



Motor Vehicle Accident (MVA) Registration Form

INSTRUCTIONS: PLEASE PRINT CLEARLY AND CIRCLE BEST ANSWERS BELOW
INSTRUCCIONES: POR FAVOR ESCRIBA CLARAMENTE Y ESCOJA MEJOR RESPUESTAS

TODAY'S DATE <i>FECHA HOY:</i>		CHIEF COMPLAINT & REASON FOR VISIT <i>QUE LE MOLESTA Y RAZON POR SU VISITA:</i>	
PRIMARY CARE PHYSICIAN (PCP) NAME <i>NOMBRE DE SU DOCTOR:</i>		PCP TEL <i>DOCTOR TEL:</i>	
REFERRED BY <i>REFERIDO POR:</i>			

PATIENT INFORMATION / INFORMACION DE EL PACIENTE

LAST NAME <i>APELLIDO:</i>		FIRST NAME <i>PRIMER NOMBRE:</i>		MIDDLE INITIAL:	
NATURAL BORN GENDER <i>SEXO:</i>	FEM / MUJ MALE / H	IDENTIFIES AS <i>SE IDENTIFICA COMO:</i>	FEMALE MUJER	MALE HOMBRE	OTHER / OTRO _____
DATE OF BIRTH <i>FECHA NACIMIENTO:</i>		MARITAL STATUS <i>STATUS SOCIAL:</i>		SOC SEC NO. <i>NUM SOCIAL:</i>	
MAILING ADDRESS <i>DIRECCION:</i>			CITY, STATE, ZIP CODE		
EMAIL:			MOBILE NO. <i>NUMERO CELLULAR:</i>		

INSURANCE INFORMATION / INFORMACION DE SEGURO

AUTO INSURANCE COMPANY NAME <i>NOMBRE COMP SEGURO DE CARRO:</i>		PRIMARY POLICY HOLDER'S NAME <i>NOMBRE DE EL PRINCIPAL EN LA POLIZA:</i>	
POLICY NUMBER <i>NUMERO POLIZA:</i>		POLICY HOLDR RELATNSHIP TO PATIENT <i>RELACION AL PACIENTE:</i>	
CLAIM NUMBER <i>NUM. RECLAMO:</i>		ADJUSTER NAME / NOMBRE AJUSTADOR	ADJUSTER TEL:

EMERGENCY CONTACT / CONTACTO DE EMERGENCIAS

FIRST NAME <i>PRIMR NOMBRE:</i>		LAST NAME <i>APELLIDO:</i>		RELATIONSHIP <i>RELACION:</i>	
MOBILE NO. <i>NUMERO CELL:</i>		OK TO RELEASE PERSONAL HEALTH INFORMATION? <i>ESTA BIEN COMPARTIR INFORMACION DE SALUD?</i>		YES / SI	NO

READ STATEMENT AND SIGN BELOW TO AGREE / LEA Y FIRME SI ESTA DE ACUERDO

The above information is true, to the best of my knowledge. I authorize my insurance benefits be paid directly to Xpress Urgent Care. I understand that I am financially responsible for any balance. I also authorize Xpress Urgent Care to release information required to process my claims. I hereby also authorize the healthcare staff to perform the necessary services that I may need. By providing an email address and consenting to receive voice mail messages, I authorize Xpress Urgent Care to leave details including but not limited to lab and diagnostic test results, as well as general Xpress Urgent Care information including locations, hours of operation and services at the phone number and email address listed above.

