

## CHIROPRACTIC PATIENT HISTORY

Date of Birth \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
Last Name \_\_\_\_\_ First Name: \_\_\_\_\_  
Address: \_\_\_\_\_ Apt # \_\_\_\_\_  
City: \_\_\_\_\_ STATE: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_ (Cell) \_\_\_\_\_  
Spouse's Name \_\_\_\_\_ (Cell) \_\_\_\_\_  
Your Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
Employer Address: \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Policy Number: \_\_\_\_\_  
Have you ever been to another doctor for this problem? Y N Who? \_\_\_\_\_  
Who referred you to this office? \_\_\_\_\_

### WHAT BRINGS YOU TO OUR OFFICE?

#### FIRST COMPLAINT: \_\_\_\_\_

- Date when symptom first appeared: \_\_\_\_\_
- Did it begin: Gradual: \_\_\_\_\_ Sudden: \_\_\_\_\_ Progressive over time: \_\_\_\_\_
- What makes the symptoms increase? \_\_\_\_\_
- What relieves the symptoms? \_\_\_\_\_
- Type of Pain \_\_\_\_\_ Sharp \_\_\_\_\_ Dull \_\_\_\_\_ Ache \_\_\_\_\_ Burn \_\_\_\_\_ Throb \_\_\_\_\_
- Does the Pain Radiate into your Arm \_\_\_\_\_ Leg \_\_\_\_\_ Other \_\_\_\_\_ Does not radiate \_\_\_\_\_
- Do you experience Numbness or Tingling? \_\_\_\_\_ Y \_\_\_\_\_ N
- How often do you experience these symptoms? 100% \_\_\_\_\_ 75% \_\_\_\_\_ 50% \_\_\_\_\_ 25% \_\_\_\_\_ 10% \_\_\_\_\_
- PAIN INTENSITY: From 1 (Least) to 10 (worst): \_\_\_\_\_
- Are there any conditions or symptoms you have that may relate to your major symptom? \_\_\_\_\_

What Makes the problem worse? Sitting \_\_\_ Standing \_\_\_ Bending \_\_\_ Coughing \_\_\_ Lying down \_\_\_ Walking \_\_\_  
Sneezing \_\_\_ Other \_\_\_\_\_

#### OTHER COMPLAINT: \_\_\_\_\_

- Date when symptom first appeared: \_\_\_\_\_
- Did it begin: Gradual: \_\_\_\_\_ Sudden: \_\_\_\_\_ Progressive over time: \_\_\_\_\_
- What makes the symptoms increase? \_\_\_\_\_
- What relieves the symptoms? \_\_\_\_\_
- Type of Pain \_\_\_\_\_ Sharp \_\_\_\_\_ Dull \_\_\_\_\_ Ache \_\_\_\_\_ Burn \_\_\_\_\_ Throb \_\_\_\_\_
- Does the Pain Radiate into your \_\_\_\_\_ Arm \_\_\_\_\_ Leg \_\_\_\_\_ Does not radiate \_\_\_\_\_
- Do you experience Numbness or Tingling? \_\_\_\_\_ Y \_\_\_\_\_ N
- How often do you experience these symptoms? 100% \_\_\_\_\_ 75% \_\_\_\_\_ 50% \_\_\_\_\_ 25% \_\_\_\_\_ 10% \_\_\_\_\_
- PAIN INTENSITY: From 1 (Least) to 10 (worst): \_\_\_\_\_
- Are there any conditions or symptoms you have that may relate to your major symptom? \_\_\_\_\_

What Makes this problem worse? Sitting \_\_\_ Standing \_\_\_ Bending \_\_\_ Coughing \_\_\_ Lying down \_\_\_ Walking \_\_\_  
Sneezing \_\_\_ Other \_\_\_\_\_

PATIENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

PLEASE UNDERLINE ALL OF THE FOLLOWING SYMPTOMS WHICH YOU HAVE NOW

**General Symptoms**

Headache  
Fever  
Chills  
Sweating  
Fainting  
Dizziness  
Convulsions  
Loss of Sleep  
Fatigue  
Nervousness  
Loss of Weight  
Numbness or Pain in  
Arms, Hands, Legs  
Allergy  
Wheezing  
Neuralgia

