PATIENT LABEL

eMed Multispecialty Group

Formulario de Autorización para Accidentes Automovilísticos

(Por favor llene el formulario completo)

Información del Paciente

Fecha de hoy: _____________

Nombre Completo: ____

Fecha de Nacimiento:_________________ Edad:_____ Sexo (M/F):_____ # de Seguridad Social ___________________

Estado Civil: □ Soltero(a) □ Casado(a) Nu. de Teléfono: (Celular)___________________ (Casa)___________________

Dirección:____ (Apt/Lot #)__________

Ciudad: ____________________ Estado: __________ Zip: ___________ Fecha del accidente: _________________

Seguro Medico

¿Tiene Seguro medico? *Si _____ NO _____

**** Su Seguro medico solo se archivará una vez recibamos la notificación de que sus benecicios se han agotado***

	Nombre del Sesuro	Número de Miembro/Póliza	Información del Suscriptor
Primario Seguro			□ Yo □ Nombre: Fecha de Nac.:
Seguro Secundario			□ Yo □ Nombre: Fecha de Nac.:
Seguro Terciario			□ Yo □ Nombre: Fecha de Nac.:

Información de Abogado

¿Tiene abogado representante del accidente? **Si ____ No ______

***** Debemos tener una forma de liberación de HIPPA firmado en el archivo de la oficina de su abogado para divulgar cualquier información. Notifique a su abogado que está recibiendo tratamiento con nuestra oficina.***

Nombre de la oficina del Abogado : ____

Administradora de casos o asistente legal: ____

Dirección del Abogado: ____

Ciudad: ____________________________ Estado: _______________ Zip Code: _______________

Teléfono del Abogado: (________) - __________-_____________ Fax del Abogado: (______) - ________-___________

Información de Seguro de Auto

(Por favor llene el formulario completo)

Fecha de Accidente: ________/_______/__________ Estado de Accidente: _______________

¿Has llamado y abierto un reclamo a su Seguro de auto?: Si / No

TENGA EN CUENTA: Florida es un estado SIN FALLAS. Independientemente de quién se considere "culpable" del accidente automovilístico, la ley nos exige que presentemos su reclamo a su transportista personal de automóviles, NO a la otra parte. Asegúrese de proporcionar SU información de autotransportista para la presentación adecuada de la reclamación, o puede estar sujeto a una factura por todos los servicios / tratamientos prestados relacionados con el accidente.

Nombre de Seguro de Auto: ____________________________ Teléfono de Seguro de Auto: (____) _____-________

Número de Polizá: ______________________________ Número de Reclamo: ________________________________

1) Nombre del Ajustador De Auto: ____

Número de Ajustador: (______) ______-________ ext.__________ Fax de Ajustador: (______) ______-________

2) Nombre del Ajustador De Auto: ____

Número de Ajustador: (______) ______-________ ext.__________ Fax de Ajustador: (______) ______-________

Dirección de envoi de Reclamo: ____

Ciudad: ____________________________ Estado: _______________ Zip Code: _______________

Lugar del accidente: ____

____

Describa brevemente las circunstancias del accidente y enumere el alcance de sus lesiones tal como las conoce:

____

____

¿Requirió hospitalización posterior al accidente: Si / No ¿Si?, ¿Donde? ____________________________

Proveedores vistos: ____________________________ Tratamiento Recibido: _________________________________

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: ____

Información Sobre Accidente o Lesiones

Por favor llene completamente la forma

Descripción:

¿Cuándo sucesidó (mes, día, año y hora del día)?

____

Como Paso?

____
____
____

Nombre de testigo presents:

____
____

Enumere todos los tratamientos que recibió del accidente:

____
____

Primeros Auxilios?

____

Otros medicos quiroprácticos o tratamiento en sala emergencias?

____
____

Historial Méedico: ***(Responda lo siguiente para que podamos tratarlo de manera segura***

Lesiones o cirugía previas por problemas similares:

