

**Standard Disclosure and Acknowledgement Form
Initial Treatment or Service Provided**

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

1. The services set forth below were actually rendered. This means that those services have already been provided.
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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. 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 state 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. 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 properly completed in all material provisions and all relevant information has been provided to 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 and invalid or not medically necessary diagnostic test as defined in Section 627.732 (15) and (16), Florida Statute or Section 627.736(5) (b) 6, Florida Statute.

Date: _____ Patient Name: _____
(Print Name)

Patient Signature: _____

Licensed Medical Professional Rendering Test: _____
(Print Name)

Signature of Technologist: _____