

**ORTHOPEDIC & SPINE CENTER OF SOUTH FLORIDA, LLC**

---

**NEW PATIENT-AUTO ACCIDENT-INFORMATION**

**MEDICAL INFORMATION SCREENING FORM**

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Orthopedic Complaints (Please Circle Appropriate Areas):**

Neck	Shoulder	Hand	Ankle
Thoracic Spine	Elbow	Hip	Foot
Lumbar Spine	Wrist	Knee	Other

**What is your current orthopedic problem?** \_\_\_\_\_

---

---

---

**Please describe the accident in detail:** \_\_\_\_\_

---

---

---

**Date of the accident:** \_\_\_\_\_

**Where were you in the vehicle?**

Rear  
Front  
Passenger  
Driver

**Were you wearing a seatbelt?** Yes No

**Were you able to drive away from the accident?** Yes No

**Did you go to the hospital?** Yes No

**If so, were you taken by ambulance?** Yes No

**Were you admitted to the hospital?** Yes No

If so, which hospital? \_\_\_\_\_

**Please describe the type of pain you are having: (Circle all that apply)**

Sharp	Aching	Dull
Burning	Cramping	Throbbing
Stabbing	Unable to describe	Mild Stiffness
Moderate Stiffness	Severe Stiffness	
Other _____		

**How often do you have this pain?**

Constant	Intermittent	Daily
Weekly	Every few days	Weekly or less
Rarely	Monthly or less	

**Rate your pain: (1-10 1-mild 10-severe)**

Problem 1 _____:	1	2	3	4	5	6	7	8	9	10
Problem 2 _____:	1	2	3	4	5	6	7	8	9	10
Problem 3 _____:	1	2	3	4	5	6	7	8	9	10
Problem 4 _____:	1	2	3	4	5	6	7	8	9	10
Problem 5 _____:	1	2	3	4	5	6	7	8	9	10
Problem 6 _____:	1	2	3	4	5	6	7	8	9	10

**What makes the pain worse?**

Activity	Prolonged Walking	Prolonged Standing
Prolonged Sitting	Bending	Changing Positions
Sleeping	Lifting Weight	Running
Reaching	Twisting or Rotation	
Other _____		

**What makes the pain better?**

Rest	Therapy	Medication
Movement	Elevation	Changing Positions
Bandage	Medication	
Cold	Heat	Other _____

**Do you have any radiating pain?**

(Pain that shoots from one area to another)

Yes No

If so, where and please describe: \_\_\_\_\_

Do you have any tingling, pins and needles, or burning sensations? Yes No

**If so, where and please describe:** \_\_\_\_\_

**Do you have any feelings of weakness?** Yes No

**If so, where and please describe:** \_\_\_\_\_

**Since the accident, is your pain:** Better Unchanged Worse

**What is your current occupation?** \_\_\_\_\_

**Have you missed any work due to the accident?** Yes No

**If so, how much?** \_\_\_\_ Days \_\_\_\_ Weeks \_\_\_\_ Months \_\_\_\_ Years

**Are you taking any medication for the pain?** Yes No

**If so, what type?**

Over the counter anti-inflammatories (Motrin, Advil, Aleve)

Prescription Anti-Inflammatories

Prescription Pain Medication

Other: \_\_\_\_\_

**Does the medication help?** Yes No

**Are you currently attending therapy?** Yes No

**If so, where?** \_\_\_\_\_

**If not, have you had therapy for this problem before?** Yes No

**What type of therapy?**

Chiropractic

Physical Therapy

Occupational Therapy

Modalities (Ultrasound, Electrical Stimulation, Hot/ Cold Pacs)

Massage Therapy

Accupuncture

**Is the therapy helping?** Yes No

**Have you had any type of injections for this problem?** Yes No

**What type of injections?**

Epidural Injection  
Trigger Point Injection (Location: \_\_\_\_\_)  
Facet Injection  
Other: \_\_\_\_\_

