CITIMED®

Since 1998, CitiMED has been serving the medical needs of traumatic injury victims throughout Miami-Dade and Broward counties.

On any given day, accidents can happen and they often negatively impact our lives, health and ability to work. Our team of dedicated professionals, quality medical care, technologically advanced reporting systems, office locations and hours of operation are all specifically designed to conveniently and efficiently get our patients on the road to recovery and back to their regular routine.

PATIENT INTAKE FORM

Lorem ipsum dolor sit amet, consectetur adipiscing elit, sed do eiusmod tempor incididunt ut labore et dolore magna aliqua. Ut enim ad minim veniam, quis nostrud exercitation ullamco laboris nisi ut aliquip ex ea commodo consequat. Duis aute irure dolor in reprehenderit in voluptate velit esse cillum dolore eu fugiat nulla pariatur.

Information to be completed by
The Patient or Legal Guardian

Information to be completed by
The Medical Provider

Information to be completed by
The Attorney

EMERGENCY MEDICAL CONDITION ASSESSMENT

CHIMED®

This facility uses the following documentation for determination of a patient's status as it relates to injuries caused by a prior trauma and medical benefits due to an Emergency Medical Condition.

To be completed by **Patient**

Name	**Date of Injury**

I certify that I have had or that I am presently suffering from severe pain due to the motor vehicle accident specified in the date above.

☐ **YES** ☐ **NO**

Patient's Signature	**Today's Date**

To be completed by **Medical Provider**

☐ **This patient is determined to have an Emergency Medical Condition (EMC);**

A medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- Serious jeopardy to patient health.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

I. Diagnosis Of Medical Condition:

AS A MEDICAL PROVIDER, I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY PROFESSIONAL KNOWLEDGE.

(This information may be completed by a physician licensed under chapter 458 or chapter 459, a dentist licensed under chapter 466, a physician assistant licensed under chapter 458 or chapter 459, or an advanced registered nurse practitioner licensed under chapter 464)

Medical Provider

☐ **Vivian Padron Fajardo, APRN** ☐ **Yxiam Toledo, APRN** ☐ **Gerald Nickerson, PM&R**

☐ **Lourdes Rivera, APRN** ☐ **Eliza Burdier, APRN**

Medical Provider's Signature	**Today's Date**

CONFIDENTIAL PATIENT CASE HISTORY

CHIMED®

This questionnaire was designed to provide important facts regarding the history of your pain or condition. The information you provide will assist in reaching a diagnosis and determining the source of your problem. Please take the time and answer each question as completely as possible. Please sign each section.

Patient Information

Email Address	**Phone Number**	**Social Security #**	
First Name	**Middle Name** (Optional)	**Last Name**	
Mailing Address		**State**	**ZIP**
Birth Date	**Marital Status** ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOW ☐ SEPARATED		
Occupation	**Employer**	**Employer Phone Number**	

Health Information

What are the chief complaints for which you are seeking treatment?
(In order of importance with 1 being most importance)

1.	**2.**
3.	**4.**
5.	**6.**

Have you had this condition in the past? And for how long?

Is the condition interfering with your:

☐ WORK ☐ SLEEP ☐ DAILY ROUTINE OTHER _____

List any medications currently being taken:

1.	**2.**
3.	**4.**

CONFIDENTIAL PATIENT CASE HISTORY

CHIMED®

This questionnaire was designed to provide important facts regarding the history of your pain or condition. The information you provide will assist in reaching a diagnosis and determining the source of your problem. Please take the time and answer each question as completely as possible. Please sign each section.

Health Information (Continuation)

Are you pregnant? *If apply*

☐ **YES** ☐ **NO** ☐ **MAYBE**

List all treatments you have had for this problem and all health professionals that you are currently seeing. *If apply*

	Physician	Specialty	Treatment and approximated date of receiving it
1.			
2.			
3.			

