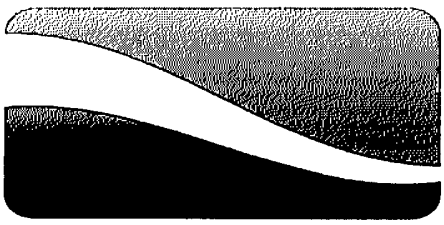


Spinal Health
& Rehab
Integrative Medicine

## RECORD RELEASE AUTHORIZATION

DOCTOR/HOSPITAL _____

ADDRESS _____

_____

I HEREBY AUTHORIZE AND REQUEST THE RELEASE OF MY MEDICAL RECORDS AND XRAYS TO:

**Spinal Health and Rehab**

**324 Cross St**

**Punta Gorda FL 33950**

**Phone: 941-205-2180**

**Fax: 941-205-2181**

THANK YOU IN ADVANCE FOR YOUR COOPERATION!

_____ _____

Patient's Signature Date

_____ _____

Patient's Name (please print) Date of Birth

_____ _____

If patient is a Minor, Signature of Parent or Legal Guardian Relationship to Patient

Patient's Name:_____ Date of accident:_____

Time of accident:_____ What type of car were you in:_____

Please describe the accident:_____

_____

_____

Were you the: Driver Front passenger Left rear passenger Right rear passenger Pedestrian

Was your car equipped with headrests? Yes No

Position of headrest: High Medium Low

Were you wearing your seat belt? Yes No

What was the damage to your car? Minor Moderate Extensive Totaled

Was your car hit on the: Front Rear Passenger Side Driver Side

The condition of the road: Wet Dry Fog-covered Other

The visibility at impact: Poor Fair Good

Was the accident: A complete surprise You saw the car coming

Position of your body at impact: Straight ahead Slouched Rotated Left/Right

What position was your neck pitched? Forward and Backward Side to side

Did your head strike any object? Yes No If yes, explain:_____

Did your body strike any object? Yes No If yes, explain:_____

Did you lose consciousness? Yes No Don't recall

How did you feel after the accident? Dizzy Confused Dazed Nervous

Where did you immediately develop pain? Head Neck Mid Back Low Back

Pelvis Chest/Ribs Arms Shoulder Elbow Wrist Hand

Hip Knees Ankles Feet Legs

Did you experience any cuts? Yes No If yes, where?_____

Were you taken to the hospital? Yes No Hospital Name:_____

If you were taken to the hospital did they take: Xrays MRI CT Scan Other:_____

What treatment was administered at the hospital?

Medication Injection Brace Ice/heat packs Collar Surgery

Other:_____

When you were discharged from the hospital, were you recommended to use:

Orthopedist Chiropractor Physical Therapist Surgeon

--What recommendations were made: No further care Rest Ice Heat

What did you do after the accident: Went home Went to work Other:_____

Since your accident/injury, have you suffered from any of the following?

Vision issues: Blurred Double Reduced Impaired

Chest pain Constipation Diarrhea Nausea Vomiting

Anxiety Depression Mood swings Nervousness Poor memory

Tension Convulsions Dizziness Headaches Fainting

Fatigue Restlessness Insomnia Light sensitivity Weakness

Ringing in ears Frequent urination Painful urination Difficulty breathing

Other:_____

Are you restricted in any of the following areas as a result of the accident/injury?

Daily living Occupation/Work Recreational Activities Other:_____

Have you missed work due to this accident/injury? Yes No If yes, list dates:_____

How did you self-treat your symptoms?

Ice Heat Bedrest Medication Other:_____

Did you seek medical care elsewhere?

Name:_____ Treatment:_____

Have you contacted an adjuster regarding this claim?

Company:_____

Adjuster:_____ Claim #:_____

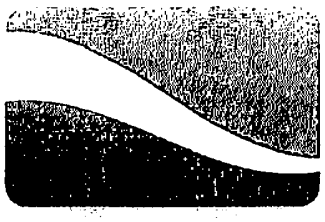
Have you engaged the services of an attorney?

Attorney:_____

Phone #:_____

_____ _____

Patient or Guardian Signature Date



Spinal Health
& Rehab
Integrative Medicine

324 Cross Street
Punta Gorda, FL 33950
Office: 941-205-2180 Fax: 941-205-2181

# LETTER OF PROTECTION

The purpose of this Letter of Protection is to provide a courtesy to a patient who requires treatment but is not able to afford the prescribed care. Our office will extend a courtesy of time if the patient cannot afford deductibles, reductions, or services in excess of available personal injury protection coverage or health insurance. This courtesy is extended to the patient, who has been injured by the fault of another, and who remains compliant with the health care provider's recommendations.

A patient receiving care in our office is ultimately responsible for payment of all services rendered, regardless of whether a recovery is made against a third-party insurance carrier.

I, _____, authorize my attorney to disburse directly to Spinal Health and Rehab all sums necessary to pay any outstanding balance due for care and treatment rendered to me, from any net proceeds recovered as a result of bodily injury, uninsured motorist, or personal injury protection benefits, for injuries that were sustained on ___/____/____.

By signing below, I hereby acknowledge that the health care provider's forbearance in the receipt of payment for medical services rendered, even though some or all of said medical services may be reimbursed by personal injury protection benefits or third party insurance coverage, is good, valuable, and sufficient consideration for the promises contained herein from myself and my attorney.

I agree to be responsible for any litigation costs and attorney fees necessary to enforce the payment of any outstanding balance and/or bills due. This Letter of Protection may be delivered to my attorney. I hereby request and direct my attorney to sign this Letter of Protection acknowledging they will abide by the terms of the Letter of Protection in my behalf. This letter is binding on any attorney who may represent me for the above stated injuries.

_____ _____
Patient/Guardian Signature Date

---

I acknowledge receipt of the above Letter of Protection and agree to abide by its terms and applicable Florida Law.

_____ _____
Attorney Signature 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 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

CONFIDENTIAL