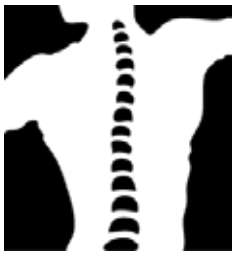
DeLand Chiropractic & Spinal Decompression
New Patient Application



The information that you will provide on this form will play a key role in determining your ability to be accepted as a patient in this office. Your qualification as a patient is determined by the nature of your injury, the doctor's ability to treat your condition, your commitment to getting well, your family and/or spousal support, your ability to pay for recommended care, and your willingness to make sacrifices to ensure your proper healing. Please be sure that you answer all questions. Thank you – Dr. Gordon's Staff.

Name: _____ Sex: ○M ○F Marital Status: ○S ○M ○D ○W
Address: _____ City: _____
State: _____ Zip Code: _____ Date of Birth: _____ SSN: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Employer: _____ Occupation: _____
Age: _____ Email: _____ Hobbies: _____
Name Of Your Medical Doctor And May We Contact Them?: _____ ○Y ○N
Race: _____ Ethnicity: _____ Are Your Pregnant? ○Y ○N
How Did You Hear About Our Clinic: _____ Preferred Language: _____
Emergency Contact Name & Phone #: _____ Relation: _____

What Is Your Chief Complaint? _____

_____

Date Of Your Injury? _____ Work Related? ○Y ○N Auto Accident Related? ○Y ○N
Have Had Chiropractic Care Before? ○Y ○N How About Acupuncture? ○Y ○N

Do You Smoke Cigarettes? ○Y ○N Currently? ○Y ○N Formerly? ○Y ○N Never? ☐
Do You Drink Alcohol? ○Y ○N If Yes, How Often? _____ How Much? _____
Do You Use Recreational Drugs? ○Y ○N What Type? _____

Do You Have A <u>Family History</u> Of: (check all that apply)

☐Heart Disease ☐Arthritis ☐Hypothyroid ☐Diabetes (☐Type I ☐Type II) ☐Seizures
☐Stroke ☐Osteoporosis ☐Rare Genetic Disease (type) _____
☐Cancer (type) _____

Do <u>You</u> Have A Past Medical History Of: (check all that apply)

☐Lower Back Pain	☐Stroke	☐Thyroid Disease	☐Diabetes (☐Type I ☐II)
☐Sciatic Pain	☐Birth Control Pills	☐Auto Accidents	☐Hormone Replacement
☐Hypertension	☐Head Trauma	☐Heart Attack	☐Osteoporosis
☐Neck / Back Trauma	☐Blood Clots	☐Balance Problems	☐Dizziness
☐Cancer (type)_____		☐Numbness On ½ Of Your Face or Body	

Please List Any Allergies, Surgeries, Accidents, Falls, Pregnancies, Or Hospitalizations:

_____

_____

List All Medications & Dietary Supplements That You Are Taking (List Dosage & Frequency):

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

If the doctor recommends a treatment plan to correct or manage your condition, are you willing to make small sacrifices (changing diet, exercise, change habits) in order to receive care in our office? ○Yes ○No

If your health insurance (if applicable) does not cover 100% of your proposed care, are you willing to make a personal financial investment in your own health in order to get well and improve your health? ○Yes ○No

IF YOU HAVE ANY QUESTIONS OR CONCERNS WITH THE INFORMATION BELOW, IT IS YOUR RESPONSIBILITY TO ADDRESS THOSE CONCERNS WITH THE DOCTOR.

Informed Consent, Financial Responsibility, and Assignment of Benefits:

