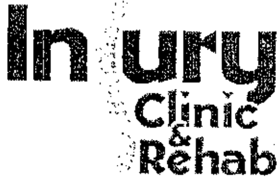

1225 North Military Trail
Suite 6
West Palm Beach, Florida 33409
Phone: (561) 687-5150, Fax: (561) 687-5051

(POR FAVOR ESCRIBIR EN LETRAS DE IMPRENTA)
PLEASE PRINT

(INFORMACION DEL PACIENTE:)
GENERAL INFORMATION:

(APELLIDO) PATIENT LAST NAME ______________________ (PRIMER NOMBRE) FIRST NAME ______________________

(DIRECCION DOMICILIARIA) ADDRESS ______________________ (ATENCION) CARE OF ______________________
(Parent/Guardian or financially responsible person)

(CIUDAD) CITY ____________ (ESTADO) STATE ________ (ZONA POSTAL) ZIP ________ (TELEFONO CELLULAR) PHONE (CELL) ____________

DRIVER' S LIC # ____________ (NUMERO DE HIJOS) NO. OF CHILDREN ______ PHONE (OTHER) ____________

(E-MAIL DIRECCION) E-MAIL ADDRESS ______________________ (Idioma) NATIVE LANGUAGE ____________

(ESPOSA (O) NOMBRE) SPOUSE'S NAME ______________________ (ESPOSA (O) TELEFONO) SPOUSE'S PHONE NUMBER ____________

(SEXO) SEX □ M □ F EDAD AGE	□ SINGLE □ MARRIED □ DIVORCED □ WIDOWED	(FECHA DE NACIMIENTO) DATE OF BIRTH / /	(NUMERO DE SOCIAL SECURITY) SOCIAL SECURITY NUMBER

(NOMBRE DEL EMPLEADOR DEL PACIENTE) PATIENT'S EMPLOYER NAME ______________________

(POSICION) POSITION ______________________

(DIRECCION) ADDRESS ______________________

(CIUDAD) CITY ____________ (ESTADO) STATE ________ (ZONA POSTAL) ZIP ________

EMPLOYED
□ FULL TIME □ PART TIME
□ RETIRED □ NOT EMPLOYED

STUDENT
□ FULL TIME □ PART TIME
□ NON STUDENT

(INFORMACION DEL SEGURO)
INSURANCE INFORMATION:

(ACCIDENTE AUTOMOBILISTICO / COMPENSACION LABORAL SOLAMENTE)
AUTOMOBILE ACCIDENT / WORKERS COMPENSATION ONLY **DOA:** ____________

(USTED FUE AL HOSPITAL? □ SI □ NO)
DID YOU GO TO THE HOSPITAL? □ **YES** □ **NO** (SI, EL NOMBRE) **If yes, NAME** ____________

(SEGURO) INSURANCE COMPANY ______________________ (RECLAMO) CLAIM NUMBER ____________

(NUMERO DE POLIZA) POLICY NUMBER ______________________ (NOMBRE DE TASADOR) ADJUSTER'S NAME ____________

(NOMBRE DEL ABOGADO) ATTORNEY'S NAME ______________________ (TELEFONO) PHONE NUMBER ____________

AUTORIZACION Y ASIGNACION
Yo autorizo el uso de esta informacion para procesar mi reclamo de seguro; asigno y solicito pagos a mis medicos directamente.

RELEASE AND ASSIGNMENT

Disclaimer and informed consent: I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the convenience of credit to my account. However, I clearly understand that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due.

(Firma del Paciente) **Patient's Signature** ______________________ (Fecha) **Date** ____________

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PATIENT QUESTIONNAIRE

Patient Name ____________________ Date of Loss ____________________

Did you go to the hospital □ Yes □ No

Transported to the hospital □ Yes □ No

What Hospital ____________________

Were you admitted □ Yes □ No

Were x-rays/MRI/CT performed □ Yes □ No

Did you lose consciousness □ Yes □ No

Dates of any previous accidents ______________________________

____

____

List all serious **injuries or surgeries** you've had ______________________________

____

____

List all other doctors you've consulted with for **this/these** condition(s) ____________________

____

____

List all **medications** you're currently taking ______________________________

____

____

List all **allergies** ______________________________

____

____

Please describe the circumstances for your visit to this office ____________________

