Synergy Wellness Clinic Motor Vehicle Accident Questionnaire

Patient's Name: ________________________________ Date of Accident: ____________ Date: ______________

PAST Medical History (Please complete the following by checking Yes or No. If Yes, describe in the space provided.)
Broken Bones: Yes No If yes, please describe ____
Knocked Unconscious: Yes No If yes, please describe ____
Previous Falls: Yes No If yes, please describe ____
Previous Auto or Work Injuries: Yes No If yes, please explain ____
Hospitalization: Yes No If yes, please explain ____
Surgery(s): Yes No If yes, please explain ____
Current or Prior Disease(s): Yes No If yes, please explain ____

History of PRESENT Accident & Injury (Please complete the following by circling all that apply)
Were you the: Driver Front Seat Passenger Back Seat Passenger Pedestrian On the job
Description of vehicle you were involved? Make _______________ Model _______________ Year ____________
Were you traveling: North South East West or a Combination ________
On what road/street were you traveling? ____
Was the car stopped at the time of the accident? Yes No
Was vehicle moving at the moment of impact? Yes No If yes, was car Slowing down, Accelerating, or Steady speed
Estimated rate of speed: _______ MPH Time of accident: ___________
Did your vehicle hit other vehicles? Yes No Where? ___________________________
Did other vehicles hit your vehicle? Yes No Where? ___________________________
Seatbelt: Worn, Not Worn, or Don't know
Air Bag Deployed: Yes No NA
Body Position at moment of impact: Leaning back, Seated erect, Leaning forward, Turned, Don't know, or Other _______
Head Position at moment of impact: Forward, Right, Left, Back, Don't know, Other _____
Aware of Crash: Aware or Surprised Did you brace yourself? Yes No If yes, with: arms, legs, or both arms and legs
Were you wearing prescribed glasses or contact lenses at time of accident? Yes, No, Can't remember, or NA

Did your body strike any interior part of the car? Yes No If yes, please complete all that apply:
My Head Hit ___________________________ My Right Left Shoulder Hit __________________________
My Chest Hit ___________________________ My Right Left Arm Hit______________________________
My Right Left Hip Hit ___________________ My Right Left Knee Hit _____________________________
My Right Left Leg Hit ___________________My Other _______ body part hit _______________________

After Crash
Did you lose consciousness or pass out? Yes No If yes, unconscious for _____________ (unit of time)
After the accident, I had: Headache Dizziness Nausea Vomiting Confusion Neck Mid Back and/or Low Back Pain
Symptoms first appeared: Immediately _______ min/hours after the accident Next Day _______ Days after the accident
Was the accident reported to the police? Yes No
Did you receive paramedic attention? Yes No If yes, what was done?____
After the accident, I went: Home Work Hospital Family Physician Other ___________________________________
If you went to the hospital after the accident, do you have hospital papers with you? Yes No. If not, please complete the following:

- Name of Hospital ____
- How did you get there? Ambulance Relative ___________ Friend ___________ Other __________________
- Did you sustain any broken bones Yes No If yes, which one(s): ______________________________________
- Did you sustain any bleeding cuts during the accident? Yes No If yes, please describe: ___________________
- Did you sustain any bruises after the accident? Yes No If yes, please describe __________________________
- What body parts were x-rayed? ____
- Were you prescribed: Pain pills Muscle Relaxers NSAIDS (Anti-inflammatory) Other ____________________

Did you report the accident to your insurance company? Yes No

INFORMED CONSENT

PATIENT NAME: ____

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment.
The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment
As a part of the analysis, examination, and treatment, you are consenting to the following procedures:

___ spinal manipulative therapy	___ palpation	___ vital signs
___ range of motion testing	___ orthopedic testing	___ basic neurological testing
___ muscle strength testing	___ postural analysis	
___ ultrasound	___ hot/cold therapy	___ EMS
___ radiographic studies		
___ Other (please explain)		

____

____

Patient should initial each procedure they are consenting to.

