



ONLY COMPLETE IF INVOLVED IN A SLIP AND FALL LEGAL CASE:

Patient name: _____ DOB: _____

Date of accident: _____

Location of Slip & Fall: _____

Please describe the accident in your own words:

Did you go to the hospital: _____

Were you admitted: _____

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 pain similar to this prior to your Slip and Fall?

Signature of patient and date: _____

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 _____