SANDS CHIROPRACTIC CLINIC

MOTOR VEHICLE ACCIDENT REPORT

Name_____ Date of Acc:_____

Name Of Your Auto Insurance Company: _____

Policy # _____ Phone # Of Insurance Company _____

Contact Person _____ Phone#_____ Ext#_____

Name Of Your Attorney if applicable: _____ Phone # _____

Your Occupation:_____ Employer: _____

Was there an Accident Report Filed: __ Yes __ No

List Or Describe Your Injuries: _____

_____

_____

Check Any Of The Following That You Have Experienced Since The Accident:

___ Headaches	___ Double or Blurred Vision	___ Loss of Energy
___ Dizziness	___ Loss of Balance	___ Insomnia or Sleep Disorder
___ Confusion	___ Ringing in Ears	___ Weakness in Arms or Legs
___ Disorientation	___ Loss of Memory	___ Nervousness
___ Nausea	___ Loss of Appetite	___ Restlessness

Were you the: Driver ___ Front seat passenger ___ Back seat passenger ___ Other _____

Describe Where Your Vehicle Was Damaged _____

Were you Wearing a Seat Belt: Yes ___ No___ Did you see the Accident Coming: Yes ___ No ___

Were you Treated at the Scene by Emergency Personnel: Yes ___ No ___

Were you Transported by an Ambulance: Yes ___ No ___

Were you Treated at a Hospital: Yes ___ No ___ Name of Hospital:_____

What was done at the Hospital:_____

Have you Been Treated by any other Doctor's for this Accident: Yes ___ No ___

Names of Doctor's_____

Have you Missed Time From Work as a Result of this Accident: Yes ___ No ___

Have your Work Duties been Affected: Yes ___ No ___ How so _____

Have your Leisure Activities been Affected: Yes ___ No ___ How so: _____

I Certify The Above Statements To Be True And Accurate.

Patient Signature:_____ Date: _____

Assignment of Benefits

Patient/Claimant Name:_____

Policy Holder Name:_____

Claim No:_____ **Policy No:**_____

Date of Accident:_____ **Social Security No:**_____

1. I hereby instruct and direct that_____ Insurance Company pay by check monies owed for medical services rendered by **Charles T Sands, Jr., DC, or J. Peter Painter, DC.** Please make checks payable to **Sands Chiropractic Clinic** and mail them to 1701 N.E. 28 Street, Pompano Beach, FL 33064.

2. I further instruct my insurance company to cooperate with the above captioned healthcare provider in resolving all medical billing disputes. Cooperation includes, but is not limited to providing the following information.

   A. Providing a pay out sheet within thirty (30) days upon request.
   B. Investigating and paying all claims within thirty (30) days after receipt of billing.
   C. Providing 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 compromise settlement or payment or delay in payment past thirty (30) days from receipt of this notice.
   D. Informing the healthcare provider promptly as to what additional information is necessary for the processing of this claim within thirty (30) days from the receipt of this notice.

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 to the amounts billed by the healthcare provider regardless of the amount paid by the insurance company. I further understand that said healthcare 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.

By executing this document, I am placing my insurance company on notice that **this is a direct assignment of benefits** pursuant to Florida law. As the insured or beneficiary of said insurance policy, I am assigning whatever rights I have under my policy of insurance and under Florida law to this healthcare provider. A photocopy of these instructions shall be considered as effective and valid as the original.

_____ _____

SIGNATURE OF POLICYHOLDER OR CLAIMANT 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 these 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.