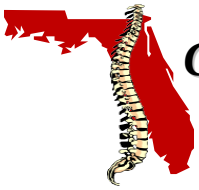

Gulf Coast Injury Center

Medical | Chiropractic | Massage | Rehabilitation

Confidential Patient Case History

First Name:_____ Last Name_____ Middle Initial_____ ***Male/ Female***

Address:_____ City State_____ Zip_____ Home /Cellphone _____

May we leave messages regarding your appointment or medical condition at the number listed above? Y/ N Age:_____ DOB / /____

SS#:____/_____/____ Marital Status: ***Married / Single /Widow*** Email_____

Do you have a DNR on file? **Y / N** -Do you have Advanced Directives in place? **Y / N** -If yes, may we have a copy? **Y / N**

Occupation:_____ Employer_____ Work Phone #_____

Emergency Contact Name:_____ *Relation:*_____ Phone#_____

Primary Care Physician: _____ Phone_____ Fax_____

Pharmacy:_____ Phone#_____

Health Insurance

Insurance Company:_____ Subscriber ID#:_____ Group#_____ Phone#_____

Are you the primary insured on this policy? ***YES / NO*** If No, Insured Name:_____ Relation_____

Primary Insured's DOB____/____/____ Address if different then above_____ City/St/ Zip_____

Do you have secondary insurance? YES / NO If yes, Insurance company:_____ Subscriber#_____

Secondary Health Insurance

Insurance Company:_____ Subscriber ID#:_____ Group#_____ Phone#_____

Are you the primary insured on this policy? ***YES / NO*** If No, Insured Name:_____ Relation_____

Primary Insured's DOB____/____/____ Address if different then above_____ City/St/ Zip_____

Do you have secondary insurance? YES / NO If yes, Insurance company:_____ Subscriber#_____

I authorize the release of a full report of examination of findings, diagnosis, treatment programs, etc., to any referring or treating physician or dentist. I additionally authorize the release of any medical information to the insurance companies for legal documentation to process claims. I understand that I am responsible for all charges for the treatment rendered to me regardless of the insurance coverage. I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that ***Gulf Coast Injury Center, LLC****. will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to* ***Gulf Coast Injury Center, LLC.*** *will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will me immediately due and payable.*

Patient/ Guardian Signature _____ ***Date*** _____

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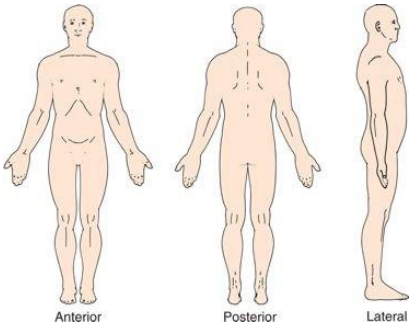
Health Information

Please mark on the figure below, your areas of pain.

Key
X SHARP
O DULL/ ACHY
Y NUMBNESS
/ PINS NEEDLES



Briefly describe your chief complaints.

_____

_____

_____

_____

_____

_____

_____

Is this condition progressively getting worse**?** ***YES / NO*** How do you rate the pain? (**1** being no pain **10** being worse pain). _____

How long have you had this condition?_____What makes the condition feel better? _____

Is this condition interfering with any of the following: ***WORK / SLEEP / DAILY ROUTINE / OTHER*** _____

Have you had this condition in the past? ***YES/ NO*** Are you currently being treated for this condition ***YES / NO*** If yes, list the doctors and treatment you have had currently or previously regarding this problem._____

_____

Are you pregnant? ***YES / NO / MAYBE*** If yes, how far along_____Number of children_____

Do you currently smoke tobacco? ***YES / NO*** If yes, How much?_____pack(s) per day. How long?_____year(s)

Do you drink alcohol? ***YES / NO*** If Yes, How much?_____drink(s) per day. How long?_____year(s)

List any surgical operations and the years they occurred._____

Have you had any prior diagnostic studies (i.e., x-ray, MRI, CT scan, ultrasound) ***YES / NO*** If yes, List the type and date they took place

_____

Are you allergic to anything? (i.e., medications, lotions, food, etc.) Yes/No _____

List any medications/supplements that you are currently taking?