Consent for Treatment

I hereby authorize your practice and whomever the doctor may designate as his assistant or to whom you refer me to for diagnostic testing to perform medical examinations, provide physical therapy, draw blood, and perform non-invasive diagnostic tests and, if any unforeseen condition arises in the course of the procedures calling for judgment, perform procedures in addition to or different from those normally performed. I further request and authorize this office to perform whatever my treating doctor deems advisable. The nature and purpose of these procedures and risks involved and the possibility of complications have been fully explained to me. I acknowledge that no guarantee has been made to me as to the result that may be obtained.

Printed Name

Patient's Signature	**Today's Date**

CHIMED®

Please check the following conditions which apply to your medical history.

Medical Conditions

Allergies

☐ HAY FEVER ☐ FOOD ALLERGIES _____ ☐ ALLERGIC TO _____

Artificial Implants

☐ HEART PACE MAKER ☐ HEART VALVE ☐ JOINT REPLACEMENT _____

☐ OTHER _____

Arthritis

☐ GOUT ☐ OSTEOARTHRITIS _____ ☐ RHEUMATOID DISEASE

☐ OTHER _____

Blood Disorders

☐ ANEMIA ☐ BLEEDING EASILY ☐ HEMOPHILIA ☐ LEUKEMIA ☐ SICKLE CELL ANEMIA

☐ OTHER _____

Endocrine Disorders

☐ DIABETES ☐ HYPOGLYCEMIA ☐ PARATHYROID DISEASE ☐ THYROID DISEASE

☐ OTHER _____

Heart/Circulatory Disorders

☐ ARTERIOSCLEROSIS ☐ CONGENITAL HEART DISEASE ☐ CORONARY ARTERY DISEASE

☐ HEART MURMUR ☐ HEART PALPITATIONS ☐ HIGH BLOOD PRESSURE

☐ POOR CIRCULATION ☐ RHEUMATIC FEVER ☐ LOW BLOOD PRESSURE

☐ OTHER _____

CONTINUES (1/3)

Please check the following conditions which apply to your medical history.

Medical Conditions

HIV Disorders

☐ TESTED HIV POSITIVE ☐ AIDS ☐ OTHER _____

Liver Disease

☐ CIRRHOSIS OF THE LIVER ☐ HEPATITIS A (INFECTION) ☐ HEPATITIS B (SERUM)

☐ OTHER _____

Kidney/Urinary Disorders

☐ BLADDER INFECTIONS ☐ BLOOD IN URINE ☐ KIDNEY DISEASE ☐ SUGAR IN URINE

☐ OTHER _____

Lung/Respiratory Disorders

☐ ASTHMA ☐ CHRONIC COLDS ☐ EMPHYSEMA ☐ FREQUENT COUGHS

☐ LUNG CANCER ☐ SHORTNESS OF BREATH ☐ TUBERCULOSIS ☐ OTHER _____

Muscle Disorders

☐ MUSCULAR DYSTROPHY ☐ MUSCLE SHAKING (TREMORS) ☐ MUSCLE SPASMS OR CRAMPS

☐ OTHER _____

Nerve Disorders

☐ CEREBRAL PALSY ☐ EPILEPSY ☐ NEURALGIA

☐ MULTIPLE SCLEROSIS ☐ PARKINSON'S DISEASE ☐ HIGH BLOOD PRESSURE

☐ POOR CIRCULATION ☐ RHEUMATIC FEVER ☐ STROKE

☐ OTHER _____

CONTINUES (2/3)

Please check the following conditions which apply to your medical history.

Medical Conditions

Stomach/Intestinal Disoders

- ☐ CONSTIPATION
- ☐ FREQUENT DIARRHEA
- ☐ FREQUENT GAS
- ☐ GALLBLADDER PROBLEMS
- ☐ HEARTBURN
- ☐ ULCERS
- ☐ OTHER _____