As with all medical or chiropractic treatments, I acknowledge and understand that there are inherent risks to receiving care including but not limited to sprains, strains, fractures, dislocations, muscle pain, bruising, and stroke. Statistically, these risks are extremely rare and uncommon (1 in 1 – 5 million in the case of strokes), especially when compared to those risks related with alternative treatment options for my condition including the use of over the counter analgesics, prescription drugs, and surgery. Due to that fact, I will not hold the physician or staff responsible for those risks listed above. In addition, I understand that the risk and danger of allowing my condition to go untreated may lead to further deterioration of my condition with possible serious and/or permanent consequences to my health. I acknowledge and understand that the use of certain prescription medications (i.e. birth control pills, hormone replacement, aspirin, Coumadin), illicit drug or alcohol use, and cigarette smoking may increase these risks and inhibit proper healing. I also understand that if I am accepted as a patient, and if I receive care, that I am the ultimate responsible party on my account regardless of the actions of any 3rd party carrier (insurance company). I agree that should my account become delinquent, I will be responsible for all collection costs, including but not limited to the outstanding balance, attorney fees, court costs, collection agency fees, and interest at the rate of 18% per annum(1.5% per month). By signing below, I also agree to allow the doctor to share any and all medial reports and findings with my primary care physician, and I allow the doctor to use my name and case history in monthly newsletters and/or patient testimonial booklets. Lastly I understand that any physician at DeLand Chiropractic & Spinal Decompression can not evaluate, examine, x-ray, diagnose, or treat me for my presenting condition without my signature below. By signing below I acknowledge that I have weighed the risks versus benefits of treatment, and I give the doctor consent to treat me for my condition.

Print Name:_____ Date:_____

Signature: _____

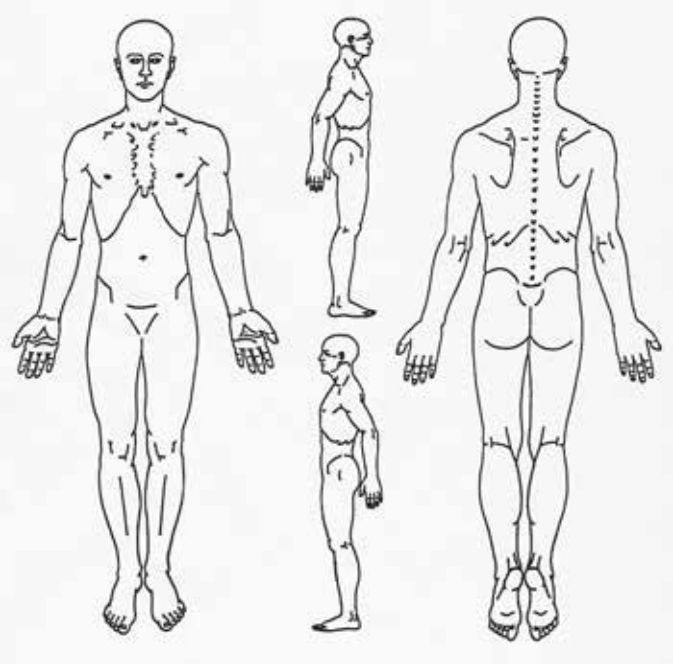
Name: _____ **Date:** _____

Auto Accident Details:

1. Were you the □ driver □ front seat passenger □ rear seat passenger □ motorcycle rider
2. The make of the vehicle that you were in during the accident was a _____
3. The make of the other vehicle involved in the accident was a _____
4. Your estimated speed at the time of the accident was _____
5. The time of day of the accident was □ daytime □ dawn □ dusk □ dark
6. Road conditions at the time of the accident were □ dry □ wet □ snow □ ice
7. Were you wearing a seatbelt at the time of the accident? □ yes □ no Did an airbag deploy? □ yes □ no
8. Was your head turned at the time of the accident? □ yes □ no
9. If you were the driver, was your foot applied on the brake at the time of the accident? □ yes □ no
10. Did you strike any part of the interior of the vehicle during the accident? □ yes □ no
11. Did you lose consciousness as a result of the accident? □ yes □ no If yes, how long? _____
12. Was a police report made at the accident scene? □ yes □ no Who was found to be "at fault"? _____
13. Estimated property damage to your vehicle _____
14. After the crash did you go □ home □ emergency room. Mode of transportation? _____
15. What were your primary symptoms after the accident? _____
16. Have you seen any other physicians or received treatment for your injuries anywhere else? □ yes □ no
    If yes, where? _____
17. Please describe and diagram your accident below:

Please mark the figures below with the letters that best describe the sensation or pain you are feeling. Please mark areas where pain radiates or spreads with a ↑, ↓, or ←, → arrow to indicate the direction of radiating pain. (Include all affected areas)

>>>	**Ache**	XXX	**Burning**	- - - -	**Throbbing**
===	**Numbness**	///////	**Stabbing**	oooo	**Pins & Needles**



Severity of Pain

List region of pain and circle severity (1=least, 10=greatest)

1._____
1 2 3 4 5 6 7 8 9 10

2._____
1 2 3 4 5 6 7 8 9 10

3._____
1 2 3 4 5 6 7 8 9 10

4._____
1 2 3 4 5 6 7 8 9 10

Name_____ Date _____

Instrumental Activities of Daily Living Scale (I.A.D.L.)

