Physician Partners of America
PERSONAL INJURY

PHYSICIAN PARTNERS OF AMERICA

PATIENT REGISTRATION FORM

(Please Print Clearly)

Date of Appointment:	Time of Appointment:

PATIENT INFORMATION

Patient's last name: First: Middle:			❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F
Street address:		Social Security#:			Home phone #: ( )
Cell Phone ( )	City:	State:	ZIP Code:		
Email:	Employer:		Employer phone #: ( )		
Please Select the Appropriate Box ❑Auto Accident ❑Work Comp ❑Other	Referring Dr.	Date of Injury:	Telephone #:		

INSURANCE INFORMATION

Primary Injury Related Insurance: (Auto/Work Comp)			
Policyholder:	Birth date: / /	Address (if different):	Home phone #: ( )
Claim Number:	Policy Number:	Social Security #:	

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

.

Patient/Guardian signature *Date*

ATTORNEY INFORMATION

Attorney Name:			
Mailing Address:	City:	Zip code:	Office Number #: ( )
Contact Person:		Fax Number: ( )	

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ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO PAY AND AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the_____ Insurance Co. to pay by check made out and mailed directly to:

Florida Pain Relief Group
PO Box 865356, Orlando, FL
32886 – 5356

I hereby authorize to the above captioned doctor, the medical expense benefits allowable and otherwise payable to me under my current insurance policy, as payment toward the total charges for the all professional services that were rendered.
This payment shall not exceed my indebtedness to the above named assignee, and I have agreed to pay, IN CURRENT MANNER, any balance of said professional service charges over and above the insurance payment.

With this form I give my consent and authorization to release any necessary medical information required to process this claim.

Signed:_____ Date:_____

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DISCLOSURE, ACKNOWLEDGMENT, AND NOTICE OF INITIATION OF TREATMENT PURSUANT TO SECTION 627.736 FLORIDA STATUES

On this date of initial treatment or service provided, the undersigned physician hereby gives notice of providing medical services upon which a claim for personal injury protection is based, and likewise, follows the requirements of law by signing below and requiring the patient's signature below for executing this acknowledgment and disclosure form, to agree and reflect the following:
A. The insured, or his/her guardian, signs below attesting to the fact that the services identified as: a comprehensive history and physical examination with complex medical decision making were actually rendered.

B. The insured, or his/her guardian, has both the right and the affirmative duty to confirm that the services were actually rendered.

C. The insured, or his/her guardian, was not solicited by any person to seek any service from the medical provider.

D. The physician rendering services for which payment is being claimed, explained to the services to the insured or his/her guardian.

E. If the insured notifies the insurer in writing of a billing error, the insured may be entitled to a certain percentage of a reduction in the amounts paid by the insured's motor vehicle insurer.

F. The Acknowledgment, Disclosure and Notice shall also serve as a notice of initiation of treatment.

_____ _____

Provider's Handwritten Signature **Patient's Handwritten Signature**

_____ _____

Date **Patient's Printed Name**

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STANDARD DISCLOSURE ACKNOWLEDGMENT FORM

The undersigned insured person (or guardian of said person) affirms the following:

1. The services that are described below were actually rendered. These services have already been provided.

_____
_____

2. It is my right and my duty to confirm that the services have already been provided.

3. No one solicited me to seek any services from the medical provider who gave the services described above.

4. The medical provider clearly explained the services to me for which payment is being claimed.

5. If the insurer is notified by me in writing of a billing error, this may entitle me to receive a portion of any reduction in the amounts paid by my motor vehicle insurer. If I am entitled to receive payment, the share I receive would be no less than 20% of the amount of the reduction up to a maximum of $500 USD.

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

Name (Print or Type): _____

Signature:_____

Date:_____

The licensed medical professional or medical director whose signature is appended, if required, confirms the statement numbered 1 (one) above. They also affirm:

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 insured person had the treatment or services rendered clearly explained to them, or in the case of a minor, his or her guardian. The explanation was sufficient for the person to sign this form with informed consent.

C. The statement or bill that accompanies this document has been properly completed with all relevant information and all material provisions provided therein. All requests for information have been responded to

truthfully, accurately, and in a substantially complete manner.

D. Proper coding procedures have been followed on the accompanying statement or bill. Services have not been uncoated, unbundled, and do not include invalid or not medically necessary diagnostic tests as defined by section 627.732(14) and (15) Florida Statues or section 627.736 (5)(b)6, Florida Statues.

Licensed medical professional rendering treatment/services or medical director, if applicable.

