BASIS MEDICAL

PERSONAL INJURY PATIENT HISTORY

NAME: _____ DATE: _____

HISTORY

DATE OF ACCIDENT: _____ TIME: _____ AM/PM WHO WAS DRIVING THE CAR? _____

PLEASE DESCRIBE THE ACCIDENT IN YOUR OWN WORDS: _____

_____

_____

WERE YOU WEARING YOUR SEATBELT? ☐ YES ☐ NO DID YOU SEE THE ACCIDENT COMING? ☐ YES ☐ NO

HEAD/BODY POSITION AT THE TIME OF IMPACT:

Head Turned: ☐ Right ☐ Left | Looking: ☐ Back ☐ Forward | Body Rotated: ☐ Left ☐ Right ☐ Other

AT THE TIME OF THE ACCIDENT, DO YOU RECALL IF YOU STRUCK ANYTHING INSIDE YOUR CAR? _____

AS A RESULT OF THE ACCIDENT YOU WERE:

☐ Rendered unconscious - length of time _____ ☐ Dazed with circumstances vague ☐ Shaken but could function

DESCRIBE ANY CUTS OR BRUISES: _____

DID YOU GO TO THE HOSPITAL AFTER THE ACCIDENT? ☐ YES ☐ NO IF YES, WHEN _____ WHERE_____

HOW DID YOU GET TO THE HOSPITAL? ☐ Ambulance ☐ Drove myself ☐ Someone else drove me ☐ Other_____

WERE YOU EXAMINED? ☐ YES ☐ NO WERE X-RAYS TAKEN? ☐ YES ☐ NO

WERE YOU PRESCRIBED MEDICATION? ☐ YES ☐ NO

DID YOU SEEK ANY ADDITIONAL MEDICAL CARE AFTER THE ACCIDENT? ☐ YES ☐ NO IF YES, DATE OF VISIT: _____

LIST ANY DOCTORS: _____

LIST ANY TREATMENT: _____

WORK STATUS

OCCUPATION: _____ EMPLOYER: _____

HAVE YOU MISSED TIME FROM WORK? ☐ YES ☐ NO IF YES, HAVE YOU RETURNED TO WORK? ☐ YES ☐ NO

PLEASE LIST ANY RESTRICTIONS YOU HAVE BEEN PLACED ON: _____

WHAT ACTIVITIES, IF ANY, AGGRAVATE YOUR CONDITION WHILE AT WORK: _____

_____ Patient's Name Printed

_____ Signature

_____ Date

Improving Health, Wellbeing & Performance
4383 Northlake Blvd., Suite 309, Palm Beach Gardens, FL 33410 | O: 561.775.4900 | F: 561.775.0003
2702 N. Federal Highway, Delray Beach, FL 33483 | **basismedical.org**

BASIS MEDICAL

NOTICE OF PROFESSIONAL LIEN

PATIENT: _____

DATE OF ACCIDENT: _____

1. I hereby authorize, Basis Medical (BM), to furnish, my attorney, with my full records and billings in regard to my accident that I am receiving treatment for.

2. I hereby direct my attorney of record, at the time of case settlement, to pay BM directly such sums as maybe due them for physical therapy rendered me by reason of this accident and any other bills that are due their office on my behalf in connection with this accident within 60 days of the settlement or conclusion of my case.

3. I hereby direct my attorney to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect all amounts BM result of the injuries for which I have been treated in connection therewith and request that I am not paid directly for BM billings or services. If I change attorney or no longer use one, I agree to inform BM.

4. I understand that I am fully responsible to BM for all s submitted by them for service rendered me and that this agreement is made solely for BM protection and in consideration of their awaiting payment. I agree to keep my debt owed to BM separate from any potential future bankruptcy filings as long as my case is still pending. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but declare the entire balance as due and payable.

5. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover the BM fees. If this account is assigned for collection and/or suit, collection costs and/or interest, and/or attorney's fees, and/or court costs will be added to the total amount due.

_____ _____

Client Signature Date

ACKNOWLEDGMENT OF ATTORNEY

The undersigned being attorney of record for the above client does hereby agree to observe all the terms of the above and agrees to with such sums form any settlement, judgment or verdict as may be necessary to adequately protect BM. I will not disburse funds directly to the client without informing BM in writing prior to doing so. I in no way represent BM, however in representing my client I will honor the requests set forth in this agreement. Attorney further agrees that in the event that this lien is litigate and that the prevailing party will be awarded attorney fees and costs.

_____ _____

Attorney's Signature Date

Attorney: Please sign, date, and return copy to Basis Medical so that we may begin or continue care.