1._____2._____3._____4._____5._____

Family Health Information

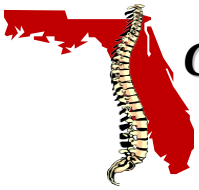
Many health problems are the result of hereditary spinal weakness, thus information about your family member will give us a better picture of your total health picture. Please list any information you may know about your family members that may be helpful.

_____

_____

_____

Patient/ Guardian Signature_____***Date***_____



Gulf Coast Injury Center

Medical | Chiropractic | Massage | Rehabilitation

Medical History

Please circle the following conditions you currently or in the past have had.

Artificial Implants: *Pace Maker | Breast Augmentation | Insulin Pump | Heart Valve | Joint Replacement*_____*Other:*_____
Arthritis: *Gout | Osteoarthritis | Rheumatoid Disease | Other:*_____
Blood: *Anemia | Leukemia | Hemophilia | HIV/AIDS | Sickle Cell Anemia | Other:*_____
Endocrine: *Diabetes Type:*_____*| Thyroid Disease | Hypoglycemia | Parathyroid Disease | Other:*_____
Eye: *Glaucoma | Ocular Herpes | Other:*_____
Heart/Circulatory: *Arteriosclerosis | Congenital Heart Disorders | Heart Attack | Coronary Artery Disease |Heart Murmur | High/ Low Pressure Rheumatic Fever | Congestive Heart Failure | Poor Circulation | Other:*_____
Kidney/Urinary: *Bladder Infection | UTI | Blood In Urine |Kidneys Disease | Sugar In Urine | Other:*_____
Liver Disease: *Cirrhosis of the Liver | Hepatitis A | Hepatitis B | Other:*_____
Lung/Respiratory: *Asthma | Emphysema | Bronchitis | Lung Cancer | COPD | Shortness of Breath | Tuberculosis | Other:*_____
Muscle: *Neck Pain | Mis Back Pain | Lower back Pain | Muscle Tremors or shaking | Other:*_____
Nerve/Other: *Cerebral Palsy | Epilepsy | Neuralgia | Multiple Sclerosis | Parkinson's Disease| Stroke | Headaches| Migraines| Vertigo | Anxiety | Depression | Bipolar Disorder | Other:*_____
Stomach/ Intestinal: *Bloating | Ulcerative Colitis | Constipation | Gallbladder Issues | IBS | Other:*_____

Patient/ Guardian Signature_____**Date**_____

Consent for Treatment

I,_____, hereby authorize your practice and whomever the doctor may designate as his/her assistant to perform examination, physiotherapy, and physical therapy and to perform non-invasive diagnostic tests. This may include any unforeseen condition that arises in the course of the procedures which may call for judgment for procedures in addition to or different from those non-complicated. I further request and authorize this office to perform whatever my treating doctor deems advisable. The nature and purpose of these procedures have risks involved and the possibility of complications have been fully explained to me. I acknowledge that no guarantee has been made to me as to the result that may be obtained.

Is the patient a minor? *Yes/No* If Yes, Legal Guardian Name:_____Relation:_____

Patient/ Guardian Signature_____**Date**_____

Authorization for Medical Information

This authorization or photocopy hereof, will authorize you to furnish all information you may have regarding my condition while under your observation or treatment, including the history obtained, x-rays, physical findings, diagnosis and prognosis. You are authorized to provide this information in accordance with the auto personal injury protection law. (Chapter 71-252f)

I authorize that my medical records can be discussed with:_____Relation:_____

Patient/ Guardian Signature_____**Date**_____

Gulf Coast Injury Center

Medical | Chiropractic | Massage | Rehabilitation

Summary of the Florida Patient's Bill of Rights and Responsibilities

Florida law requires that your healthcare provider or healthcare facility recognize your rights while you are receiving medical care and that you respect the healthcare provider's or healthcare facility's right to expect certain behavior on the parts of patients. You may request a copy of the full text of this law from your healthcare provider or health facility. A Summary of your rights and responsibilities are as follows:

