Lerner Family Chiropractic Centre

Patient's Name _____ **DOB** _____ **Date** _____

Automobile/PI Accident or Work Comp Questionnaire

Please answer all questions completely

Dear Patient: This information is considered confidential. We need this information because we care enough to want to know, and your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form.
Thank you.

Please explain in detail how your accident happened:_____
_____
_____
_____

What were the time and date of present injury? _____

Where did you feel pain immediately after the accident? _____

List the extent of your injuries as you know them: _____
_____
_____

Check symptoms you have noticed since the accident:

____Headache	_____Dizziness	_____Depression	_____Fatigue
____Stomach Upset	_____Light Bothers Eyes	_____Buzzing in Ears	_____Diarrhea
____Neck Pain	_____Head seems too Heavy	____ Loss of Memory	_____Feet Cold
____Neck Stiffness	_____Pins/Needles in Arms	_____Ears Ring	_____Hands Cold
____Fainting	_____Sleeping Problems	_____Loss of Balance	_____Back Pain
____Face Flushed	_____Pins/Needles in Legs	_____Constipation	_____Tension
____Nervousness	_____Numbness in Fingers	_____Loss of Smell	_____Fever
____Irritability	_____Numbness in Toes	_____Loss of Taste	_____Chest Pain
____Cold Sweats	_____Shortness of Breath		

Symptoms other than above: _____
_____

Where were you taken after the accident? _____

Hospitalized? Yes/ No If yes, admitted? _____How long? _____

Name of Hospital:_____

Name of Doctors: _____

What treatment was given? _____

Was any other doctor consulted after your accident? Yes/ No

_____

Patient's Name

If so, what was the doctor's name? _____ D.C., M.D., D.O., D.D.S.

What was the diagnosis? _____

What treatment was given?_____

How often did you see the doctor? _____

How long did you see the doctor? _____

Have you ever had any complaints in the involved area before? Yes/ No

If so, what were the complaints? _____

Before the injury, were you capable of working on an equal basis with others your age? Yes/ No

Are your work activities restricted as a result of this accident? Yes/ No

Since this injury, are your symptoms (circle one): Improving? Getting worse? Same?

Driver of other vehicle (if any)

Name: _____Insurance Company: _____ Policy No. _____

Driver of vehicle in which you were injured (if applicable)

Name: _____ Insurance Company: _____Policy No. _____

Name of your insurance adjustor: _____

Have you retained an attorney? Yes/ No

If so, his name and address: _____

You were heading North / East / South / West on _____(street or highway)

Other vehicle was heading North / East / South / West on _____(street or highway)

Were police notified? Yes/ No

Were you knocked unconscious? Yes/ No If so, for how long? _____

You were struck from Behind / Front / Left Side / Right Side _____

You were Driver / Passenger / Front Seat / Back Seat / Using seat belts _____

_____ _____

Patient Signature DATE

_____ _____

Doctor Signature DATE

Lerner Family Chiropractic
1405-D S. Hiawassee Rd
Orlando, FL 32835

Date _____

TO_____

_____

_____

Patient: _____

Claim#: _____

DOA: _____

Dear Adjuster,

Persuant to Florida statutes, this letter is being sent to notify you that this clinic is currently evaluating and providing treatment to the above named patient.

Evaluations and treatments are for injuries sustained as a result of an automobile accident on the above date.

Treatment records and billing claim will be forwarded within the mandated time frame.

Lerner Family Chiropractic

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 (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(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.

Lerner Chiropractic P.A.
Dr. Erik Lerner
1405-D South Hiawassee Rd.
Orlando, FL 32835

ASSIGNMENT OF BENEFITS

The undersigned patient hereby assigns the benefits of insurance under the automobile insurance with

_____ to Dr. Erik Lerner / Lerner Chiropractic P.A/ for services
(NAME OF INSURANCE COMPANY)

rendered to the undersigned patient and covered by (PIP) Personal Injury Protection coverage under

_____ policy with _____.
(INSURED'S NAME) (NAME OF INSURANCE COMPANY)

The undersigned further agrees to pay any applicable deductible or co-payment NOT covered by the PIP insurance coverage – and/or amount paid by the insurance company.

I further understand that I am 100% responsible for all fees billed by the practice of Dr. Erik Lerner / Lerner Chiropractic P.A. This is to include all charges that may be reduced for "usual and customary". I understand that should my claims be reduced and / or not paid by my appropriate auto insurance carrier, Dr. Erik Lerner will seek legal counsel to obtain his usual and customary, medically necessary fees.

In addition the undersigned requests that payment for services rendered be issued directly to Dr. Erik Lerner / Lerner Chiropractic P.A.

_____ _____
PATIENT'S SIGNATURE DATE

_____ _____
PATIENT'S NAME DATE

APPLICATION FOR FLORIDA "NO FAULT" BENEFITS

DATE	OUR POLICY HOLDER	DATE OF ACCIDENT	FILE NUMBER

TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE FLORIDA PERSONAL INJURY PROTECTION LAW, PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY. Thank You.

TO:

"ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURANCE COMPANY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE."

YOUR NAME	**PHONE NO.** (Include Area Code) **HOME**	**BUSINESS**

YOUR ADDRESS (No,Street,City or Town,State & Zip Code) **Permanent Address if Different**	**How Long Have You Lived In Florida?**	**Date of Birth**	**Social Security #**

Date and Time of Accident A.M. P.M.	**Place of Accident (Street,City or Town & State)**

Brief Description of Accident and Vehicles Involved:(If Additional Space is Needed, Use Reverse Side)

Describe Motor Vehicle You Own:

Describe Motor Vehicle Owned By Any Member of Your Family:

As a Result of This Accident Were You Injured? YES ☐ NO ☐ If Your Answer is Yes, Complete The Rest of This Form
If No, Sign Here and Return This Form To Us.

Signature _____ DATE _____

Describe Your Injury:(If Additional Space is Needed, Use Reverse Side)

Were You Treated By A Doctor YES ☐ NO ☐	**Doctor's Name and Address**

If You Were Treated In A Hospital Were You AN IN-PATIENT? ____ **OUT-PATIENT?** ____	**Hospital's Name and Address**

Amount of Medical Bills To Date $	**Will You Have More Medical Expense?** YES ☐ NO ☐	**At The Time of Your Accident Were You In The Course of Your Employment?** YES ☐ NO ☐

Did You Lose Wages or Salary As A Resu Of Your Injury? YES ☐ NO ☐	**If YES, Amount Lost To Date** $	What Is Your Average Weekly Wage or Salary? $

If You Lost Wages: **Date Disability From Work Began:** / / **Date You Returned To Work:** / /

Have you received or are you eligible for payments under any Workmen's Compensation or unemployment law? YES ☐ NO ☐ If YES, Amount $ Per Week Per Month

List Names and Addresses of Your Present Employer(s) and Give Your Occupation and Dates of Employment for Each.

Employer and Address	*Your Occupation*	*From*	*To*
Employer and Address	*Your Occupation*	*From*	*To*

As A Result of Your Injury, Have You Had Any Other Expenses YES ☐ **NO** ☐ If "YES", Explain On Reverse Side

SIGNATURE: _____ DATE: _____

IMPORTANT:
1. To Be Eligible For Benefits, Complete and Sign This Application
2. Sign Attached Authorization(s)
3. Return Promptly With Any Medical Bills You Have Received To Date