Fogarty
Chiropractic Life Clinic

LASTING PURPOSE

Kevin Fogarty, D.C., F.I.C.A. (Hon)

Please fill in below:

Name: _____ Date: _____
Address: _____ Apt: _____ City, State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Gender: M ____ F ____ Date of Birth: _____ Height: _____ Weight: _____
Marital Status: _____ SS#: _____ Email: _____

Chief Complaint: _____
Mechanism of Injury: _____
_____
How long have you had this problem? _____
Are you under the care of any other physician? Yes: _____ No: _____
If yes, please list the doctor (s) you are seeing and the conditions you are being treated for: _____
_____
_____
Please list any medication you are presently taking and the reason for taking it: _____
_____
_____
Please list any previous surgeries: _____
_____
Please list any accidents, auto accidents, or broken bones in the past: _____
_____
Please list previous imaging: _____

Have you been to a chiropractor before? Yes: _____ No: _____ Date of last visit: _____
How long were you under care? _____ Condition treated for: _____
Name of Chiropractor:
_____
Your occupation: _____
Duties you are required to perform regularly at work or home: _____
_____

Do you smoke cigarettes? Yes: _____ No: _____ # of packs per day: _____
Do you drink coffee? Yes: _____ No: _____ # of cups per day: _____
Do you consume alcohol? Yes: _____ No: ____ Approximately how much daily? _____
Do you exercise regularly? Yes: _____ No: ____ What type and how much? _____

Family Health History
Please describe the health of your:
Father: _____ Mother: _____
Spouse: _____ Children, give ages: _____

For Official Use:

Blood Pressure: _____/_____ Pulse: _____ Temp: _____

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Females: Is there a possibility of being pregnant? **YES:** _____ **NO:**_____

Have you **EVER** had any of the following? Please check:

___ Hay Fever	___ Prostate Problems	___ Heart Disease	___ Venereal Disease	___ Ulcers
___ T.B.	___ Gout	___ Thyroid Trouble	___ Hemorrhoids	___ Epilepsy/Seizures
___ Allergies	___ Pneumonia	___ Cancer	___ Tonsillitis	___ Liver Trouble
___ Polio	___ Pleurisy	___ Gall Bladder Trouble	___ Appendicitis	___ Diabetes
___ Slipped Disc	___ Asthma	___ High Blood Pressure	___ Arthritis	___ Rheumatic Fever
___ Stroke	___ Bowel Trouble	___ Menstrual Problems	___ Hypoglycemia	___ Kidney Trouble

Other: _____

Systems Review

Are you **PRESENTLY** suffering from any of the following? Please check:

Eyes:
___ change in vision
___ eye pain
___ watery eyes

Ears:
___ ear discharge
___ impaired hearing
___ ear aches
___ ringing in ears

Nose:
___ sinus pains
___ nose bleeds

Throat:
___ blisters in mouth
___ problems swallowing
___ throat lumps
___ sore throat

Cardiovascular:
___ heart palpitations
___ chest pains

Abdominal:
___ indigestion
___ heart burn
___ belching
___ vomiting
___ rectal bleeding
___ irritable bowel
___ gas
___ constipation
___ diarrhea
___ abdominal pains
___ nausea
___ change in weight
___ swelling

Musculoskeletal:
___ back pains
___ hip pains
___ leg pains
___ neck pains
___ shoulder/arm pains
___ other muscle pains
___ numbness
___ tingling
___ joint pains
___ swelling of ankles
___ swelling of joints

Neurological:
___headaches
___ balance issues
___ fatigue
___ weakness

Cognitive:
___ poor appetite
___ poor memory
___ insomnia
___ inner tension
___ nervousness
___ personality change

Pulmonary:
___ cough
___ shortness of breath
___ dizziness
___ fainting

Urinary:
___ blood in urine
___ frequency of urination
___ pain on voiding
___ cloudy urine

Skin:
___ dry skin
___ skin discoloration
___itching
___ burning
___ skin eruptions/rash
___ excessive sweating
___ bruising

Other: (Please list)
_____
_____
_____
_____
_____
_____
_____
_____

Insurance information:
Type of insurance: Regular Medical ____ Medicare ____ Medicaid ____ Auto _____ Workers Comp _____
Name of Insured: _____ SS # _____
Insured's Date of Birth: _____ Name of Employer: _____
Insurance Company: _____ Phone #: _____
Policy #: _____ Group # _____ Claim #: _____

Emergency Contact:

Name: _____ Phone # _____

Relationship to patient: _____

I certify to the best of my knowledge, the above information is complete and accurate. I agree to notify this practitioner immediately whenever I have changes in my health condition.

