



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**.

New Patient Evaluation

- 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 (<i>PRINT or TYPE</i>)	Signature	Date
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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 (<i>PRINT or TYPE</i>)	Signature	Date
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Any person who knowingly and with intent to injure, defraud or deceive any insured files a statement or other information on this form that is false, fraudulent, misleading, deceptive or untruthful, shall forfeit the right to recover under the policy and may be liable for civil penalties under Section 627.736(5)(b)6, 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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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 §172.34(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 INFORMATION

FIRST NAME: _____ MI: _____ LAST NAME: _____ DATE: _____
NOMBRE INICIAL APELLIDO FECHA

DATE OF BIRTH: _____ SOC SEC #: _____ SEX: FEMALE MALE
FECHA DE NACIMIENTO SEGURO SOCIAL SEXO FEMENINO MASCULINO

ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____
DIRECCION CIUDAD ESTADO CODIGO POSTAL

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____
TELEFONO DE CASA TELEFONO DE TRABAJO TELEFONO CELLULAR

E-MAIL _____
CORREO ELECTRONICO

EMPLOYER: _____ OCCUPATION: _____
EMPLEADOR POSICION

EMERGENCY CONTACT _____ PHONE _____ RELATIONSHIP _____
CONTACTO DE EMERGENCIA TELEFONO PARENTESCO

REFERRING DR. / PRIMARY DR.: _____ PHONE: _____
DOCTOR QUE LO REFIERE / MEDICO DE CABECERA TELEFONO

LANGUAGE PREFERENCE: _____

GUARANTOR & PARTY RESPONSIBLE FOR BILL

FIRST NAME: _____ MI: _____ LAST NAME: _____ RELATIONSHIP: _____
NOMBRE INICIAL APELLIDO PARENTESCO

DATE OF BIRTH: _____ SOC SEC #: _____ SEX: FEMALE MALE
FECHA DE NACIMIENTO SEGURO SOCIAL SEXO FEMENINO MASCULINO

ATTORNEY NAME: _____ PHONE NUMBER: _____

INSURANCE INFORMATION

MEDICARE MEDICAID AUTO WORKERS' COMP COMMERCIAL SELF PAY

PRIMARY INSURANCE: _____
SEGURO PRIMARIO

SECONDARY INSURANCE _____
SEGURO SECUNDARIO

ATTORNEY NAME: _____ PHONE NUMBER: _____

DISCLAIMER AND INFORMED CONSENT

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

I hereby request and authorize **Physical Therapy Institute and Aquatic Rehab, Inc. / Royal Palm Beach Rehab, Corp. / Action Physical Therapy, Inc.** To perform diagnostic tests and give treatment as deemed necessary. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

PATIENT'S SIGNATURE _____
FIRMA DEL PACIENTE

DATE _____
FECHA

WITNESSED BY _____
ATESTIGUADO POR

DATE _____
FECHA

If the patient is a minor, permission is hereby given by me to the doctors of this office and whomever they designate to treat the patient. I am the patients' legal guardian.

GUARDIAN'S SIGNATURE _____
FIRMA DEL REPRESENTANTE LEGAL

DATE _____
FECHA

Patients Name: _____

Patients Height: _____

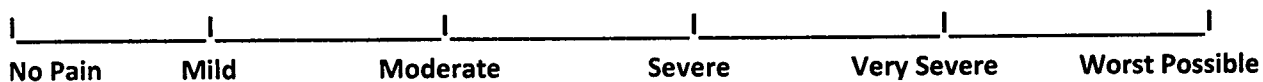
Patients Weight: _____

BMI: _____

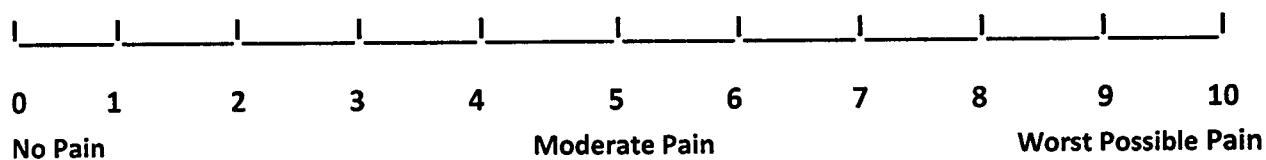
Medication List: (Please list ALL of the medications you are currently taking)