The material risks inherent in chiropractic adjustment.
As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring.
Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options.
Other treatment options for your condition may include:
- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- Surgery

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

INFORMED CONSENT

The risks and dangers attendant to remaining untreated.
Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.
PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Gustavo Marshall and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated: ______________

____
Patient's Name

____
Signature

____
Signature of Parent or Guardian (if a minor)

Dated: ______________

____
Doctor's Name

____
Signature

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AT SYNERGY WELLNESS CLINIC AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY BEFORE SIGNING.

1. OUR PLEDGE REGARDING YOUR HEALTH INFORMATION

The privacy of your health information is important to us. We understand that your health information is personal and we are committed to protecting it. We create a record of the care and services you receive at Synergy Wellness Clinic. This record is needed to provide you with the best quality care possible and to comply with certain legal requirements. This notice will tell you about the ways we may use and share healthcare information about you. We also describe your rights and certain duties we have regarding the use and disclosure of your private healthcare information.

2. OUR LEGAL DUTY

The Law requires us to:

1. Keep your healthcare information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your healthcare information.
3. Follow the terms of this current notice.

We have the right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all protected health information (PHI) that we keep, including information previously created or received before the changes took effect.

3. HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

The following section describes different ways that we use and disclose your protected health information (PHI). Not every use or disclosure will be listed. However, we have listed all the different ways we are permitted to use and disclose your PHI. We will not use or disclose your PHI for any purpose not listed below without your specific written authorization.

HIPAA

FOR TREATMENT

We may use health information about you to provide you with treatment or services. We may disclose health information about you to doctors, nurses, technicians, medical students, office staff or other personnel who are involved in taking care of you and your health. The doctor may use your health history to decide what treatment is best for you. The doctor may also tell another doctor about your health condition so that doctor can help determine the most appropriate care for you. Different personnel in our office may share information about you and disclose information to people who do not work in our office in order to coordinate your care, such as scheduling lab work and ordering diagnostic imaging.

FOR PAYMENT

We may use and disclose your health information for payment purposes. The treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company or a third party. The information on or accompanying the bill may include your health information. We may need to give your health plan information about a service you received here so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval, or determine whether your plan will cover treatment.

FOR HEALTH CARE OPERATIONS

We may use and disclose your health information for our health care operations. This may include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditations, certificates, licenses, and credentials we need to serve you better.

EMERGENCY NOTIFICATION

We may need to disclose your protected health information (PHI) to notify a family member, your personal representative, or another person legally responsible for your care in cases of emergency. We will share information about your location, general condition, or death.

AVERT SERIOUS THREATS TO HEALTH & SAFETY

We may use and disclose your protected health information (PHI) when necessary to prevent a serious threat to your health and safety or to the health of safety of the public or another person.

REQUIRED BY LAW

We will disclose your PHI when required to do so by federal, state, and local law.

DISASTER RELIEF

We may use, disclose, or share medical information about you with the Federal Emergency Management Agency (FEMA) or any other government assistance programs who can legally assist in disaster relief efforts.

PUBLIC HEALTH RISKS

As required by law, we may use and disclose your protected health information (PHI) to public health officials or legal authorities for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products. For example, we may disclose your PHI to persons subject to jurisdiction of the Food and Drug Administration (FDA) for the purposes of reporting adverse events associated with product defects or problems, to enable and track product recalls, repairs, replacements or distribution, or any other activity deemed necessary for the management of public health risks.

LAW ENFORCEMENT

We may release health information about you if asked to do so by a law enforcement official in response or pursuant to a court order, subpoena, warrant, summons or similar process, subject to all legal requirements. For example, law enforcement officials may request that we report suspected victims of crimes, fugitives, material witnesses, crimes on our premises, missing persons, and crimes in emergencies. We may share the PHI of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

CORONERS, MEDICAL EXAMINERS, & FUNERAL DIRECTORS

We may share the medical information of a person who has died with a coroner, medical examiner, and or funeral director. This may be necessary, for example, to identify a deceased person or determine the cause of death.

