pines wellness center
CHIROPRACTIC & FUNCTIONAL REHABILITATION

CONFIDENTIAL PATIENT INFORMATION

Personal Information

Full Name:	**Date:**
Address: City State Zip	
Cell phone:	**Home phone:**
Occupation:	**Work phone:**
Email address:	
Date of birth:	**Age:**
No. of children:	**Pregnant? Yes □ No □**
Weight:	**Height:**
Driver's license number:	**Social Security Number:**
Marital status: M S W D	**Spouse/guardian name:**
Emergency Contact:	**Phone:**
Name of person responsible for account:	
Do you have insurance that covers Chiropractic care? Yes □ No □	**Do you have Medicare coverage? Yes □ No □**

Who may we thank for referring you? _____

COMPLAINTS
1.
2.
3.
4.
5.
Have you experienced any serious accidents or falls within the Past year? 5 years? Over 5 years? Never?
If you have experienced an accident, what type was it? Auto Work Home Leisure Sports Other
1. Are you interested in a weight loss program? YES NO MAYBE
2. Would you take nutritional supplements if indicated? YES NO MAYBE
3. Are you interested in knowing more about how your nutrition affects your overall health and well being? YES NO MAYBE
4. If Dietary changes are indicated would you be willing to make changes to your diet? YES NO MAYBE
5. If specific exercises or stretching would help, would you consider adding them to your program? YES NO MAYBE

Medical History Form

Name: _____ Age:_____ Date of Birth:_____

Medications and dosages:

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Allergies/Reactions:

_____ _____ _____
_____ _____ _____

Past Medical History

Do you have or have <u>you</u> had any of the following <u>medical conditions</u>? (Please circle)

Cancer	Kidney Disease	Blood Disorders	Gout
Bladder problems	Neurological Disorders	High Blood Pressure	Urinary Tract
Infections	Stomach Ulcers	Stroke	Liver Disease
Heart Attack	Hepatitis	Tuberculosis	Thyroid Problems
Heart Disease	Emphysema/ COPD	Pacemaker	Congestive Heart Failure
Asthma	Diabetes	Depression	Anxiety
HIV/AIDS	High Cholesterol	Osteoporosis	Psychiatric disorder
Arthritis	Rheumatoid Arthritis	Headaches	

Other:_____

Surgical History

Have you had any of the following <u>surgical</u> procedures? (Please Circle and Include dates)

Back Surgery _____ Neck Surgery _____
Knee Surgery _____ Shoulder Surgery _____
Heart Surgery _____ Other: _____

Family History

Does anyone in your <u>family</u> suffer from any of the following <u>medical conditions</u>? (Please circle)

Cancer	Kidney Disease	Blood Disorders	Gout
Bladder problems	Neurological Disorders	High Blood Pressure	Urinary Tract
Infections	Stomach Ulcers	Stroke	Liver Disease
Heart Attack	Hepatitis	Tuberculosis	Thyroid Problems
Heart Disease	Emphysema/ COPD	Pacemaker	Congestive Heart Failure
Asthma	Diabetes	Depression	Anxiety
HIV/AIDS	High Cholesterol	Osteoporosis	Psychiatric disorder
Arthritis	Rheumatoid Arthritis	Headaches	

Other:_____

Social History

Social History: Are you: Married Single Divorced Widowed
Do you smoke? YES or NO Packs per day _____
Do you drink alcohol? YES or NO Drinks per week _____
Do you use street drugs? YES or NO

Occupation: Are you working? YES or NO Job Description:_____
Work Restrictions? YES or NO List Restrictions: _____
Do you like your job? YES or NO

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Informed Consent

Patient: _____ Date: _____

To the patient: Please read this entire document prior to signing. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment:

The primary treatment used by the doctors of chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. They may cause an audible "pop" or "click", much as you have experienced when you "crack" your knuckles. You may sense a feel of movement.

Analysis/Examination/Treatment:

As a part of the analysis, examination, and treatment, you are consenting to the following procedures:

*Spinal Manipulative Therapy	*Palpation	*Vital Signs
*Range of Motion Testing	*Orthopedic Testing	*Basic Neurological Testing
*Muscle Strength Testing	*Posture Analysis	*EMS
*Radiographic Studies	*Hot/Cold Therapy	*Other _____

The material risks inherent in chiropractic adjustments:

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. The Doctor will make every reasonable effort during examination to screen for contraindications to care; however if you have a condition that would otherwise not come to the Doctor's attention, it is your responsibility to inform the Doctor.

The probability of those risk occurring:

Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and X-ray. Stroke has been a subject of tremendous disagreement. The indications of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described are rare.