**Gastrointestinal Sympt.**

Poor Appetite  
Difficult Digestion  
Excessive Hunger  
Belching of Gas  
Nausea  
Vomiting  
Vomiting of Blood  
Pain Over Stomach  
Distention of Abdomen  
Constipation  
Diarrhea  
Colon Trouble  
Hemorrhoids (Piles)  
Intestinal Worms  
Liver Trouble  
Gall Bladder Trouble  
Jaundice  
Colitis

**Ears/Eyes/Nose/Throat**

Failing Vision  
Nearsightedness  
Farsightedness  
Crossed Eyes  
Eye Pains  
Deafness  
Earache  
Noises  
Ear Discharge  
Nose Bleeds  
Nasal Obstruction  
Sore Throat  
Hoarseness  
Hay Fever  
Asthma  
Dental Decay  
Gum Trouble  
Frequent Colds  
Enlarged Thyroid  
Tonsillitis  
Sinus Infection  
Nasal Drainage  
Enlarged Glands

**Cardio-Vascular**

Rapid Beating Heart  
Slow Beating Heart  
High Blood Pressure  
Low Blood Pressure  
Pain Over Heart  
Previous Heart Attack  
Hardening of Arteries  
Swelling of Ankles  
Poor Circulation  
Previous Stroke

**Muscle & Joint Symp.**

Neck Pain  
Low Back Pain  
Swollen Joints  
Tremors  
Foot Trouble  
Painful Tail Bone  
Hernia  
Spinal Curvature  
Faulty Posture

**Respiratory**

Chronic Cough  
Spitting up Phlegm  
Spitting up Blood  
Chest Pain  
Difficult Breathing

**Genitourinary Sympt.**

Frequent Urination  
Painful Urination  
Bloody Urine  
Pus in Urine  
Kidney Infection or Stones  
Bed Wetting  
Inability to Control Urine  
Prostate Trouble

**Skin**

Skin Eruptions  
Painful  
Itching  
Bruising  
Dryness  
Boils  
Varicose Veins  
Sensitive Skin  
Hives or Allergy

**FOR WOMEN ONLY**

Painful Menstrual Periods  
Vaginal Discharge  
Excessive Flow  
Hot Flashes  
Irregular Cycle  
Cramps or Backache  
Previous Miscarriage  
Vaginal Discharge  
Congested Breast  
Lumps in Breast  
Menopausal Symptoms  
ANY CHANCE OF YOU  
BEING PREGNANT?  
YES \_\_\_\_\_ NO \_\_\_\_\_

PATIENT SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

# PATIENT HISTORY

## Please list all previous treatments for this condition:

Name of treating physician: \_\_\_\_\_ Date of treatment: \_\_\_\_\_  
Type of treatment or Drugs Prescribed \_\_\_\_\_

Name of treating physician: \_\_\_\_\_ Date of treatment: \_\_\_\_\_  
Type of treatment or Drugs Prescribed \_\_\_\_\_

## Please list all past surgeries:

Type _____	When _____	Doctor _____
Type _____	When _____	Doctor _____
Type _____	When _____	Doctor _____
Type _____	When _____	Doctor _____

## Please list all previous accidents and falls:

What _____	When _____
What _____	When _____
What _____	When _____
What _____	When _____

## Please list any medications or vitamins you are currently taking:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