1.A patient has the right to be treated with courtesy and respect, with appreciation of his/her individual dignity, and with protection of his or her need for privacy.
2.A patient has the right to prompt and reasonable response to questions and requests.
3.A patient has the right to know who is providing medical services and who is responsible for his/her care
4.A patient has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.
5.A patient has the right to know what rules and regulations apply to his/her conduct.
6.A patient has the right to be given by the healthcare provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.
7.A patient has the right to refuse any treatment, except as otherwise provided by law.
8.A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his/her care.
9.A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment; whether the healthcare provider or health care facility accepts the Medicare assignment rate.
10.A patient has the right to receive a copy of a reasonable clear and understandable, itemized bill and upon request, to have the charges explained.
11.A patient has the right to receives, upon request, prior to treatment, a reasonable estimate of charges for medical care.
12.A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, physical handicap, or source of payment.
13.A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
14.A patient has the right to know if medical treatment is for the purpose of experimental research and to give his/her consent or refusal to participate in such experimental research.
15.A patient has the right to express grievances regarding any violation of his/her rights, as states in Florida law, through the grievance procedure of the healthcare provider or healthcare facility which served him/her and to the appropriate states licensing agency.
16.A patient is responsible for providing to the healthcare provider, to the best of his/her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his/her health.
17.A patient is responsible for reporting unexpected changes in his/her condition to the healthcare provider.
18.A patient is responsible for reporting to the healthcare provider whether he/she comprehends a contemplated course of action and what is expected for him/her. 19A patient is responsible for keeping appointments and, when he/she is unable to do so for any reason, for notifying the healthcare provider for healthcare facility. 20.A patient is responsible for his/her actions if he/she refuses treatment or does not follow the healthcare provider's instructions.
21.A patient is responsible for assuring that the financial obligations of his/her healthcare are fulfilled as promptly as possible.
22.A patient is responsible for following healthcare facility rules and regulations affecting patient care and conduct.

I have read and understand the summary of the Florida patient's bill of rights and responsibilities.

Patient/guardian Signature:_____Date_____

Emergency Management Plan

1. If the patient has a caregiver, the caregiver must accompany the patient and remain with the patient during the course of treatment
2. Please be aware that each room contains an evacuation map near the doorway which will assist in guidance to the nearest exit in the event of an emergency.
3. It is the responsibility of the facility staff member to educate patients on the nearest exit in case of emergency.
4. During an emergency, your assigned staff member has been trained to guide you to the nearest exit for safety
5. In the event of facility closure, you will be contacted and informed by a designated member of the facility. When the facility has returned to normal operating hours, you will be notified.
6. Any treatment missed due to the event of an emergency will be documented as missed in your clinical records and made up at a later date.

Please note: The staff of the facility needs to be notified of any special needs you may have so that they may properly assist you during the unforeseen even of an emergency.

I have been educated on the Emergency Management Plan for the facility and I am clear about my responsibility as well as the responsibility of the trained staff members with regard to protocols during the event of an unforeseen emergency

Patient Signature:_____Date:_____

Gulf Coast Injury Center

Medical | Chiropractic | Massage | Rehabilitation

HIPAA Privacy Authorization Form

This is an authorization for use or Disclosure of Protected Health Information.
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

This is an authorization for release of health information that covers all past, present, and future periods of my medical record. I,_____/_____/_____ _____/____/_____
Patient Name *Date of Birth* *SS#*
authorize the use or disclosure of the health information as described below to the following person or organization_____
Name /Facility *City/St*

□Entire Medical Record □ Demographic Information

□Emergency Department Record □ Consultations

□Operative Reports □ Laboratory results

□Other_____

I authorize the disclosure of the following information marked above to the following organization:

□***6963 E. Fowler Ave Temple Terrace Fl 33617 | P:813253.3111| F:813514.0108***

□***1104 W. Kennedy Blvd Tampa Fl 33607 | P:813.258.6051 | F:813.258.6064***

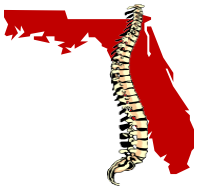
□ ***1023 Us Highway 19 Holiday Fl 34691 | P:727.931.9726 |F: 727.934.2870***

□ ***322 S. Falkenburg Rd Tampa, Fl33619 |P:813.626.2311 |F: 813.434.4233***

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. I understand that the information in my medical record may include information relating to mental healthcare, and treatment of alcohol or drug abuse. I also understand that the information may include information relating to sexually transmitted disease, AIDS or HIV. I also understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing. I understand that the revocation will not apply to information that has already been released in response to the authorization. I understand that the revocation will not apply to my insurance policy. Unless otherwise revoked, this authorization will expire in one year.