The availability and nature of other treatment options:

Other treatment options for your condition may include:

- Self Administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants, and pain killers
- Hospitalization
- Surgery

If you choose the above noted "other treatment options" you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risk and dangers of remaining untreated:

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE
(Please check the appropriate block and sign below)

I have read [ ] **or have had read to me** [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Robert Kustin and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is my best interest to undergo the treatment recommended. Having been informed of the risks, I herby give my consent to that treatment.

Date: _____

Patient Name: _____

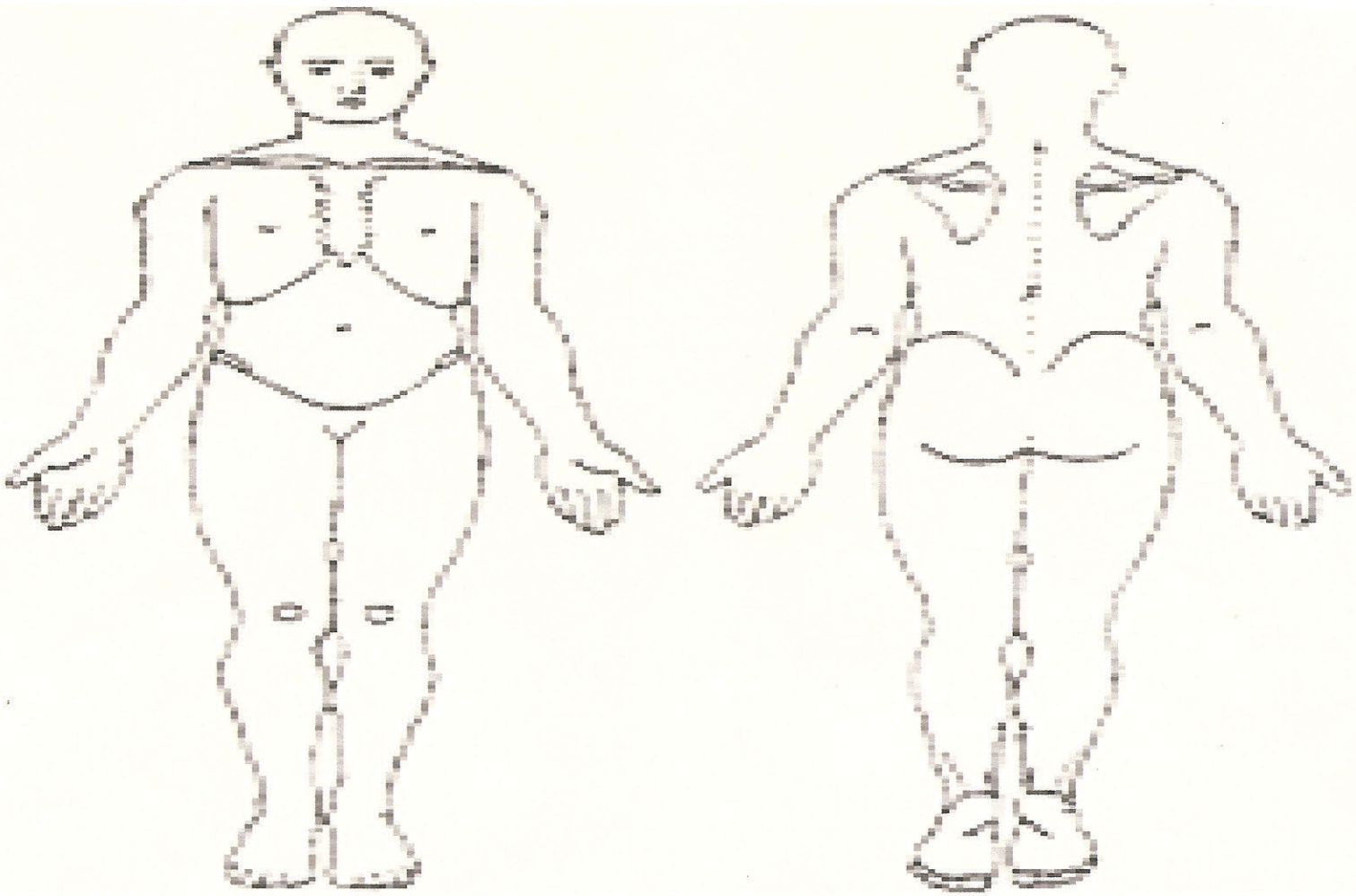
Patient Signature: _____

Doctor's Signature: _____

SHOW ME WHERE IT HURTS

Mark these drawings according to where your pain is located. Indicate with the symbols the types of pain you experience.

