AFFILIATED
PHYSICIANS OF FLORIDA

PATIENT INFORMATION

Name: ____

Birth Date: __________________ Age: ________ Gender________

Address: ____

City: ________________________ State: _____ Zip: __________

Phone: _________________________ (Home / Cell / Work)

E-Mail: ____

Occupation: ____

Date of Accident/Injury: _______________

Emergency Contact Info / Name: ____________________________

Relationship: __________________ Phone: ___________________

INSURANCE INFORMATION

Name of Policyholder: ____________________________________

Relationship to Patient: ___________________________________

Insurance Company: ______________________________________

Claim Number: ____

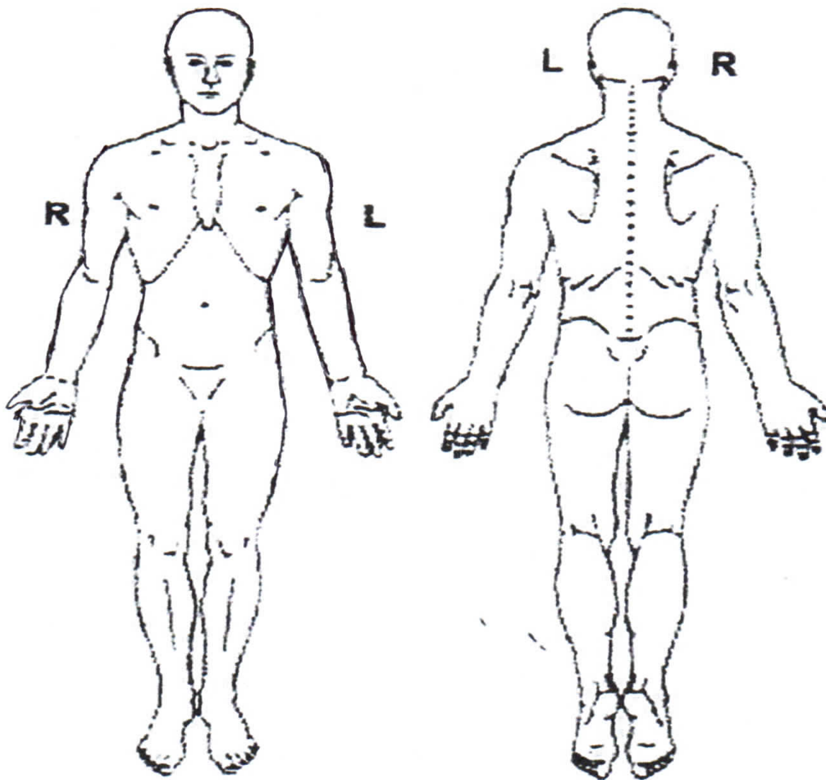
Attorney: ____

AFFILIATED PHYSICIANS OF FLORIDA

Name:____

Date of accident:____________________ **Exam date:**____________________

Please mark X below to indicate any areas of pain. Please circle below any areas of numbness.



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 or treatment set forth below were **actually rendered.** This means that those services have **already been provided.**

   99204 - New Patient Pain & Surgical Evaluation

   ____

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.
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.

Insured Person (patient receiving treatment or services) or Guardian of Insured Person:

Name *(PRINT or TYPE)*	Signature	Date

The undersigned licensed medical professional or medical director, if applicable, 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. The treatment or services rendered were explained 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(14) and (15), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Licensed Medical Professional Rendering Treatment/Services or Medical Director, if applicable *(Signature by his/ 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.

Affiliated Physicians of Florida

500 Vonderburg Drive, Suite 200 E, Brandon, FL 33511

AUTHORIZATION TO OBTAIN, RELEASE OR REVIEW PROTECTED HEALTH INFORMATION

I, ______________________________, hereby authorized the **Affiliated Physicians of Florida** (APOF) to obtain, release, or review protected health information in accordance with federal law and state law. This authorization will expire on the following date ______________________ or in one year from the date of my signature, if I fail to specify a date, event, or condition of expiration.

Issued To: ____
Name Of Physician, Individual, Agent, Agency, Or Health Care Facility

____
Address City State Zip

For the purpose of: [ ] **Medical Treatment** [ ] **Other** ______________________________
Dates of Service: **FROM** ____________________ **TO** ____________________

I understand that this authorization is revocable upon written notice to the office where the original authorization was retained, except to the extent that action has already been taken on this authorization. Mental health, alcohol, drug, HIV and/or AIDS information is confidentially protected by Federal and State law which prohibits disclosure without specific written authorization of the undersigned, or as otherwise permitted by such regulations. I further request that no genetic counseling/testing information in my record be released without my written authorization, except as otherwise required by law. I understand that I may select the information from the list below to be released by placing my initials in the space provided. Furthermore, I understand that any disclosure of information from my records carries with it the potential for an unauthorized disclosure of my health information. I understand that medical records with protected health information will be released to insurance companies for billing purposes during the processing of claims. I further understand that APOF may not condition the provision of treatment, payment and enrollment in health plan or eligibility for benefits on the provision of this authorization.

Place your initial by each item to be obtained, released, or reviewed.