Medication Name	Dosage	Frequency	Route (by mouth or injection)	Other

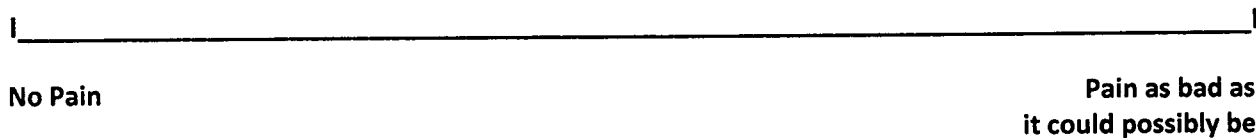
Simple Descriptive Pain Intensity Scale



0-10 Numeric Pain Intensity Scale



Visual Analog Scale (VAS)



Patients Signature: _____

Medical History

PATIENT NAME _____ DATE _____

PAST MEDICAL HISTORY - Have you had any of the following symptoms or conditions:

Allergies	YES	NO	Foot Troubles	YES	NO	Rheumatic Fever	YES	NO
Anemia	YES	NO	Gall Bladder	YES	NO	Rheumatoid Arthritis	YES	NO
Asthma	YES	NO	Pacemaker	YES	NO	Severe Headaches	YES	NO
Broken Bones	YES	NO	Head Injury	YES	NO	Shortness of Breath	YES	NO
Cancer	YES	NO	Heart Trouble	YES	NO	Yellow Jaundice	YES	NO
Diabetes	YES	NO	Hernia	YES	NO	Varicose Veins	YES	NO
Ear Trouble	YES	NO	High Blood Pressure	YES	NO	Tumor	YES	NO
Epilepsy	YES	NO	Kidney Trouble	YES	NO	Tuberculosis	YES	NO
Eye Trouble	YES	NO	Mental or Nervous Disorders	YES	NO	Skin Conditions	YES	NO
Fainting Spells	YES	NO				HIV	YES	NO

Are you presently under a Doctor's care for any condition? YES NO Please Explain _____

Do you have allergies to any medication? YES NO Please Explain _____

Current Subjective Complaints

Date symptoms started : _____

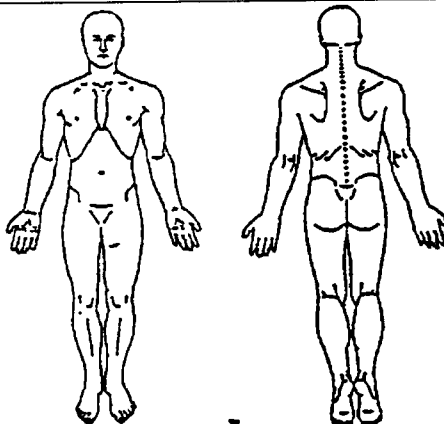
Please describe your condition and how it happened: _____

What activities if any make your condition better? _____

Date of last X-Rays _____ what body part was taken? _____

WOMEN ONLY ARE YOU PREGNANT? YES NO Date of last Menstrual Cycle _____

Please mark the diagram below to point out where your pain is:

<p>HEAD</p> <p>___ Headaches - How often? _____</p> <p>___ Light Headed</p> <p>___ Double Vision</p> <p>___ Hearing Loss</p> <p>___ Memory Loss</p> <p>___ Ringing in Ears</p> <p>___ Fainting</p> <p>___ Blurred Vision</p> <p>___ Loss of Balance</p> <p>___ Dizziness</p> <p>___ Sensitive to Light</p> <p>___ TMJ / Jaw Symptoms</p>	
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Action Physical Therapy Inc-Financial Policy/Assignment of Benefits

Thank you for choosing Action Physical Therapy Inc as your rehabilitation provider. We will work closely with you and your physician to provide you with successful treatment. Please understand that timely payment for your treatment is important. Your clear understanding of our financial policy is important to our professional relationship. Our financial policy is as stated:

- All co-pays & deductibles are due at the time of service
- Payment of patient balances are due in full at the time of service unless other arrangements have been made. If you cannot make full payment at the time of service, please discuss with our Front Office Coordinator.
- We accept cash, checks, Visa, MasterCard, Amex & Discover. There is a \$34 return check fee.
- If any portion of your account balance exceeds 60days you may be responsible for the amount regardless of your insurance.

