Innovative Back Solutions
100 SW 75th ST.
Suite 203
Gainesville, Fl 32607

NOTICE OF INITIATION OF TREATMENT

Name of Insured:

Name of PIP Insurer:

Claim #:

Pursuant to Florida Statute 627.736(5)(c)1., you are hereby notified that treatments on your insured, _____,was initiated on_____ for injuries sustained in an automobile crash on_____.

_____
Robert Ruano, D.C.

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	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 (15) and (16), 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 *(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 (11)(a), Florida Statutes.

Note: The original of this form must be furnished to the insurer pursuant to Section 627.736(6)(b), Florida Statutes and may not be electronically furnished. Failure to furnish this form may result in non-payment of the claim.

CP1F044

10010200910301J .00100001400050130011642

1. What was the date of the accident?_____

2. What time did the accident occur?_____

3. How many vehicles were involved in the accident?_____

4. What was the estimated damage to the vehicle you were in? _____

5. What state did the accident occur in? _____

6. What city did the accident occur in? _____

7. What street or intersection were you on when the accident occured? _____

9. What type of impact was the auto accident? _____

10. Did your vehicle hit anything after the accident? if yes, please describe
_____

11. Where were you sitting in the vehicle during the accident?
_____

12. Did you know the accident was coming?_____

13. What type of vehicle were you in? _____

14. What type of vehicle impacted yours? _____

15. At the time of the impact, how fast was your vehicle moving? _____

16. At the time of impact, how fast was the other vehicle moving? _____

17. During and after the crash what happened to your vehicle? (circle all that apply)
- kept going straight
- kept going straight hitting a car in front
- was hit by another vehicle
- spun around
- spun around and hit a stationary object
- hit a stationary object

18. Did you lose consciousness during the accident? -yes - no

19. How was your head positioned during the accident? _____

20. How was your torso positioned during the accident? _____

21. How were your hands positioned during the accident? _____

22. Did your head hit anything during the accident? -no - yes, please describe_____

23. Did your face hit anything during the accident? -no - yes, please describe_____

24. Did your shoulders hit anything during the accident? -no - yes, please describe_____

25. Did your neck hit anything during the accident? -no - yes, please describe_____

26. Did your chest hit anything during the accident? -no - yes, please describe_____

27. Did your hips hit anything during the accident? -no - yes, please describe_____

28. Did your knees hit anything during the accident? -no - yes, please describe_____

29. Did your feet hit anything during the accident? -no - yes, please describe_____

30. What kind of headrest was in your vehicle?
- movable fixed headrest
- nonmovable fixed headrest
- no headrest

31. Where was the headrest positioned on your head? _____

32. Did you have your seatbelt on during the accident? - yes -no

33. Did you slide out of your seatbelt during the accident? _____

34. What was damaged in your vehicle? (Circle all that apply)

- windshield	- rear bumper	- mirror
- steering wheel	- front bumper	- knee bolster
- dashboard	- trunk	- back right door
- seat frame	- front left door	- completely totalled
- side window	- front right door	
- rear window	- back left door	

35. Choose the items that dented inward
- floorboards - side door - dashboard

36. Choose the doors that would not open as a result of the accident
- front left - front right
- rear left - rear right

37. Did you go to the hospital? If no, why and do not answer 38-43
_____

38. How did you get to the hospital? _____

39. What was the name of the hospital? _____

40. Were you hospitalized over night? _____

41. Circle what you were prescribed at the hospital
- pain medication - muscle relaxors - neck brace

42. Did you recieve any stitches for any cuts at the hospital? _____

43. Were x rays taken at the hosiptal? If yes, which area was taken?
_____

44. Your Auto Insurance Company_____

45. Your Claim #_____

46. Your Adjustors name and phone #_____

47. Who was at fault?_____

48. The other drivers insurance and their claim #_____

49. Do you have additional Health Insurance?_____

PIP INSURANCE COVERAGE / INFORMATION

Patients Name:_____ DOB:_____

Policy Holder's Name : _____

Relationship:___Self___Spouse___Child___Owner of Car___Driver___Passenger

Policy Number:_____ Effective Date:_____

Insurance Company Name:_____

Claims Address:_____

City, State, Zip:_____

Date of Accident:_____

Ins Phone#:_____ Ins Fax #:_____

Claim #:_____

Adjuster's Name:_____ Ext:_____

Attorney Name:_____ Phone #:_____

Address:_____ City, St, Zip:_____

Pt Have Health Insurance: YES NO (if yes, please provide the following...)

Health Insurance Name_____ Policy #:_____

Group #:_____ Phone #:_____

Was the other driver at fault? YES or NO **Other Driver's Info**

Insurance Company Name:_____

Phone #:_____

Claim Number:_____

OFFICE USE ONLY

Deductible Amt:_____ Once Met, Payment At_____% Med Pay: YES or NO

Third party liability case pending? YES or NO *Lien Sent? YES or NO Lien Returned? YES or NO