______Complete Medical Record/Medical Record Abstract/All Diagnostic Tests.
______Medical Reports and Progress Notes
______Pathology Reports/ Laboratory Medicine
______Therapy & Rehabilitation Records
______Consultations/Disability Evaluations
______Operative Reports/Procedural Reports
______Radiology/Nuclear Medicine Studies
______Imaging Studies/MRI/CT/VF/Ultrasound
______Emergency Room/Hospital Records
______Mental Health Reports
______Electrodiagnostic Medicine
______HIV Testing/AIDS Information
______Drug or Alcohol Testing
______IME Reports
______Other______________________________

REVOKED AUTHORIZATIONS OR DENIED RELEASES

______ I do not want my medical record released to the following persons, agencies, or individuals and revoke any prior authorizations to such persons or entities.

____
NAME AND ADDRESS OF WITHHELD RELEASE ENTITIES

____
NAME AND ADDRESS OF WITHHELD RELEASE ENTITIES

PATIENTS SIGNATURE/AUTHORIZATION

____
PATIENT NAME (PRINT) PATIENT SIGNATURE DATE

SOCIAL SECURITY No: ____________________ DATE OR BIRTH ____________________

ADDRESS: ____________________ CITY ____________ STATE ________ ZIP CODE ________

AFFILIATED PHYSICIANS OF FLORIDA

ASSIGNMENT OF INSURANCE BENEFITS, RELEASE, & DEMAND

Insurer and Patient Please Read the Following in its Entirety Carefully!

I, the undersigned patient/insured knowingly, voluntarily and intentionally assign the rights and benefits of my automobile Insurance, a/k/a Personal Injury Protection (hereinafter PIP), Uninsured Motorist, 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. I understand this document will allow the provider to file suit against an insurer for payment of the insurance benefits or an explanation of benefits and to seek §627.428 damages from the insurer. If the provider's bills are applied to a deductible, I agree this will serve as a benefit to me. This assignment of benefits includes the cost of transportation, medications, supplies, overdue interest and any 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 the maximum amount directly without any reductions & 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 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 file suit for recovery 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.

Disputes: 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 (specifically the office manager) 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 PIP insurer states it can pay claims at 200% of Medicare then the insurer is instructed & directed to provide this provider with a copy of the policy of insurance within 10 days. **Any effort by the insurer to pay a disputed debt as full satisfaction must be mailed to the address above, after speaking with the office manager, and mailed to the specific attention of the Office Manager. See Fla. Stat. §673.3111.**

EUOs and IMEs: 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 authorize this provider to: furnish an insurer, an insurer's intermediary, the patient's other medical providers, and the patient's attorney and hired experts 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, the property damage 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 and experts in connection with any pending lawsuits. The insurer is directed to keep the patient's medical records from this provider private and confidential. The insurer is not authorized to provide the patient's medical records to anyone without the patient's 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 the insurer is directed to pay this provider first before the policy is exhausted. In the event 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 not 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 and when the policy is exhausted.

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, usual and customary.

Patients Name: ______________________________ Patients Signature: ____________________________________ Date: ____________

(Please Print) (If patient is a Minor, signature of parent/guardian)

AFFILIATED
PHYSICIANS OF FLORIDA

Informed Consent for Telemedicine Services

PATIENT NAME; ___________________________ DATE OF BIRTH; _____________

MEDICAL RECORD #: ___________ PHYSICIAN NAME: _______________________

DATE CONSENT DISCUSSED: ________________

I understand that Telemedicine is the use of electronic information and communication technologies by a health provider to deliver services to an individual when he/she is located at a different site than the provider; and hereby consent to Affiliated Physicians of Florida providing health care services to me via telemedicine.

I understand and agree that a medical evaluation via telehealth may limit my provider's ability to fully diagnose condition or disease. As a patient, I agree to accept responsibility for following my health care provider's recommendations – including further diagnostic testing, such as lab testing, or in-office visit.

I understand that the laws that protect privacy and confidentiality of medical information also apply to telemedicine.

I understand that I have the right to withhold or withdraw my consent to use of telemedicine during my care at any time, without affecting my right to future care or treatment. I may revokemy consent orally or in writing at any time by contacting Affiliated Physicians of Florida at (813) 920-5955. If this consent is in force (has not been revoked) Affiliated Physicians of Florida may provide health care services to me via telemedicine without the need for me to sign another consent form.

Signature of Patient (or person authorized to sign for Patient): __________________________

Date: _____________________

If Authorized signer, relationship to patient: _________________________

Witness: ____ ***Date:*** ____________________

I have been offered a copy of this consent form (Patient's Initials): _____________

AFFILIATED
PHYSICIANS OF FLORIDA

PROVIDER IRREVOCABLE LIEN

I, ______________________________, hereby authorize and direct my Attorney, __________________________________ to pay directly from the proceeds payable to client and received through the efforts of the Law Offices of __________________, the outstanding balance due Affiliated Physicians of Florida for treatments related to injuries sustained in the accident that occurred on ____________.

This Provider Irrevocable Lien is subordinate to any attorney's fees and costs.

_________________________ _________________________

Patient/Client Date

_________________________ _________________________

Affiliated Physicians of Florida Date

500 Vonderburg Drive, Suite 200 E, Brandon, FL 33511
P: (813) 920-5955 F: (813) 920-5997