Patient Name: _____ Date: _____

Signature: _____ Relation to patient: _____

(Revised 07/13/23)

Fogarty
Chiropractic Life Clinic
LASTING PURPOSE

Kevin Fogarty, D.C., F.I.C.A. (Hon)

Financial Responsibility

Lifetime Assignment and Instruction for Direct Payment to Doctor
Private and Group Accident and Health Insurance
Authorization to Release/Request Records

Patient Name: _____ Date of Birth: _____
I hereby instruct and direct my Insurance Company of record to pay benefits by check or electronic payment.

Fogarty Chiropractic Life Clinic
839 Barton Blvd.
Rockledge, Florida 32955

The professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional service rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY TO FOGARTY CHIROPRACTIC LIFE CLINIC FOR PAYMENT OF PROFESSIONAL SERVICES RENDERED**. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. I assign to said clinic all rights patient has under any contract of insurance for collection of same.

This also certifies that the above-named individual agrees to pay in full for all professional services rendered at the time they are preformed, unless other arrangements are made in advance of the set appointment. The below named guarantor understands a $50.00 returned check fee will be charged along with any appropriate collection or attorney's fee which may accrue upon collection of any outstanding balance.

_____
Initials

RECORDS REQUEST

This is to certify that the above-named patient authorized full request of any records pertinent to the health care of same individual from but not inclusive and any insurance carrier, adjustor, attorney, hospital, or other health care provider.

This also authorizes Fogarty Chiropractic Life Clinic to release records, upon receipts of the above-named patient's signature, or on an emergency basis, to but not inclusive of any insurance carrier, attorney, health care provider, hospital, or immediate family member.

_____
Initials

A photocopy of this assignment shall be considered as effective and valid as the original. This document is considered a living document and does not expire.

HIPAA

Privacy: The *Standards for Privacy of Individually Identifiable Health Information* ("Privacy Rule") establishes, for the first time, a set of national standards for the protection of certain health information. The U.S. Department of Health and Human services issued the Privacy Rule to implement the requirement of the *Health Insurance Portability and Accountability Act of 1996* ("HIPAA"). A major goal of the Privacy Rule to assure that individuals' health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care and to protect the public's health and wellbeing.
You can be assured that our clinic takes your privacy seriously and is in compliance with all HIPAA guidelines. Your health information will not be disclosed without permission or will your name, address, or telephone numbers be disclosed to any third party.

I received a copy of the HIPAA Policy

_____
Initials

CONFIDENTIAL COMMUNICATIONS

Use this section to **AUTHORIZE** others who may contact Fogarty Chiropractic Life Clinic to obtain PHI and to communicate with our practice regarding the patient above. For example: Spouse, children, parent, friends, etc.

Authorized User #1: _____ Date of Birth: _____/_____/_____
Relationship to you: _____ Phone#: _____-_____-_____

Authorized User #2: _____ Date of Birth: _____/_____/_____
Relationship to you: _____ Phone#: _____-_____-_____

Select one of the following options

_____ **I AUTHORIZE** Fogarty Chiropractic Life Clinic to leave detailed messages on my answering device.

_____ **I DO NOT AUTHORIZE** Fogarty Chiropractic Life Clinic to leave detailed messages on my answering device.

NO SURPRISES PAYMENT OPTIONS

Fogarty Chiropractic Life Clinic knows how important your health and wellness care are. And it is our top priority to ensure that each patient gets the care they need. We want to make sure that and your family get the best quality of care regardless of insurance high deductible plans, copays, and non-covered services so there are "no surprises".

You have the right to receive a "Good Faith Estimate" explaining how much your medical care will cost. Under the law, health care providers need to give patients who don't have insurance or who are not using insurance an estimate of the bill for medical items and services.

- You have the right to a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescriptions drugs, equipment, and hospital fees.
- Make sure your health care provider gives you a Good Faith Estimate in writing at least 1 business day before your medical service or item. You can also ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service.
- If you receive a bill that is at least $400.00 more than your Good Faith Estimate, you can dispute the bill.
- Make sure to save a copy or picture of your Good Faith Estimate. For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises.