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BASIS MEDICAL

LETTER OF PROTECTION
DIRECTION TO PAY

PATIENT: _____

DATE OF BIRTH: _____ DATE OF INJURY: _____

IMPORTANT: THIS IS A CONTRACT.
IF YOU DON'T UNDERSTAND THIS THEN CONSULT WITH AN ATTORNEY BEFORE SIGNING.

Patient authorizes and directs his/her present and any future attorneys related to the above-referenced date of injury ("Attorneys") to honor this agreement. This agreement is made in favor of the above-referenced Medical Provider and shall be termed a "Letter of Protection." The Letter of Protection shall serve to place a continuing lien on any proceeds I recover in any legal action related to the above-referenced date of injury. The Direction to Pay applies to the Patient's Attorneys.

Background. Medical Provider expects to be paid from any proceeds related to the above-referenced date of injury in exchange for providing medical care/treatment. Medical Provider also agrees not to place patient in collections until the resolution of Patient's claims related to the above-referenced date of injury. Patient expects to receive medical care that is reasonable, related to the above-referenced accident and medically necessary. Patient has sustained injuries as a result of injuries related to the above-referenced date of injury and does not have the funds to pay for the medical care which he/she needs. Patient is signing this Letter of Protection in order to receive medical care.

Insurance Benefits. In the event that there are disability benefits, medical payment benefits, No-Fault benefits, health and accidental benefits, worker's compensation benefits, or any other insurance benefits available to Patient besides Bodily Injury and/or Un-insured Motorist (aka Underinsured Motorist) coverage then this Letter of Protection can be used to cover any co-payments and/or deductibles.

Protection of Medical Bills. If Patient recovers any money related to the above-referenced date of injury then Patient shall withhold from those funds, sufficient money pay the outstanding balance of any bill(s) owed to Medical Provider. It is understood that Attorney's fees/costs are first-in-line and that this Letter of Protection does not interfere with Attorney's retainer agreement with Patient. Patient authorizes Medical Provider to provide Attorney with a copy of Patient's medical records, bills, etc. with regard to the above referenced date of injury.

Patient's Responsibility for Bills. Patient understands that he/she is directly responsible to Medical Provider for services rendered and that payment is not contingent on any settlement, judgment, or verdict related to the above-referenced date of injury. Regardless of any settlement, judgment, or verdict, Patient is still responsible for paying Medical Provider's outstanding bills so long as they are reasonable and related to the above-referenced date of injury and medically necessary.

Patient's Responsibility Regarding His/Her Attorney (Present and Future). Patient is responsible for informing each and every attorney retained by him/her of the existence of this agreement. Medical Provider has the right to notify Patient's Attorney(s) about the existence of this Letter of Protection. Upon request, Patient shall provide status updates about any claims related to the above-referenced date of injury as well as the contact information for any new Attorneys. It is also the Patient's responsibility to

advise the Medical Provider at least 10 days prior to collecting any funds and to request a bill for any and all outstanding charges. Patient understands that if funds related to the above-referenced date of injury are insufficient to cover the medical bill(s) then Medical Provider has the right to collect the remaining balance.

Disputes. If the Patient fails to pay the Medical Provider's full outstanding balance and Medical Provider is the prevailing party in an action to enforce this Letter of Protection then Medical Provider shall have the right to recover all attorney fees and costs including post-judgment proceedings. Binding arbitration is an option if both parties agree in writing.

Direction to Pay. ATTENTION ATTORNEY: THIS IS A DIRECTION TO PAY MY MEDICAL PROVIDER. Patient directs his/her Attorneys to pay any outstanding medical bills in connection with the above-referenced date of injury. Patient hereby directs Attorneys to provide a status update in writing within 15 days of receiving a request from Medical Provider.

Effective Date. This agreement becomes effective when the Patient signs the agreement below.

_____ _____

Patient Signature Date

Basis Medical, LLC
4383 Northlake Blvd
Suite 309
Palm Beach Gardens, FL 33410

ASSIGNMENT OF INSURANCE BENEFITS, RELEASE, & DEMAND

Insurer and Patient Please Read the Following in its Entirety Carefully!