____

____

Please list your Primary Care Physician ______________________________

(Number & Address) ______________________________

What kind of accident occurred □ Auto □ Work □ Motorcycle □ Bicycle □ Other: ____________

If auto accident, were you □ Driver □ Passenger □ Pedestrian
□ Stuck from behind □ Struck from front
□ Struck from the left □ Struck from the right

As a result of the accident, were traffic citations issued to you? □ Yes □ No

Were they issued to the driver of **your** vehicle? □ Yes □ No

Were they issued to the driver of the **other** vehicle? □ Yes □ No

Were you wearing your seatbelt? □ Yes □ No

Did any part of your body strike any part of the interior of the vehicle? □ Yes □ No

If yes, where ______________________________

____

Patient/Guardian Signature: Date:

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Please identify all symptoms applicable to you:

□ Shortness of breath	□ Pain in the head	□ Cold feet or hands
□ Chest pain	□ Mental dullness	□ Numbness in hands, feet or legs
□ Heart palpitations	□ Buzzing/Ringing in the ears	□ Pins and needles in arms or legs
□ Excessive perspiration	□ Sensitivity to light/loss of focus	□ Difficulty riding in a car
□ Neck pain/stiffness	□ Eye strain	□ Insomnia
□ Neck pain/stiffness on arising	□ Pain behind ears	□ Tension
□ Mid back pain/stiffness	□ Double vision	□ Irritability
□ Low back pain/stiffness	□ Facial flushing	□ Anxiety
□ Low back pain/stiffness on arising	□ Loss of taste	□ Depression
□ Restriction of neck motion	□ Loss of smell	□ Extreme Nervousness
□ Head/Shoulders feel heavy/tired	□ Sinus trouble	□ Extreme Fatigue
□ Headaches	□ Loss of memory	□ Nausea/Vomiting
□ Dizziness	□ Fainting	□ Diarrhea
□ Equilibrium Problems	□ Swelling (Where ___________)	□ Digestive disorders

Does the pain radiate anywhere ______________________________

Difficulty in excess: □ Walking □ Standing □ Bending □ Riding

Difficulty lifting: □ Light □ Moderate □ Heavy □ After a few lifts

List fully and describe all symptoms other than above: ______________________________

____

Social History: □ Smoke □ Drink alcohol ______/day/week □ Exercise ______/day/week

Family History: Does anyone in your family have a history of problems with the following:

□ Heart	□ Cancer
□ Lungs	□ Diabetes
□ Stroke	□ Thyroid
□ Rheumatoid Arthritis	□ Musculoskeletal (spine/joints)

List fully and describe all symptoms other than above: ______________________________

____

Are you pregnant? □ Yes □ No If No, date of last menstrual cycle ____________________

____

Patient/Guardian Signature: Date:

(By signing this, I attest that all the above information is true and accurate to the best of my knowledge)

____

Doctor's Signature: Date:

(By signing this, I state that all the above information has been reviewed with the patient)

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CONSENT TO MEDICAL CARE

PLEASE READ THIS FORM CAREFULLY AND COMPLETELY BEFORE SIGNING

I ______________________________, understand that I have a condition that requires medical treatment. I authorize Injury Clinic & Rehab Center to determine what kinds of pathological procedures (tests) must be done in order to learn more about my condition. These may include x-rays, pathological testing, diagnostic testing, or other testing. I understand that if my doctor advises a more complex test, or one which has special risks, that it will be explained in giving, or to give, the tests which my doctor will order.

I also authorize my doctor to determine what kind of treatment is to be given, and to perform such procedures as he/she may deem necessary, is his/her professional judgment, to preserve my health.

Additionally, I authorize the personnel of Injury Clinic & Rehab Center, Inc. to assist in giving me the therapy which my doctor may order. I fully understand that medical tests and treatment may involve certain unavoidable risks. If part of my treatment is very complex or carries special risks, it will be explained to me.

I acknowledge that my doctor is available to answer any questions I may have.

I also acknowledge that the following forms have been explained to me in detail:

1. Assignment of Benefits.
2. IME & EUO Notice (if applicable).
3. Radiology Warning Statement.
4. Doctor's Lien.
5. Disclosure and Acknowledgement Form (if applicable).
6. Consent to Medical Care.

