PERSONAL INJURY QUESTIONNAIRE

Name _____ Phone ( ) _____

Address _____ City _____ State _____ Zip _____

Age _____ Birthdate _____ Sex _____ S/S # _____

Employer's Name _____ Employer's Address _____

Your Ins. Co. _____ Policy # _____ Agent's Name _____

Name on Policy (if other than self) _____ Policy # _____

Responsible Party's Name _____

Address _____ City _____ State _____ Zip _____

Policy Holder's Name _____ Policy # _____

ATTORNEY

Name _____ Phone ( ) _____

Address _____ City _____ State _____ Zip _____

Were there any witnesses? ( ) Yes ( ) No Name(s) _____

NATURE OF ACCIDENT:

1. Date of Accident _____ Time of Day _____
2. Were you: ( ) Driver ( ) Passenger ( ) Front Seat ( ) Back Seat
3. Number of people in your vehicle? _____ Were you wearing seat belts? _____
4. What direction were you headed? ( ) North ( ) East ( ) South ( ) West
   on (name of street) _____
5. What direction was other vehicle headed? ( ) North ( ) East ( ) South ( ) West
   on (name of street) _____
6. Were you struck from: ( ) Behind ( ) Front ( ) Left Side ( ) Right Side
   Were you rotated or twisted in seat? _____
7. Approximate speed of your car: _____ mph Other car: _____ mph
8. Were you knocked unconscious? ( ) Yes ( ) No If yes, for how long? _____
9. Were police notified? ( ) Yes ( ) No
10. In your own words, please describe accident: _____

    _____

    _____

    _____

11. Did you have any physical complaints BEFORE THE ACCIDENT? ( ) Yes ( ) No
    If yes, please describe in detail: _____

    _____

    _____

12. Please describe how you felt:
    a. DURING the accident: _____
    b. IMMEDIATELY AFTER the accident: _____
    c. LATER THAT DAY: _____
    d. THE NEXT DAY: _____

13. What are your PRESENT complaints and symptoms? _____

_____

_____

14. Do you have any congenital (from birth) factors which relate to this problem? ( ) Yes ( ) No
If yes, please describe: _____

15. Do you have any previous illnesses which relate to this case? ( ) Yes ( ) No
If yes, please describe: _____

16. Have you ever been involved in an accident before? ( ) Yes ( ) No If yes, please describe, including date(s) and type(s) of accident(s), as well as injury(ies) received: _____

_____

_____

17. Where were you taken after the accident? _____
Were you hospitalized? ( ) Yes ( ) No If yes, for how long? _____

18. Have you been treated by another doctor since the accident? ( ) Yes ( ) No If yes, please list doctor's name and address: _____
What type of treatment did you receive? _____

_____

19. Since this injury occurred, are your symptoms: ( ) Improving ( ) Getting Worse ( ) The Same

20. CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

❑ Headache	❑ Irritability	❑ Numbness in Toes	❑ Face Flushed	❑ Feet Cold
❑ Neck Pain	❑ Chest Pain	❑ Shortness of Breath	❑ Buzzing in Ears	❑ Hands Cold
❑ Neck Stiff	❑ Dizziness	❑ Fatigue	❑ Loss of Balance	❑ Stomach Upset
❑ Sleeping Problems	❑ Head Seems Too Heavy	❑ Depression	❑ Fainting	❑ Constipation
❑ Back Pain	❑ Pins & Needles in Arms	❑ Lights Bother Eyes	❑ Loss of Smell	❑ Cold Sweats
❑ Nervousness	❑ Pins & Needles in Legs	❑ Loss of Memory	❑ Loss of Taste	❑ Fever
❑ Tension	❑ Numbness in Fingers	❑ Ears Ring	❑ Diarrhea	❑ _____

Symptoms Other Than Above: _____

21. Have you lost time from work as a result of this accident? ( ) Yes ( ) No If yes, please complete this question:
a. Last Day Worked: _____
b. Type of Employment: _____
c. Are you being compensated for time lost from work? ( ) Yes ( ) No If yes, please state type of compensation you are receiving: _____

22. Do you notice any activity restrictions as a result of this injury? ( ) Yes ( ) No
If yes, please describe: _____

_____

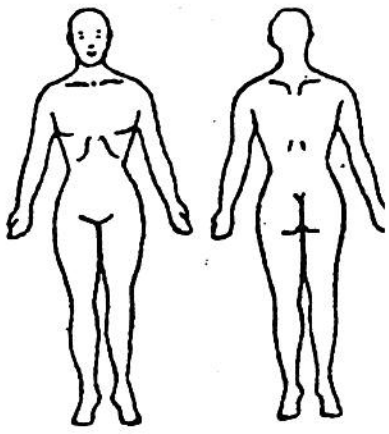
_____

23. Other pertinent information: _____

_____

_____

_____



MARK PAIN AREA

_____ DATE

_____ PATIENT'S SIGNATURE

C106

MEDICAL HISTORY SHEET

NAME:_____ DATE_____

CIRCLE YES OR NO (FURTHER DESCRIBE YES ANSWER TO THE RIGHT)

