RF MEDICAL SERVICES

* = REQUIRED

PATIENT INFORMATION AND GENERAL CONSENT

*Name: _____ *Social Security #: _____

*Date of Birth: _____ *Age: _____ *Phone: _____

*Address: _____

*City _____ *State: _____ *Zip Code: _____

Chiropractor: _____ Tel. _____

Attorney: _____ Tel. _____

Medical Insurance Company: _____ Policy #: _____

*Auto Insurance Company: _____ *Policy #: _____

*Date of Accident: _____ **Claim #:** _____

List Previous Surgeries: _____

List All Medical Conditions: _____

List Current Medications: _____

Allergy To Any Medications: ____ **Yes** ____ **No**

If yes, please list: _____

GENERAL CONSENT TO TREAT - RELEASE OF MEDICAL RECORDS - TESTIMONIAL

I hereby give my informed consent for **RF Medical Services** to perform diagnostic studies and physical exams on me. I give my informed consent to **RF Medical Services** to treat my medical condition(s). I understand that some exams and treatment may be invasive or uncomfortable and may include physical contact or inspection of different parts of my body. Furthermore, I give my informed consent to **RF Medical Services** to release and/or request my medical records when necessary to coordinate care and for payment reasons and as otherwise indicated by law. I understand that I can request the termination of this consent in writing. I also attest that my visit to this clinic is for an actual injury that I have sustained. I attest that I am not taking part in any insurance scams, and I have not agreed to any fraudulent deals and I am not exaggerating my injuries to pursue secondary gains. I understand that the clinic rejects serving suspected insurance fraud cases and reports such cases to authorities. I indemnify this company from any harm that could come from such investigations as a result of my visit. I acknowledge by signing below that this form was fully explained to me and that I have no further questions.

*Print Name: _____ * Date: _____

*Signature: _____

RF MEDICAL SERVICES

ASSIGNMENT OF INSURANCE BENEFITS, RELEASE, & DEMAND

Insurer and Patient Please Read the Following in its Entirety

I, the undersigned patient/insured knowingly, voluntarily and intentionally assign the rights and benefits of my automobile Insurance, also known as Personal Injury Protection (P.I.P.), and Medical Payments policy of insurance to the above health care provider, including the right to file a law suit to seek payment of any unpaid PIP benefits, penalty, postage and/or interest. It is the intention of the provider to accept this assignment in lieu of demanding payment at the time services are rendered and that this document will allow the provider to file suit against an insurance company for payment of the insurance benefits. This assignment of benefits includes over due interest payments and any potential claim for common law or statutory bad faith. The undersigned directs the insurer to pay the health care provider directly.

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 and the insurer as to the amount payable under the insurance policy or contract. The provider hereby 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. Please send a copy of any scheduled defense examinations or examination under oath to this provider.

Release of information: I hereby authorize this provider to furnish an insurer, an insurer's intermediary, 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 in writing (declaration sheet) 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 statements the patient provided to the insurer; obtain copies of all medical records, X-rays, IMEs, and MRIs, from any other medical provider or any insurer. The provider may produce my medical records to its attorney in connection with any pending lawsuits. The insurer is directed to keep the patient's medical records private and confidential and 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 this provider's medical bills are disputed by the insurer for any reason the undersigned hereby instructs the insurer to set aside any amount disputed (i.e., to escrow the money) and not pay the disputed amount to anyone, including myself, or any entity until the dispute is resolved. The insurer is instructed to immediately explain in writing to the above provider of any dispute.

Certification: I certify that: I have read and agree to the above.

Caution: Please read before signing. 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.

Date: _____

Patient's Name: _____

Patient's Signature: _____
(Please Print) (If patient is a minor, signature of parent/guardian)

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.**

• EVALUATION • PHYSICAL PERFORMANCE TEST • ROM • NEUROMUSCULAR RE-EDUCATION • EDUCATION & TRAINING FOR PATIENT SELF MANAGEMENT

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:

PATIENT NAME (Print or type)	PATIENT 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):*

Dr. Rodolfo Freire MD		
MEDICAL PROVIDER NAME (Print or type)	MEDICAL PROVIDER 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.

RF MEDICAL SERVICES
12264 Tamiami Trail East, Unit 201 & 203
Naples, FL 34113

Dr. Rodolfo Freire MD

NOTICE OF EMERGENCY MEDICAL CONDITION

The undersigned licensed medical provider hereby asserts:

1. The patient below, has in the opinion of this medical provider, suffered an Emergency Medical Condition, as a result of the patients's injuries sustained in an automobile accident that occurred on: _____ (date of accident).

2. The basis of the opinion 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 attention could reasonably be expected to result in any of the following: a) serious jeopardy to the patient's health; b) serious impairment to the bodily functions or c) serious dysfunction of any 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.

Dr. Rodolfo Freire MD

Name of Medical Provider (Print)	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 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 received future treatment.

Injured patient receiving this diagnosis or legal guardian of said injured patient:

Name of Patient	Signature of patient/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: