Moss Chiropractic Clinic

4223 Northlake Blvd.
Palm Beach Gardens, FL 33410
Phone: 561-627-7771

1580 SE Port St Lucie Blvd.
Port St Lucie, FL 34952
Fax: 855-952-5844

Welcome

Bienvenido

Thank you for choosing the office of

Gracias por escoger la oficina del

Dr. Damon T. Moss, DC

Please complete all information so we may serve you better.

Favor de completar toda la información para poder servirle mejor.

All information is strictly protected.

Toda la información está estrictamente protegida.

Patient Name: _____ Date: _____
Nombre del Paciente: Fecha:

Date of Birth: _____ Gender: __M or __F Social Security #: _____
Fecha de Nacimiento: Género: Número de Seguro Social :

Address: _____
Dirección:

City/State/Zip: _____ Email: _____
Ciudad/Estado/Código Postal: Correo electrónico:

Home Phone : _____ Cell Phone : _____
Número de Teléfono: Número de Celular:

Occupation: _____
Ocupación:

Emergency contact Name: _____ Tel: _____
Nombre del contacto de emergencia:

Relationship to patient: _____
Relación con el paciente:

Marital Status: __Single __Married __Divorce __Widow
Estado Civil : Soltero Casado Divorciado Viudo

Race: __ American Indian __ Asian __ African American __ Pacific Island
Raza : __ White Caucasian __ Hispanic/Latino __ Other _____

Ethnic Group: _____ Preferred Language: _____
Grupo étnico: Idioma preferido:

Case Type : ___Auto ___Slip & Fall ____Workman's Compensation
Tipo de caso : Automóvil Resbalón y caída Compensación de los trabajadores

Date of Accident: _____
Fecha del accidente

Insurance (Seguro)

Name of Policy Holder: _____ Tel: _____
Nombre del titular de la póliza: Número de teléfono:

Insurance Company: _____ Tel : _____
Compañía de seguros : Número de teléfono:

Policy num.: _____ Claim Num.: _____
Núm. De póliza: Número de reclamo:

Name of Adjuster: _____ Tel: _____ Ext: _____
Nombre del Ajustador: Número de teléfono: Extensión:

Attorney's Information (Información del abogado)

Firm's Name: _____ Tel: _____ Ext.: _____
Nombre de la Firma: Tel: Extensión:

Attorney's Name: _____ Fax: _____
Nombre del abogado:

Authorizations and Consents (Autorizaciones y Consentimientos)

Moss Chiropractic Clinic may need to contact you about test results, appointments, referrals, or billing/insurance information. To protect your privacy and follow federal guidelines, unless we have written permission to do so, we will NOT leave messages or discuss medical information with anyone unless you provide written authorization.

Es posible que Moss Chiropractic Centers necesite comunicarse con usted sobre resultados de exámenes, citas, referencias o información de facturación / seguro. Para proteger su privacidad y seguir las pautas federales, a menos que tengamos un permiso por escrito para hacerlo, NO dejaremos mensajes ni discutiremos información médica con nadie a menos que proporcione una autorización por escrito.

I give my permission for my provider of care and staff at Moss Chiropractic Clinic to leave voice mail messages, Email and or Text regarding my medical care/account information. I fully understand that this consent will remain valid until revoked in writing by me.Doy mi permiso para que mi proveedor de atención y el personal de Moss Chiropractic Clinic dejen mensajes de correo de voz, correos electrónicos o mensajes de texto con respecto a mi información de atención médica / cuenta. Entiendo perfectamente que este consentimiento seguirá siendo válido hasta que sea revocado por escrito por mí.

By initialing you authorize (Iniciando usted autoriza)
(Choose only one) (Elija solo uno)

I authorize: _____ Yo autorizo: _____
I do not authorize: ____ No autorizo: _____

What problem(s) or concerns bring you to our office?
¿Qué problema (s) o preocupaciones le traen a nuestra oficina?

_____

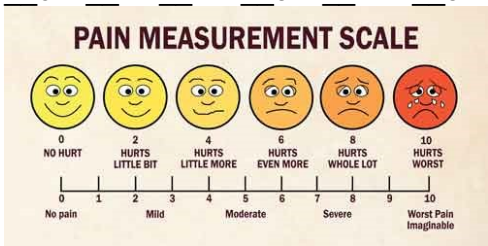
How long have you had these problem(s)?
¿Cuánto tiempo ha tenido estos problemas?

_____

How would you describe your symptom(s)?
¿Cómo describirías tus síntomas?.
__Sharp __Sore __Throbbing __Tingling __Dull Stiff
Dolor agudo Adolorido Punzante Hormigueo / Entumecido o rigido

__Ache __Spasm __ Numbness __ Weakness __ Burning
Dolor leve Espasmo Entumecimiento Debilidad Ardiente

Please rate the intensity of your pain.
Por favor califique la intensidad de su dolor.
__0 __1 __2 __3 __4 __5 __6 __7 __8 __9 __10



No Pain Moderate Pain Extreme Pain
Sin dolor Dolor moderado Dolor extremo

Is your pain getting …__Worse __Better __Staying the same
Su dolor esta .... Peor Mejor Quedando igual

What makes your pain better?
¿Qué hace que tu dolor mejore?
__Nothing __Walking __Rest __ Moving/Exercise __Medication
Nada Caminar Descanso Moverse / Ejercicio Medicación

Is your condition affecting your ability to Perform routine daily activities? How?
¿Su condición afecta su capacidad para realizar actividades diarias de rutina? ¿Cómo?

_____

_____

Are you currently taking any medications, please list: ¿Está tomando algún medicamento actualmente? Por favor, anote cuales son.

_____

_____

Do you exercise? _____ How often? _____ Do you smoke? _____ How much? _____
¿Hacer ejercicio? ¿Con qué frecuencia? Fumas? Cuánto?

Do you drink? _____ How much? _____ Any special diet? _____
¿Tu bebes? ¿Cuánto? ¿Alguna dieta especial?

Have you ever had heart, lung, bowel or bladder problems? If yes please describe.
¿Alguna vez ha tenido problemas de corazón, pulmón, intestino o vejiga? En caso afirmativo, describa.

_____

_____

Are you pregnant? Yes ___ No ___ Not sure ___ Date of last cycle? _____
¿Estas embarazada? Si No No estoy segura ¿Fecha del último ciclo?

Is there any other information you feel is important for us to know regarding your treatment?
¿Hay alguna otra información que considere importante para nosotros con respecto a su tratamiento?

_____

_____

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INFORMED CONSENT FOR CHIROPRACTIC SPINAL MANIPULATION AND TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of therapy modalities on myself (or on the patient named below for whom I am legally responsible) by the licensed doctors of chiropractic of Moss Chiropractic Clinic or any doctor, who now or in the future, works as a relief doctor. I have had the opportunity to discuss with my doctor the nature and purpose of chiropractic adjustments and other procedures. I also understand that spinal manipulation involved the doctor placing his or her hands on my spine and delivering a quick thrust or impulse to the involved area(s). I also 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, sprains, soreness, and physical therapy burns. I understand and comprehend all such risks and complications, I, by my signature below, confirm and accept care and therefore consent to and agree to those treatments deemed necessary by my doctor to be in my best interest.

Acknowledgement of Receipt of Notice of Privacy Practices

I certify that I have received a copy of Notice of Privacy Practices. The Notice of Privacy Practice describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of Moss Chiropractic Clinic health care operations. The Notice of Privacy Practices also describes my rights and Moss Chiropractic Clinic duties with respect to my protected health information. The Notice of Privacy Practices is posted in the office waiting area.

Assignment of Benefits, Release of Information and Financial Policy

I hereby authorize my Insurance benefits to be paid directly to Moss Chiropractic Clinic. I understand that I'm financially responsible for all deductibles, co-payments, co-insurances as per my insurance plan, as well as any non-covered services at the established fee rate set forth by Moss Chiropractic Clinic. I authorize the release of any medical or other information necessary to process insurance claims on my behalf. If I do not carry health or auto insurance, I understand that I have the option to pay at the time of service for a discounted rate or I will billed for my services at the full established fee rate set forth by Moss Chiropractic. I understand that I am responsible for any legal fee or collections fees that may incur from non-payment. I am aware that a No-Show fee of $100 can be applied if the appointment is not cancelled at least 24 hours before the scheduled time. I am also aware that if I fail to make my payments and my account goes to collections, I am responsible for all collection and legal fees.

COVID-19 waiver: COVID-19 has been declared a worldwide pandemic by the World Health Organization. COVID-19 is extremely contagious and is believed to spread mainly from person-to-person contact. As a result, federal, state, and local governments and federal and state health agencies recommend social distancing. Your Chiropractor/Therapist has put in place preventative measures to reduce the spread of COVID-19; however, they cannot guarantee that you will not become infected with COVID-19. By signing this agreement, I acknowledge the contagious nature of COVID-19 and voluntarily assume the risk that I may be exposed to or infected by COVID-19 by receiving treatment and that such exposure or infection may result in personal injury, illness, permanent disability, and death. I voluntarily agree to assume all of the foregoing risks and accept sole responsibility for any injury to myself (including, but not limited to, personal injury, disability, and death), illness, damage, loss, claim, liability, or expense, of any kind, that I may experience or incur in connection with my appointment. On my behalf I hereby release, covenant not to sue, discharge, and hold harmless my chiropractor or therapist, Moss Chiropractic Clinic, and any interested parties from the Claims, including all liabilities, claims, actions, damages, costs or expenses of any kind arising out of or relating thereto. I understand and agree that this release includes any claims based on the actions, omissions, or negligence of my chiropractor or the establishment where services are received, whether a COVID-19 infection occurs before, during, or after participation in any treatment session. Please visit www.cdc.gov for more information on COVID-19

No Surprise Act: While a good-faith estimate has been provided, fees are subject to change based on acuity of care and services actually rendered. By signing this, I am agreeing to waive my protections from the No Surprise Act. Failure to waive will result in refusal of treatment. Additionally, I understand that I have the right to seek services from an in-network provider and I also understand that going to another out-of-network provider could result in higher fees

_____ _____

Patient's signature or Legal guardian Date

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Port St Lucie, FL 34952-5456
Fax: 855-952-5844

Medical Records Release Form

By signing this form, I authorize you to release confidential health information about me, be releasing a copy of my medical records, or a summary or narrative of my protected health information, on the physician/person/facility/entity listed below.

Patients name: _____ Date of birth: _____

HIV/AIDS: I consent to the release of any positive or negative test result for AIDS or HIV Infection, antibodies to AIDS, or infection with any other causative agent of AIDS with the rest of my medical records.

The information you may release subject to this signed release form is as follows:

___ Complete Records ___ History & Physical ___ Progress Notes ___ Care Plan
___ Labs Reports ___ Radiology Reports ___ Pathology Reports ___ Treatment Records
___ Operative Reports ___ Hospital Reports ___ Medication Record ___ ER Records

Release my protected health information to the following physician/person/facility/entity:

FROM:

Name: _____
Address: _____
City: _____
Tel: _____
Fax: _____

TO:

Moss Chiropractic Clinic
Damon T. Moss, DC
1580 SE PSL Blvd
Port St Lucie, FL 34952
Tel: 561-627-7771
Fax: 855-952-5844

TO:

Attorney: _____
Primary Care: _ _____
PCP Address: _____
PCP Tel: _____
PCPFax: _____

FROM:

Moss Chiropractic Clinic
Damon T. Moss, DC,
1580 SE PSL Blvd
Port St Lucie, FL 34952
Tel: 561-627-7771
Fax: 855-952-5844

The purpose/reason for this release: _____

_____ _____
Signature of Patient or Legal Guardian Relationship to patient

_____ _____
Print Patient Name Date

_____
Patient's Date of Birth

MOSS CHIROPRACTIC CLINIC

Patient's name: _____ Date of Birth: _____
Date of Accident: _____

Automobile Accident History (If applicable)

Historial de accidentes automovilísticos (si corresponde)

Patient's vehicle:_____
Vehículo del paciente:

Are you the registered owner of the vehicle involved? _____ Yes _____ No
¿Es usted el propietario registrado del vehículo involucrado? _____ Si _____ No
If your answer is yes, please skip the following questions. If your answer is no, please answer:
Si su respuesta es afirmativa, omita las siguientes preguntas. Si su respuesta es no, por favor responda:

If you are not the registered owner, who owns the vehicle? _____
Si no es el propietario registrado, ¿quién es el propietario del vehículo?
What is your relationship to the person who owns the vehicle? _____
¿Cuál es su relación con la persona que posee el vehículo?
Do you live in the same household as the person who owns the vehicle? _____
¿Vive en la misma casa que la persona que posee el vehículo?
Do you own a vehicle? If yes, what insurance company insures your vehicle? _____
¿Tienes un vehículo? En caso afirmativo, ¿qué compañía de seguros asegura su vehículo?
On the date of the accident, did you live with any relatives, including aunts, uncles, cousins, or in-laws? _____ If yes, do any of them own vehicles?_____
En la fecha del accidente, ¿vivía con algún pariente, incluyendo tías, tíos, primos o suegros? En caso afirmativo, ¿alguno de ellos posee vehículos?
How many people were in your vehicle? _____
¿Cuántas personas había en tu vehículo?

In your own words, describe the accident. Please include types of vehicles involved, position of vehicle, where on the vehicle the impact occurred, and what you were doing at the time of impact (stopped, traveling, turning, etc)
En tus propias palabras, describe el accidente. Incluya los tipos de vehículos involucrados, la posición del vehículo, en qué parte del vehículo ocurrió el impacto y qué estaba haciendo en el momento del impacto (detenido, viajando, girando, etc.)

_____

_____

_____

Damage: __ Total __ Extensive __ Moderate __ Minimal
Daño: Total Extenso Moderado Mínimo
Weather Conditions: __ Sunny & dry __ Rainy & Wet __ Slippery
Condiciones climáticas: Soleado y seco Lluvioso y mojado Resbaloso
Other: _____
Otro:
Time of Day: __ Dawn __ Daylight __ Dusk __ Night
Hora del día: Amanecer Luz del día Atardecer Noche
Visibility: __ Good __ Fair __ Poor
Visibilidad: Buena Justa Pobre
Body Position at Impact: __ Straight __ Leaning Forward __ Slouched __ Turned right __ Turned Left
Posición del cuerpo en el impacto: derecha adelante encorvada Girado a la derecha Girado a la izquierda

Direction body was thrown: __ Forward then back __ Backward then forward
Dirección que su cuerpo fue lanzado: Adelante luego atrás Atrás luego adelante
__ To the right __ To the left __ Outside the vehicle __ Under the vehicle
A la derecha A la izquierda Fuera del vehículo Debajo del vehículo
__ Above the vehicle
Encima del vehículo
Head position at impact: __ Straight __ Tilted forward __ Turned right __ Turned left
Posición de la cabeza en el momento del impacto: Recta Inclinada hacia adelante Girada a la derecha Girada a la izquierda
Direction head was thrown: __ Forward then back __ Backward then forward __ Side to side
Dirección que la cabeza fue lanzada: Adelante luego hacia atrás Atrás luego hacia adelante De lado a lado
Type of passive restraint: __ Shoulder-lap belt __ Airbag __ None
Tipo de restricción pasiva: Cinturón de regazo del hombro Bolsa de aire Ninguno
Headrest position: __ High __ Middle __ Low __ Not installed
Posición del reposacabeza Alto Medio Bajo No instalado
Did you brace for impact?: __ Yes __ No __ Don't remember
¿Te preparaste para el impacto ?: Sí No No recuerdo
Did the airbags deploy?: __ Yes __ No
¿Se explotaron las bolsa de aire?: Sí No
Did you hit your head?: __ Yes __ No
¿Te golpeaste la cabeza ?: Sí No
Did you lose consciousness?: __ Yes __ No
¿Perdiste el conocimiento ?: Sí No
Did you receive any cuts, bruises or lacerations? __ Yes __ No
¿Recibió algún corte, moretones o laceraciones? Si No
If yes, where were the cuts, bruises or lacerations? _____
En caso afirmativo, ¿dónde estaban los cortes, moretones o laceraciones?
Did you go to the hospital? __ Yes __ No
¿Fuiste al hospital? Si No
If yes, when? __ From the scene __ Later that day Other: _____
¿En caso afirmativo, cuándo? De la escena Más tarde ese día Otro:
Who took you? __ Ambulance __ Private transportation
Quien te llevo? Ambulancia Transporte privado
Name of Hospital: _____
Nombre del hospital:
What test were done? __ X-rays __ CT Scan __ MRI'S Other: _____
¿Qué pruebas te hicieron? Radiografías CT Scan MRI'S Otro:
What treatment was given? __ Pain medication __ Muscle Relaxers __ Splint/braces
¿Qué tratamiento se le dio? Medicamentos para el dolor Relajantes musculares Férula / aparatos ortopédicos
Other: _____
Otro:
Were you? __ Discharged home __ Admitted If admitted, how long? _____
Fuistes: Dados de alta a casa Admitido Si fue admitido, ¿cuánto tiempo?
Please list any other doctor or facility that has treated you for this accident:
_____