Due to the increased frequency of high deductible insurance plans and out of network policies we offer a discount care program we refer to as our HMA Plan
(Healthcare Made Affordable). This allows us to legally treat our patients at a discounted rate regardless of insurance provider. Ask for more information on your first visit.

I received a copy of the Fee Explanation sheet & No Surprise Act. _____
Initials

I have read and understand all the foregoing. I have also received a copy of the HIPAA privacy statement and Fogarty Chiropractic Life Clinic's Fee Sheet.

Date: _____ Patient Signature: _____

(Revised 02/3/2023)

Fogarty
Chiropractic Life Clinic
LASTING PURPOSE

Kevin Fogarty, D.C., F.I.C.A. (Hon)

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we prescribed, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable. Please feel free to communicate any discomfort or concern with the doctor.

We may need to conduct diagnostic procedures such as spinal radiographic imaging or to recommend MRI's if indicated. It is important that you inform us if there is any possibility of pregnancy.
Chiropractic care centrally involves what is known as the chiropractic adjustment. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joints, and improving neurological functioning and overall well-being.

Treatment recommendations may include the use of modalities including but not limited to: intersegmental traction, cold laser therapy, massage therapy, trigger point therapy or ice as part of your care

Decompression therapy. Spinal decompression is a non-invasive and non-surgical therapy which addresses the intervertebral discs. I understand that spinal decompression treatment is designed to alleviate certain symptoms through a conservative approach with hopes to avoid a more invasive procedure.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the- counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as

is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date: _____

Fogarty
Chiropractic Life Clinic
LASTING PURPOSE

Kevin Fogarty, D.C., F.I.C.A. (Hon)

Automobile Accident History Form

Your Name: _____ Today's Date: _____

Date of Accident: _____ Time of Accident: _____ A.M. / P.M.

Street of Accident: _____ Heading: N / S / E / W

City of Accident: _____

Road Conditions at time of accident: WET / DRY / ICY / OTHER _____

List the year, make, anc model of the car you were in:
Year: _____ Make: _____ Model: _____
Was the vehicle you were in stopped at the time of the impact? YES / NO
If yes, was the driver's foot on the brake? YES / NO
If yes, what was the approximate speed of the vehicle you were in? _____mph

List the year, make, anc model of the other vehicle:
Year: _____ Make: _____ Model: _____

Was the other vehicle moving at the time of the collision? YES / NO
If yes, what was the approximate speed? _____mph

If the other vehicle was moving at the time of collision, was it:
____SLOWING DOWN - ____SPEEDING UP - ____TRAVELING AT A STEADY RATE OF SPEED

Which of the following vehicle parts were broken during the accident? _____

_____

What was the estimated cost damage to the vehicle you were in? $_____

Please describe, to the best of your knowledge what happened during the accident:

_____
_____
_____
_____
_____
_____
_____

Where were you seated in the vehicle? _____

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Were you aware of the impending collision prior to the impact, or did the impact surprise you?
AWARE / SURPRISED

Was the trunk of you body pointed straight forward? YES / NO
If no, in what direction was it turned? _____

Was your head pointed straight forward? YES / NO
If no, in what direction was it turned? _____

How far is the top of the headrest or seatback from the top of you head (approximately):
_____ inches ABOVE / BELOW.

Were you wearing a seatbelt? YES / NO
If yes, was it a LAPBELT ONLY or SHOULDER AND LAPBELT?
Did the police come to the accident scene? YES / NO; Is there a report? YES / NO
Did you go to the hospital? YES / NO, If yes:
What was the name of the hospital? _____
How did you get there? _____
What parts of your body were X-rayed? _____
What did the hospital do for your injuries? _____
How long did you stay at the hospital? _____
Were there any bleeding cuts sustained in the accident? _____
Were there any bruises sustained in the accident? _____
Did you receive any injury or bruising from your seatbelt? YES / NO
Did you lose consciousness (blackout) upon impact? _____
Did you experience a flash of light or explosion in your head? YES / NO
On what part of the vehicle did your body parts hit? _____
WINDSHIELD FRONTSEAT RIGHT/LEFT SIDE WINDOW
STEERING WHEEL OTHER_____

Did you become?
CONFUSED DISORIENTED LIGHTHEADED
DIZZY NAUSEATED BLURRED VISION
RINGING/BUZZING IN THE EARS

Immediately following the accident if you still have any of these symptoms which are they? _____
_____