YES NO HISTORY OF HIGH BLOOD PRESSURE_____

YES NO HISTORY OF HEART BLOOD VESSEL DISEASE_____

YES NO PREVIOUS HEART ATTACK -MI_____

YES NO PREVOUS STROKES -CVA_____

YES NO DIABETES_____

YES NO EPILEPSY_____

YES NO RESPIRATORY DIFFICULTIES_____

YES NO BROKEN BONES_____

YES NO NUMBNESS & TINGLING_____

YES NO ARTHRITIS OR JOINT PROBLEMS_____

YES NO SPECIAL DIET RESTRICTIONS_____

YES NO PRESENTLY HAVE ANY METAL IMPLANTS_____

YES NO CURRENTLY PREGNANT_____

YES NO ANY PRESENT VISUAL PROBLEMS_____

YES NO ANY PRESENT HEARING PROBLEMS_____

YES NO ANY UNUSUAL REACTION TO HEAT OR COLD_____

YES NO ANY ALLERGIES_____

****

YES NO LIST CURRENT MEDICATIONS_____

_____

_____

_____

YES NO LIST MAJOR HOSPITALIZATIONS/SURGERIES_____

_____

YES NO LIST USUAL RECREATIONAL ACTIVITES_____

_____

YES NO HISTORY CANCER_____

_____

YES NO HISTORY OF IMMUNE DISORDER OR COMMUNICABLE DISEASE_____

DATE OF NEXT DOCTORS VISIT _____

_____ _____

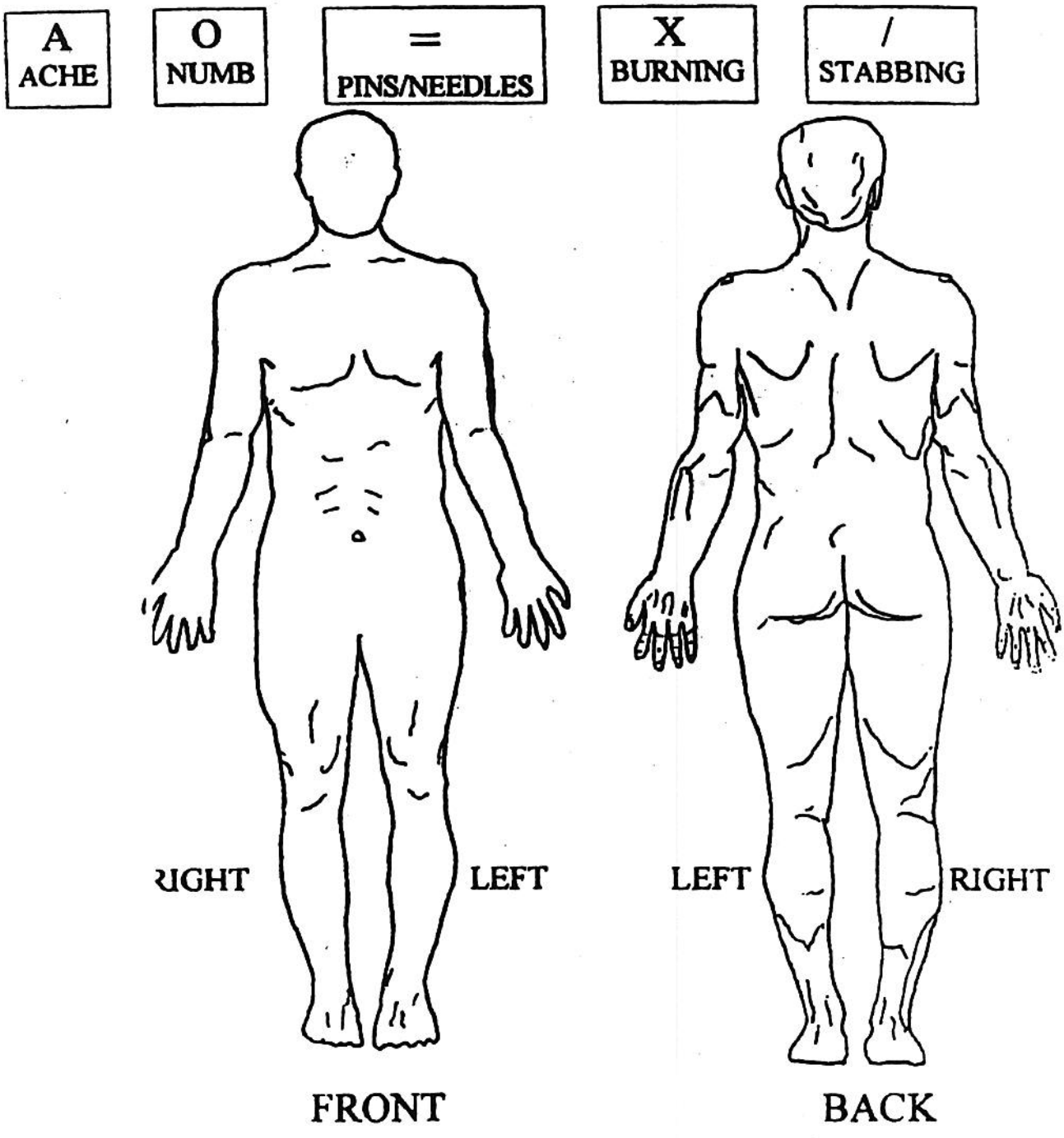
SIGNATURE THERAPIST'S SIGNATURE

Rate your pain:

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

No Pain — Worst Possible

Where is your pain now?
Use the appropriate symbol below to mark the area on your body where you feel these described sensations. Include all areas affected by your pain, and mark the type and area of pain if it radiates or spreads to other areas.