(Signature must be in his/her own hand)

Name (Print or Type): _____

Signature:_____

Date:_____

Anyone who knowingly and with intent to injure or defraud or deceive any insurer files a statement claim or an application containing false, incomplete, or misleading information is guilty of a felony of the 3rd° per 817.234(1) (b) Florida Statues

Note: The original this form must be provided by the insurer pursuant to section 627.736(4)(b) Florida Statues. These documents may not be electronically furnished. Failure to furnish this form could result in a nonpayment of the claim.

PATIENT QUESTIONNAIRE (PAGE 1)

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Please select the best answer for each question. The answers you provide will help your anesthesiologist provide you with the best care during your operation. If you do not understand the question, or are uncertain about the answer, simply use a "?" in one of the provided columns.

Answer the Following Question: Have you had or do you CURRENTLY have...	Yes	No	Remarks
A Cold			
Bronchitis			
Pneumonia			
Asthma			
Tuberculosis			
Emphysema			
Have you or are you experiencing shortness of breath?			
Have you experienced problems with your lungs?			
Are you a smoker?			
Have you had rheumatic fever?			
Have you been diagnosed with a heart murmur?			
Have you been diagnosed with high blood pressure?			
Do you experience chest pain/angina?			
Have you had heart attacks?			
Do you experience heart palpitations, irregular, or fast heartbeats?			
Have you been diagnosed with anemia?			
Have you been diagnosed with sickle cell disease?			
Have you been diagnosed with jaundice, hepatitis, or liver trouble?			
Have you been diagnosed with gallbladder trouble?			
Do you have back pain or a back injury?			
Do you have implants of any kind?			
Do you have a slipped disc or sciatica?			
Do you experience convulsions or epilepsy?			
Have you had a stroke?			
Have you been diagnosed with polio, paralysis, or meningitis?			
Have you ever had thyroid trouble?			
Have you been diagnosed with diabetes?			
Have you ever had kidney trouble?			
Have you experienced serious illness during pregnancy?			
Do you drink alcohol?			
Other illnesses not mentioned			

PATIENT QUESTIONNAIRE (PAGE 2)

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Please select the best answer for each question. The answers you provide will help your anesthesiologist provide you with the best care during your operation. If you do not understand the question, or are uncertain about the answer, simply use a "?" in one of the provided columns.

Answer the Following Question: Have you had surgery on the following areas?	**Yes**	**No**	**Remarks**
Brain, neck, or jaw			
Thyroid, breast			
Heart, lung, kidney			
Stomach, abdomen			
Other			
Blood transfusions			
Dentures, loose teeth			
ALLERGIES			
Are you allergic to any medications?			
Are you allergic to latex?			
Is anyone in your family allergic to anesthetics?			
MEDICATIONS			
Are you taking blood pressure medication?			
Are you taking antidepressants?			
Are you taking tranquilizers?			
Are you taking sedatives?			
Are you taking eye drops?			
Are you taking pain pills/shots?			
Are you taking steroids, cortisol, ACTH?			
Are you taking sleeping pills?			
Are you taking diabetic medication?			
Are you taking other medications?			

Signature X_____

Date_____

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PERSONAL INJURY

INFORMED CONSENT AND AGREEMENT TO ABIDE BY TREATMENT PLAN

I,_____, am over eighteen (18) years of age and competent to contract and make my own medical decisions. I am entering into this Agreement without coercion or inducement of any sort and understand that I may, if I wish, delay signing of this Agreement.

I am about to begin or continue a treatment plan by or under the direction of_____.

I understand that other individuals or entities may be involved in my care, and this Agreement includes all other such individuals or entities.

I understand that narcotic medication(s) may be prescribed for me, and that such medications may have serious long-term damaging effects, even if used in the recommended dosages. However, the likelihood of harmful effects increases substantially when recommended dosages are exceeded. Therefore, I will abide by the doses recommended for me, and I will not exceed those doses under any circumstances without the prior written and prescribed authorization of my physician.

I understand that the combination of the medication(s) prescribed under the present treatment plan and medications prescribed by other physicians, or certain over-the-counter medications, may result in harmful side effects. Therefore, I agree to notify my physician immediately should such medications be prescribed for or obtained by me in any manner. This notification must take place prior to the use of the above medications in combination with medications prescribed under this Agreement. The telephone contact number for such is:_____.

The medication being prescribed under this Agreement is shown immediately above my signature at the end of this document. I will not request any increase in this medication to exceed the prescription shown.