POWER OF ATTORNEY & MEDICAL RELEASE

THIS POWER OF ATTORNEY IS ONLY TO ALLOW US TO ENDORSE AND/OR SIGN ANY PAPER WHICH WILL ENHANCE OR EXPIDITE PAYMENT TO THE PROVIDER FOR SERVICES RENDERED, INCLUDING BUT NOT LIMITED TO A RELEASE OF MEDICAL RECORDS AND ASSIGNMENT OF BENEFITS OR AUTHORIZATION FOR YOUR INSURANCE/ATTORNEY TO PAY FOR YOUR SERVICES

Know by all these present that: The undersigned has made, constituted & appointed, and by these present does hereby make, constitute & appoint Action Physical Therapy Inc and any of it's duly authorized agents and employees as to be the undersigned's true & lawful attorney for & in the undersigned's name, place & stead to endorse any/all checks, drafts or money order which are made payable to the undersigned alone or to the undersigned and said Action Physical Therapy Inc, when which checks, drafts or money orders are made payable for services which have been rendered by Action Physical Therapy Inc. at the request or with the knowledge and approval of the undersigned and/or the make of the check, draft or money order. Furthermore, the undersigned allows Action Physical Therapy Inc or any of its agents to sign any paper that will be necessary to enhance, expedite and/or allow payment to said provider. This may include insurance forms and/or other forms.

The undersigned by these present does give & grant the said Action Physical Therapy Inc as attorney the full power and authority to do and perform all & every act whatsoever requisite & necessary to be done in & about the premises as fully to all intents & purposes as the undersigned might or could do It personally insofar as the endorsing & cashing of said checks are concerned as well as any other document.

Medical Release

A photocopy of this document shall be sufficient to authorize any person having records of medical treatment, services or supplies pertaining to me, the patient, to release true copies of the same to Action Physical Therapy Inc or any insured providing the coverage to me in connection with the process of any claim for benefits made by me or by the assignee herein. A photocopy of the document shall be as binding as an original signature page. The undersigned does hereby ratify and confirm and all actions taken by the said attorney in accordance with this special power and which the said attorney shall do or cause to be done by virtue of these present.

Assignment of Benefits

I, _____, hereby authorize _____
(Name of Insured/Patient) (Name of Insurance Carrier)

To make payable directly to: Action Physical Therapy Inc
Payable & mailed directly to: 4971 Le Chalet Blvd. Suite 100, Boynton Beach, FL 33436

The medical benefits otherwise payable to me for their services but not to exceed the charges of those services. I hereby IRREVOCABLY ASSIGN to Action Physical Therapy Inc any right & benefits under any policy of insurance, indemnity, agreement or any other collateral sources as defined in Florida Statutes for any services and/or charges provided by Action Physical Therapy Inc.

IN WITNESS WHEREOF the undersigned have hereunto set their hands, this _____ day of _____.

Signature of Patient (parent/guardian, if minor) _____ Date: _____

Patients Name (Please Print): _____

Insurance

We accept Medicare, all major insurances and numerous PPO & managed care contracts. Please be aware that some and perhaps all, of the services provided may be considered not medically necessary by your insurance provider. You will be responsible for these charges.

Your medical insurance is a contract between you and your insurance company. We are not a party to this contract. Action Physical Therapy Inc will submit all claims for charges to your insurance provider as a service to you. Co-pays must be paid at the time of service in order to abide by your insurance contract. If your policy requires a referral, be sure to have it with you when you come to our office. Failure to obtain & present a referral at the time of service may result in a loss of your insurance benefits. If you need assistance in obtaining a referral please ask our Front Desk Coordinator.

Royal Palm Beach Rehab. Corp.-Financial Policy/Assignment of Benefits

Thank you for choosing Royal Palm Beach Rehab. Corp. as your rehabilitation provider. We will work closely with you and your physician to provide you with successful treatment. Please understand that timely payment for your treatment is important. Your clear understanding of our financial policy is important to our professional relationship. Our financial policy is as stated:

- All co-pays & deductibles are due at the time of service
- Payment of patient balances are due in full at the time of service unless other arrangements have been made. If you cannot make full payment at the time of service, please discuss with our Front Office Coordinator.
- We accept cash, checks, Visa, MasterCard, Amex & Discover. There is a \$34 return check fee.
- If any portion of your account balance exceeds 60 days you may be responsible for the amount regardless of your insurance.

POWER OF ATTORNEY & MEDICAL RELEASE

THIS POWER OF ATTORNEY IS ONLY TO ALLOW US TO ENDORSE AND/OR SIGN ANY PAPER WHICH WILL ENHANCE OR EXPIDITE PAYMENT TO THE PROVIDER FOR SERVICES RENDERED, INCLUDING BUT NOT LIMITED TO A RELEASE OF MEDICAL RECORDS AND ASSIGNMENT OF BENEFITS OR AUTHORIZATION FOR YOUR INSURANCE/ATTORNEY TO PAY FOR YOUR SERVICES

