S&F ***PIP*** ***WC*** ***LOP*** Initial Visit: _____

Patient Name: _____

Date of Accident: _____

Insurance: _____

IF PIP:

Address: _____

Driver ___ Passenger ___ Pedestrian

_____

Name of Insured: _____

Attorney: _____

Claim#: _____

Address: _____

Policy#: _____

_____

Adjustor: _____

_____

Phone#: _____

Case Manager: _____

Phone#: _____

Policy Information:

Fax#: _____

Date called:

Email: _____

Effective Date:

Deductible: **Met? Yes No**

%Paid: **Med Pay? Yes No**

Notes and Forms:

Form	Date Sent		
NIT			
AOB			
D&A			
Dr Liens			
MRI			
Ortho			
Notes			
EMC			
PIP Suit			
F&F			

Notes:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

ARIES
PHYSICAL THERAPY

Notice of Initiation of Treatment

Date: _____

Patient: _____

Insured: _____

Date ofLoss: _____

ClaimNumber:_____

Policy Number: _____

Certified Mail Number: _____

Dear Claims Department,

Please be advised that our office has been consulted by and has begun rendering medical treatment to the above referenced patient, with the first date of treatmentoccurring on_____

Enclosed, please find a payment authorization in which the patient has directed you to send all payments for services rendered to **Aries Physical Therapy.** In accordance with statute 627.736 (5) (b), our office has 75 days to submit medical claims. Accordingly, please provide an updated PIP payout ledger to this office every thirty days. If there are any questions regarding this treatment, please notify the billing department at (305) 935-9599.

Sincerely,

Billing Department
Aries Physical Therapy

ARIES
PHYSICAL THERAPY

ASSIGNMENT OF BENEFITS

PATIENT:_____

The undersigned patient hereby assigns the benefits of insurance under their automobile insurance or any other insurance to **Aries Physical Therapy.** for services rendered to the undersigned patient and covered by Personal Injury Protection (P.I.P.) coverage or other insurance coverage under my insurance policy in accordance with Florida law.

This assignment includes, but is not limited to, all rights to collect benefits directly from the patient's insurance company for services that patients has received and all rights to proceed against patient's insurance company in any action if the insurance company fails to make payment of benefits when due.

_____ _____

Date Signature

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.**

_____

_____

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):***

Dr.

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.

ARIES
PHYSICAL THERAPY

PIP INTAKE FORM

Patient's Name: _____ DOB_ _ _ _ _ _

Address: _Tel. _ _ _ _ _ _ _ _

Dateofaccident: _ _ _ _ _ _ _ _ State of Accident: _____

Is there an attorney handling your case? Yes No

Attorney Name:_____

Firm Name: _____

Address: _____

Phone:_____Fax: _ _ _ _ _ _ _ _ _ _ _ _ _ _

Circle one: Auto Accident Slip & Fall Worker's Compensation

If **Auto Accident: Driver or ___ Passenger or_____Pedestrian**

A. If **an auto accident, did patient own an automobile at the time of the accident? Yes No**

If **Yes:** Name ofInsurance Company: _____

Adjustor's name and phone#: _____

Claim # _ _ _ _ _ _ _ _ _ _ _ _ _ _ Policy # _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

If No:

B. Did patient reside with any resident relatives (RR)? Yes _____ No ___

Name of resident relatives: _____

RR Insurance Company:_____

Adjustor's name & phone#: _____

Claim#_____Policy#_____

C. If patient does not own a vehicle and does not reside with any relative:

Name of vehicle owner: _____

Nameof Insurance Company:_____

Adjustor's name & phone#:_____

Claim#_____Policy#_____

ARIES
PHYSICAL THERAPY

DOCTOR'S LIEN

TO: Attorney/ Insurance Carrier

_____

_____

_____

Doctor

_____

_____

_____

RE: Patient records and doctor's lien for: _____

I do hereby authorize the above doctor to furnish you, my attorney/ insurance carrier, with a full report of his case history, examination, diagnosis, treatment, and prognosis of myself in regard to my accident/ illness which occurred/ began on_____

I hereby give a lien to said doctor on any settlement, claim, judgment, or verdict as a result of said accident/ illness, and authorize and direct you, my attorney/ insurance carrier, to pay directly to said doctor such sums as may be due and owing him services rendered to me, and to withhold such sums from such settlements, claim, judgment, or verdict as may be necessary to protect said doctor adequately.