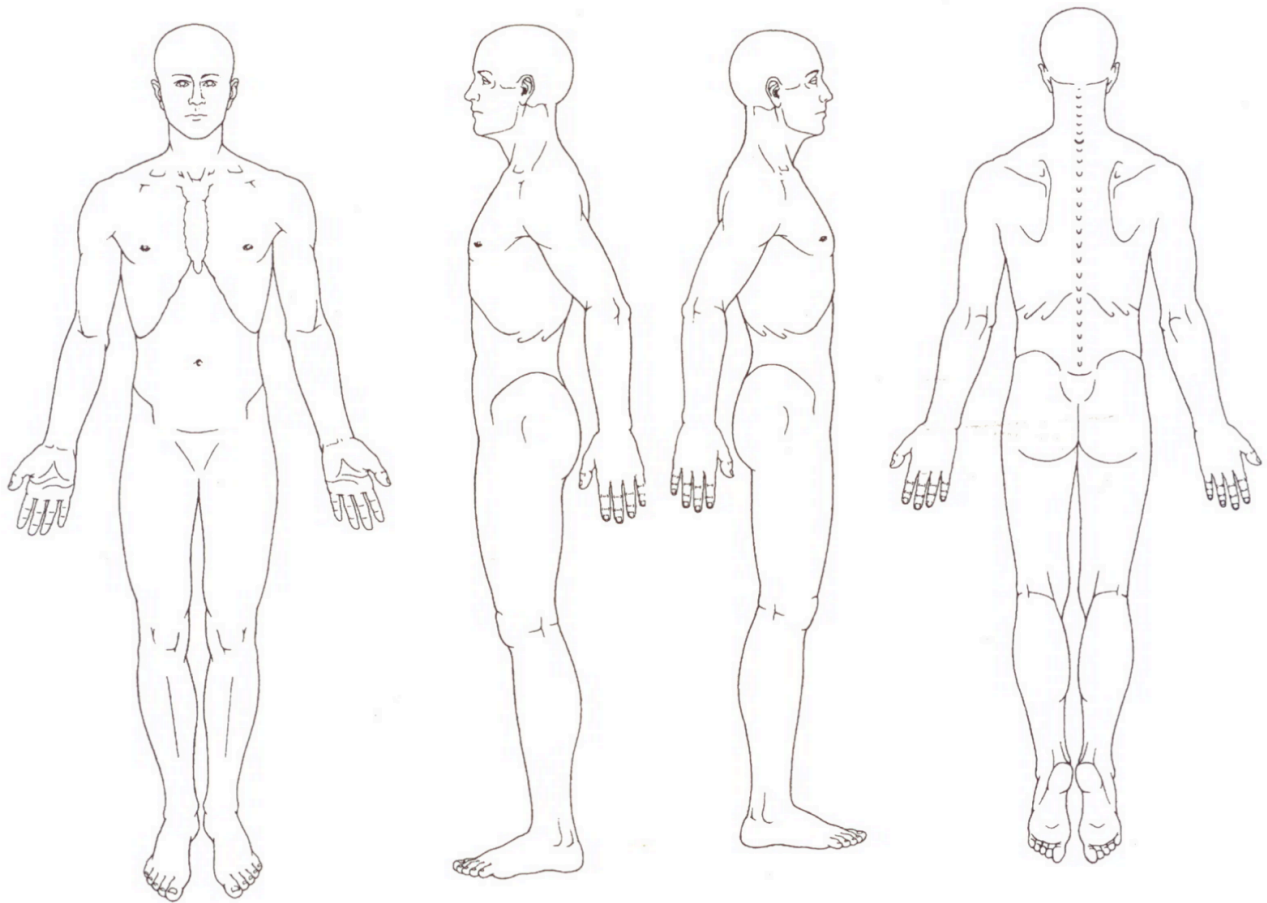
**Please do not write in this section.**

**DOCTORS NOTES:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

# PATIENT HISTORY

## PAIN LOCATION



**Please mark off the areas of your complaint on the diagram above.  
Please use the following symbols on the pain diagram to accurately describe  
your condition.**

- |            |                                      |
|------------|--------------------------------------|
| <b>PPP</b> | <b>Where you experience Pain</b>     |
| <b>NNN</b> | <b>Where you experience Numbness</b> |
| <b>TTT</b> | <b>Where you experience Tingling</b> |
| <b>BBB</b> | <b>Where you experience Burning</b>  |
| <b>CCC</b> | <b>Where you experience Cramping</b> |

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**OFFICE POLICIES**

**Patient-Doctor Agreements**

The purpose of these agreements is to allow us to more completely serve you and to get the best result in the shortest amount of time. It is our experience that those who adhere to the following agreements get the best results,

**Signing In**

When you arrive, please sign in at the front desk. You will be called and assigned a treatment room in the order you signed in. Other patients may be called before you because of the particular services being received that day or their doctor may be available before yours. When you go to the assigned treatment room, rest, relax and the doctor will be in as soon as possible.

**New Injuries**

In the event you sustain a new injury. Please let the front desk know as soon as possible. There may be additional paper work to be filed out.