**Did the injections help?** Yes No

**Have you had any surgeries for this problem?** Yes No

**If so, what type and when?** \_\_\_\_\_

**Has it helped?** Yes No

**Have you had an injury similar to this one?** Yes No

**Did you recover from that injury?** Yes No

**GENERAL MEDICAL HISTORY**

*Do you have or have you had any of the following?*

- |   |                              |                               |
|---|------------------------------|-------------------------------|
| <b>High Blood Pressure</b>                | <b>Rheumatic Fever</b>       | <b>Breast Lumps</b>           |
| <b>Low Blood Count</b>                    | <b>Chest Pain</b>            | <b>Breast Discharge</b>       |
| <b>Unusual Bleeding</b>                   | <b>Shortness of Breath</b>   | <b>Hepatitis</b>              |
| <b>Fractures, Dislocations, Sprains</b>   | <b>Heart Attack</b>          | <b>Diabetes</b>               |
| <b>Arthritis</b>                          | <b>Asthma</b>                | <b>Stomach Pain or Ulcers</b> |
| <b>Dizziness</b>                          | <b>Pneumonia</b>             | <b>Abdominal Pain</b>         |
| <b>Headaches</b>                          | <b>Enlarged Lymph Glands</b> | <b>Paralysis</b>              |
| <b>Rashes</b>                             | <b>Pain with urination</b>   | <b>Tuberculosis</b>           |
| <b>Blurred Vision</b>                     | <b>Seizures</b>              | <b>Convulsions</b>            |
| <b>Intolerance to Anti-Inflammatories</b> |                              |                               |

**Are you currently taking any medications?** Yes No

**If so, What are you taking?** \_\_\_\_\_

**Do you have any medication allergies?** Yes No

**If so, to what and what was the reaction?** \_\_\_\_\_  
\_\_\_\_\_

**Have you had any surgeries in the past?**                      Yes                      No

**If so, What type?** \_\_\_\_\_  
\_\_\_\_\_

**Do you smoke?**    Yes                      No

**If so, How many packs per day?** \_\_\_\_\_

**Do you drink more than once a week?**                      Yes                      No

**If so, How many days per week?** \_\_\_\_\_

**Are you right or left-handed?**    Right                      Left

**FAMILY HISTORY**

**Mother: (Circle Those That Apply)**

            Alive                      Healthy                      List any health problems: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Father: (Circle Those That Apply)**

            Alive                      Healthy                      List any health problems: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