Choose the option below that best describes your ability:

1. Ability to use the telephone: ○ a. Operates telephone on own initiative. Able to look up and dial numbers, etc. ○ b. Dials a few well-known numbers. ○ c. Answers telephone, but does not dial. ○ d. Does not use telephone at all.	**2. Laundry:** ○ a. Does personal laundry completely. ○ b. Launders small items. ○ c. All laundry must be done by others.
3. Shopping: ○ a. Takes care of all shopping needs independently. ○ b. Shops independently for small purchases. ○ c. Needs to be accompanied on any shopping trip. ○ d. Completely unable to shop.	**4. Mode of transportation:** ○ a. Travels independently on public transportation or drives own car. ○ b. Arranges own travel via taxi, but does not otherwise use public transportation. ○ c. Travels on public transportation when accompanied by another. ○ d. Travel limited to taxi or automobile with assistance of another. ○ e. Does not travel at all.
5. Food Preparation: ○ a. Plans, prepares and serves adequate meals independently. ○ b. Prepares adequate meals if supplied with the ingredients. ○ c. Heats, serves and prepares meals or is able to prepare meals, but does not maintain adequate diet. ○ d. Needs to have meals prepared and served.	**6. Responsibility for own medications:** ○ a. Is responsible for taking medication in correct dosages at correct time. ○ b. Takes responsibility if medication is prepared in advance in separate dosage. ○ c. Is not capable of dispensing own medication.
7. Housekeeping: ○ a. Maintains house alone or with occasional assistance. ○ b. Performs light daily tasks such as dish washing, bed making, etc. ○ c. Performs light daily tasks unsuccessfully. ○ d. Needs help with all home maintenance tasks. ○ e. Does not participate in any housekeeping tasks.	**8. Ability to handle finances:** ○ a. Manages financial matters independently (budgets, check writing, etc. ○ b. Manages day-to-day purchases, but needs help with major purchasing, etc. ○ c. Incapable of handling money.

Katz Basic Activities of Daily Living (ADL) Scale

Check "yes" if you are able to do the task independently or "no" if you are unable.

	YES	NO
1. Bathing – Able to bath without assistance.	☐	☐
2. Dressing – Able to dress without assistance.	☐	☐
3. Toileting – Able to use toilet or urinal without assistance.	☐	☐
4. Transferring – Moves in and out of bed or chair alone.	☐	☐
5. Continence – Controls bowel and bladder completely by self	☐	☐
6. Feeding – Feeds self without assistance.	☐	☐

PAIN DISABILITY QUESTIONNAIRE

Patient Name _____Date_____

Instructions: These questions ask your views about how your pain now affects how you function in every day activities. Please answer every question and mark the ONE number on EACH scale that best describes how you feel.