X

Patient OR Legal Guardian Signature

Date



***This form is REQUIRED for all patients seen under MVA visit type.

ACCIDENT INFORMATION FORM

Patient Name: _____ DOB: _____

Date of Accident: _____ Time accident occurred: _____

Year, Make & Model of your vehicle: _____

(CIRCLE ONE THE CORRECT ANSWERS AND COMMENT AS NEEDED)

Were you the: DRIVER FRONT PASSENGER REAR PASSENGER OTHER

Did the impact to your vehicle come from the: FRONT REAR DRIVER PASSENGER

Which direction was your head facing during impact? FORWARD RIGHT LEFT

Were you aware of or were you surprised by the impact? _____

Where was the base of your skull in relation to the headrest: ABOVE BELOW EVEN AWAY

Was your vehicle: MOVING or STOPPED? If moving, how fast? _____ MPH

Were you wearing a seatbelt? Y N

Did your vehicle strike anything else? Y N If yes, what? _____

Did the police come to the accident site? Y N If yes, was a report filed? Y N

Did you go to the hospital? Y N If yes, were you examined? Y N

Did you go to the hospital? Y N

If yes, how did you get there? _____

If yes, what services were performed? X-Rays MRI CT Scan Other _____

Did any other part of your body strike anything inside the vehicle or did the airbag deploy?

Did you have any pain or symptoms immediately after the accident? Please explain.

In your own words, describe the accident:

*****By signing this form, I agree that all of the above statements are true and accurate.**

Patient Signature: _____ Date: _____



ASSIGNMENT OF BENEFITS AND MEDICAL RELEASES

POWER OF ATTORNEY TO ENDORSE CHECKS AND/OR TO SIGN ANY PIECE OF PAPER WHICH WILL ENHANCE OR EXPEDITE PAYMENT TO PROVIDER FOR SERVICES RENDERED, INCLUDING BUT NOT LIMITED TO A RELEASE OF MEDICAL RECORDS AND ASSIGNMENT OF BENEFITS/AUTHORIZATION TO PAY.

Know by all these present that: The undersigned has made, constituted and appointed, and by these presents does hereby make, constitute and appoint Xpress Urgent Care and any of its fully authorized agents and employees as and to be undersigned's true and lawful attorney for and in the undersigned's name, place and stead to endorse any and all checks, drafts, or money order are made payable for services which have been made by Xpress Urgent Care, at the request or with the knowledge and approval of the undersigned and/or the maker of the check, draft or money order.

Furthermore, the undersigned allows Xpress Urgent Care or any of its agents to sign any paper that will be necessary to enhance and/or allow payment to said provider. This may include affidavits of non-ownership of vehicles, insurance forms and other statements.

The undersigned by this presents does give and grant the said Xpress Urgent Care as attorney the full power and authority to do and perform all and every act whatsoever requisite and necessary to be done in and about the premises as fully to all interest and purposes as the undersigned might or could do to personally presents insofar as the endorsing and cashing of said check are concerned as well as any other document.

MEDICAL RELEASE

A photocopy of the document shall be sufficient to authorize any person having records of medical treatment, services or supplies pertaining to me to release true copies of same to Xpress Urgent Care or any insurer providing photocopy of this document shall be as binding as an original signature page.

The undersigned does hereby ratify and confirm any and all actions taken by the said attorney in accordance with this special power and which the said attorney shall do or cause to be done by virtue of these presents.

ASSIGNMENT OF BENEFITS

I, (Patient's Name) _____ hereby authorize (Ins. co.) _____ to make medical benefits payment otherwise to me for services rendered by Xpress Urgent Care; but not to exceed the charges of those services, payable to and mailed directly to:

**Xpress Urgent Care LLC
Corporate Headquarters:
PO Box 4189
Deerfield, FL 33442**

Furthermore, I hereby IRREVOCABLE ASSIGN to Xpress Urgent Care the rights and benefits under any policy or insurance, indemnity agreement, or any other collateral source as defined in Florida Statutes for any service and or charges provided by Xpress Urgent Care.

IN WITNESS WHEREOF the undersigned have hereunto set their hand, this _____ day of _____ 20____.

Patient Name (Print): _____ **Date:** _____

Patient / Guardian Signature: _____



NOTICE OF EMERGENCY MEDICAL CONDITION

The undersigned licensed medical provider, hereby affirms:

1. The below injured patient, has in the opinion of this medical provider, suffered an Emergency Medical Condition, as a result of the patient's injuries sustained in an automobile accident that occurred on _____ (fill in date of accident).
2. The basis for the finding of an Emergency Medical Condition is that the patient has sustained acute symptoms of sufficient severity, which may include severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following: a) serious jeopardy to patient health; b) serious impairment to bodily functions; or c) serious dysfunction of a bodily organ or part.