____
____
____

Problemas medicos actuals (lista)): ☐ **Ninguno**

____
____
____

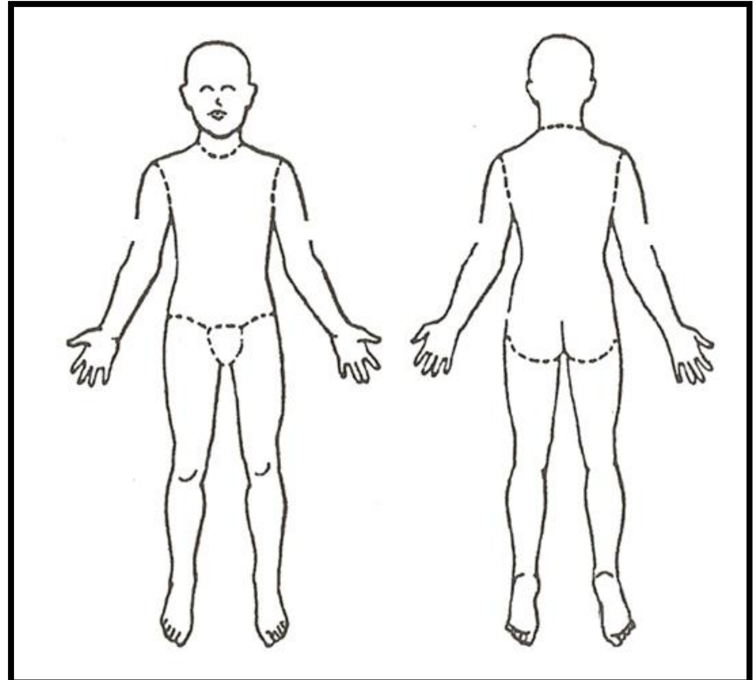
Cirugías/Operaciones principals ☐ **Ninguno**

____
____

Alergias (lista): ☐ **Ninguno**

____
____

¿Donde te duele? (Marca en el dibujo)



Severidad del dolor: (círculo)

Sin Dolor 1 2 3 4 5 6 7 8 9 10 Dolor Extremo

Tipo de dolor: (marque con círculo todos que correspondan)

Entumecida   Ardiente   Hormigueo

Dolor-Sordo   Agudo   Puntante

Medicamentos Actuales? (lista) ☐ **Ninguno**

____
____

SOCIAL

¿Fumador Actual?   Si   No
¿Ex-fumador?   Si   No

MÉDICO DE FAMILIA

Parientes Consanguíneos con:¿Enfermedad Cardíatica? ¿Cáncer? ¿Diabetes?

OTROS

¿Zurdo o Diestro?   Zurdo   Diestro
¿Has tenido úlceras estomacales?   Si   No
¿Estas Lactando?   Si   No   N/A
¿Podrías estar embarazada?   Si   No   N/A

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)

Política de accidentes automovilísticos de Emed

Para garantizar que se brinde la mejor atención a todos y cada uno de los pacientes de Emed Multispecialty Group debido a un accidente automovilístico, tenga en cuenta nuestra Política de accidentes automovilísticos

1. Emed Multispecialty Group NO acepta Carta de Protección (LOP).
2. Si los beneficios de PIP / MedPay están disponibles, se facturará al transportista automático del paciente por los servicios prestados debido al accidente automovilístico.
3. 3. Si no hay beneficios de PIP / MedPay disponibles, y el paciente tiene seguro de salud, se facturará al seguro de salud por los servicios prestados siempre que seamos un proveedor participante y su médico de atención primaria (PCP) asignado.
4. 4. Si no hay beneficios de PIP / MedPay disponibles y no hay seguro de salud, el paciente será responsable de la tasa de autopago en el momento en que se prestan los servicios.
5. 5. Si su transportista de automóviles considera que usted es responsable de un deducible o copago, el paciente es responsable de pagar el monto de su bolsillo al momento de los servicios.
6. 6. Cualquier paciente con antecedentes de abuso de drogas, abuso de alcohol o problemas psiquiátricos no recibirá ningún tipo de medicamento narcótico o cualquier otro tipo de medicamento que pueda empeorar un problema crónico.
7. 7. El paciente acepta y reconoce que será sometido a una prueba de drogas en orina tan a menudo como sea médicamente necesario (discreción del proveedor), lo que podría resultar en cada visita. Esto es para asegurar que todos los pacientes reciban la medicación más apropiada para su condición.
8. Ciertas compañías automotrices requieren que el proveedor presente un reclamo después de que se hayan proporcionado los servicios y antes de que se verifiquen los beneficios. Si el transportista de automóviles confirma que NO tiene beneficios PIP / MedPay disponibles, presentaremos el reclamo a su seguro de salud; siempre y cuando seamos un proveedor participante y seamos el PCP asignado o tengamos una referencia válida en el archivo (si tiene un plan HMO). El paciente acepta que será responsable de cualquier gasto de bolsillo o de la tasa de pago propio si el reclamo lo niega.

Si tiene alguna pregunta o inquietud con respecto a la presentación o facturación de su reclamo o beneficios de automóviles, el Departamento de Facturación de Emed estará encantado de ayudarlo.

Nombre del paciente: ____ Fecha: ______/_______/_______

Firma del paciente: ____

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: ____________________

emed Multispecialty Group

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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