**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:

X _____ X _____ _____

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**):*

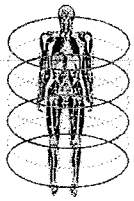
_____ _____ _____

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.

**OIR-B1-1571**
**Pub. 1/2004**



HDC

HOLLYWOOD DIAGNOSTICS CENTER

4224 Hollywood Blvd. Hollywood, FL 33021
Ph 954.966.3600 Fx 954.967.1962

## PROVIDER'S LIEN

**To Attorney:** _____

_____

_____

**RE:** _____
**PATIENT'S NAME**

I hereby authorize Hollywood Diagnostics Center to furnish you, my attorney, with a full report of their examination of myself in regard to the accident in which I was involved.

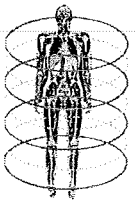
I hereby authorize and direct you, my attorney, to pay directly to Hollywood Diagnostics Center such sums as may be due and owing them for professional services rendered to me both by reason of this accident and by reason of any other bills that are due to their office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect Hollywood Diagnostics Center. I hereby further give a lien on my case to Hollywood Diagnostics Center against any and all proceeds of any settlement, judgment or verdict which may be paid to you, my attorney, or myself as a result of the injuries for which I have been treated or in connection therewith.

I fully understand that I am directly and fully responsible to Hollywood Diagnostics Center for all professional bills submitted by them for services rendered me and that this agreement is made solely for Hollywood Diagnostics Center's additional protection and in consideration of their awaiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

**Dated:** _____ **Patient's Signature:** X _____

The undersigned being attorney of record for the above patient does hereby agree to observe all terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect Hollywood Diagnostics Center, as named above.

**Dated:** _____ **Attorney's Signature:** _____



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## ASSIGNMENT OF INSURANCE BENEFITS, POWER OF ATTORNEY & RELEASE OF INFORMATION
**( Insurer: please read the following, in its entirety, upon receipt):**

**Assignment of Benefits**: I, the undersigned patient/insured knowingly, voluntarily and intentionally, assign any and all insurance benefits to the above medical provider. This assignment of benefits includes overdue interest payments and any potential claim for bad faith. I understand it is the express intention of the provider to accept this assignment of benefits in lieu of demanding payment at the time services are rendered. If the insurer disputes the validity of this assignment of benefits then the insurer is instructed to notify the provider in writing within 5 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 medical provider directly without including the patient's name on the check.

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 medical provider and the insurer as to the amount payable under the insurance policy or contact. 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.

In the event the subject medical benefits 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. If the insurer schedules a defense examination or examination under oath (herein after "EUO") the insurer is hereby instructed to send a copy of said notification to this provider. The provider is authorized to appear at any EUO set by the insurer. The medical provider is not the agent of the insurer or the patient.

I understand this assignment will remain in full force and effect and will not be revoked unless the revocation is agreed to by both the medical provider and the undersigned or the undersigned's attorney. This assignment applies to both past and future medical expenses and is valid even if undated. A photocopy of this assignment is considered to be as valid as the original.

I agree to pay any applicable deductible or co-payment for services rendered after the policy of insurance exhausts, and for any other services unrelated to the automobile accident.

**Power of Attorney:** The above medical provider is hereby given the power of attorney by the undersigned to sign my name on any checks for payment for services rendered by the above provider.

**Release of Information:** I hereby authorize this medical provider to: furnish the insurer and the patient's attorney with any and all information that may be contained in the medical records; to obtain coverage information telephonically from the insurer; to request all EOBs and non-redacted PIP payout sheets from the insurer and, to obtain 2 copies of all medical records, including but not limited to documents, reports, scans, notes, opinions, X-rays, and MRIs, from any other medical provider or insurer. The insurer is directed to keep the patient's medical records private and confidential. The insurer is **NOT** authorized to provide these medical records to anyone, including but not limited to, third party vendors without the patient's and the provider's express written permission.

I certify that I have not been solicited or promised anything in exchange for receiving medical care or that I have received any promises or guarantees from anyone as to the results that may be obtained by any medical treatment.

**Caution! Please read carefully before signing below. If you do not completely understand, please ask us to explain it to you. If you sign below, we will assume you understand and agree to these terms.**

**Patient's Name:** X_____ **Date:**_____

**Patient's Signature:** X_____
**(If patient is a minor, signature of parent/guardian)**