Stabbing = ** Burning = XXX Numbness = \\\ Weakness = +++ Pin & Needles = OOOOO



ABOUT YOUR PAIN

How Long has the pain been present?

The pain is increased when I:	Sit	Stand	Walk	Run	Bend	Lay	Exercise
The pain is Improved when I:	Sit	Stand	Walk	Run	Bend	Lay	Exercise
Do any of the following help alleviate the pain?			Ice	Heat	Massage	Stretching	

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CHIROPRACTIC & FUNCTIONAL REHABILITATION

Patient's Name _____ Today's Date_____
Date of Accident _____ Hour_____ AM PM
Location of accident

_____
Describe how the accident happen:

_____
_____
_____
_____
_____

In the Accident: (circle all that apply)

Were you the: Driver Passenger Pedestrian
Did you strike the other vehicle? Yes No Did the other vehicle strike you? Yes No
Were you struck from: Behind Front Left side Right side
Were traffic citations issued to: You Driver of your car Driver of other car None
Was you car heading: North South East West
Was the other care heading: North South East West

Were you aware of the impending impact/accident? Yes No
Were you wearing your seat belt? Yes No
Which way was your head facing upon impact: Straight ahead Turned around Up at mirror

Describe in detail your symptoms immediately following the accident:

_____
_____
_____
_____
_____

Check symptoms you have had since the accident:

Headache	Irritability	Short Breath	Loss of smell
Neck Pain	Lower back pain	Fatigue	Loss of taste
Neck stiffness	Chest pain	Depression	Diarrhea
Sleeping problems	Pins/needles in arms	Loss of memory	Constipation
Upper back pain	Pins/needles in legs	Ears ringing	Cold feet/hands
Shoulder pain	Numbness in fingers	Loss of balance	Upset stomach
Tension	Numbness in toes	Fainting	Sweats/fever

Symptoms Other than above: _____

Did you require hospitalization? Yes No Emergency Room Only
If hospitalized, date admitted _____ date discharged_____
Name of Hospital: _____

AFFADAVIT OF OWNERSHIP/NON-OWNERSHIP

At the time of the loss I was the: Driver Passenger Pedestrian Other

FILL OUT THIS PART IF THEY OR A RELATIVE THEY LIVE WITH OWN A CAR

On _____, I _____ was involved in an automobile accident, or loss, for which I am submitting a claim for the Florida no-fault benefits and/ or uninsured- underinsured motorist benefits. On the date of this loss, I resided at _____. On that date, I and/or relatives owned the following vehicle(s), either operable or inoperable with whom I resided:

Year & Make	Registered Owner	Insurance Company	Policy #
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

FILL OUT THIS PART IF NEITHER THEY OR A RELATIVE OWN A CAR

At the time of the loss, I was an occupant of, or struck by, a motor vehicle owned by _____ and was/ was not the owner of a motor vehicle myself. I am/ am not a dependent resident relative of the person against whose policy I am filing this claim for no-fault benefits and/or uninsured-underinsured motorist benefits. My relation to that person is _____.

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or files a statement of claim containing false, incomplete, or misleading information is guilty of a felony of the third degree.

_____ PRINT YOUR NAME

_____ SS#

_____ DATE OF BIRTH

_____ SIGNATURE

_____ DRIVERS LICENSE # & STATE

SWORN TO BEFORE ME, THIS _____ DAY OF _____ 20_____.

_____ NOTARY PUBLIC

MY COMMISSION EXPIRES:

STATE OF _____ COUNTY OF _____

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. Thank You.

TO:

"ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURANCE COMPANY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE."

YOUR NAME	**PHONE NO.** (Include Area Code) **HOME**	**BUSINESS**

YOUR ADDRESS (No,Street,City or Town,State & Zip Code) **Permanent Address if Different**	**How Long Have You Lived In Florida?**	**Date of Birth**	**Social Security #**

Date and Time of Accident A.M. P.M.	**Place of Accident (Street,City or Town & State)**

Brief Description of Accident and Vehicles Involved:(If Additional Space is Needed, Use Reverse Side)

Describe Motor Vehicle You Own:

Describe Motor Vehicle Owned By Any Member of Your Family:

As a Result of This Accident Were You Injured? YES ☐ NO ☐ If Your Answer is Yes, Complete The Rest of This Form
If No, Sign Here and Return This Form To Us.

