LETTER OF PROTECTION

Dear Sir or Madam :

Our office has agreed to provide services for the above named patient, related to the above noted date of accident/injury. 'Services" is defined to include supplies. In exchange for not requiring full payment at the time of service, the patient has agreed to execute this letter of protection and we have agreed to accept this letter of protection.

The patient hereby agrees to pay the billing for our services from any recovery obtained by the patient due to the above noted accident. This letter of protection is intended to be a legally enforceable agreement requiring the attorney(s) and/or law firm representing the patient to pay the billing for our services from any recovery obtained for the patient. Accordingly, this letter of protection includes both the signature of the patient and the authorized signatory for the patient's attorney(s), agreeing to pay the billing for our services from any recovery obtained for the patient.

At the time of any recovery on behalf of the patient for the above noted accident, the attorney(s) agree to request in writing the balance due from our office and we agree to respond in writing stating the balance owed for services related to the above noted accident.

The attorneys for the patient agree that any outstanding bill for services owed to us by the patient due to the above noted accident shall be paid directly to us from the amount recovered and collected, if such amount is adequate to cover the bill. The "amount recovered" for the patient shall be defined as the gross sum received, less payment of our attorney's fees and client costs, and also less statutory liens that take priority over this letter of protection.

If the patient objects to the amount of the bill, the attorney(s) agree to hold in their trust account an amount sufficient to pay the entire bill or that portion of the amount recovered that is available to pay the bill, whichever is less. The only exception would be upon an Order of a Court of competent jurisdiction directing the payment of such funds. If, after a reasonable period, there appears to be no agreement between us and the patient, the attorney(s) will notify both the patient and us that the entire amount held to pay the bill will be deposited with the Clerk of the Court in the County in which the funds are being held in trust and shall be made the subject of an interpleader action.

It is intended the patient's signature on this agreement is an irrevocable letter of protection directing payment of our bill by any subsequent attorney of the patient for the above-noted accident. If the patient obtains a recovery and has no attorney at the time of such recovery, it is intended this agreement by the patient is a direction to any party paying such recovery to honor this letter of protection. This letter of protection does not eliminate or compromise the obligation of the patient to pay the billing for our services if there is no recovery obtained by the patient.

I have reviewed, understand, and agree to the terms of this letter of protection:

Patient: ______________________________ Date: __________

Attorney(s) for the Patient: ______________________ Date: __________

RB Office Park 4657 Gulf Breeze Parkway * Units A & B * Gulf Breeze, FL. 32563
850-916-9304/05 * Fax * 850-916-9306

NOTICE OF LIEN

To: Attorney ______________________________

____

____

Phone: ____________ Fax: ____________

RE: Medical Reports and Doctor's Lien

I do hereby authorize the above doctor to furnish you, my attorney, with a full report of her examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing her for medical services rendered me both by reason of this accident and by reason of any other bills that are due her office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor. And I hereby further give a lien on my case to said doctor against any and all proceeds of any settlement, judgment, or verdict which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated or injuries connected therewith.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by her for services rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of her awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

Patient's name ____________ Date of Accident: / /

Patient's signature ____________ Date: / /

Witness: ____________ Date: / /

Attorney's Signature: ____________

Please sign before remitting to us for our files.

INTEGRATIVE CHIROPRACTIC & PHYSICAL THERAPY SOLUTIONS
RB Office Park 4657 Gulf Breeze Parkway * Units A & B * Gulf Breeze, FL. 32563
850-916-9304/05 * Fax * 850-916-9306

PROMISE TO PAY FOR TREATMENTS

I, _______________ . am seeking treatment from Dr. Cann for injuries sustained in an automobile accident occurring on _____________, 20 10 I am responsible for paying Dr. Cann for that treatment and any treatments left unpaid are due and owing by me to Dr. Cann. I hereby promise and assure Dr. Cann that any payment by check or any other form from any health insurance company, automobile insurance company or any other source as compensation or reimbursement for treatment of the aforementioned injuries by Dr. Cann shall be preserved and submitted to Dr. Cann for payment of any balance due on the aforementioned treatments.

I understand that I remain liable to Dr. Cann for any unpaid aforementioned treatments should I cash any check or accept any payment from any health insurance company, automobile insurance company or any other source as compensation or reimbursement for treatment of the aforementioned injuries.

I agree to promptly advise Dr. Cann of receipt of any payment by check or any other form from any health insurance company, automobile insurance company or any other source as compensation or reimbursement for treatment of the aforementioned injuries.

