Name: _____ Phone: _____ Cellular:

Address: _____ City: _____ State: _____ Zip:

Age: _____ Birthdate: _____ Sex: ____ SSN _____

Employer's Name: _____

Employer's Address: _____

Employer's Phone:

Your Ins. Co: _____ Policy #: _____ Agent:

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

Do you own a car?

Do you have insurance?

NATURE OF ACCIDENT

1. Date of Accident: _____
2. Make of vehicle: Year:
3. Were you ( ) Driver ( ) Front Seat Passenger ( ) Back Seat Passenger
4. Number of people in your vehicle? _____ Were you wearing seat belts? ( ) Yes ( ) No
5. What direction were you headed? ( ) North ( ) South ( ) East ( ) West
6. What direction was other vehicle headed? ( ) North ( ) South ( ) East ( ) West
7. Were you struck from : ( ) Behind ( ) Front ( ) Left side ( ) Right side
8. Approximate speed of your car _____ mph other car _____ mph
9. Were you knocked unconscious ? ( ) Yes ( ) No If yes, for how long? _____
10. At the time of impact, were you looking: ? ( ) Straight ( ) Left ( ) Right ( ) Back
11. Both hands on the steering wheel? ( ) Yes ( ) No
12. Was your foot on the brake? ( ) Yes ( ) No

13. Did you strike anything in car at the time of impact ( ) Yes ( ) No

Steering wheel Dashboard Windshield Door Window Other _____

State Part of Body:
Chest Chin Knee Shoulder Hand Head Other _____

14. Any lacerations (cuts) or bruises> ( ) Yes ( ) No

15. Were you dazed? ( ) Yes ( ) No

16. Were police notified? ( ) Yes ( ) No

17. In your own words, please describe the accident:

_____

_____

18. Did you have any physical complaints **BEFORE THE ACCIDENT**? ( ) Yes ( ) No If Yes, describe:

_____

_____

19. What are your present complains and symptoms?

_____

_____

20. Do you have any previous illnesses which relate to this case? ( )YES ( ) NO
If yes, please describe:

_____

_____

21. Have you ever been involved in an accident before? ( )YES ( ) NO
If yes, please describe include date(s) and type(s) of accidents and injuries received:

_____

_____

22. Have you been treated by another doctor since the accident? ( )YES ( ) NO

23. Since this injury occurred, are your symptoms:

( )Improving ( ) Getting Worse ( ) Same

24. CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

Review of Systems

___ Headache
___ Neck pain
___ Stiff neck
___ Sleeping problems
___ Back pain
___ Nervousness
___ Tension
___ Irritability
___ Chest pain
___ Visual Disturbances
___ Weight Loss
___ High blood pressure
___ Blood in stool
___ Blood in urine
___ Bleeding
___ Cough
___ Swelling
___ Heat/Cold intolerance
___ Heartburn
___ Dizziness
___ Head seems too heavy
___ Pins & needles in arms
___ Pins & needles in legs
___ Numbness in fingers
___ Numbness in toes
___ Shortness of breath
___ Fatigue
___ Palpitations
___ Rashes
___ Upset Stomach
___ Nausea/vomiting
___ Chills
___ Fever
___ Wheezing
___ Incontinence
___ Transfusions
___ Depression
___ Fainting
___ Loss of memory
___ Loss of balance
___ Loss of smell
___ Loss of taste
___ Ringing in ears
___ Easy bruising
___ Enlarged glands

Symptoms other than above:

_____

Have you ever had this condition/problem before ( )YES ( ) NO

25. PAIN LEVEL: On a scale of 0-10, with 0 being you're pain free and can function quite well, and 10 being you're in excruciating pain all the time, where would you rate the intensity of pain?

