MEDICAL RECORDS / X-RAY RELEASE FORM

STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Phone: 407-532-8895 Fax: 407-532-8892

Date: _____ Account #: _____

Persons Authorized to Use or Disclose Information
Information listed above will be used or disclosed by: _____

Persons to Whom Information May Be Disclosed
Information described above may be disclosed to CENTRAL FLORIDA MEDICAL & CHIROPRACTIC CENTER, INC

Name: _____ Social Security #: _____

Date of Birth: _____

I hereby request and authorize that the following medical documents/records to be released and that they be promptly transferred to CENTRAL FLORIDA MEDICAL & CHIROPRACTIC CENTER, INC

____ X-Ray Films
____ Complete Medical file
____ Medical Reports
_____ Daily Notes
_____ Other _____

Expiration Date of Authorization
This authorization is effective through ___/___/___ unless revoked or terminated by the patient or the patient's personal representative.

Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to Central Florida Medical & Chiropractic Center, Inc. You should contact the Compliance Office to terminate this authorization.

Potential for Re-disclosure
Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

_____

Patient Signature Date

_____

Representative Signature / Please Print Name Date

Central Florida Medical & Chiropractic Center, Inc
5287 Alhambra Drive
Orlando, Fl 32808

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.

ASSIGNMENT OF BENEFITS

I hereby authorize and direct you, my insurance company _____ and/or my attorney to pay directly to **Central Florida Medical & Chiropractic Center, Inc.** ("Assignee") such sums as may be due and owing Assignee for services rendered by reason of accident, illness, and for any other bills due Assignee, and to withhold such sums from any disability benefits, medical payments, No-Fault benefits, or any other insurance benefits obligated as reimbursement from any settlement, judgment or verdict on my behalf as may be necessary to adequately protect said Assignee. In the event I do not have insurance coverage, I understand I remain personally responsible for payment of services rendered. I further give an irrevocable lien to said assignee gains 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. This is to act as an assignment of my rights and benefits to the extent of the Assignee's services provided. In the event my insurance company is obligated to make payment to me upon charges made by the Assignee for its services, refuses to make such payment, upon such cause of action, that I might have or that might exist in my favor against such company, authorize Assignee to prosecute said cause of action either in my name or Assignee's and further authorize Assignee to compromise, settle or otherwise resolve said claim of action as they see fit.

Direction of Payment

I hereby authorize any insurance company or attorney to pay directly to Assignee the amount of this and/or future bills for services rendered. 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.

PIP Log & Declaration Sheet Request

I hereby authorize Assignee to release requested information, which is pertinent to my case, to my insurance company or the attorney involved in this case. Pursuant to 627.4137 Florida Statues (2001). I hereby request a copy of the pip log and declaration sheet, which reflects the policy limits available at the time of this accident, to be provided to this Assignee. I hereby authorize this Assignee to request and receive a copy of my pip log periodically as they deem necessary. If any term or provision of this Assignment, Lien and Authorization or the application thereof to any person or circumstance shall to any extent be invalid or unenforceable, the remainder of this Assignment, Lien and Authorization, or the application of such term or provision to persons or circumstances other than those as to which it is held invalid or unenforceable, shall not be affected thereby, and each term and provision of this Assignment, Lien and Authorization shall be valid and enforced to the fullest extent of the law.

Reservation of Benefits

Be further advised, I am hereby placing you on notice pursuant to Florida case law that should you (the insurance company/carrier) deny, reduce or fail to pay any part of, or an entire bill which was submitted on my behalf from this health care provide, I (the assignor) as well as the assignee (health care provider) are requesting, in advance, that you reserve, or "act-aside," the amount reduced or denied until the dispute is resolved. Should you submit a check to this health care provider which is less than the correct contractual amount, and contains any language referring to payments as "Full and Final Payment," I have instructed this health care provider to return the check to you (the carrier) and consider the bill still due and owing (i.e. a late payment as defined in F.S. 627.736). Additionally, should the remaining amount of my benefits approach an amount where there would be insufficient funds to pay the amount reduced, or failed to pay, please notify me (the assignor) and this health care provider (the assignee).

Patients Name and Date

Print Name _____

Signature _____

Date _____

Health Care Provider

Central Florida Medical & Chiropractic Center, Inc.
5287 Alhambra Drive
Orlando, Florida 32808

CENTRAL FLORIDA MEDICAL & CHIROPRACTIC CENTER
5287 Alhambra Drive Orlando, Fl 32808
PHONE 407-532-8895 FAX 407-532-8892

LETTER OF PROTECTION

Patient's Name: _____ Date of Birth _____

Date of Incident: _____

I do hereby authorize **Central Florida Medical & Chiropractic Center , Inc** to furnish my attorney will a full report of this examination, diagnosis, treatment, prognosis, etc regarding myself for medical conditions related to the accident dated above.

I hereby authorize and direct you my attorney, to pay directly to the doctor such sums as may be due and owing him for reasonable and necessary medical services rendered to me for evaluation or treatment for conditions related to this accident. I hereby further give a lien on my case to the doctor against any and all proceeds of my settlement, judgment or verdict which may be paid to you by my attorney or myself as a result of the injuries of which I have been treated or injuries in connection therewith.

I fully understand that I am responsible to the doctor for all reasonable medical bills submitted by him for necessary services rendered to me and the payments for such bills will be paid solely out of my settlement, judgment or verdict. I further understand that this agreement is made for the doctor's protection in consideration of his awaiting payment. I understand and agree that my directions to you, as my attorney, are irrevocable until either the satisfaction of my financial account with Central Florida Medical & Chiropractic Center, Inc. occurs of Central Florida Medical & Chiropractic Center, Inc. releases such Letter of Protection.

I agree to promptly notify the doctor of any change or addition of attorney(s) used by me in connection of the accident and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted or added attorney.

Please acknowledge this letter by signing below and return it to the doctor's office.

Patient's Signature: _____ Date: _____

I, being the attorney of record for the above patient, do hereby agree to observe all the terms of the above and agree to withhold such sums for any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate the doctor named above in payment of his fees.

Attorney's Signature: _____ Date: _____