PRO HEALTHCARE
1948 NE 123rd Street | Suite 107
North Miami | FL 33181
T | 305.891.2520
F | 305.891.5754

# Standard disclosure and Acknowledgment 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.

_____

_____

1. I have the right and the duty to confirm that the services have already been provided.
2. 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.
3. The medical provider has explained the services to me for which payment is being claimed.
4. 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 I 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 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 services has been upcoded, unbundled, or constitutes an invalid or not medically necessary diagnostic test as defined by Section 627.732 (15) and (16), Florida Statue or Section 627.736 (5)(b)6, Florida Statue.

(Print) (Sign) (Date)

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

(Print) (Sign) (Date)

Licensed Medical Professional Rendering Treatment (Signature by his or her own hand)

Any person who knowingly and with Intent, 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 Statue.

Note: The original of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statue and may not be electronically furnished. Failure to furnish this form may result in nonpayment of the claim

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# Patient Disclosure and Acknowledgment Form

| | | |
|---|---|---|
| _____Office Visit | _____Hot/Cold Pack | _____Gait Training |
| _____Manual Therapy | _____Whirlpool | _____Functional Activities |
| _____Therapeutic Exercises | _____Electrical Stimulation | _____Other_____ |
| _____Therapeutic Ultrasound | _____Cervical Traction | _____ _____ |
| _____Massage Therapy | _____X-rays | _____ _____ |

Date:_____ Patient's Signature:_____

1. I acknowledge that I received the treatment listed above.
2. I acknowledge that I have the right and affirmative duty to confirm that services listed was actually rendered.
3. I was not solicited by this medical facility or any of the employees to seek medical treatment for injuries sustained as a result of this accident.
4. I understand that if the insured notifies the insurer in writing of any billing errors, the insured may be entitled to a certain percentage of a reduction in the amounts being paid by the insured's motor vehicle insurer.
5. The services being provided to me for which my doctor intends to bill my insurance have been explained. I have had the opportunity to have any questions answered to my satisfaction.
6. I hereby acknowledge having been informed of the above and have considered to the treatment and billing for the treatment proposed by my provided.

Patient's Original Signature

_____ _____

Patient's Name or Legal Guardian Date

_____

Signature of Patient or Legal Guardian

_____

Provider's Original Signature
(The treatment billed for has been explained to the patient)

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# Authorization/ Protection of Balance Due
# Assignment of Benefits

I hereby authorize Pro Healthcare, to provide my attorney or insurance adjuster with whatever records or reports are needed to understand the nature and extent of my injury, the recovery process and what effects, if any, the injury will have on me in the future. I understand that you recognize my need for professional help and treatment and are willing to do so even though I do not have, at this time, sufficient funds to pay for same. Notwithstanding the foregoing, I will remain liable to you for all treatment performed through the date of termination of treatment. In an effort to see that you are paid in the future for your professional services, I hereby authorize my attorney or insurance adjuster to pay any amount do you from the proceeds of the settlement or judgment. I fully understand that I am directly responsible to you regardless of the outcome of any legal proceedings, for all bills for services rendered, provided they are reasonable and customary, and that payment of the same is not contingent on any settlement, judgment or verdict that I may ultimately obtain or receive. I hereby give lien to said office against any and all insurance benefits, any and all proceeds of any settlement, judgment or verdict which may be aid to me as a result of the injuries or illness for which I have been treated by said office. This is to act as an assignment of my rights and benefits to the extent of the Office's services provided.

Additionally, I hereby authorized Pro Healthcare., to request and receive copies of any and all litigation / settlement statements between me the patient and my lawyer(s), and such lawyer(s) are hereby authorized to disclose the same to Pro Healthcare, without any further authorization required. I hereby make and declare these instruction herein contained to be irrevocable. **As part of this assignment of rights and benefits I hereby instruct the insurance carrier that in the event the subject medical benefits are disputed for any reason, including reasonableness and or medical necessity, that the amount of benefits claimed by Pro Healthcare., and it's Associated Physicians, is to be set aside and not disbursed until the dispute is resolved.**

**Patient's**
Signature _____ Date: ____/____/_____ Witness_____

Print Name_____

## Protection of Doctor's bill / L.O.P.

I the undersigned, being attorney or insurance adjuster for he above patient, hereby agrees to withhold and pay the balance due for the doctor's professional services form any settlement, judgment, or verdict.

Dated:_____/_____/_____ _____

Attorney or Insurance Adjuster for the Patient