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
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OFFICE OF INSURANCE REGULATION
Bureau of Property & Casualty Forms and Rates

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 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 be electronically furnished. Failure to furnish this form may result in non-payment of the claim.

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