Signature _____ DATE _____

Describe Your Injury:(If Additional Space is Needed, Use Reverse Side)

Were You Treated By A Doctor YES ☐ NO ☐	**Doctor's Name and Address**

If You Were Treated In A Hospital Were You AN IN-PATIENT? ____ **OUT-PATIENT?** ____	**Hospital's Name and Address**

Amount of Medical Bills To Date $	**Will You Have More Medical Expense?** YES ☐ NO ☐	**At The Time of Your Accident Were You In The Course of Your Employment?** YES ☐ NO ☐

Did You Lose Wages or Salary As A Resu Of Your Injury? YES ☐ NO ☐	**If YES, Amount Lost To Date** $	What Is Your Average Weekly Wage or Salary? $

If You Lost Wages: **Date Disability From Work Began: / /** **Date You Returned To Work: / /**

Have you received or are you eligible for payments under any Workmen's Compensation or unemployment law? YES ☐ NO ☐ 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 Address	*Your Occupation*	*From*	*To*
Employer and Address	*Your Occupation*	*From*	*To*

As A Result of Your Injury, Have You Had Any Other Expenses YES ☐ **NO** ☐ If "YES", Explain On Reverse Side

SIGNATURE: _____ DATE: _____

IMPORTANT:

1. To Be Eligible For Benefits, Complete and Sign This Application
2. Sign Attached Authorization(s)
3. Return Promptly With Any Medical Bills You Have Received To Date

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) 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. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

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

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO ***If yes***, return to and complete item 9 a-d.

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 _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

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

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. ____ . __ 3. ____ . __

2. ____ . __ 4. ____ . __

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1										
2										
3										
4										
5										
6										

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. BALANCE DUE $

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. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

Pines Wellness Center

Robert Kustin, D.C.

17743 SW 2 Street
Pembroke Pines, FL 33029
Phone: (954) 430-8000
Fax: (954) 431-1893

HARDSHIP AGREEMENT

Date:_____

To Whom It May Concern:

By my signature below I am requesting that my doctor reduce normal and customary fees charged so as to allow me to receive chiropractic care. My financial circumstances are such that if I were to pay the customary fees charged I would be forced (due to economic reasons) to not receive care.

I recognize that any agreement made to assist me is purely confidential and that my fee arrangement would be different than that which is standard in the office.

If my insurance company policy demands full payment of the deductible or co-payments, I agree that it is my responsibility to notify my insurance carrier that due to economic hardship I am only making partial payment.

Patients Name:_____

Patients Signature:_____

Witness Signature:_____

PEMBROKE PINES PHYSICIANS ASSOCIATES, INC.

MEDICAL RELEASE AND ASSIGNMENT OF BENEFITS

RELEASE AUTHORIZATION TO PEMBROKE PINES PHYSICIANS ASSOCIATES TO ENDORSE CHECKS AND/OR TO SIGN ANY PIECE OF PAPER WHICH WILL ENHANCE OR EXPEDITE PAYMENT TO THE PROVIDER FOR SERVICES RENDERED, INCLUDING BUT NOT LIMITED TO A RELEASE OF MEDICAL RECORDS and ASSIGNMENT OF BENEFITS/AUTHORIZATION TO PAY.

Know by all these present that: The undersigned has made, constituted and appointed, and by these presents does herby make, constitute and appoint PEMBROKE PINES PHYSICIANS ASSOCIATES, INC., and any of it's duly authorized agents and employees as and to be the undersigned's true and lawful attorney for and in the undersigned's name, place and stead to endorse any and all checks, drafts or money orders which are made payable to the undersigned alone or to the undersigned and the said PEMBROKE PINES PHYSICIANS ASSOCIATES, INC., which checks, drafts or money orders are made payable for services which have been made by PEMBROKE PINES PHYSICIANS ASSOCIATES, INC., at the request or with the knowledge and approval of the undersigned and/or the maker of the check, draft of money order.

Furthermore, the undersigned allows PEMBROKE PINES PHYSICIANS ASSOCIATES, INC., or any of its agents to sign any paper that will be necessary to enhance, expedite and/or allow payment to said provider. This may include affidavits of non-ownership of vehicles, insurance forms and other statements.

The undersigned by these presents does give and grant the said PEMBROKE PINES PHYSICIANS ASSOCIATES, INC. as the attorney the full power and authority to do and perform all and every act whatsoever requisite and necessary to be done in and about the premises as fully to all intents and purposes as the undersigned might or could do to personally present insofar as the endorsing and cashing of said checks are concerned as well as any other document.