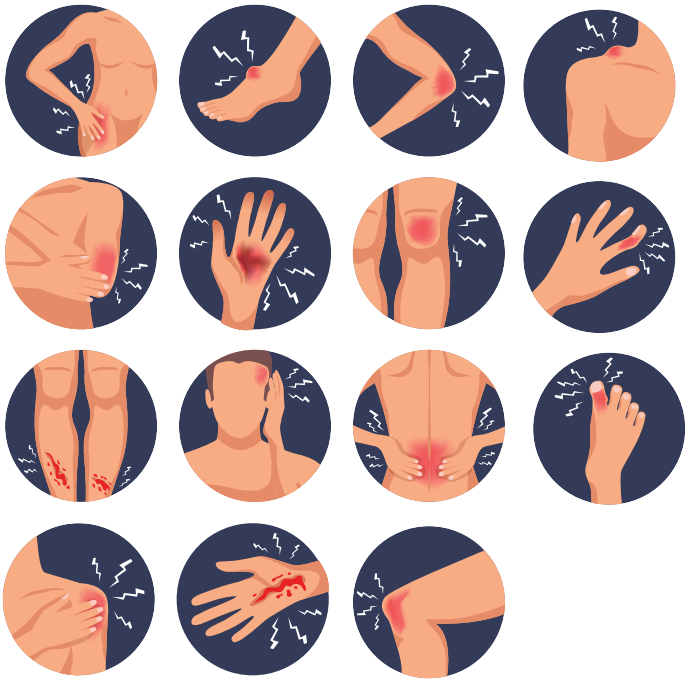
Other

- ☐ DIZZINESS
- ☐ BACKACHES
- ☐ HEART TROUBLE
- ☐ DIABETES
- ☐ ARTHRITIS
- ☐ OTHER _____

ENDS (3/3)

Areas of Pain

Please mark your areas of pain on figure



Family Health Information

Many health problems are the result of heredity; thus information about your family members will give us a better picture of your total health picture.

Please Think...

Is there anything else the doctor should know about you?

ACCIDENT INFORMATION

CHIMED®

Please read the statement below and sign in the section provided.

Accident Information (If you were involved in an accident or a traumatic incident, complete this section).

DATE OF ACCIDENT _____

What do you believe is the cause of your pain or condition? *If apply*

- ☐ A MOTOR VEHICLE ACCIDENT — DATE _____
- ☐ A MOTORCYCLE ACCIDENT — DATE _____
- ☐ A WORK RELATED ACCIDENT — DATE _____
- ☐ A SLIP & FALL — DATE _____
- ☐ ATHLETIC ENDEAVOR — DATE _____
- ☐ FIGHT — DATE _____
- ☐ OTHER TRAUMA _____ — DATE _____

Briefly describe the incident

_____

Printed Name

_____

Patient's Signature	**Today's Date**

INSURANCE INFORMATION

CHIMED®

Please read the statement below and sign in the section provided.

Insurance Information

Automobile Insurance	**Claim #**	**Policy #**
Name of the Insured	**Name of Adjuster**	
If you do not have your own automobile insurance, do you live with anybody who does? (If your answer is YES, please answer the following) ▼		
Name of the insured	**How are you related?**	
Name of insurance company	**Policy Number**	**Claim #**
Health Insurance	**Group #**	
Subscriber	**Group #**	
Name/Number	**Group #**	
Secondary Health Insurance	**Group #**	
Subscriber Name/Number	**Group #**	

Attorney Information

Name of Attorney	**Phone #**
Attorney's Address	

DISCLAIMERS

CITIMED®

Please read the statement below and sign in the section provided.

Authorization to Release Information

I authorize the release of a full Report of examination findings, diagnosis, treatment program, etc., to any referring or treating dentist or physician. I additionally authorize the release of any medical information to insurance companies or for legal documentation to process claims. I understand that I am responsible for all charges for treatment rendered to me regardless of insurance coverage.

