MOTOR VEHICLE COLLISION/PERSONAL INJURY QUESTIONNAIRE

Please answer all questions completely:

Your Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: _____ Work: _____ Cell Ph: _____

Age: _____ Date of Birth: _____ E-mail: _____

Marital Status: ☐M ☐ S ☐ D ☐ W Drivers License # _____

Your Occupation: _____ Employed by: _____

Your Spouse's Name: _____

Name of person to contact in case of emergency: _____

Their home and work phone number: _____

Name of nearest relative not living with you: _____

Their phone number: _____

Referring Physician: _____

1. Please describe the collision in you own words:

   _____

   _____

   _____

2. Where did the collision occur? City/Town: _____ State: _____
3. Date of collision: _____ Time: _____ AM PM
4. Were you the: ☐ driver ☐ passenger ☐ pedestrian
5. If passenger, were you in the ☐ front seat ☐ right rear seat ☐ left rear seat
6. What type of vehicle were you in? _____
7. What type was the other vehicle? _____
8. Did your vehicle strike the other vehicle? ☐ yes ☐ no
9. Was your car struck by the other vehicle? ☐ yes ☐ no
10. What direction was your vehicle going? _____
11. What direction was the other vehicle going? _____
12. Was the impact from: ☐ the front ☐ the rear ☐ *the left side* ☐ *the right side*

Name_____ Date_____

MOTOR VEHICLE COLLISION/PERSONAL INJURY QUESTIONNAIRE Page 2

13. What was the approximate speed at the time of the impact?
    Your vehicle _____ mph Other vehicle _____ mph
14. What was the weather at the time of the collision? ☐ dry ☐ wet ☐ icy
15. Was your vehicle in: ☐ park ☐ neutral ☐ in gear ☐moving ☐stopped
16. Were your brakes being applied? ☐ yes ☐ no
17. Was your vehicle shoved: ☐ forward ☐ backward ☐ sideways
18. Were you shoved: ☐ forward ☐ whipped backward
19. Did your seat have a head restraint (headrest?) ☐ yes ☐ no
20. If yes, what was the position ☐ low ☐ midposition ☐ high
21. Did your head ride over the headrest? ☐ yes ☐no
22. Did your hat/glasses end up in the back seat or rear window? ☐ yes ☐ no
23. Did any other part of your body hit the interior of the vehicle? ☐ yes ☐ no
24. If yes, please specify: ☐ seatbelt restraints ☐ steering wheel ☐ dashboard
    ☐ windshield ☐ side door ☐ side window ☐ other _____
25. Which part of your body? ☐ chest ☐ head ☐ chin ☐ face ☐ R L knee
    ☐ R L shoulder ☐ R L hand ☐ other _____
26. Were you holding on to the steering wheel? ☐ yes ☐ no
27. Did you brace your arms against the dash? ☐ yes ☐ no
28. Did you brace your legs against the floorboard? ☐ yes ☐ no
29. Was your ankle turned? ☐ yes ☐ no
30. Did the vehicle go into a spin or roll as a result of the impact? ☐ yes ☐ no
31. If yes, explain: _____
32. How much damage was there to the outside of the vehicle? ☐ none ☐ some ☐ a lot
33. How much damage was there to the inside of the vehicle? ☐ none ☐ some ☐ a lot
34. At the point of impact, where did you experience pain? Be specific:
    _____
35. Immediately after the accident were you: ☐ conscious ☐ dazed ☐ unconscious
36. If you lost consciousness, how long? _____
37. Were you wearing a seat belt? ☐ yes ☐ no
38. Did the belt have a shoulder harness? ☐ yes ☐ no If yes, did it contribute to the pain you are experiencing? ☐ yes ☐ no

Name_____ Date_____

MOTOR VEHICLE COLLISION/PERSONAL INJURY QUESTIONNAIRE Page 3

39. At the time of impact were you: ☐ looking straight ahead ☐ looking to the right ☐ looking to the left ☐ looking down ☐looking up