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LETTER OF PROTECTION

AUTHORIZATION AND MEDICAL ASSIGNMENT

I _____ do hereby authorize and direct my attorney's, _____ to pay Moss Chiropractic Clinic 4361 Northlake Blvd, Palm Beach Gardens, FL 33410 from the share of my proceeds of any recovery as a result of the settlement or litigation of the accident on (date of accident) _____ ,
the unpaid balance for the reasonable and customary charges as determined by the insurance company, for professional services rendered by said hospital, physician, or other medical care provider, on my behalf. In the event of a dispute between my insurance carrier and my physician, hospital, or medical care provider, any assignment of benefits executed by me to my said physician, hospital, or medical care provider to proceed against my insurance carrier in the method and manner as provided in Florida Statute, Said professional services to include those for the medically necessary and reasonable diagnosis treatment and care heretofore and hereafter rendered to me as well as those medical reports, consultations, with my attorney, and court appearances on my behalf. **Payment of these balances as herein stated shall be the same as if paid by me.**

I understand that this assignment on no way relieves me of my personal responsibility and obligation to pay my physician, hospital, or medical care provider for such charges as herein stated for such services rendered, and that such physicians, hospitals, or other care provider's fee for such services rendered is not contingent upon the outcome of this litigation. I further authorize the before said physician, hospital, or medical care provider to furnish my attorney with full report of the physician's, hospital's, or medical care provider's treatment evaluation of me in regards to the said accident. **Please be aware that any services not covered or paid upon finalization of the case will become the responsibility of the client/patient.**

In exchange for this letter of protection, it is our understanding that all such related bills will be directed to this office and not to the clent/patient and that client/patient's account will not be turned over to any type of collection agency or credit bureau, nor will any adverse credit information be reported against this client's credit **during the pendency of this case** and if this account is turned over to a collection agency or credit bureau, of if any adverse information is reported against this client's credit by you, directly or indirectly, this Letter of Protection is null and void and this law has no further obligation to you whatsoever.

_____ DOB: _____ Date: _____
Signature (Client/Patient or Legal Guardian)

_____ Date: _____
Attorney (Firm Representative)

MOSS CHIROPRACTIC CLINIC
ASSIGNMENT OF INSURANCE BENEFITS, RELEASE , & DEMAND

I, the undersigned patient/insured knowingly, voluntarily and intentionally assign the rights and benefits of my automobile insurance, also known as Personal Injury Protection (hereafter PIP) and **Medical Payments policy of insurance to the above health care providers** I understand it is the intention of the provider to accept this assignment of benefits in lieu of demanding payment at the time of services are rendered and that this document will allow the provider to file suit against an insurance company for payment of the insurance benefits. I understand the provider may file a lawsuit against my insurer for payment and if the provider's bill are paid or applied to a deductible I agree this will serve as a benefit to me and I authorize and request such litigation. This assignment of benefits includes the cost of **transportation, medications, supplies**, overdue interest and any potential claim common law or statutory bad faith/unfair claims handling. If the insurer disputes the validity of this assignment of benefits then the insurer is instructed to notify the provider in writing within five days of receipt of this document. Failure to inform the provider shall result in a waiver by the insurer to contest the validity of this document. The **undersigned directs the insurer to pay the healthcare provider** directly without reductions & without including the patient's name on the check. To the extent the PIP insurer contends there is a material misrepresentation on the application for insurance resulting in the policy of insurance is declared voided, rescinded or canceled, I as the named insured under said policy of insurance, hereby assign the right to receive the premiums paid for my PIP insurance to this provider and to file suit for recovery of the premiums. The insurer is directed to issue such a refund check payable to this provider only. Should the medical bills not exceed the premiums refunded, the provider is directed to mail the patient/named insured a check which represents the difference between the medical bills and the premiums paid.