Signed this __________ day of ______________, 2010

____
(Patient's name)

____
(Patient's signature)

_______________________ _______________________
(Witness) (Witness)

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RB Office Park 4657 Gulf Breeze Parkway * Units A & B * Gulf Breeze, FL. 32563
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NOTICE TO INSURANCE COMPANY
DIRECT PAYMENT AUTHORIZATION WITHOUT ASSIGNMENT OF BENEFITS
AND/OR REVOCATION OF ASSIGNMENT

TO: Insurance Company

____
____
____

Pt. Name: ________________
Date Signed: ____/____/____
Claim # : ________________

By way of original or copy hereof, I, the undersigned, insured, hereby direct my applicable Personal Injury Protection and/or Medical Payment insurance carrier to make payment DIRECTLY to any and all medical providers for services and supplies rendered to me by my said medical providers which were necessitated by the motor vehicle accident occurring on the date as outlined in my application for PIP benefits. Additionally, I hereby authorize and direct my Personal Injury Protection and/or Medical Payment insurance carrier to make any and all checks out to the medical providers only and to forward the same to the medical provider's place of business.

The purpose of this document is for my convenience, your insured, to avoid the necessity of payments to me by the insurance carrier and in turn, my having to pay the aforementioned bills to the medical provider.

The authorization for direct payment should not be deemed an assignment of benefits, in that I, the patient/insured, retain all rights to enforce my insurance contract. The undersigned retains these rights even if the insurance carrier subsequently receives a document or form or some other writing from the health care provider that there was an assignment of benefits. This writing supersedes those forms and in spite of any language to the contrary, **there is no assignment of benefits.** The only way this direct payment authorization can be revoked or superseded is by subsequent written notice from me or my duly authorized representative by certified mail. Furthermore, this direct payment authorization without assignment of benefits transfers no right, title or interest in the said contract other than the right to receive direct payment as specified herein above.

In the event that the insurance carrier has already received a form or writing indicating that there is an assignment of benefits, this is a revocation of that assignment of benefits and any payments herein should be made paid subject to the terms of this document.

Pt. Signature: ____________________ SS#: ________________
Guardian: ____________________

Pay directly to provider: Dr Karen A. Cann D.C., LPT

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PIP- UNDERSTANDING THE BILLING PROCESS

Welcome to Integrative Chiropractic & Physical Therapy Solutions (ICPTS). This letter will help to clarify the billing and collection process. Feel free at any time to contact us with any questions or regards you might have.

HOW IT WORKS:

Your primary auto insurance will be billed throughout the course of your treatment. They will pay a portion of the charges directly to us.

The remaining balance will then be billed to the secondary insurance, which is the insurance of the member who was at fault in the accident. If payment is unable to be rendered from the member at fault, then you will be responsible for the balance unless notice of lien has been signed by you and your attorney (if you have retained one).

If you were at fault, we will workout a payment arrangement with you. If you were not at fault we will contact the secondary insurance. However, because we are the third party, they will only negotiate with you, not with us. If we are still owed money, the adjuster in charge of the claim, will offer a settlement for the case. Please do not accept any offer for settlement until you have spoken with us.

The insurance company will then send you a check in the mail. This check is to cover medical expenses, not for your personal use. You may either, bring the endorsed check given to you by the insurance carrier, or write us a personal check fro the settled amount immediately. Mail the check to our office, or bring it in on your next visit. **Under no circumstance is it legal for you to spend money still owed in your case.**

Please sign the bottom portion of this form to insure that you have read and understood the content of this letter. Thank you for your cooperation, and once again, welcome to ICPTS. We look forward to taking care of your and your needs to achieve health.

SECONDARY INSURANCE AGREEMENT

I, ________________________________ agree that I have read and understand the billing and collections process. I understand that my responsibility is to cooperate with the staff at ICPTS. If ICPTS is owed money, I will not make a settlement with any insurance carrier without their prior consent. Once I receive the payment by the insurance carrier, I will pay ICPTS the amount due to them immediately. By signing this agreement, I accept full responsibility for this matter. I understand that failure to honor this agreement will give ICPTS the right to pursue this matter legally in an attempt to collect a debt

____________________	____________________	____________
Print Name	Signature	Date

RB Office Park 4657 Gulf Breeze Parkway * Units A & B * Gulf Breeze. FL. 32563
850-916-9304/05 * Fax * 850-916-9306