______________________________ ______________________

Patient Signature Date

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IME & EUO NOTICE AND PATIENT'S FINANCIAL RESPONSIBILITY

Please be advised that your insurance company reserves the right by law, to schedule an Independent Medical Examination (IME) and/or Examination Under Oath (EUO). A letter will be mailed to your attention, as well as to your attorney, It is your responsibility to attend the appointment (s).

Failure to be present on the required date would make you responsible for any unpaid balance of medical bills left outstanding. Your P.I.P carrier will not make payment without your cooperation regarding this matter.

I, the patient also agree to be financially responsible for all charges incurred at this facility including my insurance deductible, co-payment and any services rejected by my insurance company.

Su compañia de seguro tiene el derecho de citarlo/a para una examinacion medica independiente y una examinacion bajo juramento. Usted sera notificado por correo y su abogado recibira una copia. Es su responsabilidad de asistir a esas citas.

Si usted no se presenta a esta cita en la fecha requerida, sera responsable por las cuentas medicas que esten pendientas. Su compañia de seguro no hara ningun pago sin su cooperacion al respecto.

Yo, el paciente, estoy de acuerdo de ser responsable economicamente por todos los cargos incurridos en esta oficina, incluyendo, mi deducible, co-pago, ó cualquier otros cargos, no cubiertos ó no pagos por mi compañia de seguro.

I fully understand the context of this letter:
Entiendo el contenido de esta carta en su totalidad:

Patient Signature / Firma del Paciente ______________________________

Date/Fecha ______________________

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

   ( ) O.Visit ( ) Hot/Cold Packs ( ) E.M.S ( ) Mech.Traction ( )X-Rays: ____________
   ( ) Therp. Ex. ( ) Ultrasound ( ) Trigger Pt. ( ) Other: ____________

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 (15) and (16), 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.

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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 you obtained, x-rays and physical findings and prognosis. You are authorized to provide this information in accordance with Florida "No Fault" auto insurance law (Chapter 71-252F.S)

____

Patient or Legal Guardian 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 Florida "No Fault" auto insurance law (Chapter 71-252F.S)

____

Patient or Legal Guardian Signature Date

Social Security Number ____________________________

APPLICATION OF "NO FAULT" BENEFITS

DATE	YOUR POLICY HOLDER	DATE OF LOSS	CLAIM NUMBER

DETERMINATION OF BENEFITS DUE UNDER "NO FAULT" AUTO INSURANCE LAW, REQUIRES, THE ATTENDING PHYSICIAN TO COMPLETE THIS REPORT IT DIRECTLY

TO: ______________________________
CLAIM DEPARTMENT
(Name of Insurance Company)

(Pursuant to Florida Statute 817.234, any person who knowingly and with intent to injure, defraud or deceive any insurance company by filing a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree.)

TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE PERSONAL INJURY PROTECTION LAW, PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY.

YOUR NAME | PHONE NUMBER: HOME | BUSINESS

YOUR ADDRESS (NO. STREET, CITY OR TOWN, STATE AND ZIP CODE) PERMANENT ADDRESS, IF DIFFERENT, HOW LONG HAVE YOU LIVED IN FLORIDA? | DATE OF BIRTH | SOCIAL SECURITY NO.

DATE AND TIME OF ACCIDENT A.M. P.M. | PLACE OF ACCIDENT (STREET, CITY, OR TOWN AND STATE)

BRIEF DESCRIPTION OF ACCIDENT
SEE POLICE REPORT

DESCRIBE MOTOR VEHICLES YOU OWN: OTHER VEHICLES: IN YOUR FAMILY:

VEHICLE:	OWNER	INSURER
1. ______	1. ______	1. ______
2. ______	2. ______	2. ______
3. ______	3. ______	3. ______

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

SIGNATURE: DATE:

DESCRIBE YOUR INJURY
FULL EXTENT OF INJURY NOT KNOWN AT THE PRESENT TIME

WERE YOU TREATED BY A DOCTOR? YES ☑ NO ☐ | DOCTOR'S NAME AND ADDRESS Dr. Ayal Goldstein
1225 N Military Trail, WPB FL 33409 suite 6