0 1 2 3 4 5 6 7 8 9 10

No pain Low pain Moderate Pain Intense Pain Excruciating pain

Patient Name: _____

26. Have you lost time from work as a result of this accident? ( )YES ( ) NO If YES, please complete:

Last day of work: _____

Type of employment: _____

Are you compensated for lost time at work? ( )YES ( ) NO

If YES, please detail how: _____

27. Do you notice any activity restrictions as a result of this injury? ( )YES ( ) NO If YES, please explain: _____

28. Other patient information _____

HOSPITAL INFORMATION:

1. Did you go to the hospital? ( )YES ( ) NO
2. When did you go? _____
3. How did you get to the hospital? ( )Ambulance ( ) Private Transportation
4. Name of Hospital? _____
5. Were you x-rayed? ( )YES ( ) NO
6. Did you receive any medication? ( )YES ( ) NO

PASSENGER INFORMATION ONLY:

1. Do you own a car? ( )YES ( ) NO
2. If no, does anyone in your house own a car? ( )YES ( ) NO
3. If yes, please provide the information below :

Name: _____

Address: _____

Insurance Co: _____

Policy Number: _____

Signature _____ Date _____

Dr. Daniel Brandwein, D.P.M., F.A.C.F.A.S
159. S Pompano Parkway
Pompano Beach, Fl 33069
Phone (954) 984-7500 Fax (954) 984-8884

Weight: _____ Height: _____ Shoe Size: _____

Emergency Contact: _____
Relationship: _____
Email address: _____

Reason For Today's Visit: _____

_____

Primary Care Physician: _____ Phone: _____

Date Last Seen: ___ /___ /___

Please List Any Allergies: _____

_____

Current Medications: _____

Medical Conditions: _____

Please Check All That Apply

( ) Heart Disease	( ) Arthritis	( ) Thyroid Condition
( ) Epilepsy	( ) Hypertension	( ) Blood Disorders
( ) Diabetes	( ) Liver Disease	( ) Lung/Respiratory Problem

If other please list: _____

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Pompano Beach, Fl 33069
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ASSIGNMENT OF INSURANCE BENEFITS, RELEASE, & DEMAND

I, the undersigned patient/insured knowingly, voluntarily, and intentionally assign the rights and benefits of my automobile insurance, also known as personal injury protection (Here after PIP), and medical payments policy of insurance to the above healthcare provider. I understand it is the intention of the provider to accept this assignment of benefits in lieu of demanding payments at the time services are rendered and that this document will allow the provider to file suit against an insurance company for payment of the insurance benefits. I understand the provider may file a lawsuit against my insurer for a payment and if the provider's bills are paid or applied to a Deductible I agree this will serve as a benefit to me and I authorize and request such litigation. This assignment of benefits includes transportation over do you interest and any potential claim for common law or attorney bad faith. If the insurer disputes the validity of this assignment of benefits then the insurer is instructed to notify the provider in writing within five days of receipt of this documents. Failure to inform the provider shall results in a waiver by the insurer to contest the validity of this document. The undersigned directs the insured to pay the health care provider directly without including the patients name on the check.

The insurer is directed by the provider and the undersigned to not issue any checks or drafts in partial settlements of a claim that contain or are accompanied by language releasing the insurer or it's insured/patient from liability unless there has been a prior written settlement agreed to by the health provider and the insurer as to the amount payable under the insurance policy. The provider hereby contests and objects to any reductions or partial payments. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by the provider shall be done so under protest, at the risk of the insurer, and the deposit shall not be deemed a waiver, accord, satisfaction, discharge, settlement or agreement by the provider to accept a reduced amount as payment in full. The insurer is hereby placed on notice that this provider reserves the right to seek the full amount of the bills submitted.

If the insurer schedules a defense examination or examination under oath (here in after EUO) the insurer is hereby instructed to send a copy of side notification to this provider. The provider or the providers attorney is expressly authorized to appear at any EEO or I am he sat by the insurer the healthcare provider is not the agent of the insurer or the patient for any purpose.

This assignment applies to both past and future medical expenses and to valid even if undated. A photocopy of this assignment is to be considered as valid as the original. I agree to pay any applicable deductible, copayments, for services rendered after the policy of insurance exhausts and for any other services unrelated to the automobile accident. The healthcare provider is given the power of attorney two: endorse my name on any checks for services rendered by the above provider, and to request and obtain a copy of any statements of examinations under oath given by patient.