Florida Physical Therapy & Wellness Center
2703 South Kurt Street
Eustis, FL 32726

Assignment and Authorization

For the good and valuable consideration, including the agreement of Florida Physical Therapy and Wellness Center to accept this assignment in lieu of demanding full payment for services from the undersigned on the date each service is rendered, the undersigned patient executes this document hereby assigning to Florida Physical Therapy and Wellness Center the right to receive insurance benefits directly from any insurance company that may be obligated to provide insurance benefits, to me or on my behalf, for services rendered by Florida Physical Therapy and Wellness Center, for a motor vehicle accident that occurred on or about _____.

Any insurance company that may be obligated to pay any insurance to me, or on my behalf, for the aforesaid accident for services provided by Florida Physical Therapy and Wellness, is hereby directed to issue payment for those benefits directly to and payable to Florida Physical Therapy and Wellness.

I also authorize and assign to Florida Physical Therapy and Wellness the right to file suit and pursue all legal remedies to obtain payment for services provided to me by Florida Physical Therapy and Wellness Center. This authorization to file suit is an assignment of my cause of action to obtain payment for services provided to me by Florida Physical Therapy and Wellness Center and includes the assignment of pursue declaratory relief or any other legal remedies.

Florida Physical Therapy and Wellness Center accepts the foresaid assignment and hereby notifies any insurer issuing payment that Florida Physical Therapy and Wellness Center object to any "re-pricing" or reduction of billing amounts unilaterally made by any insurer. Any such reduced payments issued by any insurer are accepted under protest and without waiving any right of the provider to pursue all legal remedies against the insurer.

Please read this document completely before signing. If you do not completely understand this document or have any questions about this document, please ask us to explain it to you. If there is any portion of this document that you do not wish to authorize, we will remove that portion from this document. Your signature below is your agreement you fully understand this document and you fully agree to the terms of this document.

_____ _____
Patient's Signature (or legal guardian) **Date**

_____ _____
Witness to Patient's Signature **Date**

_____ _____
Provider's Signature **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):*

Florida Physical Therapy & Wellness Ctr.		
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.

Florida Physical Therapy and Wellness Center, LLC

Cancellation/No-Show Policy

Thank you for choosing us. Your successful rehabilitation is very important to us. In order to achieve the best possible outcome, we, with your doctors, have recommended a treatment schedule. To get you the desired results, it is very important that you attend each of your therapy appointments.

We reserve time for each of our patients in order for them to complete their plan of care successfully. With this in mind, we ask for your cooperation by making every effort to keep your scheduled appointments.

Please take a moment to review our guidelines put into place to ensure you get the most out of your rehabilitation with Florida Physical Therapy and Wellness Center.

- Please give us at least a 24-hour notice in the event you need to cancel. If you do not call, you are considered a NO SHOW. NO SHOW/NO CALLS will be charged a $50.00 cancellation fee. This amount will be billed *to you directly*, as your insurance company *will not* be responsible.
- You will be called after your first NO SHOW/NO CALL as a courtesy reminder, but any additional NO CALL/NO SHOWS will result in the removal from any further scheduled appointments. You will need to call to resume and reschedule your appointments. The accumulation of 3 NO SHOW/NO CALLS will result in a discharge from the therapy program. You will need to get a new order from your referring physician before we will be able to schedule any further appointments.
- If you are more than 15 minutes late, you will most likely need to reschedule due to conflicting appointments. We want you to get the therapy you need and not interfere with another patient's scheduled time. Please call the office if you are going to be late so we can decide to either change your appointment time or check and see if being late will conflict scheduled patients.

Worker's Compensation and Personal Injury Patients: Your cancelled appointments are documented, as the case manager calls to verify each appointment that you are scheduled for. This could jeopardize your claim and prolong or stop any benefits you are entitled to.

PLEASE DO NOT CANCEL if you are feeling worse and believe treatment is not working. Keep your appointment and discuss any changes with your therapist. Please understand that your pain will probably fluctuate as your course of treatment progresses.

PLEASE DO NOT CANCEL if you are feeling better. Keep your appointment in order to progress your plan and prepare for discharge.

When you don't show as scheduled, three people are affected: You, because you don't get the treatment you need. The therapist, who now has a gap in his/her schedule since the time was reserved for you. And finally, another patient, who could have had your appointment time.

We are glad you are here. You are the reason our Physical Therapy practice exists and we are thankful to be able to work with you to improve your health.

I HAVE READ AND UNDERSTAND THE CANCELLATION AND NO-SHOW POLICY.

Patient Printed Name	Patient Signature	Date