PHYSICAL MEDICINE & REHAB CENTER OF ORLANDO
Pedro T. Oliveros, MD, PT
Medical Director

ASSIGNMENT OF BENEFITS

I, ______________________________________ assign, to Physical Medicine & Rehab Center of Orlando all rights,
Name of Patient / Guardian
claims, benefits and causes of action for personal injury protection and medical payment benefits available to me under

the policy issued by________________________________ to ________________________________for medical claims
Insurance carrier **Policy Holder**
resulting from an automobile accident which occurred on ______________________________.
Date of Accident

Patient Signature:____**Date**:______________________________

The undersigned hereby accepts assignment of insurance benefits for services to ___________________________and to be paid directly to Physical Medicine & Rehab Center of Orlando under the personal injury protection and/or medical payment benefits coverage with ____________________________________and in accordance with the Florida Statute 627.736(5)

Representative:____**Date**:______________________________

PIP LOG & DEC SHEET REQUEST

I hereby authorize Assignee to release any information requested that is pertinent to my case to my insurance company or attorney involved in this case. Pursuant to 627.4137 Florida Statutes (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 authorized this Assignee to request and receive a copy of my pip log periodically as they deem to be necessary. If any term or provision of this Assignment, Lien and Authorization or the application thereof to any person or circumstances 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.

Patient Signature:____**Date**:______________________________

RESERVATION OF BENEFITS

Be further advised that I am hereby placing you on notice pursuant to Florida case law that should you ___________________________________(insurance carrier) deny, reduce or fail to pay any part of, or an entire bill which was submitted on my behalf from this health care provider, I_________________________________and assignee Physical Medicine & Rehab Center of Orlando are requesting in advance that you reserve, or "act-aside, the amount you reduced or deny 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 payment 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 inefficient funds to pay the amount you reduced, denied or failed to pay, please notify me (the assignor) and the assignee, Physical Medicine & Rehab Center of Orlando of this fact. Lastly, should my benefits become exhausted; please notify me (the assignor) and this health care provider, Physical Medicine & Rehab Center of Orlando

Patient Signature:____**Date:**______________________________

Print Name:____

Address:______________________________**City**_______________**St**__________________**Zip**__________

341 N. Maitland Avenue ◆ Ste. 200 ◆ Maitland FL 32751 ◆ P: 407-265-2100 ◆ F: 407-265-2872

PHYSICAL MEDICINE & REHAB CENTER OF ORLANDO
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Medical Director

RE: MEDICAL REPORTS AND DOCTOR'S LIEN

I do hereby authorize Physical Medicine & Rehab Center of Orlando to furnish you, my attorney, with a full report of examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident which I was recently involved.

I hereby authorize and direct you, my attorney, to pay directly to said clinic such sums as may be due and owing him for medical service rendered me both by reason of this accident and by reason of any other bills that are due the clinic and to withhold such sums from any settlement, judgment or verdict as my be necessary to adequately protect said clinic. And I hereby further give a Lien on my case to said clinic against any and all proceeds and notify you of an assignment of a portion of my settlement, judgment or verdict which may be paid to you, my attorney, or myself, as the result of the injuries for which I have been treated or injuries in connection therewith.

I agree never to rescind this document and that a rescission will not be honored by my attorney. I hereby instruct that a rescission will not be honored by my attorney. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney will honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by him.

I fully understand that I am directly and fully responsible to said clinic for all medical bills submitted for service rendered to me and that this agreement is made solely for said clinic's additional protection and in consideration of awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

Please acknowledge this letter by signing below and returning to Physical Medicine & Rehab Center of Orlando. I have been advised that if my attorney does not wish to cooperate in protecting the clinic's interest the clinic will not await payment but will require me to make payments on a current basis.

Dated____________________ Patient Signature ____

Address______________________________City_____________St_________Zip___________

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict, as may be necessary to adequately protect said clinic above-named. The undersigned attorney also agrees to deliver a copy of this lien agreement to replacement counsel, in the event of his withdrawal form representation of the patient.

Dated____________________ Attorney's Signature____

SERVICES PROVIDED

Onsite Massage/Physical Therapy (MM20830)
Neuro and Post-Surgical Rehabilitation
Wellness & Exercise Fitness Programs
Sports / Auto Accidents Injuries
DRS Lumbar Spinal Decompression
Dizziness & Fall/Balance Testing & Rehab
EMG/Nerve Conduction Studies
IME's/ Impairment Ratings
Therapeutic Botox Injections

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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 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. This means that no person has initiated contact with me and/or persuaded me to use the doctor or licensed professional, clinic, or medical institution that provided the services.
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.

The undersigned licensed medical professional 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. I have **explained** the services rendered 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.

Insured Person (patient receiving treatment) or Guardian of Insured Person:

Name *(PRINT or TYPE)*	Signature	Date

Licensed Medical Professional Rendering Treatment *(Signature by his or 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.

OIR-B1-1571
10/03