Release of information: I hereby authorize this provider to: furnish and ensure, and ensures intermediary, the patient's other medical providers, and the patient's attorney via mail, fax, or email, with any and all information that may be contained in the medical records to obtain insurance coverage information in writing (declaration sheets) and telephonically from the insurer, request from any insurer all explanation of benefits (EOBs) for all providers and non-redacted PIP payout sheets; obtain any statements the patient provided to the insurer, obtain copies of all medical records, including but not limited to, documents, reports, scans, notes, bills, opinions, x-rays, IMEs, and MRIs From any other medical provider or any insurer. The provider is permitted to produce my medical records to its attorney in connection with any pending lawsuits. The insurer is directed to keep the patient's medical records from this provider private and conditional and the insurer is not authorized to provide these medical records to anyone without the patient's and the provider's prior express written permission.

Demand: demand is hereby made for the insurance to pay all bills within 30 days without reductions and to mail the latest non-redacted PIP payout sheet and the insurance coverage deduction sheet to the above provider within 15 days. The insurer is directed to pay the bills in the order they are received. however, it's a bill from this provider and a claim from anyone else is received by the insurer on the same day the insurer is directed to not apply this provider's bill to the deductible. it's a bill from this provider and claim from anyone else is received by the insurance on the same day than the insurer is directed to pay this provider first before the policy is exhausted. In the event the providers medical bills are disputed or reduced by the insurer for any reason, or amount, the insurer is two: set aside the entire amount disputed or reduced; escrow the full amount at issue; And not pay the disputed amount to anyone or any Anthony, including myself, until the dispute is resolved by a quarts. Do not exhaust the policy. The insurer is instructed to inform, and writing, the provider of any dispute.

Certification: I certify that: I have read and agree to the above; I have not been promised anything in exchange for receiving healthcare; I have not received any promises or guarantees from anyone as to the results that may be obtained by any treatment or service; I agree the providers prices for medical services, treatment and supplies are reasonable and customary.

Caution: Please read before signing. If you do not completely understand this document please ask us to explain it to you. If you sign below we will assume you understand and agree to the above.

Patient's Name: _____ Patient's Signature: _____

(Please print) (If patient is a minor, signature of parent/guardian)

Date: _____

Dr. Daniel Brandwein, D.P.M., F.A.C.F.A.S
159. S Pompano Parkway
Pompano Beach, Fl 33069
Phone (954) 984-7500 Fax (954) 984-8884

TO: _____ RE: _____

_____ DOB: _____

_____

_____

DOL: _____

I do hereby authorize the office of Dr. Daniel Brandwein, to furnish you, my attorney, with, a full such sums as may be due and owing him for medical services rendered me both by reason of this accident and by reason of any and all other bills that are due his office and to withhold such suns from any settlement, judgment, or verdict as may be necessary to adequately protect and full compensate this office of Dr. Daniel Brandwein. I hereby further give a lien on my case to said doctor against any and all proceeds of my settlement, judgment or verdict which may be paid to you, my attorney, or myself, as the result of injuries for which I have been treated, in connection therewith.

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

I agree to promptly notify the office of Dr. Daniel Brandwein of any changes or addition of attorney(s) used by lien connection with this accident, and I instruct my attorney to do the same and promptly deliver a copy this lien to any substituted or added attorney(s).

Please acknowledge this letter by signing below and returning to the Doctors office. I have been advised that if my attorney does not wish to cooperate in protecting the office of Dr. Daniel Brandwein's interest, his office will not await payment but may declare the entire balance due and payable. I further direct my attorney to pay the office of Dr. Daniel Brandwein one hundred percent of all costs associated with my treatment. I understand all costs associated with my dare and believe them to be necessary, reasonable and customary report of his 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 the office of Dr. Daniel Brandwein.

Dated: _____ _____

Patient Signature

The undersigned being the attorney of record for the above Patient does hereby agree to observe all the terms of the above and agree to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and full compensate the office of Dr. Daniel Brandwein. Attorney further agrees that in the event this lien is litigated that the prevailing party will be awarded attorney fees, costs and interest at the applicable legal interest rate.