IF YOU WERE TREATED IN A HOSPITAL WERE YOU AN IN-PATIENT? ☐ OUT-PATIENT? ☐ | HOSPITAL'S NAME AND ADDRESS

AMOUNT OF MEDICAL BILLS TO DATE $ | WILL YOU HAVE MORE MEDICAL EXPENSE? YES ☑ NO ☐ | AT THE TIME OF ACCIDENT WERE YOU IN THE COURSE OF YOUR EMPLOYMENT? YES ☐ NO ☐

DID YOU LOSE WAGES OR SALARY AS A RESULT OF YOUR INJURY? YES ☐ NO ☐ | IF YES, AMOUNT LOST TO DATE $ | WHAT IS YOUR AVERAGE WEEKLY WAGE OR SALARY? $

IF YOU LOST WAGES: DATE DISABILITY FROM WORK BEGAN | DATE YOU RETURNED TO WORK

HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR PAYMENTS UNDER ANY WORKERS' COMPENSATION OR UNEMPLOYMENT LAW? IF YES:
$ __________ per week Name of W/C insurer:
$ __________ per month __________

Have you received or are you eligible for benefits from the following sources:

				Health Insurer, is any, (name):
Medicaid	NO ☐	YES ☐	$ ______	
Medicare	NO ☐	YES ☐	$ ______	______
Military Benefits	NO ☐	YES ☐	$ ______	$ ______

LIST NAMES AND ADDRESSES OF YOUR PRESENT EMPLOYER(S) AND GIVE YOUR OCCUPATION AND DATES OF EMPLOYMENT FOR EACH

EMPLOYMENT AND ADDRESS	OCCUPATION	FROM	TO
EMPLOYMENT AND ADDRESS	OCCUPATION	FROM	TO

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

I hereby authorize release of medical information including, but not limited to, medical bills and reports, to such parties as the company may deem necessary to prefect its rights of recovery under the No-Fault Act.

SIGNATURE. ______________________________ DATE: ______________

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PATIENT NAME ____

ASSIGNMENT OF BENEFITS

I hereby assign from any and all automobile or health or casualty insurance policies which provide medical benefits or no-fault benefits, all benefits, rights, title and interest to **Injury Clinic & Rehab Center**; as Assignee, for services rendered unto me both by reason of accident or illness. This is to act as a limited assignment of my rights and benefits to the extent of the Assignee's services provided and in no way should be construed as a delegation of any duties by the Assignor to Assignee, or a delegation of any conditions precedent under the above referenced insurance policies.

ASSIGNMENT OF CAUSE OF ACTION

In the event my insurance company fails to pay Assignee the full amount due and owing to Assignee after notice is given, I hereby assign and transfer to Assignee any and all causes of action, and proceeds from such causes of action, that I might have or that might exist in my favor against such insurance company and authorize Assignee to prosecute said cause of action either in my name or Assignee's name and further I authorize Assignee to compromise, settle or otherwise resolve said claim or cause of action as they see fit.

This assignment includes but is not limited to all rights to collect benefits directly from the insurance company for services that I have received and all rights to proceed against the insurance company obligated to provide benefits in any action including legal suits for any reason the company fails to make payment to which I am due. As part of this assignment I authorize Provider to sign my name as an endorsement on any check made payable to myself and Provider for services or supplies rendered. This assignment also includes the right to collect payment for the reasonable costs for copying and mailing records. This assignment also includes any right to recover attorney's fees and costs for such action brought by the Provider as patient's assignee. I understand and agree that the attorney selected may be different than the attorney handling my personal injury/bodily injury claim or case.

DIRECTION OF PAYMENT

I hereby authorize my or any insurance company or attorney to pay directly to Assignee the amount of this and/or any future bills for services rendered to me. I also agree to pay in a current manner any difference between the total charges and the amount paid by the insurance company directly to Assignee. I further agree to pay any applicable deductible or co-payment not covered by my insurance. In the event that I do not have insurance coverage, I understand that I remain personally responsible for payment of services rendered. I hereby further give an irrevocable lien to said Assignee against any and all insurance benefits named herein and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by the Assignee.

