NCNF
NEUROLOGY CENTER OF NORTH FLORIDA

NOTICE OF EMERGENCY MEDICAL CONDITION

The undersigned licensed medical provider, hereby asserts:

1. The below patient, has an 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 ___________________________ (date of accident)

2. The basis of the opinion for finding 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 function; 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.

______________________	______________________________	__________
Medical Provider	Signature of Medical Provider	Date

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

1. The symptoms I reported to the medical provider are true and accurate
2. I understand the medical provider has determined I sustained and **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:

______________________	______________________	__________
Name of insured person or Guardian	Signature of insured person or Guardian	Date

Auto Insurance Verification

Last Name: ______________First Name: ___________________ Middle:________________

Insurance Company: ____

D.O.A: ________

Claim Number: _________________________

Adjuster's Name: _________________________Phone Number:______________________

Deductible: __________

Med Pay: ____

Basic Benefits: ____

Claim Address: ____

City:_______________State:____________Zip Code:____________

Spoke With: ___________________

Verified by: _______________

Notes:

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NEUROLOGY CENTER OF NORTH FLORIDA

PATIENT RECORD RELEASE AND LETTER OF PROTECTION

I do hereby authorize NEUROLOGY CENTER OF NORTH FLORIDA to furnish my attorney as identified below with full report of any medical records and charges pertaining to my treatment.

I do hereby authorize said attorney to pay directly to NEUROLOGY CENTER OF NORTH FLORIDA such sums that may be due and owing for services rendered to me, and to withhold such sums from any settlement, judgement, or verdict which may be paid to you, my attorney or me as the result of the injury for which I have been treated. I also agree to promptly inform NEUROLOGY CENTER OF NORTH FLORIDA if any other attorney represents me, and that this release and letter of protection will be immediately executed with my new attorney, if charges occur.

If a new release and letter of protection is not immediately executed upon a change of attorney, I agree that my full charges shall become immediately due and payable.

I fully understand that I am directly responsible to NEUROLOGY CENTER OF NORTH FLORIDA for all charges and bills submitted by NEUROLOGY CENTER OF NORTH FLORIDA for services rendered to me. This agreement is made solely for additional protection and consideration of waiting for payment; I also understand that such payment is not contingent on any settlement, judgement or verdict by which I may eventually recover said fee.

Date of accident: ______________________

ATTORNEY NAME: ______________________

PATIENT NAME: ______________________

PATIENT SIGNATURE: ______________________

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.**

____

____

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(14) and (15), 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 CONSENT AND AUTHORIZATION

I, UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY MY INSURANCE. I FURTHER ACKNOWLEDGE THAT IN THE EVENT NEUROLOGY CENTER OF NORTH FLORIDA IS FORCED TO RETAIN THE SERVICES OF A COLLECTION AGENCY AND/OR ATTORNEY; I WILL BE RESPONSIBLE FOR THE COLLECTION AND/OR LEGAL FEES.

I HEREBY AUTHORIZE THE MEDICAL PROVIDER TO RELEASE MEDICAL INFORMATION TO MY INSURANCE COMPANY TO SECURE PAYMENT OF BENEFIT. I ALSO AUTHORIZE THE USE OF MY SIGNATURE ON ALL INSURANCE SUBMISSIONS AND AS AUTHORIZATION FOR PAYMENT TO BE SENT TO NEUROLOGY CENTER OF NORTH FLORIDA AT 4241 NW AMERICAN LN, LAKE CITY, FLORIDA 32055 I HEREBY CONSENT TO THE FOLLOWING TREATMENTS:

ADMINISTRATION AND PERFORMANCE OF ALL TREATMENTS, PERFORMANCE OF SUCH PROCEDURES, USE OF PRESCRIBED MEDICATION, PERFORMANCE OF DIAGNOSTIC PROCEDURES/TEST AND CULTURES AS MAY BE DEEMED NECESSARY OR ADVISABLE IN THE TREATMENT OF THIS PATIENT.

PERFORMANCE OF OTHER MEDICALLY ACCEPTED LABORATORY TEST THAT MAY BE CONSIDERED MEDICALLY NECESSARY OR ADVISABLE BASED ON THE JUDGEMENT OF THE ATTENDING PHYSICIAN OR THEIR ASSIGNED DESIGNEES. I FULLY UNDERSTAND THAT THIS IS GIVE IN ADVANCE OF ANY SPECIFIC DIAGNOSIS OR TREATMENT. I INTEND THIS CONSENT TO BE CONTINUING IN NATURE EVEN AFTER A SPECIFIC DIAGNOSIS OR TREATMENT. THE CONSENT WILL REMAIN IN FULL FORCE UNTIL REVOKED IN WRITING.

I, THE UNDERSIGNED, ACKNOWLEDGE THAT NEUROLOGY CENTER OF NORTH FLORIDA WILL USE AND DISCLOSE MY INFORMATION FOR THE PURPOSE OF TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS AS DESCRIBED IN THE NOTICE OF PRIVACY PRACTICE. PHOTOCOPY OF THIS CONSENT SHALL BE CONSIDERED AS VALID AS THE ORIGINAL MEDICARE PATIENTS. I AUTHORIZE TO RELEASE MEDICAL INFORMATION ABOUT ME TO THE SOCIAL SECURITY ADMINISTRATION OR ITS INTERMEDIARIES FOR MY INSURANCE CLAIMS. I ACKNOWLEDGE THAT I HAVE BEEN GIVEN NEUROLOGY CENTER OF NORTH FLORIDA'S NOTICE OF PRIVACY PRACTICES. I UNDERSTAND THAT IF I HAVE QUESTIONS OR COMPLAINTS, THAT I SHOULD CONTACT THE PRIVACY OFFICIALS. I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE STATEMENTS AND CONSENTS FULLY AND VOLUNTARILY TO ITS CONTENTS.

Patients consent, Authorization and assignment of benefits:

I ASSIGN THE BENEFITS PAYABLE FOR SERVICES TO NEUROLOGY CENTER OF NORTH FLORIDA, I, the undersigned patient/ insured knowingly, voluntarily and intentionally assign the rights and benefits of my automobile insurance, a/k/a Personal Injury Protect and Medical payments policy of Insurance to the above caption healthcare provider, I understand it is the intention of the provider to accept this assignment of benefits in lieu of demanding payments at the time services are rendered. I understand this document will allow the provider to file suit against the insurer for payment of the insurance benefits and to seek damages from the insurer per Florida statute 627.428.

Receipt of Notice of Privacy Practices

I, have received a copy of NEUROLOGY CENTER OF NORTH FLORIDA's Notice of Privacy Practices. The physicians and staff of NEUROLOGY CENTER OF NORTH FLORIDA have my permission to speak to any family/friends I designate in writing in reference to my medical care.

______________________	______________________	____________
Name of responsible part	Signature of responsible party	Date