Dated: _____ _____

Attorney Signature

PLEASE DATE, SIGN AND RETURN ONE COPY TO DOCTOR'S OFFICE, ALSO KEEP ONE FOR YOUR RECORDS.

APPLICATION FOR FLORIDA "NO FAULT" BENEFITS

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 WITH INTENT TO INSURE, DEFRAUD, OR DECRAVE ANY INSURANCE COMPLANY MAKES A STATEMTN OF CLAIM CONTAINING ANY FALSE, INCOMPLETE, OR MISELEADING 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 (STREE, CITY OR TOWN, AND STATE)

BRIEF DESCRIPTION OF ACIDNET AND VEHICLE 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 FORM TO US. SIGNATURE: DATE;	

DESCRIBE YOUR INJURY

WERE YOU TREATED BY A DOCOTR?		DOCTOR NAME AND ADDRESS
IF YOU WERE TREATED IN A HOSPITAL, WERE YOU AN IN PATIENT __ OR AN OUT PATIENT ___		HOSPITAL'S NAME AND ADDRESS
AMOUNT OF MEDICAL BILLS TO DATE	WILL YOU HAVE MORE MEDICAL EXPENSES?	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 INUURY?		IF YES, AMOUNT OF LOSS TO DATE: WHAT IS YOUR AVERAGE WAGE OR SALARY?
IF YOU LOSE WAGEWS:	DATE DISABILITY FROM WORK BEGAN:	DATE YOU RETUEND 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 ADRESS	YOUR OCCUPATION	FROM	TO
EMPLOYER AND ADRESS	YOUR OCCUPATION	FROM	TO
EMPLOYER AND ADRESS	YOUR OCCUPATION	FROM	TO

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

SWORN AFFIDAVIT

STATE OF FLORIDA)
) ss.
COUNTY OF BROWARD)

BEFORE ME; the undersigned authority, personally appeared _____ (Patient's Name), who after being duly cautioned under oath, deposes and says:

1. My name is _____ (Patient's Name), and I make this affidavit upon personal knowledge.
2. I am a resident of the State of Florida, over the age of 18, and competent.
3. I am a patient of Dr. DANIEL BRANDWEIN
   159 S. POMPANO PKWY
   POMPANO BEACH, FL 33089
4. I was injured in an automobile accident on _____ (date of accident).
5. At the time of the accident I was (place on "X"):
   _____ the driver _____ a passenger _____ a pedestrian

FURTHER AFFIANT SAYETH NAUGHT:

_____
Patient's Signautre

The foregoing instrument was acknowledged before me this _____ day of _____, 20____, by _____ (Patient's name), who is personally known to me or who has produced _____ as identification

(AFFIX SEAL OR STAMP HERE)

X_____
Signature of Notary Public, State of Florida

Dr. Daniel S. Brandwein, DPM, FACFAS

HARSHIP AGREEMENT

TO WHOM IT MAY CONCERN:

_____ HAS AGREED TO ACCEPT ASSIGNMENT ON THE UNDERSIGNED PATIENT. THE MENTIONED OFFICE HAS ALSO AGREED TO ACCEPT WHAT THE INSURANCE PAYS ONLY AS FULL PAYMENT FOR SERVICES RENDERED THE UNDERSIGNED PATIENT.

IT HAS BEEN ESTABLISHED THAT THIS PATIENT IS IN NEED OF CORRECTIVE CHIROPRACTIC AND MEDICAL CARE, HOWEVER, HE/SHE IS UNABLE TO PAY FOR THESE SERVICES AT THS TIME DUE TO A DRASTIC FINANCIAL HARDSHIP.

IN THE EVENT THE UNDERSIONED PATIENT'S INCOME INCREASE AND HE/SHE IS ABLE TO PAY THE CO-PAYMENT, THIS AGREEMENT WILL BECOME NULL AND VOD AT THAT TIME.