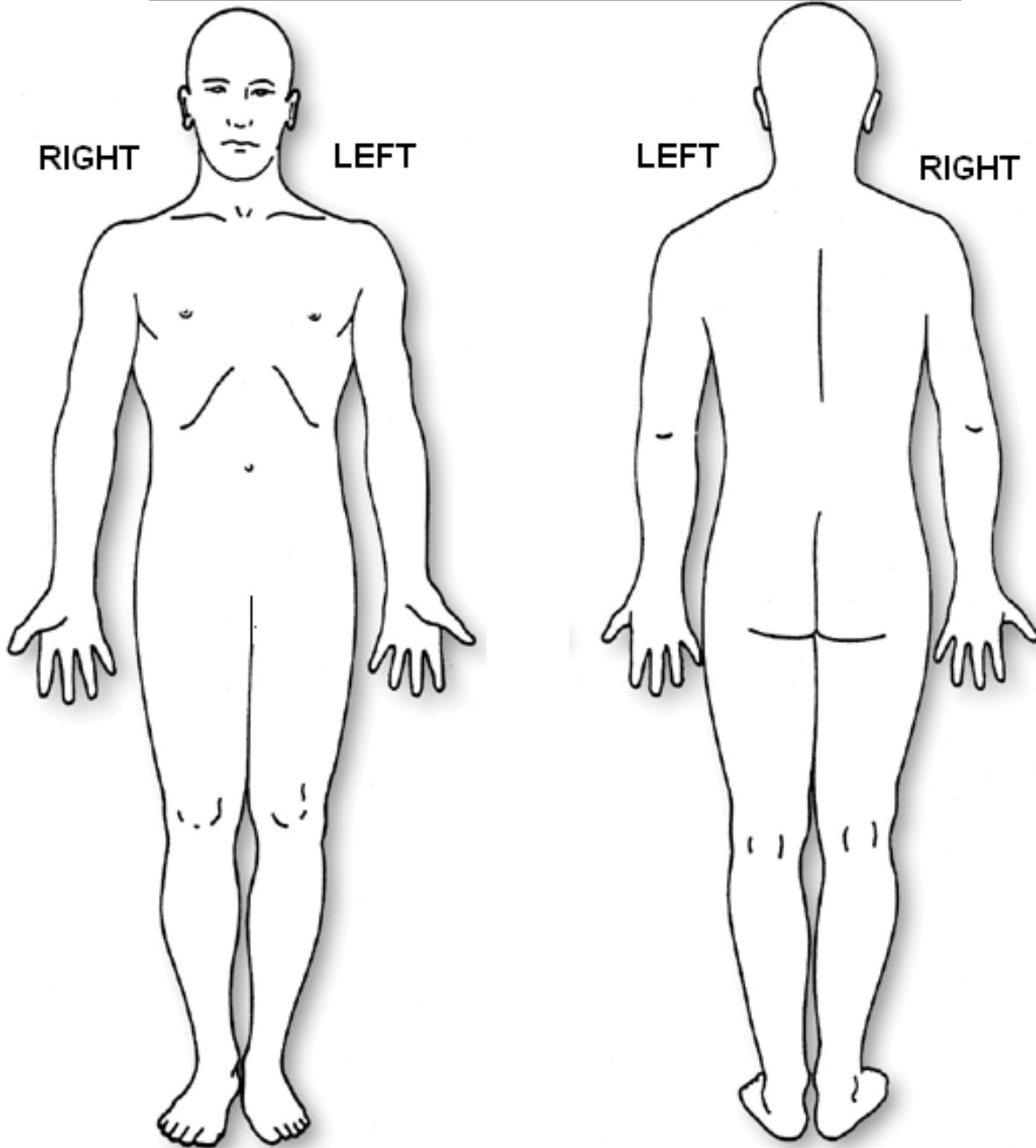
**What is your height:** \_\_\_\_\_

**What is your weight:** \_\_\_\_\_

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

Please mark the location of your pain using the Symbols below:

//// = Ache    xxxx = Pain    ooo = Tingling    --- = Numb



**ORTHOPEDIC & SPINE CENTER OF SOUTH FLORIDA, LLC**

1. I, the undersigned patient or person responsible for the patient, do hereby direct and authorize Orthopedic Spine Center of South Florida, LLC to furnish my insurance company, attorney, personal physician, or any representative thereof, any and all information which may be pertinent regarding my medical condition and medical treatment rendered to me.
2. I, the undersigned patient or person responsible for the patient, do hereby acknowledge that I am responsible for the payment of fees for medical services rendered to me by Orthopedic Spine Center of South Florida, LLC to act as my agent in assisting me to obtain payment from my insurance company of bills for medical services rendered. I authorize and direct orthopedic Spine Center of South Florida, LLC to furnish upon request medical or other information necessary to process claims to any insurance company responsible for payment of fees for medical services rendered on my behalf be Orthopedic Spine Center of South Florida, LLC
3. I, the patient or person responsible for the patient, do hereby authorize and direct that payment of bills for medical services rendered by Orthopedic Spine Center of South Florida, LLC be made directly to Orthopedic Spine Center of South Florida, LLC on my behalf. I permit a copy of this authorization to be used in place of the original.
4. I hereby declare by my signature below that I have read and understand all of the provisions above.

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

Witnessed By: \_\_\_\_\_ Date: \_\_\_\_\_

**ORTHOPEDIC & SPINE CENTER OF SOUTH FLORIDA, LLC**

**POWER OF ATTORNEY AND MEDICAL RELEASE**

POWER OF ATTORNEY TO ENDORSE CHECKS AND OR SIGN ANY PIECE OF PAPER WHICH WILL ENHANCE OR EXPEDITE PAYMENT TO PROVIDER FOR SERVICES RENDERED, INCLUDING BUT NOT LIMITED TO, 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 hereby make constitute and appoint ORTHOPEDIC SPINE CENTER OF SOUTH FLORIDA, LLC, and any of its 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, draft and money orders which made payable to the undersigned alone or to the undersigned and the said ORTHOPEDIC SPINE CENTER OF SOUTH FLORIDA, LLC, which checks, drafts or money orders are made payable for the services which have been made by ORTHOPEDIC SPINE CENTER OF SOUTH FLORIDA, LLC, at the request or with the knowledge and approval of the undersigned and/or the marker of the check, draft or money order.

Furthermore, the undersigned allows ORTHOPEDIC SPINE CENTER OF SOUTH FLORIDA, LLC, or any of its agents to sign any paper that will be necessary to enhance, expedite and/or allow payment said provider. This may include affidavits of non-ownership of vehicles, insurance forms and other statements.

The undersigned by these present does give grant the said ORTHOPEDIC SPINE CENTER OF SOUTH FLORIDA, LLC, as attorney the full power and authority to do and perform all and every act whatsoever and requisite and necessary to be done in and about fine 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 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 ORTHOPEDIC SPINE CENTER OF SOUTH FLORIDA, LLC., or any other insurer providing coverage to me 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 these presents.