40. Did the seat break as a result of the impact? ☐ yes ☐ no

41. Were you braced for the impact? ☐ yes ☐ no

42. Were you surprised by the impact? ☐ yes ☐ no

43. Did you go to the hospital? ☐ yes ☐ no

44. If yes, when? ☐ right after the accident ☐ next day ☐ other _____

45. If yes, how did you get there? ☐ ambulance other: _____

46. If by ambulance, did the ambulance attendants place you in a: ☐ neck brace ☐ back brace ☐ other _____

47. Any medication or medical supplies given? _____

48. Did you have x-rays taken at the hospital? ☐ yes ☐ no

If you went to the hospital, please answer the following:

Name of hospital _____

Name of doctor _____

Diagnosis _____

Treatment Received _____

_____

49. Have you had any similar problems before? ☐ yes ☐ no

50. If yes, explain: _____

51. Are you diabetic? ☐ yes ☐ no

52. Do you have high blood pressure? ☐ yes ☐ no

53. Do you have low blood pressure? ☐ yes ☐ no

54. Do you have arthritis or degenerative joint disease? ☐ yes ☐ no

55. What type of work do you do? _____

56. What are your job requirements? _____

57. Have you lost any days of work from this injury? ☐ yes ☐ no

58. Did the airbags deploy? ☐ yes ☐ no

Name_____ Date_____

Present Complaints (please circle the appropriate ones) Page 4

Headache	Feet/hands cold	Head seems heavy	Pins and needles in arms Right / Left
Mental dullness	Depression	Confusion	Pins and needles in hands Right / Left
Loss of memory	Pins and needles in arms	Constipation	Pins and needles in legs Right / Left
Dizzy	Rib pain	Unbalanced	Midback stiffness
Neck Pain	Neck stiffness	Chest pain	Double vision
Fainting	Shortness of breath	Ears ringing/buzzing	Loss of smell
Upper back pain	Upper back stiffness	Midback pain	Tension
Lower back pain	Lower back stiffness	Blurred vision	
Neck restriction	Eye strain / pain	Loss of taste	
Nervousness	Fear	Irritability	

Difficulty in: ☐ Standing ☐ Sitting ☐ Bending ☐ Walking

Pain radiation to the: ☐ Right arm ☐ Left arm ☐ Right leg ☐ Left leg

Cannot lift: ☐ Light ☐ Moderate ☐Heavy ☐ Repetitive

Pain radiating to: ☐Neck ☐ Base of skull ☐ Ribs ☐ Shoulders ☐ Arms

Pain in the: ☐ Foot ☐ Ankle ☐ Knee ☐ Hip

OTHER SYMPTOMS: _____

_____

Since the time this (these) complaint(s) began, what, if anything, have you tried that **did not** work?

_____

Has the problem interrupted your sleep? Yes / No How: _____

Does anyone in your family have the same or similar condition: Yes / No

Who: _____

List any doctors or therapists that you have seen for **this** complaint:

1. _____ Specialty _____
2. _____ Specialty _____
3. _____ Specialty _____

Name_____ Date_____

List any operations that you've had and approximate dates:

1. _____ Date: _____ Dr: _____

2. _____ Date: _____ Dr: _____

3. _____ Date: _____ Dr: _____

Are you allergic to any medication? Please list: _____

_____

Are you taking any medications? Please list: _____

_____

Have you ever been in any **other** auto accident or **other** personal injury? ☐ Y ☐ N

Describe and give dates if possible:

_____

_____

Are you pregnant? ☐ Yes / ☐ No Due date: _____

Do you have a family physician? Name _____

Patient Signature _____ Date _____

Witness _____ Date _____

Print Name _____

Name _____ Date _____

FAMILY HISTORY List any of the diseases listed above which run in your family.

Relative	Age if Living	Age at Death	Cause of Death	State of Health	Illnesses
Father					
Mother					
Brother(s)					
Sister(s)					
Maternal Grandfather					
Maternal Grandmother					
Paternal Grandfather					
Paternal Grandmother					

SOCIAL HISTORY Check the boxes and fill in.

