GREENWAVE
FAMILY WELLNESS CENTER

625 Jenks Avenue - Panama City, Florida 32401
Office: (850) 215-5657 Fax (850) 215-5658
Frontdesk@PanamaCityWellness.com

Name: _____ Age:_____ Sex :_____

Address _____City_____

State: _____ Zip _____Phone_____ Email: _____

Marital Status: □ Married □ Single □ Divorced □ Widowed Number of Dependents_____

Date of Accident_____

Auto Insurance Company

Name of Company_____

CLAIM#_____

Adjuster's Name_____

Adjuster's Telephone #_____

Do you have Medical Insurance YES___ NO___?

Medical Insurance

Name_____

Member ID#_____

Attorney's Name_____

Attorney's Address_____

Attorney's Telephone # _____

GREENWAVE
FAMILY WELLNESS CENTER

625 Jenks Avenue - Panama City, Florida 32401 Office: (850) 215-5657 Fax (850) 215-5658

Date: _____

PERSONAL INJURY/AUTO ACCIDENT FORM
IMPORTANT - Please fill out the following in complete detail:

1. What was the time and date of present injury? _____ am/pm Year 20_____
2. What were your immediate symptoms? _____
3. What are your symptoms now? _____
4. Where were you taken after the accident? _____
5. Was any other doctor consulted after your accident? _____
6. If yes, what was the doctor's name? _____
7. What care was given? _____
8. How often did you see the doctor? _____
9. Have you been unable to work due to this accident? _____
10. If yes, give dates_____
11. Have you returned to work? _____ If yes, when? _____
12. If you have not returned to work, when do you expect to return? _____
13. Have you ever had any complaints in the area involved prior to this injury? _____
14. If yes, what were your complaints? _____
    _____
15. Have you had any surgeries? _____
16. If yes, what and when? _____
17. Have you had any accidents or injuries prior to this injury? _____
18. If yes, explain_____
19. Is your injury covered by insurance? _____
20. If yes, name of insurance company and adjuster_____
    _____
21. Have you retained an attorney? _____If yes, his name and address _____
    _____

PLEASE BRIEFLY EXPLAIN HOW ACCIDENT HAPPENED

_____
_____
_____
_____

GREEN WAVE FAMILY WELLNESS CENTER
STANDARD DISCLOSURE AND ACKNOWLEDGMENT FORM

Personal Injury Protection - Initial Treatment or Service Provided

*(an original of this form will be provided)

The undersigned insured person (or guardian of such person) affirms:

1. The services set forth below were actually rendered. This means that those services have already been provided.

_____

_____

_____

2. I have the right and ability 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. This means that no person has initiated contact with me and/or persuaded me to use the doctor or licensed professional, clinic, or medical institution that provided the services.

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 $500.00.

The undersigned licensed medical professional affirms the statement numbered #I 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. **I have explained the services** rendered 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.

Insured Person (patient receiving treatment) or Guardian of Insured Person:

NAME (Print of Type: _____ Signature: _____ Date: _____

Licensed Medical Professional Rendering Treatment (Signature by his/her own hand):

NAME (Print of 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), Fl 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.