Are you currently suffering from any of the following?
RESTLESSNESS DIFFICULTY CONCENTRATING SLEEPLESSNESS IRRITABILITY
DIFFICULTY WITH MEMORY FORGETFULNESS REDUCED TOLERANCE TO COLD
REDUCED TOLERANCE TO HEAT REDUCED TOLERNACE TO ALCOHOL

Do you have legal representation for this accident? If yes, name of attorney:_____
If no, do you plan on obtaining legal representation? _____

(REVISED 07/25/2023)

Fogarty
Chiropractic Life Clinic
LASTING PURPOSE

Kevin Fogarty, D.C., F.I.C.A. (Hon)

LETTER OF PROTECTION
DIRECTION TO PAY

PATIENT NAME: _____

DATE OF BIRTH: _____

DATE OF INJURY: _____

IMPORTANT: THIS IS A CONTRACT. IF YOU DO NOT UNDERSTAND THIS THEN CONSULT WITH AN ATTORNEY BEFORE SIGNING.

Patient authorizes and directs his/her present and future attorneys related to the above-referenced date of injury ("Attorneys") to honor this agreement. This agreement is made in favor of the above-referenced Medical Provider and shall be termed a "Letter of Protection." The Letter of Protection shall serve to place a continuing lien on any proceeds I recover in any legal action related to the above-referenced date of injury. The Direction to Pay applies to the Patient's Attorneys.

Background: Medical Provider expects to be paid from any proceeds related to the above-referenced date of injury in exchange for providing medical care/treatment. Medical Provider also agrees not to place patient in collections until the resolution of Patient's claims related to the above-referenced date of injury. Patient expects to receive medical care that is reasonable, related to the above referenced accident and medically necessary. Patient has sustained injuries as a result of injuries related to the above-referenced date of injury and does not have the funds to pay for the medical care which he/she needs. Patient is signing this Letter of Protection in order to receive medical care.

Insurance Benefits: In the event that there are disability benefits, medical payment benefits, No-Fault benefits, health and accidental benefits, worker's compensation benefits or any other insurance benefits available to patient besides Bodily Injury and/or Un-insured Motorist (aka Underinsured Motorist) coverage then this Letter of Protection can be used to cover any co-payments and/or deductibles.

OVER

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Protection of Medical Bills: If Patient recovers any money related to the above referenced date of injury, then Patient shall withhold from those funds, sufficient money to pay the outstanding balance of any bill(s) owed to Medical Provider. It is understood that Attorney's fees/costs are first-in-line and that this Letter of Protection does not interfere with Attorney's retainer agreement with Patient. Patient authorizes Medical Provider to provide Attorney with a copy of Patient's medical records, bills, etc. with regard to the above-referenced date of injury.

Patient's Responsibility for Bills: Patient understands that he/she id directly responsible to Medical Provider for services rendered and that payment is not contingent on any settlement, judgment, or verdict related to the above referenced date of injury. Regardless of any settlement, judgment or verdict, Patient is still responsible for paying Medical Provider's outstanding bills so long as they are reasonable and related to the above-referenced date of injury and medically necessary,

Patient's Responsibility Regarding His/hers Attorney (Present and Future). Patient is responsible for informing each and every attorney retained by him/her of the existence of this agreement. Medical Provider has the right to notify Patient's Attorney(s) about the existence of this Letter of Protection. Upon request, Patient shall provide status updates about any claims related to the above-referenced date of injury as well as the contact information fir any new Attorneys. It is also the Patient's responsibility to advise the Medical Provider at least 10 days prior to collecting any funds and to request a bill for any and all outstanding charges. Patient understands that if funds related to the above-referenced date of injury are insufficient to cover the medical bill(s) then Medical Provider has the right to collect the remaining balance.

Disputes: If the patient fails to pay the Medical Provider's full outstanding balance and Medical Provider is the prevailing party in an action to enforce this Letter of Protection then Medical Provider shall have the right to recover all attorney fees and costs including post-judgment proceedings. Binding arbitration is an option if both parties agree in writing.

Direction to Pay: ATTENTION ATTORNEY: THIS IS A DIRECTION TO PAY MY MEDICAL PROVIDER. Patient directs his/her attorneys to pay any outstanding medical bills in connection with the above-referenced date of injury. Patient hereby directs Attorneys to provide a status update in writing within 15 fays of receiving a request from Medical Provider.

Effective Date: This agreement becomes effective when the Patient signs the agreement below.

Patient Signature / Parent Date

APPLICATION FOR FLORIDA "NO FAULT" BENEFITS

NAME OF INSURANCE COMPANY

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.