Current Weight _____ Have you recently lost or gained weight? _____

Mental Work ☐ Heavy ☐ Moderate ☐ Light Hours per day _____

Physical Work ☐ Heavy ☐ Moderate ☐ Light Hours per day _____

Exercise ☐ Heavy ☐ Moderate ☐ Light Hours per week _____ Type _____

Smoking ☐ Current ☐ Previous Packs/Day _____ No. of years _____

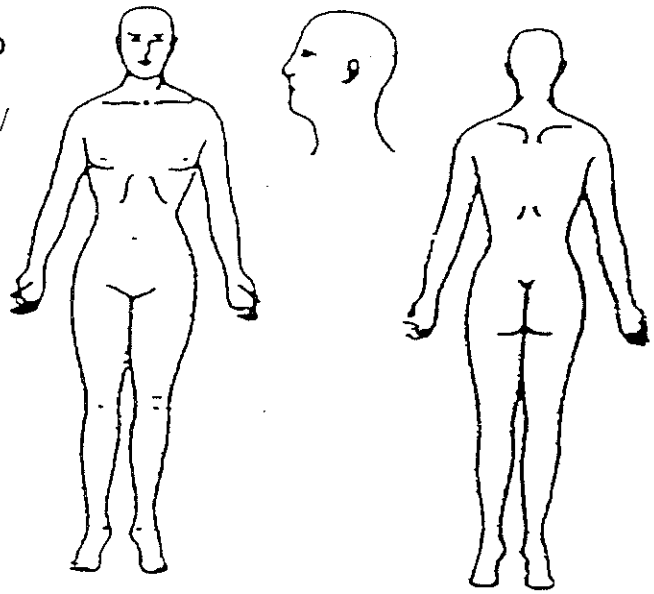
Alcohol Beer/Week _____ Liquor/Week _____ Wine/Week _____ No. of Years _____

Caffeine *(Coffee, Tea, Cola)* Cups/Day _____ No. of Years _____

Aspirin No./Day _____ No. of Years _____ Others _____

MARK THE AREAS OF YOUR SYMPTOMS ON THE FIGURE TO RIGHT. Use the following symbols:

Aches ^^^^ Numbness oooo Pins/Needles -••• Stabbing /



MARK AN "X" ON THE LINES:

How bad are your symptoms now?

None _____ Most Severe

How bad have they been in the past?

None _____ Most Severe

Name _____ Date _____

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

I. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing and fundraising activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.
You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information:

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:_____ Signature _____ Date_____

Hochman Family Chiropractic
"Where our family heals your family"
Miramar Town Center
11613 Red Road
Miramar, Florida 33025

Dr. Ian Hochman
Chiropractic Physician

Tel: 954-392-BACK (2225)
Fax: 954-432-6305
ihochmandc@aol.com

Informed Consent for Examination and Treatment

I hereby consent to the performance of examination and treatment on me, _____, by the licensed doctors of chiropractic, medical doctors, and/or licensed physical therapists who may be employed by or engaged in practice in this clinic.

I have had an opportunity to discuss with the doctor(s) or other clinic personnel the nature and purpose of the different physical therapy procedures and chiropractic treatment (manipulation/adjustment). I understand that neither chiropractic nor medical treatment is an exact science and that my care may involve judgments based upon facts and information known to the doctor. The doctor uses this judgment to attempt to anticipate or explain risks and complications and an undesirable result does not necessarily indicate an error in judgment. No guarantee for results can be made or expected but rather I wish to rely on the doctor to choose and recommend a best course of treatment based upon facts known that is in my best interests.

I further understand that there are certain degrees of risk associated with chiropractic health care and physical therapy, which includes rarely, but not limited to fractures, disc injuries, strokes, and strain/sprains and am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

I have read, or the above information has been explained regarding consent. I have had an opportunity to ask questions about my examination and treatment. By signing below, I agree and intend this consent form to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment.

Female Patients: By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time.
Date of last menstrual period _____.

