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.

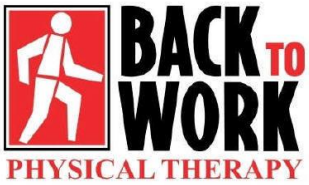
D. The coding of procedures on the accompanying statement or bill is proper. This means that **no service has been upcoded, unbundled**, or constitutes an invalid **or not medically necessary diagnostic test** as defined by Section 627.732(14) and (15), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Licensed Medical Professional Rendering Treatment/Services or Medical Director, if applicable *(Signature by his/ her **own hand**):*

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.



*****FOR AUTO INJURY PATIENTS ONLY****

DIRECT PAYMENT AUTHORIZATION WITH ASSIGNMENT Of BENEFITS

This agreement allows me, the named patient/insured to be treated by Back To Work Physical Therapy, without paying for my care and treatment in advance. The company above will be paid within 30 days of submission of claims for my care directly by my Personal Injury Protection carrier. This mutual consideration is considered good and sufficient by the parties. I hereby guarantee full payment to the above companies and agree that I will remain personally responsible for any unpaid charges. I also grant the above companies a lien against any recovery which I may have now or in the future against any tortfeasor or any responsible insurance carrier. I promise to sign a Letter of Protection in favor of the above companies and I hereby direct that any attorney representing me now or in the future execute a letter of protection in favor of the above companies. I hereby authorize and direct you, my personal injury protection insurance company or companies, to pay directly to the above companies, my personal injury benefits are for care and treatment rendered to me by the above companies. I am assigning my personal injury protection benefits rights including but not limited to the right to file legal suit to collect benefits under my personal injury protection policy. If any portion of this document is deemed to be inconsistent with an assignment of rights and benefits within the meaning of Florida Statutes 627.736, said portion shall be rewritten to conform with Florida law to give full effect to the intended purpose of this agreement, said intended purpose being to create an assignment of rights and benefits from the below named patient/insured to the above companies. I authorize and direct my present or future attorneys and my personal injury protection insurance companies to release medical and legal information to the named above companies.

_____

Patient Name (PRINT)

_____ _____

Signature of Patient or Legal Guardian Date