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

YOUR NAME	PHONE NO.	HOME	BUSINESS

YOUR ADDRESS (NO, STREET, CITY OR TOWN, STATE AND ZIP CODE)	DATE OF BIRTH	SOCIAL SECURITY NO.

PERMANENT ADDRESS, IF DIFFERENT	HOW LONG HAVE YOU LIVED IN FLORIDA?

DATE AND TIME OF ACCIDENT	PLACE OF ACCIDENT (STREET, CITY OR TOWN AND STATE)

BRIEF DESCRIPTION OF ACCIDENT AND VEHICLES INVOLVED:

DESCRIBE MOTOR VEHICLE YOU OWN -	DESCRIBE MOTOR VEHICLE OWNED BY ANY MEMBER OF YOUR FAMILY-

AS A RESULT OF THIS ACCIDENT, WERE YOU INJURED? 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

WERE YOU TREATED BY A DOCTOR?	Yes	DOCTOR'S NAME AND ADDRESS Dr. Kevin Fogarty, D.C. - Fogarty Chiropractic Life Clinic - 839 Barton Blvd., Rockledge, FL 32955
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?	AT THE TIME OF YOUR ACCIDENT, WERE YOU IN THE COURSE OF YOUR EMPLOYMENT?

DID YOU LOSE WAGES OR SALARY AS A RESULT OF YOUR INJURY?	IF YES, AMOUNT OF LOSS 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 EMPLOYMENT LAW?	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
EMPLOYER AND ADDRESS	YOUR OCCUPATION	FROM	TO

AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES?	IF YES, EXPLAIN ON REVERSE SIDE
SIGNATURE: DATE:	

IMPORTANT: 1. TO BE ELIGIBLE FOR BENEFITS COMPLETE AND SIGN THIS APPLICATION
2. SIGN AND ATTACH AUTHORIZATION(S)
3. RETURN PROMPTLY WITH ANY MEDICAL BILLS YOU HAVE RECEIVED TO DATE

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.

Fogarty
Chiropractic Life Clinic
LASTING PURPOSE

Kevin Fogarty, D.C., F.I.C.A. (Hon)

ASSIGNMENT OF BENEFITS

I, _____, hereby assign all rights, title, and interest from any and all automobile insurance policy which provided medical benefits or no-fault benefits to the Fogarty Chiropractic Life Clinic, for payment for services rendered to me by Fogarty Chiropractic Life Clinic for treatment of injuries sustained in the automobile accident which occurred on _____, _____.

_____ _____
Patient Date

In the event my Insurance Company fails to pay Fogarty Chiropractic Life Clinic the full amount owing to Fogarty Chiropractic Life Clinic after proper statutory notice, I hereby also assign the below cause of action to Fogarty Chiropractic Life Clinic.

ASSIGNMENT OF CAUSE OF ACTION

I, _____, by this instrument assign all right and causes of action in tort, in contract, and the Laws of Florida against my Personal Injury Protection Carrier _____, for its failure to pay or fully pay for services rendered to me by Fogarty Chiropractic Life Clinic regarding injuries sustained in an accident which occurred on _____.

_____ _____
Patient Date

_____ _____
Kevin Fogarty D.C. Date

(Revised 02/24/23)

Fogarty
Chiropractic Life Clinic
LASTING PURPOSE

Kevin Fogarty, D.C., F.I.C.A. (Hon)

THIRD PARTY BILLING

This is to certify that the below signed is a patient of the Fogarty Chiropractic Life Clinic and is receiving Chiropractic care for injuries obtained in an auto accident.

Per your request and/or the request of your attorney, you have asked this clinic to submit the charges for services rendered to a supplemental insurance carrier. This is a supplemental insurance policy to your personal injury protection covered by your auto insurance policy.

By signing below, you understand that any payment received by your insurance company, if not paid in full will act as a supplemental payment which will go towards your outstanding balance.

If this clinic is under contract to a group health policy under an HMO/PPO or capitation arrangement, any payment received will not be considered as payment in full, but rather a supplement to your outstanding balance and will be credited to your account as such.

Our clinic will be happy to continue to work with you and your attorney under a Letter of Protection to defer payment until settlement is reached if necessary.

I understand that I remain personally liable for payment of services rendered.

I certify that I have read and understand the above.

_____ _____

Patient's Signature Date

_____

Print Name

_____ _____

Witness Signature Date

_____

Print Name

(Revised 02/03/2023)