I fully understand that I am directly, personally and fully responsible to said doctor for all chiropractic bills submitted by him for services rendered to me, and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, claim, judgment, or verdict by which I may eventually recover said fee.

_____
Date

_____
Patient's Signature

_____
Print Name

The undersigned, being attorney ofrecord for the above patient, or authorized representative of insurance carrier for the above patient does hereby acknowledge receipt of the above named doctor. I agree to pay **Aries Physical Therapy** all funds owed prior to distributing any money to the above patient.

_____
Date

_____
Authorized Signature

_____
Print Name

Notice: Please date, sign and return one copy to doctor's office at once. Keep one copy for your records. Reply envelope attached.

ARIES
PHYSICAL THERAPY

DOCTOR'S LIEN

TO: Attorney/ Insurance Carrier

_____

_____

_____

Doctor

_____

_____

_____

RE: Patient records and doctor's lien for: _____

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Date

_____
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_____
Print Name

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_____
Date

_____
Authorized Signature

_____
Print Name

Notice: Please date, sign and return one copy to doctor's office at once. Keep one copy for your records. Reply envelope attached.

ARIES
PHYSICAL THERAPY

HARDSHIP AGREEMENT

Date: _____

To whom it may concern:

By my signature below, I am requesting that my doctor reduce normal and customary fees charged so as to allow me to receive chiropractic care. My financial circumstances are such that if I were to pay customary fees charged, I would be forced (due to economic reasons) not to receive care.

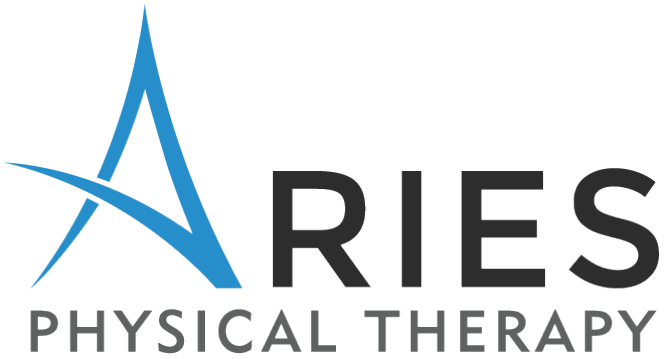
I recognize that any agreement made to assist me is purely confidential and that my fee arrangement would be different than which is standard in the office.

If my insurance company demands full payment of the deductible or co-payments, I agree that it is my responsibility to notify my insurance carrier that due to economic hardship, I am only making partial payment.

Patient's Name (Please Print): _____

Patient's Signature: _____

Witness Name (Please Print): _____



AUTHORIZATION FOR RELEASE OF INFORMATION

Section A: Must be completed for all Authorizations

I hereby authorize the use of disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the release information may no longer be protected by federal privacy regulations.

Patient Name:_____ **ID Number:** _____

Persons/Organizations providing the information:

_____
_____
_____
_____

Person/Organizations receiving information:

_____
_____
_____
_____

Specific description of information (including dates(s)):

_____
_____
_____
_____

Section **B: Must be completed only** if **a health plan or health care provider has requested the authorization**

1. The provider must complete the following statement:
   Will the healthcare provider requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above? Yes_____ No_X_

2. The patient must read and initial the following statement:
   I understand that I get a copy of this form after I sign it. Pt. Initials:

Section C: Must be completed for all authorizations:

The patient or the patient's representative must read and initial the following statements:

1. I understand that this authorization **will** expire on __/__/___. Pt. Initials:

2. I understand that I may revoke this authorization at any time by notifying the practice in writing, but if I do it won't have any affect on any actions they took before they received the revocation. Pt. Initials:

_____ _____
Signature of Patient or Patient's representative **Date**

Printed name of patient's representative:_____
Relationship to the patient:_____

·YOU MAY REFUSE TO SIGN THIS AUTHORIZATION*