TOTALMD

# Patient Initial Evaluation



Date: _____

Name: _____

Date of Birth: ____/____/____ Sex: ☐ Male ☐ Female Height: _____ Weight: _____

Date of Accident: ____/____/____ Time of Accident: _____

Do you have personal AUTO insurance: ☐ Yes ☐ No

If YES, please provide the following:

Auto Insurance Company: _____ Policy #: _____

Road Condition: ☐ Wet ☐ Dry ☐ Raining

Describe the accident (speed, location of accident, time of accident, how did it happen?)

_____

_____

_____

_____

What city? _____ Street name: _____

Were you the driver or a passenger? ☐ Driver ☐ Passenger

Which area of the vehicle was hit? _____

Were there any immediate injuries? _____

_____

Did you feel any pain later in time (describe areas of injury) _____

_____

Did you lose consciousness? ☐ Yes ☐ No How long? _____

Did you go to the Hospital? ☐ Yes ☐ No When? _____ Ambulance? _____

If yes, what hospital? _____

List all of the doctors that you have seen for injuries sustained in this accident:

_____

_____

List all medications that you have received for injuries sustained in this accident?

_____

_____

List all tests or treatments that you have received for injuries sustained in this accident?
(i.e. X-rays, CT scans, Stitches, Casts, Manipulation, Physical Therapy, Injections)

_____

_____

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# Patient Initial Evaluation



Are you right or left handed? ☐ Right ☐ Left Are you a smoker? ☐ Yes ☐ No Frequency? _____

Occupation? _____

Describe your job (What are your job duties? Do you sit or stand for long periods of time? Do you lift heavy objects or do repeated bending or stooping? )

_____

_____

_____

_____

Have you ever been injured in a motor vehicle or other accident in the past?

_____

Do you have any major medical problems? _____

_____

Do you take any medication on a regular basis? (please list) _____

_____

Have you had any surgery? _____

Are you pregnant? _____

Are you allergic to any medication? _____

Since the accident have you had problems with any of the following: (please describe)