1. Does your pain interfere with your normal work inside and outside the home?

Work Normally — Unable to work at all

○0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10

2. Does your pain interfere with personal care (such as washing, dressing, etc.)?

Take care of myself completely — Need help with all my personal care

○0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10

3. Does your pain interfere with your traveling?

Travel anywhere I like — Only travel to see doctors

○0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10

4. Does your pain affect your ability to sit or stand?

No problems — Can not sit/stand at all

○0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10

5. Does your pain affect your ability to lift overhead, grasp objects or reach for things?

No problems — Can not do at all

○0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10

6. Does your pain affect your ability to lift objects off the floor, bend, stoop or squat?

No problems — Can not do at all

○0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10

7. Does your pain affect your ability to walk or run?

No problems — Can not walk/run at all

○0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10

8. Has your income declined since your pain began?

No decline — Lost all income

○0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10

9. Do you have to take pain medication every day to control your pain?

No medication needed — Need medication throughout the day

○0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10

10. Does your pain force you to see doctors much more often than before your pain began?

Never see doctors — See doctors weekly

○0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10

11. Does your pain interfere with your ability to see the people who are important to you?

No problem — Never see them

○0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10

12. Does your pain interfere with recreational activities and hobbies?

No interference — Total interference

○0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10

13. Do you need the help of your family and friends to complete everyday tasks?

Never need help — Need help all the time

○0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10

14. Do you now feel more depressed, tense, or anxious than before your pain began?

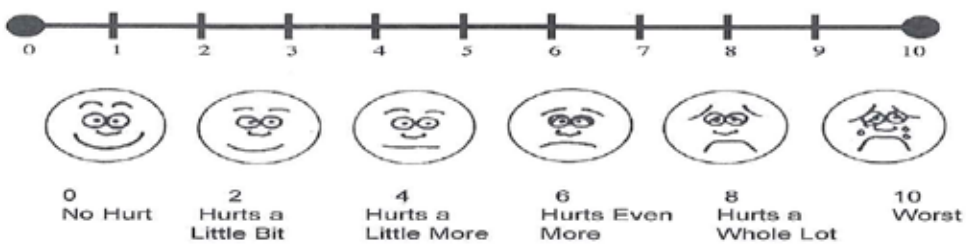
No depression/tension — Severe depression/tension

○0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10

15. Are there emotional problems caused by your pain that interfere with your family, social and or work activities?

No problems — Severe problems

○0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10



DELAND CHIROPRACTIC & SPINAL DECOMPRESSION
DR. JEREMY M. GORDON

905 NORTH STONE STREET
DELAND, FL 32720

PHONE (386)734-9995
FAX (386)734-9949

Nutritional Counseling *DRX Spinal Decompression* *Chiropractic* *Acupuncture* *Comprehensive Blood Analysis*

INSURANCE INTAKE FORM

Patient Name: _____ **DOB:** _____ **Date:** _____

Primary Insurance:

Insurance Co. _____
Policy Number/Claim# _____ Policy Holder SS # _____

Insurance Address _____
Insurance Phone Number (___)_____ Insurance Fax Number (___)_____

Adjuster/Case Manager: _____

In Network:

of Visits Per Year: _____ **CoPay:** _____ % Covers: _____
Dedcutible: _____ ☐**Met** ☐**Not Met** How much has been paid _____

Out of Network:

of Visits Per Year: _____ **CoPay:** _____ % Covers: _____
Dedcutible: _____ ☐Met ☐Not Met How much has been paid _____
Authorization: ☐Yes ☐No **Authorization #** _____
Authorization Phone Number: _____
Backbrace ☐**Yes** ☐**NO** Acupuncture ☐**Yes** ☐**NO** Cold Laser ☐**Yes** ☐**No**

Secondary Insurance:

Insurance Co. _____
Policy Number/Claim# _____ Policy Holder SS # _____

Insurance Address _____
Insurance Phone Number (___)_____ Insurance Fax Number (___)_____

Adjuster/Case Manager: _____

In Network:

of Visits Per Year: _____ **CoPay:** _____ % Covers: _____
Dedcutible: _____ ☐**Met** ☐**Not Met** How much has been paid _____

Out of Network:

of Visits Per Year: _____ **CoPay:** _____ % Covers: _____
Dedcutible: _____ ☐Met ☐Not Met How much has been paid _____
Authorization: ☐Yes ☐No **Authorization #** _____
Authorization Phone Number: _____
Backbrace ☐**Yes** ☐**NO** Acupuncture ☐**Yes** ☐**NO** Cold Laser ☐**Yes** ☐**No**

DeLand Chiropractic & Spinal Decompression
Dr. Jeremy M. Gordon & Dr. Michael Munson

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DeLand, FL 32720

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ASSIGNMENT, LIEN AND AUTHORIZATION OF BENEFITS

I,_____, hereby authorize and direct you, my insurance company, and/or attorney, to pay directly to DeLand Chiropractic and Spinal Decompression such sums as may be due and owing this office for services rendered me, both by reason of accident or illness, and by reason of any other bills that are due this office, to withhold such sums from any disability benefits, medical payments benefits, "no-fault benefits", health and accidental benefits, workmen's compensation benefits, or any other insurance benefits obligated to reimburse me or from my settlement, judgment or verdict on my behalf as may be necessary to adequately project this office. I hereby further give a lien to said office against any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness from which I have been treated by this office. Signature of this document authorizes the release of any medical or other information necessary to process this claim, and I request payment of government benefits and authorize payment of medical benefits to the undersigned physician or durable medical goods supplier for goods or services provided. This is to act as an assignment of my rights and benefits to the extent of the office's services provided.