PATIENT/GUARDIAN INITIALS: ________

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PIP LOG REQUEST

I hereby authorize my insurance company to release any information requested that is pertinent to my case to Assignee. Pursuant to §627.4137 Florida Statutes (2001), I hereby request a copy of the pip log, declaration sheet and copy of the insurance policy, which reflects the policy limits available at the time of this accident, to be provided to Assignee. I hereby authorize Assignee to request and receive a copy of my pip log periodically as they deem to be necessary.

RESERVATION OF BENEFITS

Please be advised that I am hereby placing you on notice that, pursuant to Florida case law, should you deny, reduce or fail to pay either a portion of or an entire bill submitted on my behalf from this healthcare provider, I am requesting that you reserve, or hold aside, that same amount until this dispute is resolved. Additionally, should the remaining amount of benefits for assignor/policy holder/insured approach an amount where there would be insufficient funds to pay the amount you reduced, denied or failed to pay, please provide us with written notification.

CARRIER MUST NOTIFY PROVIDER

As part of this assignment of benefits, I further instruct the insurance carrier to notify the Provider immediately after any dispute as to the payment so that it may preserve and exercise its legal rights. Also, in addition to notifying me and my legal representative, I instruct the insurance carrier to immediately notify the Provider of any scheduled examinations under oath or independent medical examinations.

If any term of this Assignment or the application thereof to any person or circumstances shall be determined invalid or unenforceable the remainder of this Assignment shall not be affected thereby, and each term and provision of this Assignment shall be valid and enforced to the fullest extent of the law.

PATIENT NAME____

____________________________ ________________

PATIENT/GUARDIAN SIGNATURE DATE

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RADIOLOGY WARNING STATEMENT

I, ______________________________ authorize the performance of diagnostic x-ray examinations of myself, which the above doctor (s) or the facility may consider necessary or advisable in the course of my examination and treatment.

____
Patient Signature

____
Date

RADIOLOGY WARNING STATEMENT

THE FOLLOWING IS TO BE READ AND SIGNED BY ALL FEMALE PATIENTS IN THE CHILD BEARING YEARS WHEN SCHEDULED FOR DIAGNOSTIC X-RAYS.

X-Rays taken during pregnancy may be extremely dangerous to the unborn child unless adequate safeguards are employed during the procedure. The most dangerous period for the unborn child is during the first three months of pregnancy. Therefore, you are asked to inform the x-ray technician if there is any possibility that you may be pregnant.

I certify to the best of my knowledge that I AM NOT PREGNANT and that the above doctor (s) or the facility has/have my permission to perform diagnostic x-ray examination.

Signature: ______________________________

Date: ______________________

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RELEASE OF INFORMATION

Patient Name: ______________________________________

I, the above named patient hereby authorize INJURY CLINIC & REHAB CENTER to release any information pertinent to my case/automobile accident/incident/ injury to any insurance company, adjuster, and/or attorney involved with my file, and hereby release INJURY CLINIC & REHAB CENTER of any consequences thereof.

PATIENT RECORD OF DISCLOSURE

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their Protected Health Information (PHI). The individual is also provided the right to request confidential communications or that a communication on PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

_____ Home/Portable Phone

_____ OK to leave a message with detailed information

_____ Leave message with call-back number only

_____ Written Communication

_____ Mail at home address

_____ Fax at: ____________________

Other: ____

Patient Signature: ________________________

Date: ______________________

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Date: ______________

DISCLOSURE OF PROTECTED HEALTH INFORMATION

Information may be disclosed by: ____

Tel: (   ) _______________ Fax: (   ) _______________

Information to be disclosed to: **INJURY CLINIC & REHAB CENTER**
1225 North Military Trail
Suite 6
West Palm Beach, Florida 33409
Phone: (561) 687-5150, Fax: (561) 687-5051
Dr. Ayal Goldstein D.C. (Medical Director)

PATIENT WHOSE PROTECTED HEALTH INFORMATION IS TO BE DISCLOSED

Patient Name: ____________________________ Date of Birth: __________________

Social Security # __________________________ Date of Accident: ________________

INFORMATION TO BE DISCLOSED

	All Medical Records (Please Mail/Fax)		X-rays / CT scan / MRI / Ultrasound **(PLEASE FAX RESULTS)**
	Patient was involved in a prior MVA on or approximately ______________		Final narrative Dictated Report
	Progress Notes / Consultation		Other:

EXPIRATION DATE: This authorization will expire (Date:__________________) 2 years from the above referenced date. I understand that I fail to specify an expiration date or event , this authorization will expire in six (6) months from the date on which was signed.