I have been advised that if I do not wish to enter into or continue treatment with_____ or his designees, I may transfer to another physician for care. If this is my choice, I will notify _____ promptly before beginning treatment with the other physician, and I hereby agree to authorize_____ to release to the physician, of my choice, copies of all records in his possession concerning my treatment. In connection with such release, I understand that the confidentiality of substance use/abuse patient records is protected by federal and state law and regulations.

I further understand that it will be important for any other physicians who are treating me for other conditions to have a record of my treatment by _____. Therefore, I accept the responsibility of obtaining these reports for my treating physicians. In addition, treatment rendered by those other physicians must be important to_____. Therefore, I will obtain copies of all such records from physicians who have treated me within the past____years, provide them to_____ and I will update those records by copy to_____ every____months or sooner if

significant changes in my treatment plan occurs.

I agree to abide by the pain management recommendation that_____ renders in my medication usage. It is my full and complete understanding that my relationship with_____ will be terminated according to the laws of the state of Florida and the terms of this contract if I do not abide by this Agreement.

If treatment is terminated by_____, I will have ten (10) days in which to obtain the services of a subsequent treating physician, and during this time,_____ and his associates will be responsible for emergency care only. It will be my responsibility to obtain medical records for the use of my subsequent treating physician.

The possible complications and adverse effects of treatment by the method outlined include addiction and other serious and long-term effects, and these disadvantages have been explained to me, as well as possible alternative modes of treatment. After due consideration, I have selected the method outlined by the prescription below.

THIS AGREEMENT FORMS A CONTRACT BETWEEN ME AND_____ AND ALL OTHER INDIVIDUALS OR ENTITIES ASSOCIATED WITH THEM. IT IS INTENDED TO BE A LEGALLY BINDING CONTRACT, AND MAY BE ALTERED ONLY BY A SUBSEQUENT FULLY EXECUTED WRITTEN AGREEMENT. NO ORAL REPRESENTATION SHALL BE APPLICABLE OR BINDING UPON THE PARTIES. I HAVE BEEN ADVISED NOT TO SIGN THIS DOCUMENT UNLESS I FULLY UNDERSTAND ITS TERMS, AND HAVE FURTHER BEEN ADVISED THAT I SHOULD SEEK LEGAL COUNSEL FOR CLARIFICATION.

The prescription for my treatment is as follows:

_____

_____

ATTACH A COPY OF RX HERE

Patient_____ Date_____

Witnesses: _____

_____

Doctor:_____

Date:_____

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REQUEST FOR RELEASE OF MEDICAL RECORDS

TO_____
NAME OF FACILITY

ADDRESS_____

CITY_____ **FL** _____ **ZIP** _____

I HEREBY AUTHORIZE THAT MY MEDICAL RECORDS BE RELEASED TO:

Florida Pain Relief Group
4728 N. Habana Ave., Suite 202
Tampa, FL 33614

Phone (813) 682-0355
Fax (813) 348-4243

I AUTHORIZE A COPY OF THE SIGNATURE TO ALWAYS SERVE AS AN AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS.

_____ _____

Patient Signature **Date**

_____ _____

Social Security Number **Date of Birth**

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MEDICAL REPORTS AND DOCTOR'S LIEN

I do hereby authorize_____ to furnish my attorney with a full report of examination, diagnosis, treatment, prognosis, etc. of myself in regard to the accident in which I was involved.

I hereby authorize and direct my attorney to pay directly to said doctor such sum, as may be due and owing him for medical service rendered me both by reason of this accident and by reason of any other bills that are due his office and to which hold such sums from any settlement, judgment, or verdict which may be paid to my attorney or myself as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am entirely and solely responsible
to_____

for all medical bills and expenses which may have been incurred by me, regardless of the outcome of any claim which I may have and that the payment of such bills and expenses is not contingent upon any settlement judgment or verdict.

I agree to never resend this document and that a recession will not be honored by my attorney. I hereby instruct that in the event another attorney is substituted in this manner that the new attorney honor this lien as inherent to the settlement, judgment, or verdict which I may eventually recover said fee.

I acknowledge the conditions of this letter by signing below and furnishing this letter to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but will require me to make payments on a current basis.

Date_____

Print Name_____

Patient Signature_____

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment, and verdict, as may be necessary to adequately protect said doctor above-named.

Date_____ Attorney Signature_____

NOTE TO ATTORNEY: PLEASE DATE, SIGN, AND RETURN SIGNED LETTER OF PROTECTION FORM TO DOCTORS OFFICE

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Name (Print or Type): _____

Signature:_____

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