Only complete if involved in MVA - MOTOR VEHICLE ACCIDENT

Patient name:__________________________ DOB: ____________________________

Date of accident: ____/_____/_____ Location of MVA:_________________________

Please describe the accident in your own words: _________________________________
____
____
____
____
____

Were you:
DRIVER / FRONT PASSENGER / REAR PASSENGER / PEDESTRIAN / BICYCLIST

Does your vehicle have an airbag: YES NO Did your airbag deploy: YES NO

Were you wearing: LAP SEATBELT SHOULDER SEATBELT HELMET

Did your car or bicycle impact another vehicle? YES NO

Was impact from: FRONT REAR LEFT SIDE RIGHT SIDE

What was the aprox speed at the time of impact: ________________ MPH

At the time impact were you: LOOKING STRIGHT AHEAD LOOKING UP
LOOKING DOWN LOOKING TO THE LEFT LOOKING TO THE LEFT

Immediately after the accident, where did you experience pain? Be specific:
____
____

Did you go to the hospital: YES NO IF yes, how did you get there: _______________

Were you admitted to the hospital: YES NO How long was your stay: ____________

Have you received medical &/or therapeutic treatment since your injury? YES NO

If yes, what type of care have you received (i.e. emergency, chiropractic, naturopathic, massage, etc)?
____

Have you retained an attorney? YES NO Name of attorney: ___________________

Did you have any pain similar to this prior to your MVA?
____
____

IS there anything else you would like me to know about your MVA?
____
____

PATIENT SIGNATURE: ____

Florida Sports Injury and Orthopedic Institute

ASSIGNMENT OF BENEFITS

I hereby assign from any and all automobile, health or casualty insurance which provide medical benefits or no-fault benefits, all benefits, rights, title and interest to **"Florida Sports Injury and Orthopedic Institute"**, as, Assignee, for services rendered unto me both by reason of accident or illness. This is to act as a limited assignment of my rights and benefits to the extent of the Assignee's services provided and in no way should be construed as a delegation of any duties by the Assignor to Assignee, or a delegation of any conditions precedent under the above referenced insurance policies.

ASSIGNMENT OF CAUSE OF ACTION

In the event my insurance company fails to pay Assignee the full amount due to owing to Assignee after notice is given, I hereby assign and transfer to Assignee any and all causes of action, and proceeds from such causes of action, that I might have or that might exist in my favor against such insurance company and authorize Assignee to prosecute said cause of action either in my name or Assignee's name and further I authorize Assignee to compromise, settle or otherwise resolve said claim or cause of action in Assignee's sole discretion.

DIRECTION OF PAYMENT

I hereby authorize my or any insurance company or attorney to pay directly to Assignee the amount of this and/or any future bills for services rendered to me. 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. I further agree to pay any applicable deductible or co-payment not covered by my insurance. In the event that I do not have insurance coverage, I understand that I remain personally responsible for payment of services rendered. I hereby further give an irrevocable lien to said Assignee against 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.

PIP LOG REQUEST

I hereby authorize my insurance company to release any information requested that is pertinent to my case to Assignee. I hereby request a copy of the PIP log, declaration sheet and copy of the insurance policy, which reflects the policy limits available at the time of this accident, to be provided to Assignee. I further authorize Assignee to request and receive a copy of my PIP log periodically as they deem to be necessary.

RESERVATION OF BENEFITS

Please be advised that I am hereby placing you on notice that, pursuant to Florida case law, should you deny, reduce or fail to pay either a portion of or an entire bill submitted on my behalf from this healthcare provider, I am requesting that you reserve, or hold aside, that same amount until this dispute is resolved.

If any term of this Assignment or the application thereof to any person or circumstances shall be determined invalid or unenforceable the remainder of this Assignment shall not be affected thereby, and each term and provision of this Assignment shall be valid and enforced to the fullest extent of the law.

PATIENT:______________________________________ DATE:_______________

GUARDIAN ______________________________________

PATIENTS BILL OF RIGHTS AND RESPONSIBILITIES:

The staff of this health care facility recognizes you have rights while a patient receiving medical care. In return, there are responsibilities for certain behavior on your part as the patient. These rights and responsibilities include:

- ✓ Be treated with courtesy and respect, with appreciation of this individual dignity and with protection of his need for privacy.
- ✓ A prompt and reasonable response to questions and requests.
- ✓ Know who is providing medical services and who is responsible for his care.
- ✓ Know what patient support services are available, including whether an interpreter is available if he does not speak English.
- ✓ Know what rules and regulations apply to his conduct.
- ✓ Be given, by his health care provider, information concerning diagnosis, a planned course of treatment, alternatives, risks and prognosis.
- ✓ Know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.
- ✓ Receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
- ✓ Receive a copy of a reasonably clear and understandable itemized bill and, upon request, to have charges explained.
- ✓ Impartial access to medical treatment or accommodations, regardless of race, national origin, religion, physical disability or source of payment.
- ✓ Treatment for any emergency medical condition will deteriorate from failure to provide treatment.
- ✓ Know if medical treatment is for purposes of experimental research and to give his consent or refusal to participate in such experimental research.
- ✓ Express concerns regarding any violation for patient rights.

A patient is Responsible for:

- ✓ Providing to his health care provider, to the best of his knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications and other matters relation to his health.
- ✓ Reporting unexpected changes in his condition to his health care provider.
- ✓ Reporting to health care provider whether he comprehends a contemplated course of action and what is expect of him.
- ✓ Following the treatment plan recommended by his health care provider.
- ✓ Keeping appointments.
- ✓ His actions if he refuses treatment or does not follow the health care providers instructions.
- ✓ Assuring that the financial obligations for his health care are fulfilled as promptly as possible.
- ✓ Following health care facility rules and regulations affecting patient care and conduct.

COMPLAINTS:

If you have a question or concern about your rights or responsibilities, please let us know. We want to assure that we provide you with excellent service, including answering your questions and responding to your concerns.