Patient Signature : _____ Date: _____

Witness : _____ Date: _____

Dr. Daniel S. Brandwein, DPM, FACFAS

MULTI CONSENT FORM

PATIENT CONSENT TO X-RAYS

I, _____, authorize the performance of diagnostic X-ray Examination of myself, which the above doctor or his associates may consider necessary or advisable in the course of my examination and treatment;

Signed: _____ Date: _____

NON-PREGNANCY VERIFICATION

This is to certify that, to the best of my knowledge, I am not pregnant and the above doctor and his associates have my permission to perform diagnostic X-ray examination. I have been advised that X rays can be hazardous to an unborn child.

Date of last menstrual period: ___ / ___ / ___

Signed: _____ Date: _____

CONSENT TO TREAT/X-RAY A MINOR

I, _____, authorize the performance of diagnostic X-ray Examination and/or treatment of my child or ward, _____ which the above doctor or associates may consider necessary or advisable in the course of examination and treatment. The patient is a minor, ___ years of age.

Signed: _____ Date: _____

Notice of Information Practices and Privacy Statement

How We Collect Information About You: Dr. Daniel Brandwein Podiatry and Surgery(DBPS), and its employees and volunteers collect data through a variety of means including but not necessarily limited to letters, phone calls, emails, voice mails, and from the submission of applications that is either required by law, or necessary to process applications or other requests for assistance through our organization.

What We Do Not Do With Your Information: Information about your financial situation and medical conditions and care that you provide to us in writing, via email, on the phone (including information left on voice mails), contained in or attached to applications, or directly or indirectly given to us, is held in strictest confidence.

We do not give out, exchange, barter, rent, sell, lend, or disseminate any information about applicants or clients who apply for or actually receive our services that is considered patient confidential, is restricted by law, or has been specifically restricted by a patient/client in a signed HIPAA consent form.

How We Do Use Your Information: Information is only used as is reasonably necessary to process your application or to provide you with health or counseling services which may require communication between DBPS and health care providers, medical product or service providers, pharmacies, Insurance companies, and other providers necessary to: verify your medical information is accurate; determine the type of medical supplies or any health care services you need including, but not limited to; or to obtain or purchase any type of medical supplies, devices, medications, insurance.

If you apply or attempt to apply to receive assistance through us and provide information with the Intent or purpose of fraud or that results in either an actual crime of fraud for any reason including willful or un-willful acts of negligence whether intended or not, or in any way demonstrates or indicates attempted fraud, your non-medical information can be given to legal authorities including police, investigators, courts, and/or attorneys or other legal professionals, as well as any other information as permitted by law.

Information We Do Not Collect: We do not use cookies on our website to collect date from our site visitors. We do not collect information about site visitors except for one hit counter on the main index page (www.drdanbrandwein.com) that simply records the number of visitors and no other data. We do use some affiliate programs that may or may not capture traffic date through our site. To avoid potential data capture that you visited a diabetes website simply do not click on any of our outside affiliate links.

Limited Right to Use Non-Identifying Personal Information From Biographies, Letters, Notes, and Other Sources: Any pictures, stories, letters, biographies, correspondence, or thank you notes sent to us become the exclusive property of DBPS. We reserve the right to use non-identifying information about our clients (those who receive services or goods from or through us) for fundraising and promotional purposes that are directly related to our mission.

Clients will not be compensated for use of this information and no identifying information (photos, addresses, phone numbers, contact information, last names or uniquely identifiable names) will be used without client's express advance permission. You may specifically request that NO information be used whatsoever for promotional purposes, but you must identify any requested restrictions in writing. We respect your right to privacy and assure you no identifying information or photos that you send to us will ever be publicly used without your direct or indirect consent.

Dr. Daniel Brandwein Podiatry and Surgery

159 South Pompano Pkwy, Pompano Beach, FL 33069 (954)984-7500 Feetdoc@aol.com

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

Patient Name: _____ Date: _____

Parent, Guardian, or Legal Representative: _____

Signature: _____

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.

DR. DANIEL S. BRANDWEIN, P.A.

