict which I may eventually recover and that in the event I do not obtain any settlement, Judgment or verdict without regard to the above date of Injury/loss, I am still responsible to the SpineX Injury for any outstanding balance.

I further agree not to submit bills for services provided by my health insurer, PIP or Med Pay carrier regarding my injury/loss or have them submitted on my behalf, in the event they are submitted, and payment Is made to SpineX Injury shall remain liable for any balance owed. Any application of a fee schedule by the health insurer, PIP or Med Pay Carrier shall not apply to the balance. I shall remain liable for any balance owed or the entire amount owed if SpineX Injury required or elects to return any payment to the health insurer, PIP or Med Pay Carrier.

I agree that in the event this document or the underlying debt Is litigated, the prevailing party shall be awarded reasonable attorney's fees as well as costs.

I hereby authorize Spinex Injury to furnish you, my attorney of record, with a fall report of examinations, diagnosis, treatment, prognosis, etc. concerning the injury/illness for which I am treated.

If I currently do not have an attorney, but retain an attorney in the future, or change my attorney of record, I will notify SpineX Injury in writing within in two weeks of doing so.

I hereby understand I have had an opportunity to ask questions and acknowledge acceptance of the terms of this document In Its entirely by signing below and returning the same to the doctor. I have been advised if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but may declare the entire balance due.

Patient Signature: _____ Date: _____

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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.)

x _____

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.)

x _____

Signature Date

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ATTENDING PHYSICIAN'S REPORT

DATE_____ POLICY HOLDER_____ DATE OF ACCIDENT_____

TO ASSIST US IN DETERMINING BENEFITS DUE INDER THE AUTOMOBILE PERSONAL INJURY PROTECTION LAW, THE ATTENDING PHYSICIAN MUST COMPLETE THIS REPORT AND RETURN IT DIRECTLY

Physician's Name: _____ Hospital or Office Name: _____

Street Address: _____ City, State, Zip Code: _____

Patient's Name: _____ Street Adress: _____

City: _____ State: _____ Zip Code: _____

Date Of Birth: _____ Sex: _____ Occupation: _____

AUTHORIZATION TO RELEASE INFORMATION: PLEASE FURNISH THE FOLLOWING REPORT REGARDING MY CONDITION AS A RESULT OF THIS ACCIDENT WHICH OCCURRED ON: _____, 20_____

_____

x Signature DATE

TO BE COMPLETED BY ATTENDING PHYSICIAN

History of Occurrence as described by the patient: _____

Diagnosis and concurrent conditions: _____

If x-ray taken where? _____

When did symptoms first appear? _____

When did patient first consult you far this condition? _____

Has the patient ever had Iha same or similar condition? YES NO If "yes" state when & describe.

_____

Is the condition solely a result of this accident? YES NO If "no" please explain below:

_____

Nature of surgical procedures and dates, if any: _____

Charge to patient for this procedure including post care: $ _____ Location of procedure: _____

Is the condition due to Injury or sickness arising out of the patient's employment? YES NO

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Will injury result in permanent disfigurement or disability? YES NO If "yes" describe below

---

Patient was disabled (unable to work) from _____ through _____

If still disabled, date patient should be able to return to work _____

Other medical services and charges: Service _____ Charges: $ _____

Service _____ Charges: $ _____

Service _____ Charges: $ _____

Total Charges to Date.....Charges: $_____

Is the patient still under your care for this condition? Yes No Estimated future Charges: $_____

Physician's Name: _____ IRS Identification Number: _____

Physician's Street Address: _____ City, State, Zip Code: _____

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AFFIDAVIT

COMES NOW, _____ who, after being first duly sworn by me, deposes and says as follows:

1. My name is _____ and on _____, 20_____, I resided at _____ _____.

2. I was a (passenger in a) (operator of a) vehicle described as a _____owned by_____on_____ , 20_____ , which was involved in a motor vehicle accident at or near _____ _____.

3. I did not own a drivable vehicle at the time of the subject accident and was residing at the above address at the time of the accident. No blood relative resides at the household who has insurance on a vehicle.

4. I am not provided coverage by any other NO FAULT insurance policy for the injuries sustained by me in the motor vehicle collision of_____, 20_____.

FURTHER AFFIANT SAYETH NOT

_____

SWORN TO AND SUSCRIBED before me this

_____day of _____, 20_____.

_____

NOTARY PUBLIC

SpineX Injury Centers

SpineX Injury Centers
2328 10th Ave N
Ste 200
Lake Worth, FL 33461

PROVIDER'S LIEN: AUTHORIZATION FOR RELEASE OF INFORMATION; SPECIAL POWER OFATTORNEY AND ASSIGNMENT OF RIGHTS & BENEFITS WITHIN THE MEANING OF 627.736, FLORIDA STATUTES

This agreement allows me, _____, to be treated by SpineX Injury Centers without paying for my care end treatment in advance. SpineX Injury Centers will be paid within 35 days of submission of claims for my care directly by my personal Injury protection insurance carrier. The parties agree that this is good and sufficient mutual consideration.

I hereby guarantee full payment to SpineX Injury Centers and agree that I will remain personally responsible for any unpaid charges. I also grant SpineX Injury Centers a lien against any recovery which Imay have now or in the future against any tort-feasor or any responsible Insurance carrier.

I hereby authorize and direct my personal injury protection insurance company or group health insurance companies to pay directly to SpineX Injury Centers my personal Injury protection benefits for care and treatment rendered to me by SpineX Injury Centers. I hereby assign my personal injury protection rights and benefits to SpineX Injury Centers, If any portion of this document is deemed to be inconsistent with an assignment of rights and benefits within the meaning of Florida Statutes 627.736, said portion shall be rewritten in order to conform within Florida law to give full effect to the intended purpose of this agreement, said intended purpose being to create an assignment of rights and benefits from _____ to SpineX Injury Centers.

I hereby grant SpineX Injury Centers a limited Power of Attorney to endorse checks made payable to me for PIP benefits. I grant to SpineX Injury Centers full power and authority to endorse and sign checks or drafts for payment of bills submitted by SpineX Injury Centers.

I authorize and direct my present or future attorneys and my personal injury protection insurance carrier, or carriers, to release medical and legal Information about me to SpineX Injury Centers.

In the event that _____ have a claim against a third party I authorize my counsel to release and disclose the amount of the settlement and a copy of the closing statement prior to your office agreeing to any reduction of any outstanding balance I may owe.

_____

x Signature Date