RE DISCLOSURE: I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

CONDITIONING: I understand that completing this authorization form is voluntary. I realize that treatment will not be denied if I refuse to sign this form.

REVOCATION: I understand that I have the right to revoke this authorization at any time by giving a written/verbal notice to the office listed above.

______________________________________ ____________________
Patient's Name (If minor, parent/guardian) Date

You are entitled to a copy of this undersigned authorization.
A photocopy of this signed release form is as valid as the original

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LETTER OF PROTECTION & MEDICAL LIEN

PATIENT: ____________________

DATE OF BIRTH: ____________________

ACCIDENT DATE: ____________________

ATTORNEY: ____________________

ATTORNEY PHONE NO.: ____________________

I, the above noted Patient, do hereby authorize and direct my present and any future attorney to honor this Letter of Protection and Medical Lien. This Document shall serve to place a continuing lien on any proceeds I recover in any legal action related to the above-noted accident date. I do hereby authorize the above-referenced medical center to furnish you, my attorney, with a full report of examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident which I was recently involved.

Consideration. I hereby authorize and direct you, my attorney, to pay directly to said clinic such sums as may be due and owing for medical services rendered me both by reason of this accident and by reason of any other bills that are due the clinic and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said clinic. In consideration of the medical treatment and time provided to pay for said medical treatment, I hereby further give a lien on my case to said clinic against any proceeds. I notify you to assign a portion of my settlement, judgment, or verdict which may be paid to me, as the result of the injuries for which I have been treated or injuries in connection therewith to said clinic. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by him.

Patient Responsibility. I fully understand that I am directly and fully responsible to said clinic for all medical bills submitted for services rendered to me and that this agreement is made solely for said clinic's additional protection and in consideration of awaiting payment. I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee. It is my responsibility to advise each and every attorney of the existence of this agreement. Further, I must advise the above-named Medical Provider at reasonable intervals the status of the legal case.

__________/__________
Patient Initials / Date

1225 North Military Trail
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Phone: (561) 687-5150, Fax: (561) 687-5051

I agree to notify the provider within 5 days of the third party case settling to indicate the availability of funds to pay the Provider's bill. I hereby direct my present attorney and any future attorney to advise the Medical Provider as soon as possible about any funds related to the accident case becoming available to me. Further, if the legal action fails to fully pay the Medical Provider's outstanding balance(s), then the remaining amounts are to be paid by me. The Medical Provider may at his/her discretion at any time bill any third party payer or government payer.

Disputes. If there is a dispute over the Medical Provider's outstanding charges, I agree to submit the full amount due to the Medical Provider and agree to bring an action in Florida State Court for recovery of the disputed difference. If I fail to pay the Medical Provider's full outstanding balance, and thereafter Medical Provider brings suit to collect said sums, Medical Provider shall then have the right to recover attorney fees and costs for bringing an action to enforce this particular provision. The parties agree that both parties shall be considered equally drafting parties to this Letter of Protection.

This agreement becomes effective when I sign the agreement below. I agree never to rescind this document and instruct my attorney not to honor any rescission. My present attorney is instructed to deliver a copy of this letter of protection to replacement counsel in the event of his withdrawal from representing me.

______________________________ ______________________________
Patient Signature **Date**

______________________________ ______________________________
Attorney Signature **Date**

AFFIDAVIT OF NON OWNERSHIP

STATE OF FLORIDA

COUNTY OF PALM BEACH

I, ______________________________, duly sworn, hereby depose and say that:

1. I am of legal age and believe in the obligation of an oath or affirmation;

2. I make this affidavit based upon my personal knowledge;

3. On ____________ (***Date of accident***), I resided at ____; and

4. On that date, I ***did / did not*** own a vehicle and

5. I ***do / do not*** live with a blood relative that owns a Florida No-Fault insurance policy.

____
(***Patient Signature***)

Personally appeared before me and acknowledged the truth of the foregoing this ______ day of ____________, 20___.

____
NOTARY PUBLIC, STATE OF FLORIDA