_____ _____
Patient's Name (Print) Patient's Signature

_____
Date

_____
Witness

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ASSIGNMENT OF BENEFITS, DIRECTION TO PAY, RELEASE OF RECORDS, AUTHORITY TO SIGN

The undersigned patient/insured_____assigns the benefits of insurance and any over due interest payment under the No-Fault Policy of Automobile Insurance, also known as Personal Injury Protection with my insurance carrier or the responsible insurer to HOCHMAN FAMILY CHIROPRACTIC, INC. for services rendered to the undersigned patient. DIRECTION TO PAY: The undersigned patient directs the insurer to pay the medical provider directly (i.e. payments to be mailed to and made payable to the medical provider) for services rendered. I assign my right to receive a PIP payout sheet at any and all times. You are further instructed that if you deny or reduce payments of any bills from Hochman Family Chiropractic, Inc. that those funds to cover the reduced or denied bills must be placed into escrow pending resolution by a court of competent jurisdiction.

The undersigned agrees to comply with all the terms and conditions of the policy of insurance at issue, including but not limited to appearing for an independent medical examination and/or sworn statement at the request of the insurance. In the event the medical provider is required to file a lawsuit against the insurer for payment, the undersigned patient agrees to cooperate with the medical provider's attorney and the insurer. In the event the subject medical benefits are disputed or reduced for any reason, including but not limited to medical reasonableness and/or necessity; the undersigned patient hereby instructs the insurer to set aside any amount disputed and not pay the disputed amount to anyone including myself or any entity until the dispute is resolved. Further, I hereby instruct the insurer to notify the provider immediately of any dispute as to payment so the medical provider can exercise its legal rights.

I hereby authorize HOCHMAN FAMILY CHIROPRACTIC, INC. to sign on my behalf, any and all documents including but not limited to HICFA forms and furtherance of obtaining payment for services rendered by the facility. HOCHMAN FAMILY CHIROPRACTIC, INC.

I hereby assign to HOCHMAN FAMILY CHIROPRACTIC, INC. any benefits under any policy of insurance for service and or charges provided by HOCHMAN FAMILY CHIROPRACTIC, INC. Regardless of whether an insurance company is listed or the incorrect insurance company is listed herein. I am assigning benefits from any policy that would owe me insurance benefits for treatment rendered herein.

I have understood and agreed to all the above.

Patient's signature_____ Date_____
(If patient is a minor, signature of parent/guardian)

APPLICATION FOR BENEFITS - PERSONAL INJURY PROTECTION

FILE NUMBER	OUR POLICYHOLDER	DATE OF ACCIDENT

TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE FLORIDA AUTO MOBILE REPARATIONS REFORM ACT, PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY.

"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	DATE OF BIRTH	SOCIAL SECURITY NO.
YOUR FLORIDA ADDRESS: STREET, CITY OR TOWN, STATE, ZIP CODE	HOME PHONE	BUSINESS PHONE
YOUR PERMANENT ADDRESS IF DIFFERENT	HOW LONG HAVE YOU LIVED IN FLORIDA?	

DATE AND TIME OF ACCIDENT	PLACE OF ACCIDENT: STREET, CITY OR TOWN, STATE

BRIEF DESCRIPTION OF ACCIDENT AND VEHICLES INVOLVED

DESCRIBE ALL MOTOR VEHICLES YOU OWN

DESCRIBE ALL MOTOR VEHICLES OWNED BY ALL RELATIVES IN YOUR HOUSEHOLD

AS A RESULT OF THIS ACCIDENT, WERE YOU INJURED? ☐ YES ☐ NO IF YOUR ANSWER IS YES, COMPLETE THE REST OF THIS FORM.
IF YOUR ANSWER IS NO, SIGN HERE AND RETURN THIS FORM TO US.

