The ExerScience Center

Physical Therapy
PIP(Auto) Form

Patient's Name	
Date of Accident	
Claim Number	
PIP Carrier's Name	
PIP Carrier's Phone Number	
Social Security Number	
Description of Injury	
Attorney's Name	
Attorney's Phone Number	

Assignment of Benefits / Policy Rights

The Assignment of Benefits concerns the following:

Patient: _____
Provider: The ExerScience Center
Provider Address: 24706 State Road 54 Lutz, FL 33549
Date of Incident: _____
Auto/Ins Company Name: _____
Policy Owner's Name: _____
Policy or Claim #: _____

I, the assigned patient, understand and agree that the above referred provider requires payment at the time services are rendered, in consideration of provider agreeing to not require at the time services are rendered, hereby assign the rights and benefits of insurance of the applicable personal injury protection, medical payments and/or other insurance which may be available to pay this provider on my behalf to the said provider for billings submitted by or on behalf of this provider. This assignment is for services and/or supplies rendered for treatment of personal injuries sustained in the automobile accident or incident on the above referenced date to myself, the undersigned patient, who is covered by personal injury protection (PIP) coverage or other insurance coverage under the above named Policy Owner's name, in accordance with Florida Statute 627.736 (5). The undersigned is responsible for any applicable deductible or co-payment not covered by the said PIP or other insurance. PIP or other insurance policy rights, which I am assigning hereby,are to be covered through a policy of insurance with the company commonly known as the above referred insurance company, under the above referred policy or claim number. Notwithstanding anything to the contrary contained herein, it is the intent of the parties herein that this assignment of benefits shall only apply to goods, services and treatment rendered to the undersigned by this particular provider/facility.

This assignment is intended to transfer all of the patient's rights to collect benefits from the said insurance company, including, but not limited to, all rights to collect benefits directly from the insurance company for services that I have received and all rights to proceed against the insurance company which is obligated to provide benefits in any action including legal suitif for any reason the insurance company fails to make payment of benefits to which I am due. This assignment further includes the right to collect payment for the reasonable cost connected with coping and mailing records to the insurer at the insurer's request and in accordance with Florida Statute 627.736 (6). This patient's assignee I agree that the said provider may select any attorney it wishes and understand and agree that the attorney selected by them may be different than the attorney handling my personal injury/bodily injury claim or case. In the event of litigation or arbitration, I agree to cooperate with the said provider and in any matter reasonably required. I understand that this cooperation may include giving sworn testimony at deposition, trial of the

Assignment of Benefits / Policy Rights

case, or any other proceeding that may be reasonably required, and I also agree to execute any releases, settlement papers, and settlement checks. I further agree not to compromise or extinguish the value of this assignment by taking a position inconsistent with the said provider's pursuit of payment.

This Assignment of Rights and Benefits is intended to become effective immediately and binding upon the said insurance carrier upon execution. I hereby instruct the said insurance carrier that in the event the subject medical benefits are disputed for any reason, including medical reasonableness and/or necessity, that the amount of benefits claimed by the provider is said the be set aside and not disbursed until the dispute is resolved. As part of this Assignment of Rights and Benefits, I further instruct the insurance carrier to notify the provider immediately of any dispute as to payment so that it may exercise its legal rights. I have read and understood the information herein, and it's true to the best of my knowledge and belief.

Patient/Guardian Signature: _____ Date: _____
Patient/Guardian Print: _____

Provider: The undersigned, on behalf of the above referred Provider, hereby accept assignment of the insurance rights and benefits for the goods, services and treatment rendered to the above-referred patient's Personal Injury Protection (PIP) or the other insurance with above-referred insurance carrier and in accordance with Florida Statute 627.736 et.Seq.
By: _____ Date: _____

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(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**):*

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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