TREATMENT ALTERNATIVES

We may tell you about or recommend possible treatment options or alternatives that may be of interest to you.

HEALTH RELATED PRODUCTS & SERVICES

If you have a condition that requires the utilization of a certain health related product(s) and or service(s), we will inform you about these different products and services that may be of interest to you during your healing process. For example, if you have sustained an acute traumatic injury to your neck and or low back, we may offer a cervical collar and or a lumbar brace, respectively, for support. If you have a certain condition that could be complemented with nutritional supplements, we may prescribe specific vitamins, minerals, herbs, etc. to assist your body during the healing process.

NOTICE OF PRIVACY PRACTICES

RESEARCH
Our philanthropic commitment is to contribute to the efforts of scientific research in order to continually make technological advances in the state-of-the-art care of your health. For this reason, we may use and disclose your PHI for research projects that are subject to a special approval process. We will ask you for your permission if the researcher may have access to your name, address, or other information that reveals who you are and or be involved in your care.

MILITARY, VETERANS, NATIONAL SECURITY & INTELLIGENCE
If you are or were a member of the armed forces or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.

WORKERS' COMPENSATION
We may release health information about you when authorized or necessary to comply with laws relating to workers' compensation or other work related programs. These programs provide benefits for work related injuries and or illnesses.

LAWSUITS & DISPUTES
If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order, subpoena, discovery request, or other lawful process, subject to all applicable legal requirements and under certain circumstances.

HEALTH OVERSIGHT ACTIVITIES
We may disclose health information to a health oversight agency for audits, investigations, inspections, licensing, or disciplinary purposes authorized by law. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

APPOINTMENT REMINDERS
We may contact you as a reminder that you have an appointment for treatment.

4. YOUR INDIVIDUAL RIGHTS REGARDING YOUR HEALTH INFORMATION

You have the following rights regarding health information we obtain about you:

RIGHT TO INSPECT & COPY
You have the right to inspect and copy your health information, such as medical and billing records, that we use to make decisions about your care. You must submit a written request to our privacy official in order to inspect and/or copy your health information. If you request a copy of the information, we will charge you a fee of $1 per page and postage or other associated supplies if you want the copies mailed to you.

RIGHT TO AMEND
If you believe health information about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as this office keeps the information. To request an amendment, complete and submit a *Health Record Amendment / Correction Form* to our privacy official. We may deny your request if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- We did not create, unless the person or entity that created the information is no longer available to make the amendment.
- Is not part of the health information that we keep.
- You would not be permitted to inspect and copy.
- Is accurate and complete.

If we deny your request, we will provide a written explanation. You may respond with a statement of disagreement that may be added to the information you wanted changed.

RIGHT TO AN ACCOUNTING OF DISCLOSURES
You have the right to request an "accounting of disclosures." This is a list of all the disclosures we made of health information about you for purposes other than treatment, payment, and health care operations. To obtain this list, you must submit your request in writing to our privacy official. Your request should indicate in what form you want the list (for example, on paper, electronically, or by fax). We may charge you for the costs of providing the list. We will notify of the cost involved and you may choose to withdraw or modify your request at the time before any costs are incurred.

RIGHT TO REQUEST RESTRICTIONS OR LIMITATIONS
You have the right to request additional restrictions or limitations on the PHI we use and disclose about you about treatment, payment, or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had. We are not required to agree to these additional restrictions, but if we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you may complete and submit a *Request For Restricting Uses and Disclosures of PHI* to our privacy official.

RIGHT TO REQUEST CONFIDENTIAL COMMUNICATION
You have the right to request that we communicate with you about your health matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. Your request that we communicate your health information to you by certain means or by certain locations must be made in writing. To request confidential communications, you may complete and submit the *Confidential Communications Form* to our privacy official. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how and where you wish to be contacted.