SIGNATURE: DATE:

DESCRIBE YOUR INJURY

WERE YOU TREATED BY A DOCTOR? ☐ YES ☐ NO
IF YES, DOCTOR'S NAME & ADDRESS:

IF YOU WERE TREATED IN A HOSPITAL, WERE YOU AN: ☐ INPATIENT ☐ OUTPATIENT
HOSPITAL'S NAME & ADDRESS:

AMOUNT OF MEDICAL BILLS TO DATE: $	WILL YOU HAVE MORE MEDICAL EXPENSES? ☐ YES ☐ NO IF YES, EXPLAIN

AT THE TIME OF YOUR ACCIDENT, WERE YOU IN THE COURSE OF YOUR EMPLOYMENT? ☐ YES ☐ NO	DID YOU LOSE WAGES AS A RESULT OF INJURY? ☐ YES ☐ NO IF YES, AMOUNT OF WAGES LOST TO DATE: $	WHAT IS YOUR AVERAGE WEEKLY WAGE? $

IF YOU LOST WAGES, DATE DISABILITY FROM WORK BEGAN	DATE YOU RETURNED TO WORK

HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR PAYMENT UNDER ANY WORKMEN'S COMPENSATION OR UNEMPLOYMENT LAW? ☐ YES ☐ NO
IF YES, AMOUNT PER WEEK: $ AMOUNT PER MONTH: $

LIST NAMES AND ADDRESSES OF YOUR EMPLOYER AND OTHER EMPLOYERS FOR ONE YEAR PRIOR TO ACCIDENT DATE

EMPLOYER AND ADDRESS	YOUR OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	YOUR OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	YOUR OCCUPATION	FROM	TO

AS A RESULT OF YOUR INJURY, HAVE YOU HAD ANY EXPENSES? ☐ YES ☐ NO IF YES, EXPLAIN ON REVERSE SIDE

SIGNATURE: X DATE:

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Tel: 954-392-BACK (2225)
Fax: 954-432-6305
ihochmandc@aol.com

PATIENT RECORDS AND DOCTOR'S LIEN

TO: ATTORNEY/INSURANCE CARRIER

_____

_____

_____

I do hereby authorize the above provider to furnish you, my attorney/insurance carrier, with a full report of his/her case history, examination, diagnosis, treatment, and prognosis of myself in regard to my injury/illness which occurred/began on: _____

I hereby give a lien to said provider on any settlement, judgment, or verdict as a result of said injury/illness, and authorize and direct you, my attorney/insurance carrier, to pay directly to said provider such sums as may be due and owing him/her for services rendered me, and to withhold such sums from such settlement, claim, judgment or verdict as may be necessary to protect said provider adequately. I fully understand that I am directly and fully responsible to said provider for all bills submitted by him/her for service rendered me, and that this agreement is made solely for said provider's additional protection and in consideration of his/her awaiting payment.

I further understand that such payment is not contingent on any settlement, claim, judgment, or verdict by which I may eventually recover said fee. I further agree to be fully responsible for reasonable attorney's fees and costs that have accrued due to the pursuance of payment of my account. Also, that in the event of noncompliance to payment agreement I understand the amount of balance due will be subject to a 1% per month service charge.

Patient's Signature: _____ Dated: _____

The undersigned, being attorney of record or authorized representative of insurance carrier for the above patient does hereby acknowledge receipt of the above lien, and does agree to honor the same to protect adequately the above named provider.

Attorney's Signature: _____ Dated: _____

ATTORNEY: Please sign, retain a copy for your records, and return this copy to us promptly.

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.)

SIGNATURE: _____ DATE: _____

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 _____

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Miramar, Florida 33025

Dr. Ian Hochman
Chiropractic Physician

Tel: 954-392-BACK (2225)
Fax: 954-432-6305
ihochmandc@aol.com

RELEASE OF RECORDS AND X-RAYS

I, _____ hereby authorize you to release any and all information including x-rays, diagnostic scans and records pertaining to the examination, diagnosis and treatment rendered to me and acknowledge receipt of this information to transferred to:

HOCHMAN FAMILY CHIROPRACTIC, INC
11613 RED ROAD
MIRAMAR, FL. 33025
954-392-2225
FAX: 954-432-6305

_____
DATE SIGNATURE

_____
DATE WITNESS