MEDICAL RELEASE

A photocopy of this document shall be sufficient to authorize any person having records of medical treatment, services, or supplies pertaining to me to release true copies of same to PEMBROKE PINES PHYSICIANS ASSOCIATES, INC. or any insurer providing coverage to mi in connection with the processing of any claim for benefits made by me or by the assignee herein. A photocopy of this document shall be as binding as an original signature page.

The undersigned does hereby ratify and confirm any and all actions taken by the said attorney in accordance with this special power and which the said attorney shall do or cause to be done by virtue of there presents.

ASSIGNMENT OF BENEFITS

I, _____ Hereby authorize _____
(Name of Insured/Patient) (Name of Insurance Carrier)

to make medical benefits payments otherwise payable to me for services rendered by PEMBROKE PINES PHYSICIANS ASSOCIATES, INC, but not to exceed the charges of those services, payable to and mailed to:

PEMBROKE PINES PHYSICIANS ASSOCIATES, INC.
17743 SW 2ND STREET
PEMBROKE PINES, FL 33029

I herby instruct the insurance carrier that in the event the subject medical benefits are disputed for any reason, including medical reasonableness and/or necessity that the amount of unpaid benefits claimed by PEMBROKE PINES PHYSICIANS ASSOCIATES, INC. is to be set aside and not disbursed until the dispute is resolved. Furthermore, I hereby IRREVOCABLY ASSISN to PEMBROKE PINES PHYSICIANS ASSOCIATES, INC. the rights and benefits and any and all causes of action resulting from non payment under any policy of insurance, indemnity agreement, or any other collateral source as defined in Florida Statutes for any service and or charges provided by PEMBROKE PINES PHYSICIANS ASSOCIATES, INC.
IN WITNESS WHEREOF the undersigned have hereunto set their hands, this _____ day of _____, 20___.

_____ _____
PATIENTS SIGNATURE PATIENT'S NAME (PLEASE PRINT

MEDICAL REPORTS RELEASE AND PROVIDER'S LIEN

PEMBROKE PINES PHYSICIANS ASSOCIATES, INC.
PINES WELLNESS CENTER
17743 SW 2 Street Pembroke Pines, FL 33029
PH: 954.430.8000 FAX: 954-431-1893

RE: _____

D/A:_____

I do hereby authorize the above provider to furnish you, my attorney, with a full report of their examination, diagnosis, treatment, prognosis, billing statements, etc. of myself in regard to my accident.

I hereby give a Lien and Letter of Protection, and authorize and direct you, my attorney, to provide a written Letter of Protection, guaranteeing Pembroke Pines Physicians Associates, INC., Pines Wellness Center, any sums as may be due for medical services and diagnostic testing rendered that are medically necessary, and fall within usual and customary fee ranges for these services. This lien excludes those procedures that are not generally accepted within the medical community and that are not normally paid by PIP, Workers' Compensation, or Group Health insurance. I authorize you to withhold such sums from any settlement, judgment, or verdict, after deduction of attorney fees and costs, as may be necessary to adequately pay said provider. I hereby further give lien on my case to said provider against any proceeds of any settlement, judgment, or verdict after deduction of attorney fees and cost, which may be paid to myself or to you my attorney, for me, as the result of the injuries for which I have been treated or injuries in connection therewith.

This letter also serves to notify you of my waiving any of your office's requirements and/or policies necessitating my counter-signing your Letter of Protection.

If the amount recovered, less attorney's fees/ costs s less than the total outstanding charges owed to all health providers with executed Letters of Protections/Liens, funds will be distributed on a pro rata basis.

I fully understand that I am directly fully responsible to said provider for all medical bills submitted by them for services rendered me that are medically necessary, and fall within usual and customary fee ranges for these services, and that this Lien is made solely for said provider's additional protection. This lien is in consideration of his awaiting payment and I further understand that such payment is not contingent on any settlement, judgment or verdict which I may eventually obtain. Additionally, if it becomes necessary for Pembroke Pines Physicians Associates, INC., Pines Wellness Center to resort to legal actions to collect its charges, then I guess I agree that the prevailing party shall be entitled to attorneys' fees and costs.

Please be advised that even if you, as the holder of this document, do not desire to acknowledge receipt of this document, I direct you to honor these directions, without hesitation. Furthermore, receipt of this document by certified mail or facsimile will verify your receipt of this directive and my stated desires.

I acknowledge and agree that this Lien and Letter of Protection is irrevocable until satisfaction of my financial accounts occurs or Pembroke Pines Physicians Associates, INC., Pines Wellness Center releases such Lien and Letter of Protection.

Patient's Signature: _____ Date: _____

Witness Signature: _____ Witness Name: _____

Attorney Acknowledgement: _____ Date: _____