☐ Headaches _____

☐ Sleep _____

☐ Toileting, bathing, combing hair, etc. Sitting _____

☐ Standing _____

☐ Driving _____

☐ Eating _____

☐ Lifting _____

☐ Fear or anxiety _____

How do your injuries effect your ability to work? _____

_____

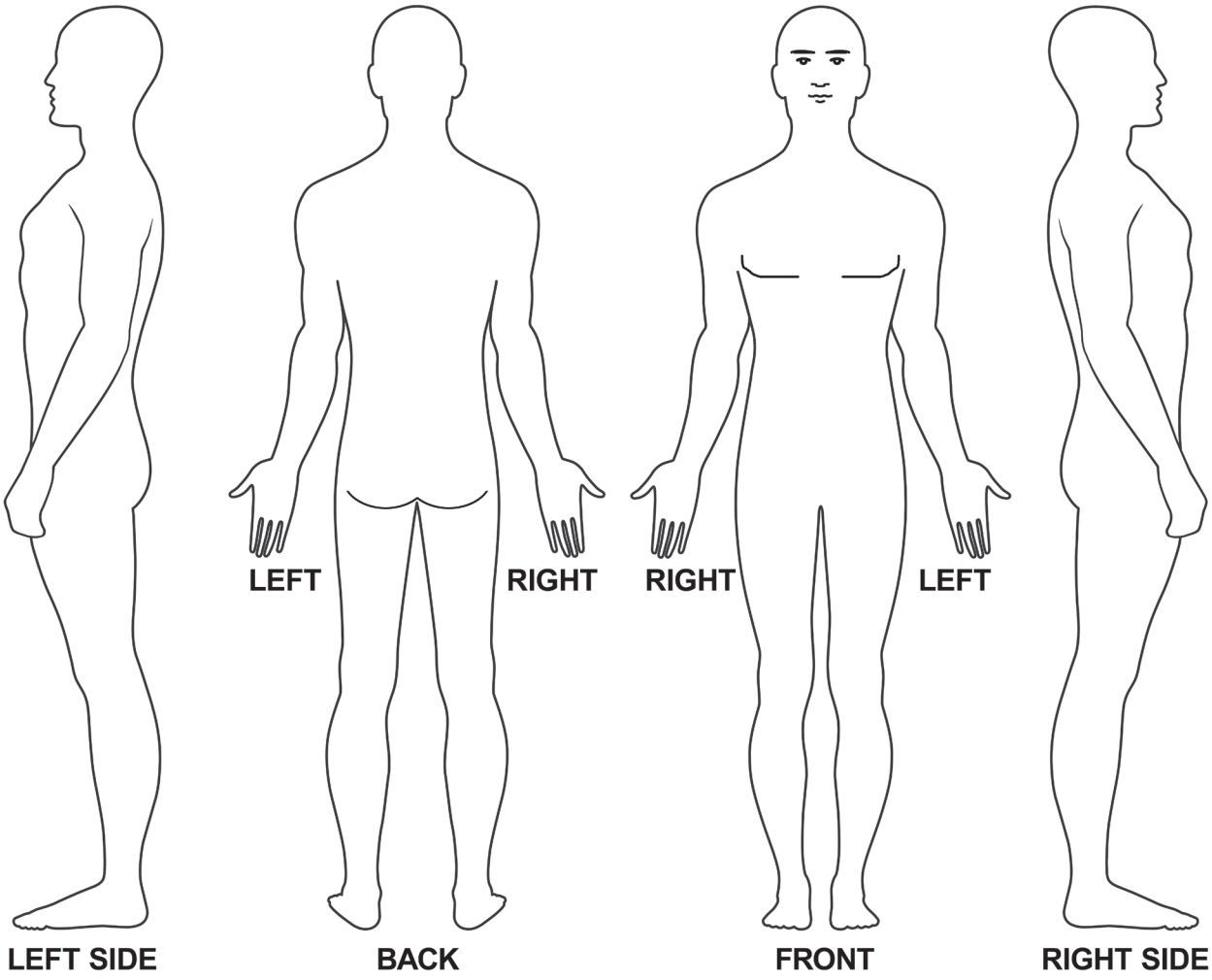
TOTALMD

**Patient Initial Evaluation**



## Where is your pain now?

**Please mark an "X" in the area where you feel pain that was a direst result of the accident.**




Patient's Name

X

Patient's Signature

**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(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.

☐ Central Palm Beach Physicians and Urgent Care, Inc.
☐ Medical Center Imaging, LLC
☐ Total MD Orthopedics and Neurosurgery, LLC
***CHECK ONLY ONE BOX***

Corporate Office
4623 Forest Hill Blvd., Ste 101
West Palm Beach, FL 33415
P:561-967-8888 F: 561-641-8303

**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. I understand this document will allow the provider to file suit against an insurance company for payment of the insurance benefits or an explanation of benefits. If the provider's bills are applied to a deductible, I agree this will serve as a benefit to me and I authorize and request such litigation. The assignment of benefits includes the cost of transportation, medications, supplies, and 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 healthcare provider the maximum amount directly without any 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 insurance resulting in the policy of insurance being declared void, rescinded or canceled, I, as a named insured under said policy of insurance, hereby assign to this provider the right to receive the premiums paid for my PIP insurance and the right 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 in the premiums paid.

The insurer is directed by the provider and the undersigned to not issue any checks or drafts and partial settlement 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 care provider and the insurer as to the amount payable under the insurance policy. The insured and the provider hereby contest and object 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 healthcare 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 or copayments for services rendered after the policy of insurance exhausts and for any other services unrelated to the automobile accident. The healthcare provider is given a 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 e-mail, with any and all information that may be contained in medical records; to obtain insurance coverage information (declaration sheet and the policy of insurance) in writing and telephonically from the insurer; request from any insurer while explanations of benefits (EOB's) for all providers and non-redacted PIP pay out 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, IME's 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 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 a 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 healthcare; 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 signed below we will assume you understand and agree to the above.**

Patient's name: _____ Patient's signature: _____
(Please Print) (If Patient is a Minor, Signature of Parent/Guardian)

Date: _____