In the event my insurance company which is obligated to make payments to me for the charges incurred at this office refuses to make such payments, upon demand of this office, I hereby assign and transfer to this office any and all causes of action that I might have or that might exist in my favor against such company and authorize this office to prosecute said cause of action either in my name or in the office's name and further I authorize this office to compensate settle or otherwise resolve said claim or cause of action as they see fit.

DeLand Chiropractic and Spinal Decompression accepts the aforesaid assignment and hereby notifies any insurer issuing payment that DeLand Chiropractic and Spinal Decompression objects to any repricing or reduction of billed amounts unilaterally made by any insurer. Any such reduced payments issued by any insurer are accepted under protest and without waving any right of the provider to pursue all legal remedies against the insurer.

I, _____, understand that I remain personally responsible for the total amounts due the office for their services that are not paid by the insurance company.

I, _____, authorize the office to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under this assignment, lien and authorization. I agree that the above-mentioned office be given power of attorney to endorse/sign my name on any and all checks for payment of my doctor (medical) bill.

Please read this document completely before signing. If you do not understand this document or have any questions about this document, please ask us to explain it to you. If there is any portion of this document that you do not wish to authorize, we will remove that portion from this document. Your signature below is your agreement you fully understand this document and you fully agree to the terms of this document.

_____ _____

Patient or guardian's signature ***Date***

_____ _____

Witness to patient or guardian's signature ***Date***

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Medical Records & Privacy Practices

Release and Receipt of Medical Records

I, _____, hereby authorize DeLand Chiropractic and Spinal Decompression to release any information contained in my medical records file to another physician, my attorney, my insurance company and/or my immediate family on my behalf. I understand that I may revoke this release of records at any time by notifying DeLand Chiropractic and Spinal Decompression in writing. I also hereby authorize DeLand Chiropractic & Spinal Decompression to acquire copies of my medical records from other physicians. Further, I agree that a copy of this authorization may be used in place of the original.

_____ _____

Patient Signature ***Date***

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, acknowledge that DeLand Chiropractic and Spinal Decompression has issued or offered to issue me a copy of the Notice of Privacy Practices. This notice describes how medical information about me may be used and disclosed and how I may obtain access to this information. ***With my signature below, I am acknowledged such receipt.***

_____ _____

Patient Signature ***Date***

AUTO ACCIDENT INFORMATION NEEDED

PATIENTS NAME: _____

INSURANCE COMPANY NAME: _____

MEDICAL CONTACT NAME: _____

MEDICAL CONTACT PERSON PHONE NUMBER: _____

_____

DATE OF INJURY: _____

MEDICAL CLAIM NUMBER: _____

POLICY NUMBER: _____

DEDUCTIBLE: _____

Policy Type: ☐80/20 or ☐100%

MAILING ADDRESS FOR CLAIMS: _____

_____

_____

_____

_____

OTHER INFO: _____

_____

_____

_____

_____

_____

_____

OFFICE OF INSURANCE REGULATION
Bureau of Property & Casualty Forms and Rates

Standard Disclosure and Acknowledgement Form
Personal Injury Protection - Initial Treatment or Service 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 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.

The undersigned licensed medical professional 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. 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 or TYPE)*	Signature	Date

Licensed Medical Professional Rendering Treatment *(Signature by his or 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 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.