Know by all these present that: The undersigned has made, constituted & appointed, and by these present does hereby make, constitute & appoint Royal Palm Beach Rehab. Corp. and any of it's duly authorized agents and employees as to be the undersigned's true & lawful attorney for & in the undersigned's name, place & stead to endorse any/all checks, drafts or money order which are made payable to the undersigned alone or to the undersigned and said Royal Palm Beach Rehab. Corp. when which checks, drafts or money orders are made payable for services which have been rendered by Royal Palm Beach Rehab. Corp. at the request or with the knowledge and approval of the undersigned and/or the make of the check, draft or money order. Furthermore, the undersigned allows Royal Palm Beach Rehab. Corp. or any of its agents to sign any paper that will be necessary to enhance, expedite and/or allow payment to said provider. This may include insurance forms and/or other forms.

The undersigned by these present does give & grant the said Royal Palm Beach Rehab. Corp. as attorney the full power and authority to do and perform all & every act whatsoever requisite & necessary to be done in & about the premises as fully to all intents & purposes as the undersigned might or could do it personally insofar as the endorsing & cashing of said checks are concerned as well as any other document.

Medical Release

A photocopy of this document shall be sufficient to authorize any person having records of medical treatment, services or supplies pertaining to me, the patient, to release true copies of the same to Royal Palm Beach Rehab. Corp. or any insured providing the coverage to me in connection with the process of any claim for benefits made by me or by the assignee herein. A photocopy of the document shall be as binding as an original signature page. The undersigned does hereby ratify and confirm and all actions taken by the said attorney in accordance with this special power and which the said attorney shall do or cause to be done by virtue of these present.

Assignment of Benefits

I, _____, hereby authorize _____
(Name of Insured/Patient) (Name of Insurance Carrier)

To make payable directly to: Royal Palm Beach Rehab. Corp.
Payable & mailed directly to: 4971 Le Chalet Blvd. Suite 100 Boynton Beach, FL 33436

The medical benefits otherwise payable to me for their services but not to exceed the charges of those services. I hereby IRREVOCABLY ASSIGN to Royal Palm Beach Rehab. Corp. any right & benefits under any policy of insurance, indemnity, agreement or any other collateral sources as defined in Florida Statutes for any services and/or charges provided by Royal Palm Beach Rehab. Corp.

IN WITNESS WHEREOF the undersigned have hereunto set their hands, this _____ day of _____.

Signature of Patient (parent/guardian, if minor) _____ Date: _____

Patients Name (Please Print): _____

Insurance

We accept Medicare, all major insurances and numerous PPO & managed care contracts. Please be aware that some and perhaps all, of the services provided may be considered not medically necessary by your insurance provider. You will be responsible for these charges.

Your medical insurance is a contract between you and your insurance company. We are not a party to this contract. Royal Palm Beach Rehab. Corp. will submit all claims for charges to your insurance provider as a service to you. Co-pays must be paid at the time of service in order to abide by your insurance contract. If your policy requires a referral, be sure to have it with you when you come to our office. Failure to obtain & present a referral at the time of service may result in a loss of your insurance benefits. If you need assistance in obtaining a referral please ask our Front Desk Coordinator.

Physical Therapy Institute and Aquatic Rehab Inc-Financial Policy/Assignment of Benefits

Thank you for choosing Physical Therapy Institute and Aquatic Rehab Inc as your rehabilitation provider. We will work closely with you and your physician to provide you with successful treatment. Please understand that timely payment for your treatment is important. Your clear understanding of our financial policy is important to our professional relationship. Our financial policy is as stated:

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Know by all these present that: The undersigned has made, constituted & appointed, and by these present does hereby make, constitute & appoint Physical Therapy Institute and Aquatic Rehab Inc and any of it's duly authorized agents and employees as to be the undersigned's true & lawful attorney for & in the undersigned's name, place & stead to endorse any/all checks, drafts or money order which are made payable to the undersigned alone or to the undersigned and said Physical Therapy Institute and Aquatic Rehab Inc, when which checks, drafts or money orders are made payable for services which have been rendered by Physical Therapy Institute and Aquatic Rehab Inc. at the request or with the knowledge and approval of the undersigned and/or the make of the check, draft or money order. Furthermore, the undersigned allows Physical Therapy Institute and Aquatic Rehab Inc or any of its agents to sign any paper that will be necessary to enhance, expedite and/or allow payment to said provider. This may include insurance forms and/or other forms.

The undersigned by these present does give & grant the said Physical Therapy Institute and Aquatic Rehab Inc as attorney the full power and authority to do and perform all & every act whatsoever requisite & necessary to be done in & about the premises as fully to all intents & purposes as the undersigned might or could do It personally insofar as the endorsing & cashing of said checks are concerned as well as any other document.