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

\_\_\_\_\_  
Patient Name (PLEASE PRINT)

\_\_\_\_\_  
Date

**ORTHOPEDIC & SPINE CENTER OF SOUTH FLORIDA, LLC**

**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT**

I understand that under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”). I have certain rights to privacy regarding my protected Health Information. I understand that this information can and will be used to:

- *Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly*
- *Obtain payment from third-party payers.*
- *Conduct normal healthcare operations such as quality assessments and physicians and certifications.*

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to the address below to obtain a current copy of the Notice of Privacy Practices.

**ORTHOPEDIC SPINE CENTER OF SOUTH FLORIDA, LLC.  
150 S.Andrews Ave  
Suite #410  
Pompano Beach, FL 33069**

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

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

**OFFICE USE ONLY**

---

I attempted to obtain the patient’s signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

<b>Date:</b>	<b>Initials:</b>	<b>Reason(s):</b>

# ORTHOPEDIC & SPINE CENTER OF SOUTH FLORIDA, LLC

## HEALTHCARE ARBITRATION AGREEMENT

### ARTICLE 1: *GENERAL PROVISIONS*

The patient agrees that any controversy, including any malpractice claim, arising out of or in any way relating to the diagnosis, treatment, or care of that patient by the undersigned physician, including any partners, agents, or employees of the physician, shall be submitted to binding arbitration.

The patient further agrees that any controversy arising out of or in any way relating to the **past** diagnosis, treatment, or care of the patient by a provider or medical services, or the provider's agents or employees, shall likewise be submitted to binding arbitration.

INITIAL: \_\_\_\_\_

Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of a binding arbitration.

### ARTICLE 2: *ALL CLAIMS MUST BE ARBITRATED*

It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or services provided by the provider of medical services, including any spouse or heirs of the patient and any children, whether born or unborn at the time of the occurrence giving rise to the claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

### ARTICLE 3: *PROCEDURES*

Within fifteen days after a party to this agreement has given written notice to the other of demand for arbitration of a dispute or controversy, the parties to the dispute or controversy shall each appoint an arbitrator and give notice of such appointment to the other. Within a reasonable time after such notices have been given the two arbitrators so selected shall select a neutral arbitrator and give notice of the selection thereof to the parties. The arbitrators shall hold a hearing within a reasonable time from the date of notice of selection of the neutral arbitrator.

Expenses of the arbitration shall be shared equally by the parties to this agreement. Except as herein provided, the arbitration shall be conducted and governed by the provisions of the Florida Arbitration Code, Florida Statutes s. 682.01 et. seq.

In the even that any party to this agreement refuses to go forward with arbitration, the party compelling arbitration reserves the right to proceed with arbitration, the appointment of an arbitrator, and hearings to resolve the dispute, despite the refusal to participate or absence of the opposing party. Submission of any dispute under this agreement to arbitration may only be avoided by a valid court order, indicating that the dispute is beyond the scope of the arbitration agreement, or contains an illegal aspect precluding the resolution of the dispute by arbitration. Any party to this agreement who refuses to go forward with arbitration hereby acknowledges that the arbitrator will go forward with the arbitration hearing and render a binding decision without the participation of the party opposing arbitration or despite its absence at the arbitration hearing.

**ARTICLE 4: PATIENTS RIGHT TO CANCEL ARBITRATION AGREEMENT**

The patient has the right to rescind this agreement by written notice to the provider of medical services within 7 days after the agreement has been signed and executed. The patient may rescind by merely writing "canceled" on the face of his copies of the agreement, signing his name under such word, and mailing, by certified mail, return receipt requested, such a copy to the provider of medical services within such 7 day period.

**ARTICLE 5: ARBITRATION AS EXCLUSIVE REMEDY**

With respect to any dispute or controversy that is made subject to arbitration under the terms of this agreement, no suit at law or in equity based on such dispute or controversy shall be instituted by either party, except or enforce the ward of the arbitrators.

**ARTICLE 6: DEATH OF PARTY NOT TO AFFECT SUBMISSION**

This submission shall not be withdrawn or affected by the death of either of the parties pending a final award, but the executor, administrator, or other representative of the party shall be deemed to be a party to this submission made, any rule of law or equity to the contrary notwithstanding. The parties agree that this agreement is to be binding on the parties assign, heirs, executors, and administrators.