**Appointments**

After your treatment, please be sure to stop at the front desk to take care of any co-pays or balances, and be sure to make your next appointment.

**Payment of Bills**

We will expect that you honor all financial agreements made with our office. If you find that you cannot fulfill your financial obligation, notify our financial manager immediately so that new arrangements can be made. Our policy is that patients maintain a zero personal balance. Insurance companies are expected to pay their portion within 45 days of claim submission. If they do not, we expect the patient to call the insurance company on our behalf to help get the claim paid. If an insurance company sends a check to your home, it should be brought or sent to our office as soon as possible unless told specifically this is not the case. Please also bring in the attached explanation of benefits (EOB).

**Rescheduling Appointments**

We have set up a specific course of treatment for you. A certain number of treatments in a set amount of time are required for us to get the results we both desire. If you need to change this time, please reschedule your appointment for another time on the same day if possible. If the same day is not possible, be sure to make up the missed appointment within one week. **For our massage therapy patients and counseling patients, a 24-hour advance notice phone call is required, so that we may fill that slot. If 24 hours notice is not given a cancellation fee will be charged to your account.**

**Progress Evaluations and Re-Examinations**

Progress evaluations and re-examinations will be performed periodically to determine your rate of progress and future course of treatment. A special time will be set up for your re-evaluation appointments.

**Upsets**

We are here to serve YOU. Please speak with the staff or doctor about anything that could be upsetting you (i.e. long waits, staff insensitivity, treatment confusion etc.). We see your comments as helping us to help you and others.

Patient Signature \_\_\_\_\_

Date: \_\_\_\_\_

# GREEN WAVE FAMILY WELLNESS CENTER

## Informed Disclosure and Consent: Chiropractic Spinal Adjustment Procedures and Physical Modalities

You have the right as a patient to be informed about your injuries and/or condition, as well as the doctor's recommended procedures and any necessary referrals to be utilized to evaluate and treat your complaints. There are potential risks and benefits in all forms of commonly used treatment, including deciding on non-treatment in the hope that the pain and/or lack of ability to perform normal activities will eventually go away. Evaluations at this office consist of a thorough regional examination of your complaints and any necessary diagnostic X-rays. If you are a female of child bearing age, you must inform the physician if there is even the slightest possibility that you may be pregnant (you must be sexually active and have missed a menstrual period), as X-rays can have harmful effects on a fetus. The physician will perform various Range of Motion and Orthopedic Stress Tests to determine the most likely cause of your pain and most appropriate course of treatment for each of your complaints. Your non-surgical spinal-related complaints will be treated with specific chiropractic spinal adjustment procedures using the hands or a mechanical instrument. You may feel joint movement and hear joint noises during the procedure. Minor temporary soreness may occur, particularly early in the treatment, or during periods of flare-up with your return to normal activities; this is also true of massage therapy and physical therapy. More significant risks (for example, fractures, sprains/strains, strokes and disc injuries) are rare. Chiropractors, or D.C.'s, have the lowest medical malpractice insurance claims of all primary care physicians in the USA, including M.D., D.O., D.D.S., D.V.M. and D.P.M. practitioners. The for-profit malpractice insurance industry has determined there is less risk involved in chiropractic spinal adjustment procedures and the adjunct therapies than in the prescribing of medication and surgery (both of which, however, may be necessary for a patient's recovery). I do not expect the doctor to be able to anticipate and explain all potential risks and complications, and I wish to rely on the doctor's education, training and experience to exercise judgment during the course of treatment, based on the facts then known, to do what is in my best interest. I further acknowledge that treatment may worsen or fail to relieve all of my spinal-related pain and that no guarantee of a "new spine" or complete cure have been given. I have had the opportunity to ask questions, and all my questions have been answered fully and satisfactorily. By signing below, I consent to the prescribed treatment plan and intend for this consent form to cover the entire course of treatment for my current complaints and for future conditions for which I seek treatment for my current complaints and/or therapists working at this office (or for the minor patient named below for whom I am the custodial parent or legal guardian).