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A photocopy of this document shall be sufficient to authorize any person having records of medical treatment, services or supplies pertaining to me, the patient, to release true copies of the same to Physical Therapy Institute and Aquatic Rehab Inc or any insured providing the coverage to me in connection with the process of any claim for benefits made by me or by the assignee herein. A photocopy of the document shall be as binding as an original signature page. The undersigned does hereby ratify and confirm and all actions taken by the said attorney in accordance with this special power and which the said attorney shall do or cause to be done by virtue of these present.

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Signature of Patient (parent/guardian, if minor) _____ Date: _____

Patients Name (Please Print): _____

Insurance

We accept Medicare, all major insurances and numerous PPO & managed care contracts. Please be aware that some and perhaps all, of the services provided may be considered not medically necessary by your insurance provider. You will be responsible for these charges.

Your medical insurance is a contract between you and your insurance company. We are not a party to this contract. Physical Therapy Institute and Aquatic Rehab Inc will submit all claims for charges to your insurance provider as a service to you. Co-pays must be paid at the time of service in order to abide by your insurance contract. If your policy requires a referral, be sure to have it with you when you come to our office. Failure to obtain & present a referral at the time of service may result in a loss of your insurance benefits. If you need assistance in obtaining a referral please ask our Front Desk Coordinator.

Notice of Doctor's Lien

Please sign and fax back to 561-791-9071.

TO: Attorney:

Royal Palm Beach Rehab
106 Ponce De Leon
Royal Palm Beach, FL 33411
561-791-9090
Fax: 561-791-9071

Re: Medical Reports & Doctor's Lien

I do hereby authorize the above doctor to furnish you, my attorney, with a full report of his/her examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was involved.

I hereby authorize and direct you, my attorney, to pay said doctor such sums as may be due and owing for his/her medical services rendered me by reason of this accident and by reason of any other bills that are due his/her office and withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect said doctor. And I hereby further give a lien on my case to said doctor against any and all proceeds of any settlement, judgment or verdict which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all medical and/or surgical benefits, including major medical, submitted by him/her for service rendered me and that this agreement is made solely for said doctor's additional protection. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee. If this account is assigned for collection and/or suit, collection costs and/or interest, and/or attorney fees and/or court costs will be added to the total amount due.

Date: _____

Patient's Name: _____

Witness: _____

Patient's Signature: _____

Acknowledgement of Attorney

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor above named. Any settlement of this claim without honoring this assignment/lien will cause you to be responsible to this office for payment. The prevailing party in any litigation resulting from enforcement of this lien shall be entitled to actual attorney's fees and court cost.

Date: _____ Attorney's Signature: _____

Attorney: Please date, sign and return one copy to the above doctor's office immediately.
Please keep one copy for your records.

PERSONAL INJURY PATIENT HISTORY

Name _____ Date _____

History

Date of Accident _____ Time of Accident _____ AM PM

_____ Neck Pain	Mild Moderate Severe	_____ Shoulder Pain R L	Mild Moderate Severe
_____ Low Back Pain	Mild Moderate Severe	_____ Headaches	Mild Moderate Severe
_____ Mid Back Pain	Mild Moderate Severe	_____ Knee Pain R L	Mild Moderate Severe

In your own words, describe how the accident happened _____

Were you wearing your seatbelt Yes No Did you see the Accident coming Yes No
Did you brace for the impact? Yes No I braced with my hands, I braced with my feet, Other
Did you strike anything within your vehicle at the time of impact Yes No Not Sure

If Yes, what _____

Did the seat back break? Yes No Describe any cuts or bruises _____
Immediately following the accident, how did you feel? Dizzy / Dazed Disoriented Confused Nervous
 Nauseous Upset Weak Shaken Up

Were you knocked unconscious? If so, for how long _____

Did you go to the Hospital? Yes No Which Hospital _____ When _____
How did you get to the Hospital? Ambulance Drove Myself Someone else drove me (who) _____
Were X-Rays taken at the Hospital? Yes No Prescribed Medication? Yes No What type _____

List any other Doctors you have seen as a result of this accident

Date _____ Dr. _____
Date _____ Dr. _____

Past History

Have you been involved in a previous Motor Vehicle Accident? Yes No Please Describe _____

Did you have any physical complaints before this accident Yes No Please Explain _____

Work Status

Occupation _____ Employer _____
Have you missed work Yes No Dates of Loss _____ Have you returned to work Yes No

Please list any restrictions you have been placed on: _____

What activities, if any, aggravate your condition at work _____