Diplomate American Board of Podiatric Surgery

Fellow American College of Foot and Ankle Surgery

DO NOT DETACH

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-RAY AND PHYSICAL FINDINGS DIAGNOSIS AND PROGNOSIS. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE FLORIDA "NO FAULT" AUTO INSURANCE LAW (CHAPTER 71-252 F.S.).

_____

Print name

_____

Signature Date

DO NOT DETACH

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 BY YOU. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE FLORIDA "NO FAULT" AUTO INSURANCE LAW (CHAPTER 71-252 F.S.).

_____

Signature Date

_____

Social Security Number

159 S. Pompano Parkway Pompano Beach, FL 33069
Office: (954) 984-7500 Fax: (954) 984-8884

feetdoc@aol.com

Dr. Daniel Brandwein, D.P.M., F.A.C.F.A.S
159. S Pompano Parkway
Pompano Beach, Fl 33069
Phone (954) 984-7500 Fax (954) 984-8884

Patient: _____

Date: _____

RECORDS/X-RAY RELEASE:

I, _____, have requested the release of records/ x-rays which are part of my permanent records at the above stated clinic.

I hereby acknowledge receipt of these records/radiographs in consideration of the foregoing:

I hereby release and forever discharge the aforesaid clinic/doctor from any and all responsibility and liability of any type, nature or character, whatsoever arising from said records.

The transaction is consummated at my specific request.

_____

Signature

_____

Witness

159. S Pompano Parkway
Pompano Beach, Fl 33069
Phone (954) 984-7500 Fax (954) 984-8884

AFFIDAVIT OF NON-OWNERSHIP

STATE OF FLORIDA

COUNTY OF BROWARD

BEFORE ME, the undersigned authority personally appeared:

_____

_____

1. That I was involved in an automobile accident on: _____

2. That I did not own an operable motor vehicle on the date of the accident.

3. That I do not and did not at the time of the accident reside with any relative who owned an operable motor vehicle on the date of the accident.

FURTHER AFFIANT SAYETH NOT.

Signature: _____

SWORN TO AND SUBSCRIBED before me this _____ day of _____ 20 _____

_____

Notary Public (SEAL)

_____

Signature

My commission expires: _____

Office of Insurance Regulation ***Bureau of Property & Casualty Forms and Rates***

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 for 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 Statues.

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 Statues.

Note: The original of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statues and may not be electronically furnished. Failure to finish this form ay result in non-payment of the claim.

Dr. Daniel Brandwein, D.P.M., F.A.C.F.A.S
159. S Pompano Parkway
Pompano Beach, Fl 33069
Phone (954) 984-7500 Fax (954) 984-8884

Attorney Information Sheet

Patient Name: _____ DOA: _____

Have you consulted with an Attorney for this case? ( ) YES ( ) NO

If yes, please provide us with the following:

Attorney name: _____

Attorney Address: _____

_____

_____

Attorney Phone: (_____) _____ - _____ Attorney Fax: (_____) _____ - _____

Do you have your Attorney's business card? ? ( ) YES ( ) NO

If yes, please provide us with one.

~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~

Office Use Only

Office Contact: _____

LOP Sent: ( ) YES ( ) NO To Fax # : (_____) _____ - _____

LOP Received: ( ) YES ( ) NO Reason: _____

Primary Insurance: _____

Total Billing: $_____ Total Payments: $_____ Final Bill $_____

Secondary Insurance: _____

Total Billing: $_____ Total Payments: $_____ Final Bill $_____

Settlement Received: $_____

For Office Use Only

Date: _____

Patient's Name: _____ Date of Birth: _____

Insurance Company: _____

Telephone #: _____ Fax #: _____

Policy #: _____ Group #: _____

Member ID #: _____

Ded: _____ Been Met: _____ Not Been Met: _____

X-rays: _____% Orthotics : _____% Therapy: _____%

Address Claims Sent To:

_____

City: _____ State: _____ Zip Code: _____

Spoke With: _____ Ext: _____

Taken By: _____