Terms of Payment

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that CITIMED will prepare any necessary Reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to CITIMED will be credited to my account on receipt. 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, including any applicable deductibles and/or co-payments. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Power of Attorney

The undersigned has made, constituted and appointed, and by these presents does hereby-make, constitute and appoint CitiMed. and any of its duly authorized agents and employees to be the undersigned's true and lawful attorney for and in the undersigned's name, place and stead to endorse any and all checks, drafts or money orders which are made payable to the undersigned alone or to the undersigned and its agents which checks, drafts or money orders are made payable for services which have been made by any insurance company or collateral source provider at the request or with the knowledge and approval of the undersigned and/or the maker of the check, draft or money order. The undersigned does hereby ratify and confirm any 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 presents.

Patient's or Guardian's Signature	**Today's Date**

NOTICE OF INITIATION

CITIMED®

Notice of Initiation of Medical Treatment Pursuant to FLA. STAT. 627.736 and Notice of Assignment.

Patient Information

To all Insurance Carriers including	
Patient/Claimant	**Claim #**
Policy #	**Date of Accident**

Dear Sir/Madam:

Please be advised that this medical provider has agreed to accept the above patient's assignment of all of his/her rights under any and all insurance policies which may exist and may provide insurance coverage for the subject date of accident. Please read the attached assignment form carefully so as to comply with the terms of the assignment and to protect your rights. If a copy of the assignment form is missing or misplaced, please notify the undersigned immediately and a copy will be resent again.

Each and every PIP insurance company receiving this document is advised that Citimed is hereby giving notice pursuant to Fla. Stat. 627.736 of initiation of medical treatment within 21 days after first examination or treatment of the claimant.

By giving the aforementioned notice, the medical provider may bill for charges for treatment or services rendered up to, but not more than, 75 days before the postmark date of the billing statement.

Should you have any questions, please do not hesitate to contact the undersigned.

Very truly yours,

Billing Department
CITIMED

Enclosures

ASSIGNMENT OF BENEFITS

CITIMED®

Assignment of Benefits and Instructions to Insurance Carrier.

1. I hereby assign to CITIMED any and all rights and causes of action I may have under any insurance policy or collateral source agreement including but not limited to the above-referenced collateral source provider.

2. CITIMED and I further instruct my insurance company to cooperate with the above-captioned healthcare provider in resolving all medical billing matters. You are requested to do the following during the handling of this claim:

a. Provide pay-out sheets immediately upon payment of bills.
b. Investigate and pay directly to CitiMed all claims within thirty (30) days after receipt of billing.
c. Provide said healthcare provider with a prompt and reasonable explanation in writing of the basis in the insurance policy, in relation to the facts of the case or applicable law, for denial of a claim or for the offer of a settlement or payment or delay in payment past thirty (30) days from receipt of this notice.
d. Inform the health care provider promptly as to what additional information is necessary for processing of the claim.
e. Return all phone calls from the provider promptly.
f. Provide the medical provider with notice of each and every Independent Medical Examination (hereafter IME) and statement or Examination Under Oath (hereafter “EUO”) scheduled for me.
g. Provide to the medical provider with a copy of each and every IME, paper IME or paper review generated with respect to me as required by Fla. Stat. 627.736.
h. Timely notify CitiMed when applicable insurance policies have been exhausted of benefits.

These payment instructions are for benefits payable to me under my current insurance policy as payment toward the total charges for professional services rendered. I as the patient have agreed to remain personally liable for the amounts billed by the healthcare provider regardless of the amount paid by the insurance company unless ordered otherwise by a court of law. I further understand that said health services are being provided to me in consideration for an unconditional promise to pay and for me providing these instructions to my insurance company. I as the patient further agree to be liable for reasonable attorney's fees and costs incurred in collecting any delinquent accounts or unpaid balances. A photocopy of these instructions shall be considered as effective and valid as the original.

This Assignment may be re-assigned back to me only in the form of a written document that has been signed by myself and a representative of CITIMED.

Signature of Policyholder	**Today’s Date**

AUTHORIZATIONS

CITIMED®

Please read the statement below and sign in the section provided.

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 automobile personal injury protection law.

