PATIENT LABEL

Auto Accident Authorization Form

(Please fill out the entire form)

Patient Information

Today's Date: _____

Name (First, MI, Last): _____

Date of Birth:_____ Age:_____ Sex (M/F):_____ Social Security # _____

Marital Status: □ Single □ Married Phone Number: (Cell)_____ (Home)_____

Street Address:_____ (Apt/Lot #)_____

City: _____ State: _____ Zip: _____ Date of Accident: _____

Attorney Representation: _____

Phone Number: (_____) _____-_____ Fax Number: (_____) _____-_____

Medical Insurance Information

Do you have medical insurance? *Yes _____ NO _____

Your medical insurance will only be filed once we receive notification your Auto Benefits have exhausted.

	Carrier/Insurance Name	Member/Policy Number	Subscriber Information
Primary Insurance			□ Self □ Name: DOB:
Secondary Insurance			□ Self □ Name: DOB:
Tertiary Insurance			□ Self □ Name: DOB:

Attorney Information

Do you have attorney representation for this accident? **Yes ____ No _____

***** We must have a SIGNED RELEASE on file from your attorney's office to release any information to their firm. Please notify your attorney you are treating with our office for injuries related to your Auto accident.***

Attorney Name and Law Firm: _____

Case Manager or Legal Assistant: _____

Attorney Address: _____ City: _____ State: _____ Zip Code: _____

Attorney Phone Number: (_____) - _____-_____ Attorney Fax Number: (_____) -_____-_____

Auto Insurance Information

(Please fill out the entire form)

Date of accident _____/_____/_____ State the Accident Occurred: _____

Have you called and file a claim with your Auto carrier?: Yes / No

PLEASE NOTE: ***Florida is a NO-FAULT state. Regardless who is deemed "at fault" for the auto accident, the law requires us to submit your claim to your personal Auto carrier, NOT the other party involve. Please ensure you provide YOUR auto carrier information for proper claim filing, or you may be subject to be billed for all services/treatment rendered related to the accident.***

Name of Auto Carrier: _____ Auto Carrier Tel. Number: (____) _____-_____

Policy Number: _____ Claim Number: _____

1) Adjuster Name: _____

Adjuster Tel. Number: (_____) _____-_____ ext._____ Adjuster Fax Number: (_____) _____-_____

2) Adjuster Name: _____

Adjuster Tel. Number: (_____) _____-_____ ext._____ Adjuster Fax Number: (_____) _____-_____

Billing Address: _____

City: _____ State: _____ Zip: _____

Location of Accident: _____

_____

Please briefly describe the circumstances of the accident and list the extent of your injuries as you know them:

_____

_____

Did you require post-accident hospitalization: Yes / No If yes, Where? _____

Doctor(s) seen: _____ Treatment Received: _____

FOR OFFICE USE ONLY

Deductible: YES / NO Amount $_____ Deductible Remaining: _____

Med Pay: YES / NO Amount $_____ Med Pay Remaining: _____

PIP Benefit $ _____ Insurance Pays: 80% 100% Other _____

Verified by: _____ Date: _____

Additional Notes: _____

_____

Accident or Injury Information

Please fill out the entire form

Description:

When did it happen (month, day, year, and time of day)?

_____

How did it happen?

_____
_____
_____

Name of co-workers or witnesses present:

_____
_____

List All WC treatment you have received for this accident:

_____
_____

First Aid?

_____

Other doctors, chiropractor or Emergency Room treatment?

