Patient label

RIVERSIDE
PAIN PHYSICIANS

Accident History Intake Form

Date of accident: _____

Pain prior to accident: Yes No

Are you in litigation regarding this accident? Yes No

Patient's vehicle make and year: _____

Were you driver or passenger? Driver Passenger

Estimated speed (miles per hour): _____

Were you wearing a seat belt? Yes No

Were the air bags deployed? Yes No

Did you lose consciousness? Yes No

(Other vehicle) Make and year: _____

(Other vehicle) Estimated speed (miles per hour): _____

Where did you develop pain following the accident? _____

_____

Did you develop any weakness following the accident? Yes No

If yes, where: _____

Did you develop any numbness following the accident? Yes No

If so, where: _____

Were you seen in the emergency room following the accident? Yes No

Please describe specifics of the accident: _____

_____

_____

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 (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.

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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 bodily organ or part:

I hereby attest that I am a physician licensed under chapter 468 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.

_____	_____	_____
Name (Print or Type)	Signature of Medical Provider	Date

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:

_____	_____	_____
Name (Print or Type)	Signature of Injured Patient/Guardian	Date