OFFICE OF INSURANCE REGULATION
PROPERTY & CASUALTY PRODUCT REVIEW

HEALTH CARE PROVIDER CERTIFICATION OF ELIGIBILITY FOR PIP BENEFITS

(This form is to be provided to the insurer providing coverage for injured patient)

I, JEREMY GORDON (Print or type name), PRESIDENT (Print or type title) pursuant to Section 627.736(1)(a), Florida Statutes, under oath do swear and attest, based on the signing health care provider's personal knowledge, under penalty of perjury, that medical benefits as described in Section 627.736(1)(a), Florida Statutes are being provided by:

(Check all applicable boxes)

☑ 1. An entity wholly owned by one or more physicians licensed under chapter 458 or chapter 459, chiropractic physicians licensed under chapter 460, or dentists licensed under chapter 466 or by such practitioner or practitioners and the spouse, parent, child, or sibling of that practitioner or those practitioners.

Please list the name(s), address(es), Florida practice license number(s) (including prefixes and suffixes, if any), and the percentage owned by each licensed health care practitioner having an ownership interest in the clinic. (Please add additional pages if necessary)

Name	Address	License Number	% Owned
JEREMY GORDON	905 N. STONE STREET - DELAND 32720	CH 7770	100%
Enter total from family members, below	→		
	Add all percentages owned. This sum must equal 100%		**100%**

Identification of Family Member Owners (When Applicable): Please provide requested information for the spouse, child, sibling or parent of the health care practitioner who has an ownership interest in the clinic, and the percentage owned. (Please add additional pages if necessary.)

Name	Address	Relationship to Practitioner	% Owned
	Enter % here and on Family Member Total, above (Add all percentages owned)		

☐ 2. An entity wholly owned, directly or indirectly, by a hospital or hospitals.

Name of Hospital:_____

Explanation of ownership relationship to Hospital:

_____

_____

_____

_____

☐ 3. A health care clinic licensed under Sections 400.990-400.995 Florida Statutes that is:

☐ a. Accredited by the Joint Commission on Accreditation of Healthcare Organizations, the American Osteopathic Association, the Commission on Accreditation of Rehabilitation Facilities, or the Accreditation Association for Ambulatory Health Care, Inc.; or

Please state the name of the accrediting agency and the date of current accreditation:

_____ Date_____

☐ b. A health care clinic that:

☐ 1. Has a medical director licensed under chapter 458, chapter 459, or chapter 460; and give the full name of Medical Director shown on the Board license and telephone number where director may be contacted.

Name on License_____ Lic.No._____

Telephone #_____

☐ 2. Has been continuously licensed for more than 3 years or is a publicly traded corporation that issues securities traded on an exchange registered with the United States Securities and Exchange Commission as a national securities exchange; and

- HCC License #_____, effective date first HCC license_____
- Name of Exchange (i.e. NYSE, NASDAQ) and Exchange symbol for company:

_____

☐ 3. Provides at least four of the following medical specialties:

☐ General medicine	☐ Orthopedic medicine	☐ Radiography
☐ Physical therapy	☐ Physical medicine	☐ Physical rehabilitation
☐ Prescribing or dispensing outpatient prescription medication	☐ Laboratory services	

Note: Items 3. b. 1, 2 & 3 above are all required for eligibility.

DC — EXECUTIVE OFFICER

(Signature) Executive Officer, Medical or Clinic Director — (Title)

JEREMY GORDON — CH 7770

(Print or Type Name) — (Board or Department of Health License No. with suffix)

JEREMY M. GORDON, DC, PA

(Corporate Name of Entity or Clinic, as filed with Florida Department of State, i.e. Inc., LLC, LLP, P.A., etc.)

905 N. STONE STREET	DELAND	FL	32720	386-734-9995
Address)	(City)	(State)	(Zip)	(Phone)

(AFTER AN INITIAL, NOTARIZED SUBMISSION TO AN INSURER THIS FORM MAY BE COPIED FOR SUBMISSION TO THAT INSURER, PROVIDED THERE HAS BEEN NO CHANGE TO THE INFORMATION CONTAINED ON THE FORM.)

Notarization of Health Care Provider:

STATE OF Florida
COUNTY OF Volusia

Sworn to and subscribed before me this 5th day of June, 2008 by Jeremy Gordon.

Personally Known X OR Produced Identification_____ (Type of Identification Produced)

Notary Signature Angi A Mandese

My commission expires: 12/14/2008

Notary Public State of Florida
Angi A Mandese
My Commission DD379246
Expires 12/14/2008

Angi A Mandese