Notice of Change to Privacy Practices:
We reserve the right to change this notice and make the revised notice effective for health information we already have about you as well as any information we receive in the future. Before we make an important change in our privacy practices, we will change this notice and post the new notice in the office with its effective date in the top right hand corner. You are entitled to a copy of the notice currently in effect.

QUESTIONS & COMPLAINTS

If you have any questions about this notice or if you believe your privacy rights have been violated, please contact us so that we may have an opportunity to resolve it. You may also submit a written complaint with the Secretary of the Department of Health and Human Services. You will not be penalized for filing a complaint.

PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received a copy of this Notice of Privacy Practices and I have been provided an opportunity to review it.

PRINT NAME ____ DOB ____________________________

SIGNATURE ____ DATE ____________________________

HIPAA

Synergy Wellness Clinic
138 NE 2 Ave, Suite 300 Miami, FL 33132
Office (305) 371-5775 Fax (305) 675-5797

DOCTOR'S LIEN

DOCTOR: Gustavo H. Marshall, DC

I fully understand that I am directly and fully responsible to Synergy Wellness Clinic, LLC and Gustavo Marshall, DC for all professional bills, submitted by him to third party payers for services rendered to me, that are not reimbursed by the third party payer or in the event that there is no settlement at all from any party.

I fully understand that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment for all the services provided to me. I hereby authorize Synergy Wellness Clinic and its doctor's access to the final settlement statement regarding this personal injury case.

I hereby authorize Synergy Wellness Clinic to furnish my insurance company and attorney with a full report of his examination, diagnosis, treatment, prognosis, etc. of myself in regard to the injury I have sustained from the accident.

I hereby authorize and direct my attorney to pay directly to Synergy Wellness Clinic such sums as may be due and owing to him for professional services rendered me both by reason of this accident and by reason of any other bills that are due to his office.

I hereby give a lien on my case to said doctor against any and all proceeds to any settlement, judgment or verdict which may be paid to my attorney or myself as a result of the injuries for which I have been treated or injuries in connection therewith.

______________________________ ________________
Patient's Signature Date

______________________________ ________________
Patient's Name Date of Loss/Accident

The undersigned, being the attorney of record for the above patient, does hereby agree to observe all terms of the above and agree to withhold such sums of money from any settlement, judgment or verdict as may be necessary to adequately protect the said doctor above.

______________________________ ________________
Attorney Signature Date

____
Attorney Name

Synergy Wellness Clinic, LLC

ASSIGNMENT OF INSURANCE BENEFITS, RELEASE, & DEMAND

Insurer and Patient Please Read the Following in its Entirety Carefully!

I, the undersigned patient/insured knowingly, voluntarily and intentionally assign the rights and benefits of my health/automobile Insurance, also known as Personal Injury Protection (hereinafter PIP), and Medical Payments policy of insurance to **Synergy Wellness Clinic** 138 NE 2ND Avenue Floor 3, Miami, FL 33132. I understand it is the intention of the provider to accept this assignment of benefits in lieu of demanding payment at the time services are rendered and that this document will allow the provider to file suit against an insurance company for payment of the insurance benefits. I understand the provider may file a lawsuit against my insurer for payment and if the provider's bills are paid or applied to a deductible I agree this will serve as a benefit to me and I authorize and request such litigation. This assignment of benefits includes the cost of transportation, medications, supplies, overdue interest and any potential claim for common law or statutory bad faith/unfair claims handling. If the insurer disputes the validity of this assignment of benefits then the insurer is instructed to notify the provider in writing within five days of receipt of this document. Failure to inform the provider shall result in a waiver by the insurer to contest the validity of this document. The undersigned directs the insurer to pay the health care provider directly without reductions & without including the patient's name on the check. To the extent the PIP insurer contends there is a material misrepresentation on the application for insurance resulting in the policy of insurance is declared voided, rescinded, or canceled, I, as the named insured under said policy of insurance, hereby assign the right to receive the premiums paid for my PIP insurance to this provider and to file suit for recovery of the premiums. The insurer is directed to issue such a refund check payable to this provider only. Should the medical bills not exceed the premium refunded, then the provider is directed to mail the patient/named insured a check which represents the difference between the medical bills and the premiums paid.