**ARTICLE 7: ACKNOWLEDGMENTS**

The patient, by signing this agreement, also acknowledges that he or she has been informed that:

- 1) Medical or hospital care, diagnosis, or treatment will be provided whether or not the patient signs the agreement to arbitrate;
- 2) The agreement may not be submitted to a patient for approval when the patient's condition prevents the patient from making a rational decision whether or not to agree;
- 3) The decision whether or not to sign the agreement is solely a matter for the patient's determination without any influence by the physician or hospital;
- 4) The patient must be furnished with a copy of this agreement upon request.

**ARTICLE 8: AWARDABLE DAMAGES**

The damages awardable at arbitration are limited to those available under Florida Law.

**BY SIGNING THIS CONTRACT YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL**

\_\_\_\_\_, 20\_\_\_\_

By: \_\_\_\_\_  
Physician: \_\_\_\_\_

\_\_\_\_\_, 20\_\_\_\_

By: \_\_\_\_\_  
Patient: \_\_\_\_\_

By: \_\_\_\_\_  
(Parent or Guardian if patient is a Minor)

**ORTHOPEDIC & SPINE CENTER OF SOUTH FLORIDA, LLC**

150 S. Andrews Ave. | Ste. #410 | Pompano Beach, FL 33069

**TEL: 954.941.2679 | FAX: 954.941.6169**

**ASSIGNMENT OF INSURANCE BENEFITS, RELEASE & DEMAND**

*Insurer and Patient Please Read the Following in its Entirely Carefully!*

I, the undersigned patient/insured knowingly, voluntarily and intentionally assign the rights and benefits of my automobile insurance, also known as Personal Injury Protection (hereinafter PIP) , and Medical Payments policy of insurance to the above health care provider. I understand it is the intention of the provider to accept this assignment of benefits in lieu of demanding payment at the time services are rendered and that this document will allow the provider to file suit against an insurance company for payment of the insurance benefits. I understand the provider may file a lawsuit against my insurer for payment and if the provider's bills are paid or applied to a deductible I agree this will serve as a benefit to me and I authorize and request such litigation. This assignment of benefits includes the cost of transportation, medications, supplies, over due interest and an potential claim for common law or statutory bad faith/unfair claims handling. If the insurer disputes the validity of this assignment of benefits then the insurer is instructed to notify the provider in writing within five days of receipt of this document. Failure to inform the provider shall result in a waiver by the insurer to contest the validity of this document. The undersigned directs the insurer to pay the health care provider directly without reductions and without including the patient's name on the check. To the extent the PIP insurer contends there is a material misrepresentation on the application for the insurance resulting in the policy of insurance is declared voided, rescinded, or canceled, I, as the named insured under said policy of insurance, hereby assign the right to receive the premiums paid for my PIP insurance to this provider and to the file suit for recover of the premiums. The insurer is directed to issue such a refund check payable to this provider only. Should the medical bills not exceed the premium refunded, then the provider is directed to mail the patient/named insured a check which represents the difference between the medical bills and the premiums paid.

The insurer is directed by the provider and the undersigned to not issue any checks or drafts in partial settlement of a claim that contain or are accompanied by language releasing the insurer or its insured/patient from liability unless there has been a prior written settlement agreed to by the health provider and the insurer as to the amount payable under the insurance policy. The insured and the provider hereby contests and objects to any reductions or partial payments. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by the provider shall be done so under protest, at the risk of the insurer, and the deposit shall not be deemed a waiver, accord, satisfaction, discharge, settlement or agreement by the provider to accept a reduced amount as payment in full. The insurer is hereby placed on notice that this provider reserves the right to seek the full amount of the bills submitted.

If the insurer schedules a defense examination or examination under oath (hereinafter "EUO") the insurer is hereby INSTRUCTED to send a copy of said notification to this provider. The provider or the provider's attorney is expressly authorized to appear at any EUO or IME set by the insurer. The health care provider is not the agent of the insurer or the patient for any purpose.

This assignment applies to both past and future medical expenses and is valid even if undated. A photocopy of this assignment is to be considered as valid as the original. I agree to pay any applicable deductible, co-payments, for services rendered after the policy of insurance exhausts and for any other services unrelated to the automobile accident. The health care provider is given the power of attorney to: endorse my name on any check for services rendered by the above provider, and to request and obtain a copy of any statements or examinations under oath given by patient.

