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.**

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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 (15) and (16), 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.

Patient Name Date of Birth

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PIP FORM

Automobile Insurance Company Name ____

Automobile Insurance Company Phone Number _____________________________________

Name of Adjuster ____________________________Phone Number ___________________

Claim Number: ____

Is the patient the policy holder? Otherwise Name of Insured:

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Date of Accident: ________________________________STATE: _____________________

Did you go to the hospital? ____

Medical PIP Benefits $ ___________________Deductible? $______________ ___________

Claims Address:

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LAWYER (Name /Phone#) ____________________________________

I Authorize to be seen and evaluated due to my auto insurance accident and that the claims resulting from my visit be submitted on my behalf to my motor vehicle insurance carrier. I understand that I will be responsible for any cost incurred due to my medical visit (s) , in the event my PIP benefits are denied or exhausted.

X____

PATIENT SIGNATURE

Requirements:

- Patient must have an UPDATED RECORDS RELEASE FORM signed and on file
- Copy of (Personal) Auto Insurance Carrier Card

MEDICAL RECORDS RELEASE FORM

We, the office of Dr. Andres Patron want to make your transition as smooth as possible and for the purpose of medical treatment, It is important we obtain a copy of your past medical record(s). Therefore, if you would complete the form below so we may submit it, as necessary to any of your previous attending Physicians, Specialists, Hospitals and or Pharmacies in order to obtain vital background, history and medical information.

I HEREBY AUTHORIZE AND REQUEST THAT YOU SEND A COPY OF MY COMPLETE MEDICAL RECORD TO:

PCP: Andres Patron, D.O. / PatronMedical PHONE (954) 885-5555

ADDRESS:10796 PINES BLVD SUITE 205 PEMBROKE PINES, F L 33026 FAX (954) 885-5333

PATIENT'S NAME: ________________________ **Relationship to Patient** ____________

SSN: ________________________ **DOB:** ________________________

ADDRESS: ____

I hereby authorize the release of all medical documentation and other information including protected health information that I could personally obtain upon request, which may be in the possession of any health care provider, medical care facility, insurer, physician, hospital, ambulance service or nurse and or any other covered entity under HIPAA Accountability Act of 1996.

Information to be obtained and or forwarded as follows:

History & Physical	Laboratories	Eye Exam
Progress Note	XRay/Scans	Pap/Cervical Scrn
Consultation/Counseling	EKG/EEG	Mammo
Narrative Summary	Treatment Plan	ColoKit/Colonoscopy

This may also authorize PatronMedical to release /obtain general health Information as well as 1). psychiatric/psychological treatment, 2). HIV/AIDs diagnosis as well as 3). Alcohol and 4). Drug Abuse information, from my medical record, in *accordance with Florida Statutes and Federal regulations.* In addition but not limited to any test, counseling and results of treatment(s), thereof are also authorized. I understand that my records have a privilege and confidential status, and I am in approval and acceptance of such order/request in an effort to establish, provide and set forth an accurate medical patient history and physical Upon Presentation of this authorization or photocopy of you are authorized to release a copy of the records to any person who is my personal representative. I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the personal representative and may no longer be protected by federal law. The purpose of the disclosure is to enable the person(s) named above to fully act as my personal representative under HIPAA, including the ability to access and re-release my medical records. This authorization shall be deemed to comply with all the requirements of HIPAA; 45cfr section 16.

PATIENT OR LEGAL GUARDIAN SIGNATURE: ____

This authorization shall become effective on the date it is signed and expire two years after my death. I understand that I may revoke this authorization at any time, without regard to my mental or physical condition, by sending a written and certified notice to my medical provider(s) and revoking a health care agency under law.

Witness to Patient of legal Guardian Signature.: ____