The insurer is directed by the provider and the undersigned to not issue any checks or drafts in partial settlement of a claim that contain or are accompanied by language releasing the insurer or its insured/patient from liability unless there has been a prior written settlement agreed to by the healthcare provider and the insurer as to the amount payable under the insurance policy. The insurer and the provider hereby contests and objects to any reductions or partial payments. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by the provider shall be done so under protect, 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 reduce amount as payment in full. The insurer is hereby placed on notice that this provider reserves the right to seek the full amount of the bills submitted.

If the insurer schedules a defense examination or examination under oath (hereinafter "EUO") the insurer is hereby INSTRUCTED to send a copy of said notification to this provider. The provider or the provider's attorney is expressly authorized to appear at any EUO or IME set by the insurer. The health care provider is not the agent of the insurer or the patient for any purpose.

The assignment applies to both past and future medical expenses and is valid even if undated. A photocopy of this assignment is to be considered as valid as the original. I agree to pay any applicable deductible, co-payments, for services rendered after the policy of insurance exhausts and for any other unrelated to the automobile accident.

Release of information: I hereby authorize this provider to: furnish an insurer, an insurer's intermediary, the patient's other providers, and the patient attorney via mail, fax, or email, with any and all information that may be contained in the medical records; to obtain insurance coverage information (declaration sheet & policy of insurance) in writing and telephonically from the insurer; request from any insuret all explanation of benefits (EOB's) for all providers and non-redacted PIP payout sheets; obtain any written and verbal statements the patient or anyone else provided to the insurer, obtain copies of the entire claim file and all medical records, including but not limited to, documents, reports, scans, notes, bills, opinions, x-rays, IME's and MRI's, from any other medical provider or any insurer. The provider is permitted to produce my medical records to its attorney in connection with any pending lawsuits. The insurer is directed to keep the patient's medical records from this provider private and confidential and the insurer is authorized to provide these medical records to anyone without the patient's medical records from this provider private and confidential and the insurer is not authorized to provide these medical records to anyone without the patient's and the provider's prior express written permission.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers, or any other insurance agencies, my information needed for any commercial or manager care claim or related Medicare claim. I permit a copy of this authorization to be used in place of original, and request payments of medical insurance benefits either to myself or to the party who accepts assignment. I understand is is mandatory to notify the health care provider of any party who may be responsible for paying for my treatment. (Section 1128b of Social Security Act an 31 U.S.C 3801-3812 Provides penalties for withholding this information) Regulation pertaining to Medicare benefits also apply.

Demand: Demand is hereby made for the insurer to pay all bills within 30 days without reductions and to mail the latest non-redacted PIP payout sheet and the insurance coverage declaration sheet to the above provider within 15 days. The insurer is directed to pay the bills in the order they are received. However if a bill from this provider and a claim from anyone else is received by the insurer on the same day the insurer is directed to not apply this provider's bill to the deductible. If a bill from this provider and claim from anyone else is received by the insurer on the same day then the insurer is directed to pay this provider first before the policy is exhausted, In the event the provider's medical bills are disputed or reduced by the insurer for any reason, or amount, the insurer is to;: set aside the entire amount disputed or reduced; escrow the full amount at issue, and not pay the disputed amount to anyone or any entity, including myself, until the dispute is resolved by Court. Do not exhaust this policy. The insurer is instructed to inform, in writing, the provider of any dispute.

Certification: I certify that: I have read and agree to the above: I have not been solicited or promised in exchange for receiving health care; I have not received any promises or guarantees from anyone as to the results that may be obtained by any treatment or service: and I agree the provider's prices for medical services, treatment and supplies are reasonable, usual and customary.

Patient's Name: _____ Patient's Signature: _____
(Please print, If a minor please print patient's name) (If the patient is a minor the signature of the parent of legal guardian)

DOB: _____ Date: _____
(Patient's date of birth)

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.**
Office visits New & Established, Massage Therapy, Electrical Stimulation, Manipulation Services, Decompression & Traction Services, Therapeutic Services, Ultrasound, Mechanical Traction, Manual Trigger Points.

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**)*:

Damon T. Moss, DC		
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.