I hereby attest that I am a physician licensed under chapter 458 or chapter 459, a dentist licensed under chapter 466, a physician assistant licensed under chapter 458 or chapter 459, or an advanced registered nurse practitioner licensed under chapter 464, and that the above facts are true and correct.

Patient Name (Print): _____ **Date:** _____

Provider Signature: _____

The undersigned injured person or legal guardian of such person affirms:

1. The symptoms I reported to the medical provider are true and accurate.
2. I understand the medical provider has determined I sustained an Emergency Medical Condition as a result of the injuries I suffered in the car accident.
3. The medical provider has explained to my satisfaction the need for future medical attention and the harmful consequences to my health which may occur if I do not receive future treatment.

Injured patient receiving this diagnosis or legal guardian of said injured patient:

Patient Name (Print): _____ **Date:** _____

Patient / Guardian Signature: _____



NOTICE OF PHYSICIAN'S LIEN (LOP)

Law Office	
Address	
City	
State	
Phone	

I do hereby authorize **XPRESS URGENT CARE** to furnish you, my attorney, with a full report of the examination, diagnosis, prognosis, treatment, etc., of myself in regard to the injuries I sustained in the accident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to **XPRESS URGENT CARE**, such sums as may be due and owing them for medical services rendered to me, both by reason for this accident and by reason of any other bills, including interest on the unpaid balance of my account, that are due his office, and to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect **XPRESS URGENT CARE** against any and all proceeds of my settlement, judgment, or verdict which may be paid to you, my attorney, or to myself as a result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly responsible to **XPRESS URGENT CARE** for all medical bills submitted by him for services rendered to me, and that this agreement is made solely for **XPRESS URGENT CARE** additional protection and in consideration of his awaiting payment until my claim is resolved. I hereby further give a lien on my case to Xpress Urgent Care LLC against any and all proceeds of any settlement or verdict which may be paid to you, my attorney, or me as a result of the injuries for which I have been treated in connection therewith.

I further agree and understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee(s).

In the event any suit is filed for collections on medical bills due to Xpress Urgent Care LLC, I agree to pay in addition to any medical bills, all expenses related to collections of said medical bills, including reasonable interest, collections, attorney's fees and costs incurred by Xpress Urgent Care, LLC. I understand my insurance company may apply the charges toward my deductible or co-insurance, and if my benefits are exhausted, and that I am financially responsible for the outstanding balance of the claim. If I disregard my financial responsibility, I understand I may be turned over to a collection agency, which may significantly affect my credit rating and that a 1099C report may be made to the Internal Revenue Service.

Patient Name: _____ Date: _____

Patient Signature: _____

ACKNOWLEDGMENT BY ATTORNEY

The undersigned being attorney of record for the patient named above does hereby agree to observe all terms of the above, and agrees to withhold such sums for any settlement, judgement, or verdict as may be necessary to adequately compensate Xpress Urgent Care LLC, and it's rendering medical providers. I understand that as the responsible attorney we will not make any settlements or payments of this claim without honoring and satisfying this lien. By signing below, you as the attorney and your client agree to reimburse Xpress Urgent Care LLC in full for their services immediately upon any settlements. The prevailing party in any litigation resulting from enforcement of this lien shall be entitled to actual attorney's fees and court cost. This lien does not take priority over attorney's fees and cost.

Attorney Name: _____ Date: _____

Attorney Signature: _____

I hereby state and agree that a photocopy of this document will be deemed as valid and binding on all parties involved as the original copy. **ALTERATIONS TO THIS DOCUMENT WILL BE DEEMED AS NULL AND INVALID.** Please date, sign, and return to the office above. Keep one copy for your records.