The insurer is directed by the provider and the undersigned to not issue any checks or drafts in partial settlement of a claim that contain or are accompanied by language releasing the insurer or its insured/patient from liability unless there has been a prior written settlement agreed to by the health provider and the insurer as to the amount payable under the insurance policy. The insured and the provider hereby contests and objects to any reductions or partial payments. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by the provider shall be done so under protest, at the risk of the insurer, and the deposit shall not be deemed a waiver, accord, satisfaction, discharge, settlement or agreement by the provider to accept a reduced amount as payment in full. The insurer is hereby placed on notice that this provider reserves the right to seek the full amount of the bills submitted. If the insurer schedules a defense examination or examination under oath (hereinafter "EUO") the insurer is hereby INSTRUCTED to send a copy of said notification to this provider. The provider or the provider's attorney is expressly authorized to appear at any EUO or IME set by the insurer. The health care provider is not the agent of the insurer or the patient for any purpose.

This assignment applies to both past and future medical expenses and is valid even if undated. A photocopy of this assignment is to be considered as valid as the original. I agree to pay any applicable deductible, co-payments, for services rendered after the policy of insurance exhausts and for any other services unrelated to the automobile accident. The health care provider is given the power of attorney to: endorse my name on any check for services rendered by the above provider; and to request and obtain a copy of any statements or examinations under oath given by patient.

Release of information: I hereby authorize this provider to: furnish an insurer, an insurer's intermediary, the patient's other medical providers, and the patient's attorney via mail, fax, or email, with any and all information that may be contained in the medical records; to obtain insurance coverage information (declaration sheet & policy of insurance) in writing and telephonically from the insurer; request from any insurer all explanation of benefits (EOBs) for all providers and non-redacted PIP payout sheets; obtain any written and verbal statements the patient or anyone else provided to the insurer; obtain copies of the entire claim file and all medical records, including but not limited to, documents, reports, scans, notes, bills, opinions, X-rays, IMEs, and MRIs, from any other medical provider or any insurer. The provider is permitted to produce my medical records to its attorney in connection with any pending lawsuits. The insurer is directed to keep the patient's medical records from this provider private and confidential and the insurer is not authorized to provide these medical records to anyone without the patient's and the provider's prior express written permission.

Demand: Demand is hereby made for the insurer to pay all bills within 30 days without reductions and to mail the latest non-redacted PIP payout sheet and the insurance coverage declaration sheet to the above provider within 15 days. The insurer is directed to pay the bills in the order they are received. However, if a bill from this provider and a claim from anyone else is received by the insurer on the same day the insurer is directed to not apply this provider's bill to the deductible. If a bill from this provider and claim from anyone else is received by the insurer on the same day then the insurer is directed to pay this provider first before the policy is exhausted. In the event the provider's medical bills are disputed or reduced by the insurer for any reason, or amount, the insurer is to: set aside the entire amount disputed or reduced; escrow the full amount at issue; and not pay the disputed amount to anyone or any entity, including myself, until the dispute is resolved by a Court. Do not exhaust the policy. The insurer is instructed to inform, in writing, the provider of any dispute.

Certification: I certify that: I have read and agree to the above; I have not been solicited or promised anything in exchange for receiving health care; I have not received any promises or guarantees from anyone as to the results that may be obtained by any treatment or service; and I agree the provider's prices for medical services, treatment and supplies are reasonable, usual and customary.

Caution: Please read before signing. Please ask to view a copy of our charges. If you do not completely understand this document please ask us to explain it to you. If you sign below we will assume you understand and agree to the above.

Patient's Name________________________ Signature __________________________________ Date ______________
(Please Print) (If patient is a minor, signature of parent/guardian)

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**):*

Gustavo H. Marshall, DC		
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.