**Release of Information:** I hereby authorize this provider to: furnish an insurer, an insurer's intermediary, the patient's other medical providers, and the patient's attorney via mail, fax or email, with any and all information that may be contained in the medical records; to obtain insurance coverage information (declaration sheet & policy of insurance) in writing and telephonically from the insurer; request from any insurer all explanation of benefits (EOBs) for all providers and non-redacted PIP payout sheets; obtain any written and verbal statements the patient or anyone else provided to the insurer; obtain copies of the entire claim file and all medical records, including but not limited to, documents, reports, scans, notes, bills,. Opinions, X-Rays, IMEs, and MRIs, from any other medical provider or any insurer. The provider is permitted to produce my medical records to its attorney in connection with any pending lawsuits. The insurer is directed to keep the patient's medical records from this provider private and confidential and the insurer is not authorized to provide these medical records to anyone without the patients and the provider's prior express written permission.

**Demand:** Demand is hereby made for the insurer to pay all bills within 30 days without reductions and to mail the latest non-redacted PIP payout sheet and the insurance coverage declaration sheet to the above provider within 15 days. The insurer is directed to pay the bills in the order they are received. However, if a bill from this provider and a claim from anyone else is received by the insurer on the same day the insurer is directed to not apply this provider's bill to the deductible. If a bill from this provider and claim from anyone else is received by the insurer on the same day then insurer is directed to pay this provider first before the policy is exhausted. In the event of the provider's medical bills are disputed or reduced by the insurer for any reason, or amount, the insurer is to; set aside the entire amount disputed or reduced; escrow the full amount at issue; and most pay the disputed amount to anyone or any entity, including myself, until the dispute is resolved by a Court. Do not exhaust the policy. The insurer is instructed to inform, in writing, the provider of any dispute.

**Certification:** I certify that; I have read and agree to the above; I have not been solicited or promised anything in exchange for receiving health care; I have not received any promises or guarantees from anyone as to the results that may be obtained by any treatment or service; and I agree the provider's prices for medical services, treatment and supplies are reasonable, usually and customary

**Caution:** Please read before signing. Please ask to view a copy of our charges. If you do not completely understand this document please ask us to explain it to you. If you sign below we will assume you understand and agree to the above.

**Patient's Name:** \_\_\_\_\_ **Patient's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
(Please Print) (If patient is minor, signature of parent/guardian)



**Orthopedic & Spine Center Of South Florida**  
**Irrevocable Assignment of Benefits**  
**Instructions to Insurance Carrier**

**PATIENT / CLAIMANT:** \_\_\_\_\_  
**INSURANCE CO.:** \_\_\_\_\_  
**CLAIM NUMBER:** \_\_\_\_\_  
**POLICY NUMBER:** \_\_\_\_\_  
**DATE OF ACCIDENT:** \_\_\_\_\_

1. I hereby irrevocably assign to *Orthopedic & Spine Center Of South Florida* any and all rights and causes of action I may have under any insurance policy or collateral source agreement including but not limited to above-referenced collateral source provider.

2. *Orthopedic & Spine Center Of South Florida* and I further instruct my insurance company to cooperate with the above captioned healthcare provider in resolving all medical billing matters. You are requested to do the following during the handling of this claim:

- a. Provide all pay-out sheets immediately upon payment of bills.
- b. Investigate and pay directly to *Orthopedic Spine Center Of South Florida* all claims within thirty (30) days after receipt of billing.
- c. Provide said healthcare provider with a prompt and reasonable explanation in writing of the basis in the insurance policy, in relation to the facts of the case or applicable law, for denial of a claim or for the offer of a compromise settlement or payment or delay in payment past thirty (30) days from receipt of this notice.
- d. Inform the healthcare provider promptly as to what additional information is necessary for processing of the claim.
- e. Return all phone calls from the provider promptly.
- f. Provide the provider with notice of each and every Independent Medical Examination (hereafter "IME") and statement or Examination Under Oath (hereafter "EUO") which is scheduled for me.
- g. Provide to the medical provider with a copy of each and every IME, paper IME or paper review generated with respect to me as required by Fla. Stat. 627.736.

These payment instructions are for benefits payable to me under my current insurance policy as payment toward the total charges for professional services rendered. I as the patient have agreed to remain personally liable for the amounts billed by the healthcare provider regardless of the amount paid by the insurance company unless ordered otherwise by a court of law. I further understand that said health services are being provided to me in consideration for an unconditional promise to pay and for me providing these instructions to my insurance company as the patient further agree to be liable for reasonable attorney's fees and costs incurred in collecting any delinquent accounts or unpaid balances. A photocopy of these instructions shall be considered as effective and valid as the original.

X \_\_\_\_\_  
SIGNATURE OF POLICY HOLDER                      DATE

Orthopedic Spine Center Of South Florida,LLC.