_____
_____

Medical History: ***(Please answer the following so that we may treat you safely.)***

Previous injuries or surgeries for similar problems:

_____
_____
_____

Current medical problems (list): ☐ **None**

_____
_____
_____

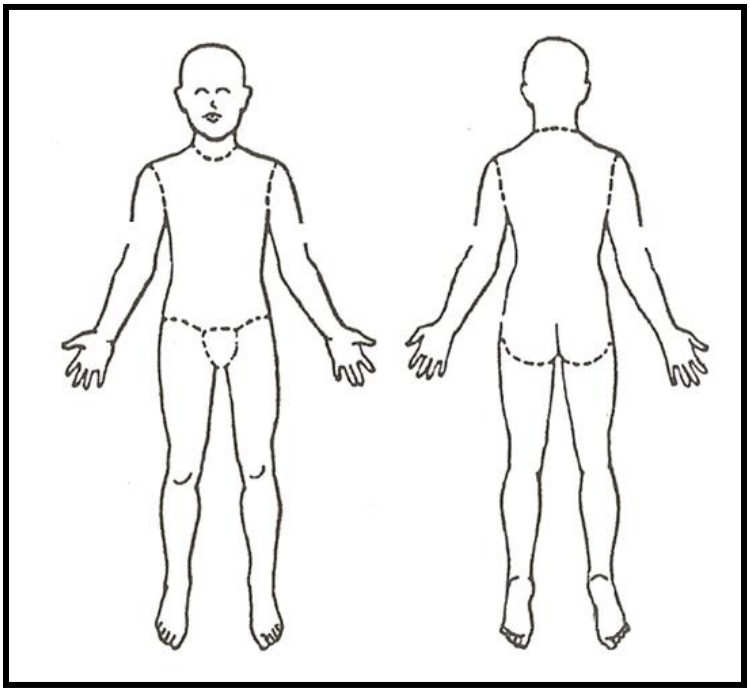
Surgeries or major operations (list): ☐ **None**

_____
_____

Allergies (list): ☐ **None**

_____
_____

Where do you hurt? (Mark on Drawing)



Severity of Pain: (circle)

No Pain 1 2 3 4 5 6 7 8 9 10 Extreme Pain

Type of Pain: (circle all that apply)

Numb Burning Tingling Dull-Ache Sharp Shooting

Current Medications? (list) ☐ **None**

_____
_____

SOCIAL

Current smoker?	**Yes**	**No**
Ex-smoker?	**Yes**	**No**

FAMILY MEDICAL

Blood relatives with: Heart Disease Cancer Diabetes

OTHER

Left or Right Handed?	**Left**	**Right**	
Have you had stomach ulcers?	**Yes**	**No**	
Are you breast feeding?	**Yes**	**No**	**N/A**
Could you be pregnant?	**Yes**	**No**	**N/A**

PATIENT LABEL

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name: _____ **Patient Phone #:** _____

I request and authorize you to release any information which may be related to treatments and examinations, including substance abuse, mental health, or communicable diseases, which may be contained in my medical records (e.g. HIV/AIDS, TB, STD) for the purpose of treatment, payment and/or healthcare operations.

Provider (who is releasing the information): _____

Provider Address: _____

Provider Phone #:_____ **Provider Fax #**:_____

Provider Name (who is receiving the information): Emed Multispecialty Group
Provider Address: 2624 Atlantic Blvd. Jacksonville, FL 32207
Provider Phone #: (904) 513-3240 **Provider Fax #: (904) 398-7871**

This request and authorization applies to:

- ☐ ALL RECORDS
- ☐ LAST TWO (2) OFFICE NOTES
- ☐ IMAGING (CT SCAN, MRI, X-RAY REPORTS)
- ☐ LAB AND PATHOLOGY RESULTS
- ☐ BLOOD WORK, PAP RESULTS, IMMUNIZATIONS
- ☐ EKG, ECHO, STRESS, MAMMOGRAPHY TEST RESULTS
- ☐ OFFICES NOTES PERTAINING TO OPIOID/ALCOHOL DEPENDANCY
- ☐ URINE DRUG SCREEN RESULTS
- ☐ STD TEST RESULTS
- ☐ HIV/AIDS TEST RESULTS (POSITIVE OR NEGATIVE)
- ☐ MENTAL HEALTH TREATMENT
- ☐ OTHER:

_____

_____

The purpose of releasing this information is (Ex: Continuity of care, transfer of care**):** _____