Disclosure Authorization

As consideration for my medical care, CITIMED (hereinafter referred to as “Medical Provider”) may be providing medical services to me pursuant to an Assignment of Benefits and/or a Letter of Protection. I acknowledge that pursuant to Florida Statute 627.736, any insurance company that covers my claim under personal injury protection benefits may pay up to either Two Thousand Five Hundred Dollars ($2,500) or up to Ten Thousand Dollars ($10,000) in medical benefits. This will depend upon whether or not I had an Emergency Medical Condition as defined in Florida Statutes. Further, I acknowledge that if I do not seek initial medical services within 14 days after a motor vehicle accident (if applicable), that personal injury protection insurance may not pay my claim.

I further acknowledge that in order for Medical Provider to be fully and fairly compensated for services, it may need to collect any outstanding balances from a third party claim that I may have. In doing so, I instruct my attorney to be fully candid and disclose to Medical Provider any relevant information that may be pertinent prior to resolving my case (whether said case is resolved either by a settlement or as a result of litigation). Said information may include, but not be limited to a proposed closing statement, an executed closing statement, and copies of any settlement checks and/or any other information that Medical provider requests. I understand that I may be responsible for any outstanding balance of Medical Provider, and therefore, it is in my best interest for my attorney to utilize good faith negotiations with Medical Provider and enter into a written agreement that resolves my outstanding balance as full and final.

Patient’s Signature	**Email Address**	**Today’s Date**

LETTER OF PROTECTION (PAGE 1 OF 2 – FOR PATIENT)

CITIMED®

Please read the statement below and sign in the section provided.

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

I irrevocably authorize and direct you, my attorney, to pay directly to CITIMED ("Provider") such sums as may be due and owing for medical services rendered to me both by reason of this accident and by reason of any other bills that are due to the provider and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate said doctor. I hereby further give a lien on my case to said Provider against proceeds from my settlement, judgment or verdict which may be paid to any party or myself, as the result of the injuries for which I have been treated by Provider. This lien shall be satisfied prior to any disbursement of any proceeds. If the aforementioned date of accident is not accurate, I acknowledge the scrivener error and I will not contest this Letter of Protection on those grounds.

I fully understand that I am directly and fully responsible to said Provider for all medical bills submitted by Provider for services rendered to me including but not limited to any applicable deductibles and co-pays as per my insurance policy and that this agreement is made for said Provider's protection and in consideration of the provider awaiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee. I authorize and instruct my attorney to disclose any third party settlement offers/amounts on my case and any other outstanding balances/agreed amounts for other medical providers to Provider. If any settlement, judgment, or verdict is reached on my case, then I instruct my attorney to pay these medical bills to said Provider after receipt of any recovered funds. I agree to promptly notify said Provider of any change or addition of attorney(s) used by me in connection with this accident, and I instruct my attorney to do the same. In the event that my case is referred to another attorney, I acknowledge that this Letter of Protection must be accepted by the new attorney, otherwise the obligations of this Letter of Protection rest with me.

I agree that this document will remain binding even if it lacks the signature of my attorney. I further acknowledge that in the event my attorney signs a copy of this Letter of Protection with my signature affixed or if two separate Letters of Protection are signed, one by myself and the other by my attorney, each shall be read as incorporating the original signature of the other.

Patient Information

Print Name	**Date of Accident**
Patient's Signature	**Today's Date**

Please read the statement below and sign in the section provided.

The undersigned being attorney of record for the above patient does hereby agree to observe all of the above terms and agrees to withhold funds from any recoveries made arising from or relating to the aforementioned accident that are necessary to compensate. ("Provider"). I agree to provide Provider with third party insurance information, including BI/UM carrier coverage amounts, and I will forward to provider any third party settlement offers in writing in addition to other medical providers negotiated balances. I will request a balance confirmation when a recovery is imminent and will use best efforts to either pay Provider in full or negotiate with the Provider in good faith in order to resolve any outstanding balances.

I, furthermore, understand and agree to notify Provider in writing should there occur a substitution of counsel, referral to another attorney or law firm, and retention of co-counsel or should the attorney/client relationship be terminated or modified in any manner.