I, the undersigned patient/insured knowingly, voluntarily and intentionally assign the rights and benefits of my automobile Insurance, a/k/a Personal Injury Protection (hereinafter PIP), and Medical Payments policy of insurance to the above health care provider. I understand it is the intention of the provider to accept this assignment of benefits in lieu of demanding payment at the time services are rendered. I understand this document will allow the provider to file suit against an insurer for payment of the insurance benefits or an explanation of benefits and to seek §627.428 damages from the insurer. If the provider's bills are applied to a deductible, I agree this will serve as a benefit to me and I authorize and request such litigation. This assignment of benefits includes the cost of transportation, medications, supplies, over due interest and any potential claim for common law or statutory bad faith/unfair claims handling. If the insurer disputes the validity of this assignment of benefits then the insurer is instructed to notify the provider in writing within five days of receipt of this document. Failure to inform the provider shall result in a waiver by the insurer to contest the validity of this document. The undersigned directs the insurer to pay the health care provider the maximum amount directly without any reductions & without including the patient's name on the check. To the extent the PIP insurer contends there is a material misrepresentation on the application for insurance resulting in the policy of insurance is declared voided, rescinded, or canceled, I, as the named insured under said policy of insurance, hereby assign the right to receive the premiums paid for my PIP insurance to this provider and to file suit for recovery of the premiums. The insurer is directed to issue such a refund check payable to this provider only. Should the medical bills not exceed the premium refunded, then the provider is directed to mail the patient/named insured a check which represents the difference between the medical bills and the premiums paid.

Disputes: The insurer is directed by the provider and the undersigned to not issue any checks or drafts in partial settlement of a claim that contain or are accompanied by language releasing the insurer or its insured/patient from liability unless there has been a prior written settlement agreed to by the health provider (specifically the office manager) and the insurer as to the amount payable under the insurance policy. The insured and the provider hereby contests and objects to any reductions or partial payments. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by the provider shall be done so under protest, at the risk of the insurer, and the deposit shall not be deemed a waiver, accord, satisfaction, discharge, settlement or agreement by the provider to accept a reduced amount as payment in full. The insurer is hereby placed on notice that this provider reserves the right to seek the full amount of the bills submitted. Any effort by the insurer to pay a disputed debt as full satisfaction must be mailed to the address above, after speaking with the office manager, and mailed to the attention of the **Office Manager**. See 673.3111.

EUOs and IMEs: If the insurer schedules a defense examination or examination under oath (hereinafter "EUO") the insurer is hereby INSTRUCTED to send a copy of said notification to this provider. The provider or the provider's attorney is expressly authorized to appear at any EUO or IME set by the insurer. The health care provider is not the agent of the insurer or the patient for any purpose.

This assignment applies to both past and future medical expenses and is valid even if undated. A photocopy of this assignment is to be considered as valid as the original. I agree to pay any applicable deductible, co-payments, for services rendered after the policy of insurance exhausts and for any other services unrelated to the automobile accident. The health care provider is given the power of attorney to: endorse my name on any check for services rendered by the above provider; and to request and obtain a copy of any statements or examinations under oath given by patient.

Release of information: I hereby authorize this provider to: furnish an insurer, an insurer's intermediary, the patient's other medical providers, and the patient's attorney via mail, fax, or email, with any and all information that may be contained in the medical records; to obtain insurance coverage information (declaration sheet & policy of insurance) in writing and telephonically from the insurer; request from any insurer all explanation of benefits (EOBs) for all providers and non-redacted PIP payout sheets; obtain any written and verbal statements the patient or anyone else provided to the insurer; obtain copies of the entire claim file and all medical records, including but not limited to, documents, reports, scans, notes, bills, opinions, X-rays, IMEs, and MRIs, from any other medical provider or any insurer. The provider is permitted to produce my medical records to its attorney in connection with any pending lawsuits. The insurer is directed to keep the patient's medical records from this provider private and confidential and the insurer is not authorized to provide these medical records to anyone without the patient's and the provider's prior express written permission.

Demand: Demand is hereby made for the insurer to pay all bills within 30 days without reductions and to mail the latest non-redacted PIP payout sheet and the insurance coverage declaration sheet to the above provider within 15 days. The insurer is directed to pay the bills in the order they are received. However, if a bill from this provider and a claim from anyone else is received by the insurer on the same day the insurer is directed to not apply this provider's bill to the deductible. If a bill from this provider and claim from anyone else is received by the insurer on the same day then the insurer is directed to pay this provider first before the policy is exhausted. In the event the provider's medical bills are disputed or reduced by the insurer for any reason, or amount, the insurer is to: set aside the entire amount disputed or reduced; escrow the full amount at issue; and not pay the disputed amount to anyone or any entity, including myself, until the dispute is resolved by a Court. Do not exhaust the policy. The insurer is instructed to inform, in writing, the provider of any dispute.

Certification: I certify that: I have read and agree to the above; I have not been solicited or promised anything in exchange for receiving health care; I have not received any promises or guarantees from anyone as to the results that may be obtained by any treatment or service; and I agree the provider's prices for medical services, treatment and supplies are reasonable, usual and customary.

Caution: Please read before signing. **Please ask to view a copy of our charges. If you do not completely understand this document please ask us to explain it to you. If you sign below we will assume you understand and agree to the above.**

Patient's Name _____ Patient's Signature _____

(Please Print) (If patient is a minor, signature of parent/guardian)

Date ______________________________ 12/31/18