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

If a minor (less than 18 years old), Parent or Guardian's name: \_\_\_\_\_

Parent or Guardian's signature: \_\_\_\_\_

# GREEN WAVE FAMILY WELLNESS CENTER

## Release Of Records / Payment Agreement And Assignment Of Benefits

*Patient to sign prior to any medical treatment to be performed*

Patient: \_\_\_\_\_ Date: \_\_\_\_\_

**I hereby authorize:** Green Wave Family Wellness Center, my Health Care Provider/Facility, **to release any and all medical information** to the above named insurance carrier(s), or to my designated attorney, now or in the future, and/or to my physician(s), if necessary, for the purposes of payment of my medically related outstanding debts, administration and evaluation, utilization review and financial audit. This, authorization remains valid and effective from the date of this signing until revoked in writing, to both my insurance carrier and to this provider of services. This authorization is given pursuant to Florida Statute 456.057 and HIPAA regulations. I understand that Florida Statute 456.057 (10) makes clear that any third party to whom records are disclosed is prohibited from further disclosing any information in the medical records are without the expressed written consent of the patient or the patient's legal representatives.

**Payment Agreement:** All charges are due at the time of service, unless other arrangements have been made in advance. All professional services rendered are charged to the patient and the patient is responsible for all fees, regardless of insurance coverage. I understand I am responsible to the above -mentioned facility/provider, for charges not covered by this assignment, including deductibles & co-payment requirements by my insurance policy or certificate. I further agree that in the event of non-payment, I will bear the expenses of collection and /or court costs, and reasonable legal fees, should this be required. I understand if my commercial insurance has not paid the bill within 60 days of my visit(s), for my services received by my provider /facility, I am responsible, and I will then make whatever arrangements are necessary & available to me to pay all unpaid charges.

**Assignment of Benefits:** I hereby assign to Green Wave Family Wellness Center my health Care Provider /Facility, all money to which I am entitled for medically related expenses, received at, or through the above mentioned facility. The payment shall not exceed my indebtedness. Any payment that facility/health care provider, received by the insurance company, beyond my indebtedness shall be refunded to me, when my outstanding bill(s) with them are paid.

I understand I may request a copy of any or all of my medical records for a reasonable fee or a fee allowed by State Statute or Workers' Compensation Statute. Any copy of this document shall be as valid as if it were the original. I have read the above authorization to release medical records, assignment of benefits, and payment agreement, and hereby acknowledge that I understand it. The payment agreement portion of this instrument may not be revoked in writing or otherwise.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

# GREEN WAVE FAMILY WELLNESS CENTER

## ACKNOWLEDGEMENT 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 (Please Print) \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_  
Parent, Guardian, or Patient's legal representative

\_\_\_\_\_  
Signature

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

**Personal Injury/Auto Accident History Form**

**Important-** Please fill out the following in complete detail:

Your Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Date of Accident: \_\_\_\_\_ Time of accident: \_\_\_\_\_ am./pm.

City of Accident: \_\_\_\_\_ Street of accident: \_\_\_\_\_

Road conditions at the time of the accident: WET DRY ICY OTHER \_\_\_\_\_

Did the police come to the accident scene? YES \_\_\_ NO \_\_\_; Is there a report? YES \_\_\_ NO \_\_\_

Did you go to a hospital? YES \_\_\_ NO \_\_\_

If yes, what is the name and city of the hospital? \_\_\_\_\_

How did you get to the hospital? \_\_\_\_\_

What parts of your body were X-rayed at the hospital? \_\_\_\_\_

What did the hospital do for your injuries? \_\_\_\_\_

How long did you stay at the hospital? \_\_\_\_\_

What bleeding cuts did you sustain during this accident? \_\_\_\_\_

What bruises did you sustain during this accident? \_\_\_\_\_

**WHERE** were you seated in the vehicle? \_\_\_\_\_

Were you aware of the approaching collision prior to impact, or did impact catch you by surprise?

AWARE VS SURPRISE

Did you lose consciousness (black out) upon impact? YES \_\_\_ NO \_\_\_; How long? \_\_\_\_\_

Did you experience a flash of light or explosion in your head? YES \_\_\_ NO \_\_\_

From the accident, did you become? (please circle): CONFUSED DISORIENTED LIGHT HEADED  
DIZZY NAUSEATED BLURRED VISION RING/BUZZ IN EARS

If you still have any of those symptoms, which ones? \_\_\_\_\_

Are you currently suffering from any of the following (please circle):

RESTLESSNESS IRRITABLE  
DIFFICULT CONCENTRATING DIFFICULT WITH MEMORY  
SLEEPLESSNESS FORGETFULNESS  
REDUCED TOLERANCE TO HEAT REDUCED TOLERANCE TO ALCOHOL

How far was the top of the headrest or seatback from the top of your head?