_____

Patient Signature: _____ Date: _____

This request is an exchange of health information between healthcare providers for treatment, payment, or healthcare operations, therefore a HIPPA compliant release is not required (HIPPA 164.506)

Emed Multispecialty Group
2624 Atlantic Blvd. Jacksonville, FL 32207
Tel: (904) 513-3240 | Fax: (904) 398-7871 | www.emedmultispecialtygroup.com

Emed Auto Accident Policy

To ensure that best care is given to each and every patient at Emed Multispecialty Group due to an Auto Accident, please be aware of our Auto Accident Policy

1. Emed Multispecialty Group does **NOT** accept Letter of Protection (LOP).
2. If PIP/MedPay benefits are available, the patient's auto carrier will be billed for services rendered due to the auto accident.
3. If no PIP/MedPay benefits are available, and the patient has health insurance, the health insurance will be billed for services rendered as long as we are a participating provider and your assigned Primary Care Physician (PCP).
4. If no PIP/MedPay benefits are available and there is no health insurance, the patient will be responsible for the self-pay rate at the time services are rendered.
5. If your auto carrier deems you are responsible for a Deductible or copay, the patient is responsible to pay the out-of-pocket amount at the time of services
6. Any patient with a history of drug abuse, alcohol abuse, or psychiatric problems will not be issued any type of narcotic medication or any other type of medication that may make a chronic issue worse.
7. The patient agrees and acknowledges they will be subject to a urine drug test as often as medically necessary (provider discretion), which could result at each visit. This is to ensure that all patients are receiving the most appropriate medication for their condition.
8. Certain auto carriers require the provider to submit a claim after services have been provided, and before benefits are verified. If the auto carrier confirms that you do NOT have PIP/MedPay benefits available, we will file the claim to your health insurance; as long as we are a participating provider and we are the assigned PCP or have a valid referral on file (if you have an HMO plan). The patient agrees they will be responsible for any out of pocket expenses or the self-pay rate if the claim denies

If you have any questions or concerns regarding the filing or billing of your auto claim or benefits, the Emed Billing Department will be happy to assist.

Patient Name: _____ Date: _____/_____/_____

Patient Signature: _____

EMED MULTISPECIALTY GROUP

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, 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, 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 directly without reductions & without including the patient's name on the check.

The insurer is directed by the provider and the undersigned not to 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. 1 agree to pay any applicable deductible, co-payments, for services rendered after the proof 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 un-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 patient's and the provider's prior express written permission.

Demand: Demand is hereby made for the insurer to pay any bills within 30 days without reductions and to mail the latest un-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.

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.

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: _____

Notice of Emergency Medical Condition

The undersigned licensed medical provider, hereby affirms:

1. The below injured patient, has in the opinion of this medical provider, suffered an Emergency Medical Condition as a result of the patient's injuries sustained in an automobile accident that occurred on _____/_____/_____.

2. The basis for the finding of an Emergency Medical Condition, is that the patient has sustained acute symptoms of sufficient severity, which may include severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:
    a. Serious jeopardy to the patients' health;
    b. Serious impairment to bodily functions; or
    c. Serious dysfunction of a bodily organ or part.

I hereby attest that I am a Physician licensed under Chapter 458 or Chapter 459, a Physician Assistant licensed under Chapter 458 or Chapter 459, or an Advanced Registered Nurse Practitioner licensed under Chapter 464, and the above facts are true and correct.

_____	_____	_____
Provider Name (PRINT)	Provider Signature	Date

The undersigned injured person or legal guardian of such affirms:

1. The symptoms I reported to the medical provider are true and accurate.

2. I understand that the medical provider has determined I sustained an Emergency Medical Condition as a result of the injuries I suffered in an automobile accident.

3. The medical provider has explained to my satisfaction the need for medical attention and the harmful consequences to my health which may occur if I do not receive treatment.

Injured patient, or legal guardian of said patient, receiving this diagnosis:

_____	_____	_____
Patient Name (PRINT)	Patient Signature	Date

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.**

_____

_____

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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