DR. ROBERT E. FORD, M.D.

311 MANATEE AVE. E
BRADENTON, FL. 34208

PHONE: 941-752-1916
FAX: 941-752-2936

REGISTRATION INFORMATION

Date:_____ Home Phone:_____
Cell Phone:_____

Patient:_____
Last First Initial

Responsible Party (if minor)_____

Street Address:_____

City:_____ State:_____ Zip:_____ [ ] Married [ ] Single [ ] Widowed [ ] Divorced

Sex: [ ] Male [ ] Female Age:_____ Birthdate:___/___/____ Social Security #_____

Patient Employed By:_____ Business Phone:_____
Address:_____ City:_____ State:_____

Occupation:_____ Years doing this type of work:_____

Name of Primary Physician:_____

Nature of Problem/Injury/Main Complaint:_____
Is Injury related to: [ ] Auto [ ] Work

Date of Injury:_____/_____/_____ In which State did Injury Accur:_____

Have you been seen by anyone within 14 days of accident/injury?_____

If yes by whom:_____

Auto Insurance
Insurance Company:_____Phone:_____

Claim Number:_____ ID/Policy #_____

Name of Insured:_____ Birthdate: ___/___/____
[ ] Medicare [ ] Health Ins. [ ] Auto Ins. [ ] Workers Compensation [ ] Other

Emergency Contact
If you wish to allow us to speak to anyone other than yourself, regarding your personal information, please list below:

Name:_____ Relationship:_____

Phone Number:_____

PATIENT HEALTH QUESTIONNAIRE

DR. ROBERT E. FORD M.D.

NAME:_____

DATE OF BIRTH:_____

DATE OF ACCIDENT:_____

HAVE YOU HAD ANY PREVIOUS ACCIDENTS? _____ **DATE:**_____

ARE YOU STILL TREATING FOR THE PREVIOUS ACCIDENT?_____

IF YES, WAS THE CONDITION SIMILAR PLEASE DESCRIBE?

_____

_____

_____

PATIENT SIGNATURE:_____

DATE:_____

ROBERT E. FORD, M.D.

311 Manatee Ave. E. Bradenton, FL. 34208 OFFICE NUMBER: 941-752-1916

ASSIGNMENT OF INSURANCE BENEFITS, LIEN, RELEASE, & DEMAND

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

I, the undersigned patient/insured knowingly, voluntarily and intentionally irrevocably assign the rights and benefits of my automobile Insurance, also known as Personal Injury Protection (hereinafter PIP), Uninsured Motorist 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. This assignment of benefits includes transportation, medications, supplies, overdue 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. 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 he 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.

Lien: I, the undersigned patient guarantee full payment to Robert E. Ford M.D. and agree that I will remain personally responsible for unpaid charges as a result of any deductible, co-payment, and treatment after benefits are exhausted and/or for any other treatment/service that remains unpaid. Furthermore, I grant Robert E. Ford M.D. a lien against any recovery, which I may have against any tortfeasor, responsible party, or any responsible insurance carrier. I direct my attorney to withhold any funds I receive from any settlement to pay for any outstanding balance to Robert E. Ford M.D. I agree to and instruct my attorney to promptly advise Robert E. Ford M.D. of any settlement as a result of the injuries sustained in the _____(Date) motor vehicle accident, slip-n-fall, or motorcycle accident. Additionally, I agree and instruct my attorney that I will not accept any settlement check until the remaining balance is resolved with Robert E. Ford M.D.

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 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. If the PIP insurer states it can pay claims at 200% of the Medicare Fee Schedule or any other fee schedule contained within F.S. 627.736 then the insurer is instructed & directed to provide this provider with a copy of the policy of insurance within 10 days. 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/billing manager and mailed to the attention of the office manager. *See Fla. Stat. §673.3111.*

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; and for my insurance carrier to **send insurance coverage information (declaration sheet & policy of insurance) in writing and telephonically to the above-named provider**; 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. The insurer is not authorized to provide these medical records to anyone without the patient's and the provider's prior express written permission. **PLEASE NOTE: The insurer is not authorized to release protected health information (PHI) to third party vendors that schedule independent medical examinations or independent medical examination physicians.**

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, and the insurance policy to the above provider within 15 days, as well as notify the provider pursuant to F.S. 627.736(6)(f) when benefits have been exhausted. 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. The insurer is instructed to inform, in writing, the provider of any dispute.

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. I certify that I have read and agree to all of the above and was not solicited or promised anything in exchange for receiving health care. I agree that the prices for the medical care is reasonable.

Patient's Name _____ Patient's Signature _____

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

Date _____

New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my health care, Dr. Robert E. Ford, M.D. originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Dr. Robert E. Ford, M.D. is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Dr. Robert E. Ford, M.D. reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Dr. Robert E. Ford, M.D. change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept / decline the terms of this consent.

_____

Patient's Signature

_____

Date

Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of this provider's Notice of Privacy Politics, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning my personal medical information:

_____

_____

_____

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignments. Regulations pertaining to medical assignment of benefits apply.

Signed:_____ **Date:**_____

FOR OFFICE USE ONLY

[ ] Consent received by _____ on _____.

[ ] Consent refused by patient, and treatment refused as permitted.

[ ] Consent added to the patient's medical record on _____.

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.

OIR-B1-1571
Pub. 1/2004

DR. ROBERT E. FORD, M.D.

Mailing Address
PO Box 9284
Bradenton, FL. 34206

Physical Address
311 Manatee Ave. E.
Bradenton, FL. 34208

Office: 941-752-1916 **Fax: 941-752-2936**

REQUEST FOR LETTER OF PROTECTION

Date:_____

To:_____
Attorney's Name

_____
Attorney's Phone Number

_____

Patient Name:_____ Date Of Injury:_____

I hereby authorize and direct you, my attorney, to pay directly to Dr. Robert E. Ford, MD., such sums as may be due and owing this office for services rendered to me, and to withhold such sums from any disability benefits, medical payment benefits, No-Fault/Liability Benefits, health and accident benefits, worker's compensations benefits, or any other insurance benefits obligated to reimburse me from any settlement, judgment or verdict on my behalf as may be necessary to adequately protect this office.

In the event there is no recovery of benefits, I understand that I remain personally responsible for the total amounts due this office for their services rendered.

I authorize Robert E. Ford, MD., to release any information pertinent to my case to my attorney to facilitate collection under this authorization.

I authorize Robert E. Ford, MD., to perform any treatment that they deem necessary, and that I hereby give my consent to such treatment.

Patient Signature:_____ Date:_____

Attorney Signature:_____ Date:_____