Attorney Information

Print Name	
Attorney's Signature	**Today's Date**

APPLICATION FOR FLORIDA "NO FAULT" BENEFITS (PAGE 1/2) CHIMED®

To enable us to determine if you are entitled to beneftis 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.**

Insurance and Accident Information

Insurance Company	**Today's Date**	**Our Policy Holder**
Your Full Name		**Phone #** ☐ HOME ☐ BUSINESS
Your Address (No, street, city or town, state and ZIP code)		**DOB** / **SS#**
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?
☐ YES ☐ NO

▶ If your answer is YES, please complete the rest of this form on next page. If NO, just sign below.

Important:

1. To be eligible for benefits, please complete and sign this application.
2. Sign and attach authorization(s).
3. Return promptly with any medical bills you have received to date.

Signature	**Today's Date**

APPLICATION FOR FLORIDA "NO FAULT" BENEFITS (PAGE 2/2) CHIMED®

Continuation.

Injuy and Employer Information

Describe your Injury

Were you treated by a doctor? ☐ YES ☐ NO	**Doctor's Name and Address** (If apply)
If you were treated in a hospital, were you: ☐ AN IN-PATIENT ☐ AN OUT-PATIENT	**Hospital's Name and Address** (If apply)
Amount of Medical Bills to date	**Will you have more medical expense?** ☐ YES ☐ NO ☐ NOT SURE
At the time of your accident, were you in the course of your employment? ☐ YES ☐ NO	**Did you lose wages or salary as a result of your injury?** ☐ YES ☐ NO **If YES, enter amount of loss to date.** _____ **What is your average weekly wage?** ▸ _____
Date disability from work began (If you lost wages)	**Date you returned to work**

Have you received, or are you elegible for, payments under any workmen'scompensation or employment law? ▸ ☐ YES ☐ NO

If YES, enter amount _____ ☐ PER WEEK ☐ PER MONTH

List names and address of your present employer(s) and provide your occupation and dates of empployment.

Employeer Name and address	Your Occupation	From	To
Employeer Name and address	Your Occupation	From	To
Employeer Name and address	Your Occupation	From	To

As a result of your injury, have you had any other expenses?

☐ YES ☐ NO EXPLAIN _____

Signature	**Today's Date**

AUTHORIZATIONS

CITIMED®

Please read the statement below and sign in the section provided.

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.)

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.)

Acknowledgement of Receipt of Notice of Privacy Practices

I HAVE RECEIVED A COPY OF THE NOTICE OF PRIVACY PRACTICES FROM CITIMED. THE NOTICE DESCRIBES HOW MY HEALTH INFORMATION MAY BE USED OR DISCLOSED. I UNDERSTAND THAT I SHOULD READ IT CAREFULLY. I AM AWARE THAT THE NOTICE MAY BE CHANGED AT ANY TIME.

Print Name	**Signature**	**Today’s Date**

If the personal representative of the above individual, I acknowledge receipt of the Notice on his or her behalf.

Signature	**Relationship**	**Today’s Date**

AUTHORIZATION TO TREAT A MINOR

CITIMED®

Please read the statement below and sign in the section provided.

Authorization

I HEREBY AUTHORIZE THE DOCTORS AND THE STAFF OF CITIMED TO EXAMINE, TREAT, AND PERFORM ALL NECESSARY DIAGNOSTIC TESTING ON

_____

Patient Name

Parent/Guardian Print Name	**Signature**	**Today's Date**

Witness Print Name	**Signature**	**Today's Date**

CHIMED®

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**	**Today's 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
Pub. 1/2004

Standard Disclosure and Acknowledgement Form Personal Injury Protection - Initial Treatment or Service Provided.

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):

- ☐ **Vivian Padron Fajardo, APRN**
- ☐ **Yxiam Toledo, APRN**
- ☐ **Gerald Nickerson, PM&R**
- ☐ **Lourdes Rivera, APRN**
- ☐ **Eliza Burdier, APRN**

Name (Print or Type)	**Signature**	**Today's 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
Pub. 1/2004