PERSONAL INJURY PATIENT INFO

Name______________________________ Home
Address____
Email_______________________
Phone #___________W__________C___________
Age_______DOB_________S/S______________________________
Employer's Name____
Employer's Address_____________________________________
Your Ins. Co_____________________________Policy #__________
Agents Name/#____
Name on Policy (if other than self) __________________Policy#__________
Responsible Party's Name _______________________________
Address___________________City___________State______Zip_______
Policy Holders Name ______________________Policy#_____________

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information fro the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of you Patient Health Information we encourage you to read the HIPPA NOTICE that is available to you at the from desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office. ICPTS has my consent to use my name for the purpose of Referral Boards, Testimonials, Kids photo boards, birthdays, an etc… My name and/or photos will strictly be used for special acknowledgements

Patient's Signature:_____________________________ Date:______________
Guardian's Signature Authorizing Care:_______________Date:______________

ATTORNEY ____See info below ___None ___Yes/___No, I wish to retain an attorney

Name_________________________Phone_______________________
Address____

Where there any witnesses? ___Yes ___No
Name(s)____

NATURE OF ACCIDENT:

1. Date_______________Time of day______________
2. Location_______________________________________
3. I was ( )Driver ( )Passenger ( )Front Seat ( )Back Seat ( )Pedestrian

4. Type of car (yours)________________(theirs)________________
5. I was struck from ( )Behind ( )Front ( )L/side ( )R/side ( )Head on
6. Approximate speed of your car______mph Their car ________mph
7. Were you looking ( )Straight ahead ( ) R ( )L Down ( ) Don't remember
8. Did your body hit anything?____
____
9. Were you knocked unconscious ( )Yes ( ) No If yes, how long?_____
10. Property damage to yours?____
____
11. Property damage to theirs?____
____
12. # people in car__________#wearing seat belts__________
13. What direction were you traveling (circle) N E S W
14. Street Name:____
15. Direction other was traveling (circle) N E S W
16. Street Name:____
17. Was your car ________stopped ____Parked _____Moving
18. Were you going to work ___Yes ___No
19. Were police notified? ____Yes ____No ______________Departmt
20. Accident Report? ____Yes ____No ________________Departmt
21. Ticket or Citation to: ____
22. Were you taken to hospital/which/when____
23. Did you go by ambulance____
24. In your own words, please describe in detail how the accident occurred:____
____
____
____
25. Any physical complaints before the accident? ( ) Yes ( )__No If yes, describe in detail:____
____
____
26. Please describe how you felt:
    a. During the accident:____
    ____
    b. Immediately after:
    ____
    ____

c. Later that day:____

d. The next day:____

27. What are your Present complaints and symptoms:

28. Any congenital factors which relates to this problem?____Yes _____No
    If yes describe:____

29. Any previous illnesses which relate to this case?
30. If yes describe____

31. Ever been in a car accident before ( )Yes ( ) No Describe if yes:

32. Have you been treated for this accident? ( ) Yes ( ) No Please Describe

33. Are your symptoms: ( ) Improving ( ) Getting Worse ( ) Same
34. Lost time from work as a result of this accident? ( ) Yes ( ) No
35. Describe in detail (include last day worked, type of employment, salary, compensation you receive).

36. Describe any activity restrictions as a result of this injury:

37. Have you been contacted by an adjuster from the other party's insurance company regarding this claim? ( )Yes ( )No

38. Adjusters Name/#: ______________________________

39. Company's Name: ______________________________

40. Check all that apply:

□ I have settled my personal injury claim with ________________ Ins. Co.

□ I have settled the property damage claim

□ I have signed an agreement which will pay my medical expenses for a period of time (explain)

____

____

____

Authorization fro medical information

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 third degree.

Authorization for wage and salary information

This authorization or photocopy hereof, will authorize you to furnish all information you may have regarding my wages or salary while employed b y you. You are authorized to provide this information in accordance with the Florida "no fault" auto insurance law (chapter 71-252 f.s.).

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing nay false, incomplete, or misleading information is guilty of a felony of third degree.

Name ______________________ SS# ______________________

Signature of Patient ______________________ Date ______________________

Signature of Guardian ______________________ 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.**

Office visit Manual Therapy Therapeutic Stretching Therapeutic Ultrasound X-Rays Infrared heat
Massage Therapy Hot/Cold Packs Electrical Stimulation Phonophoresis Iontophoresis
Manual Traction Intersegmental Traction Spinal/Extremity Adjustment Gait Training
Functional Activities Fluidotherapy Therapeutic Exercise/Activities Activities of Daily Living
Neuromuscular Re-education Ergonomic Procedures

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