(Approximately): \_\_\_\_\_ inches above or below

Were you wearing a seatbelt? YES \_\_\_ NO \_\_\_

If yes, check which type. Lap seatbelt \_\_\_\_\_ or shoulder-lap seatbelt \_\_\_\_\_.

## Personal Injury/Auto Accident History (Continued)

List the year, make and model of the vehicle you were in:

Year \_\_\_\_\_ Make \_\_\_\_\_ Model \_\_\_\_\_

Was your car stopped at the time of impact? YES \_\_\_ NO \_\_\_

If yes, was the driver's foot also on the brake? YES \_\_\_ NO \_\_\_

If no, then estimate the speed of the vehicle you were in: \_\_\_\_\_ mph.

If your vehicle was moving at the time of impact, was it:

Slowing down? YES \_\_\_ NO \_\_\_

Gaining speed? YES \_\_\_ NO \_\_\_

Traveling at a steady rate of speed? YES \_\_\_ NO \_\_\_

On what part of the automobile did your following body parts hit?

Head hit \_\_\_\_\_

Chest hit \_\_\_\_\_

Right/left shoulder hit \_\_\_\_\_

Right/left arm hit \_\_\_\_\_

Right/left hip hit \_\_\_\_\_

Right/left leg hit \_\_\_\_\_

Right/left knee hit \_\_\_\_\_

Other \_\_\_\_\_

Did you receive any injury from the seat belt? YES \_\_\_ NO \_\_\_

If Yes, then describe: \_\_\_\_\_

What is the estimated cost in damage to the vehicle you were in \$ \_\_\_\_\_

Which of the following car parts broke during the accident? (Please circle)

Windshield \_\_\_\_\_

Front seat back \_\_\_\_\_

Right/left side window \_\_\_\_\_

Other \_\_\_\_\_

Steering wheel \_\_\_\_\_

Other \_\_\_\_\_

Was the trunk of your body pointed straight forward at the time of the collision? YES \_\_\_ NO \_\_\_

If No, how was it turned? \_\_\_\_\_

Was your head pointed straight forward? YES \_\_\_ NO \_\_\_; If No, what direction was it turned

and by how much? \_\_\_\_\_

What is the year, make and model of the other vehicle?

Year \_\_\_\_\_ Make \_\_\_\_\_ Model \_\_\_\_\_

Was the other vehicle moving at the time of the collision? YES \_\_\_ NO \_\_\_

If yes, what was its approximate speed? \_\_\_\_\_ mph

If the other vehicle was moving at the time of the collision, was it (please circle):

Slowing down

Gaining speed

Traveling at a steady speed

Please describe, to the best of your knowledge, what happened during this accident:

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## Personal Injury/Auto Accident History (Continued)

Was any other doctor consulted after your accident? \_\_\_\_\_

If yes, what was the doctor's name? \_\_\_\_\_

What care was given? \_\_\_\_\_

How often did you see the doctor? \_\_\_\_\_

Have you been unable to work due to this accident? \_\_\_\_\_

If yes, give dates \_\_\_\_\_

Have you returned to work? \_\_\_\_\_ If yes, when? \_\_\_\_\_

If you have not returned to work, when do you expect to return? \_\_\_\_\_

Have you ever had any complaints in the area involved prior to this injury? \_\_\_\_\_

If yes, what were your complaints? \_\_\_\_\_

\_\_\_\_\_

Have you had any surgeries? \_\_\_\_\_

If yes, what and when? \_\_\_\_\_

Have you had any accidents or injuries prior to this injury? \_\_\_\_\_

If yes, explain \_\_\_\_\_

Is your injury covered by insurance? \_\_\_\_\_

If yes, name of insurance company and adjuster \_\_\_\_\_

\_\_\_\_\_

Have you retained an attorney? \_\_\_\_\_ If yes, his name and address \_\_\_\_\_

\_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**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.**