Patient /Guardian Signature:_____***Date:***_____
*If signed by Legal Rep., relation to Patient*_____

Witness_____***Date:***_____



Gulf Coast

Injury Center

Financial Policy Agreement Self-Pay / Health Insurance Coverage

Gulf Coast Injury Center is committed to providing excellent, affordable medical care. You have the right and responsibility of knowing the cost of your medical treatment. Should you be a cash patient, we may not ask for full payment at the time of service, although you will remain responsible for the full payment of all fees for service provided. If you have health insurance; even if we bill your insurance company directly, you may be responsible for copayment, coinsurance, deductible, and non-covered amounts. For your convenience, our office accepts personal checks, credit cards, cash, and when appropriate, can provide you with a mutually agreed upon payment plan. All treatments which are not covered by your health insurance plan will still require payment due at the time of service. Please read the following carefully, as it outlines our financial policy.

It is important that insurance patients understand how insurance billing works. Insurance companies require us to break down every component of your office visit into universal, numerical procedure codes, and charge for each code. The insurance companies will arbitrarily change, combine, and disallow procedure codes, and then apply their company's individual fee schedule. This result is the insurance company's determination of "reasonable and customary" changes - the amount they are willing to cover. The insurance company usually reduces the actual reimbursement further by the individual's policy annual deductible, copayment or coinsurance.

This method of billing designed by the insurance industry, forces us to bill at full price procedure codes that the insurance company will likely reduce, combine, or simply deny. This system in fact, has the insurance company determining our fees. If we have a contract with your insurance company, we write-off the amount over the "reasonable and customary", and bill you for your coinsurance and deductible. If we do not have a contract with your insurance carrier, you are responsible for that amount as well as any deductible and coinsurance.

We are required by all insurance carriers to collect from patients any deductible and copayment or coinsurance amounts. These fees can be reduced only in those cases where true financial hardships can be demonstrated. If you feel that you are in a position of financial hardship, please discuss your financial hardship with our patient account supervisor. In the unlikely event you stop payment, are notified of Nonsufficient Funds or your account is turned over to Collections, you will be responsible for all related costs.

I have read and understand Gulf Coast Injury Center's financial policy as outlined above. The following constitutes an agreement between the undersigned patient/guarantor and Gulf Coast Injury Center. In the event Gulf Coast Injury Center agrees to seek payment initially from my insurance company, I request payment to be made directly to them of all medical benefits otherwise payable to me for services rendered. I understand that final obligations for payment are mine. Any portions of my bill not paid by insurance are my responsibility and are due and payable on demand. I hereby authorize Gulf Coast Injury Center to release all information necessary to secure payment of benefits.

Patient Signature:_____***Date:***_____

Gulf Coast Injury Center

Medical | Chiropractic | Massage | Rehabilitation

PATIENT NAME: _____

ARTICLE 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process, except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. Further, the parties will not have the right to participate as a member of any class of claimants, and there shall be no authority for any dispute to be decided on a class action basis. An arbitration can only decide a dispute between the parties and may not consolidate or join the claims of other persons who have similar claims.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, as to whether this agreement is unconscionable, and any procedural disputes, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider, including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care provider, preceptors, or interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not. All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitations, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days, and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration incurred or approved by the neutral arbitrator, not including counselor fees, witness fees, or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator. The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction, or related circumstances, shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature, and if not revoked, will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example emergency treatment), patient should initial here. _____. Effective as of the date of first professional services.

If any provision of the Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

PATIENT SIGNATURE _____ **DATE** _____

OFFICE SIGNATURE _____ **DATE** _____

CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic procedures, including various modes of physical therapy/physiotherapy, diagnostic x-rays, and any supportive therapies on me (or on the patient names below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with, or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand that chiropractic adjustments and supportive treatment are designed to reduce and/or correct subluxations, allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, I understand and am informed that, as is with all healthcare treatments, results are not guaranteed, and there is no promise to cure. In addition, I understand and am informed that, as is with all healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns from heat lamps, ice or heating devices, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that there are treatment options available for my condition other than chiropractic procedures. Their treatment options include, but are not limited to, self-administered, over-the-counter analgesics and rest; medical care with prescription drugs, such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and to secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I understand that all payment(s) for treatment(s) are final and no refunds will be issues. However, prorated fees for unused, prepaid treatments will be refunded if I wish to cancel the treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below, I agree to have the above-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

PATIENT SIGNATURE: _____ **DATE** _____

CHIROPRACTOR NAME: _____

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED  DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd. for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.