CENTER FOR ORTHOPEDIC AND SPINAL SURGERY

ROBERT D. SIMON M.D.

NEW PATIENT INFORMATION

MEDICAL INFORMATION SCREENING FORM

Patient Name:_____ **Date:**_____

Complaints (Please Circle Appropriate Areas):

Neck	Shoulder	Hand	Ankle
Thoracic Spine	Elbow	Hip	Foot
Lumbar Spine	Wrist	Knee	Other

Date of onset:_____

What is your current orthopedic problem?_____

_____

Describe the accident/injury in detail (if any):

_____

_____

O Driver O Passenger O Seat Belt on

Please fill out the following regarding your current injury:

Were you taken to the emergency room? Yes No

If so, did you go by ambulance? Yes No

Were you admitted to the hospital? Yes No

If so, name of the hospital:_____

Please describe the type of pain you are having: (Circle all that apply)

Sharp	Aching	Dull
Burning	Cramping	Throbbing
Stabbing	Unable to describe	
Mild Stiffness	Moderate Stiffness	Severe Stiffness

Patient Name:_____ **Date:**_____

How often do you have this pain?

Constant	Intermittent	
Daily	Every few days	Weekly or less
Monthly or less	Rarely	

Rate your pain: (1-10 1-mild 10-severe)

Location 1_____:	1	2	3	4	5	6	7	8	9	10
Location 2_____:	1	2	3	4	5	6	7	8	9	10
Location 3_____:	1	2	3	4	5	6	7	8	9	10
Location 4_____:	1	2	3	4	5	6	7	8	9	10

What makes the pain worse?

Activity	Prolonged Walking	Prolonged Standing
Prolonged Sitting	Bending	Changing Positions
Sleeping	Lifting Weight	Running
Reaching	Twisting or Rotation	
Other_____		

What makes the pain better?

Rest	Therapy	Medication
Movement	Elevation	Changing Positions
Heat	Other_____	

Do you have any bowel or bladder changes? Yes No

Do you have any effects from coughing, sneezing, or straining? Yes No

Do you have any radiating pain?
(Pain that shoots from one area to another) Yes No

If so, where and please describe:_____
_____

Do you have any tingling, pins and needles, or burning sensations? Yes No

If so, where and please describe:_____

Patient Name:_____ **Date:**_____

Do you have any feelings of weakness? Yes No

If so, where and please describe:_____
_____

Since the onset, is your pain: Better Unchanged Worse

Are you taking any medication for the pain? Yes No

If so, what type?
Over the counter anti-inflammatories (Motrin, Advil, Aleve)
Prescription Anti-Inflammatories
Prescription Pain Medication
Other:_____

Does the medication help? Yes No

Are you currently attending therapy? Yes No

If so, where?_____

What type of therapy?
Chiropractic
Physical Therapy
Occupational Therapy
Modalities (Ultrasound, Electrical Stimulation, Hot/ Cold Pacs)
Massage Therapy
Acupuncture

***If not*, have you had therapy for this problem before?** Yes No

Has therapy helped? Yes No

Have you had any type of injections for this problem? Yes No

Patient Name:_____ **Date:**_____

What type of injections?

Epidural Injection
Trigger Point Injection (Location:_____)
Facet Injection
Other:_____

Did the injections help? Yes No

Did you have surgery for this problem? Yes No

If yes, date of surgery:_____

what type?_____

Has it helped? Yes No

Have you had an injury similar to this one? Yes No

Did you recover from that injury? Yes No

What is your current occupation?_____

Have you missed any work? Yes No

If so, how much? _____Days _____Weeks _____Months _____Years

GENERAL MEDICAL HISTORY

Do you have or have you had any of the following?

High Blood Pressure	**Rheumatic Fever**	**Breast Lumps**
Low Blood Count	**Chest Pain**	**Breast Discharge**
Unusual Bleeding	**Shortness of Breath**	**Hepatitis**
Fractures, Dislocations, Sprains	**Heart Attack**	**Diabetes**
Arthritis	**Asthma**	**Stomach Pain or Ulcers**
Dizziness	**Pneumonia**	**Abdominal Pain**
Headaches	**Enlarged Lymph Glands**	**Paralysis**
Rashes	**Pain with urination**	**Tuberculosis**
Blurred Vision	**Seizures**	**Convulsion**
Intolerance to Anti-Inflammatories		

Patient Name:_____ **Date:**_____

Are you currently taking any medications? Yes No

If so, What are you taking?_____
_____

Do you have any medication allergies? Yes No

If so, to what and what was the reaction?_____
_____

Have you had any surgeries in the past? Yes No

If so, What type?_____
_____

Do you smoke? Yes No

If so, How many packs per day?_____

Do you drink more than once a week? Yes No

If so, How many days per week?_____

Are you right of left-handed? Right Left

FAMILY HISTORY

Mother: (Circle Those That Apply)

Alive Healthy List any health problems:_____
_____
_____

Father: (Circle Those That Apply)

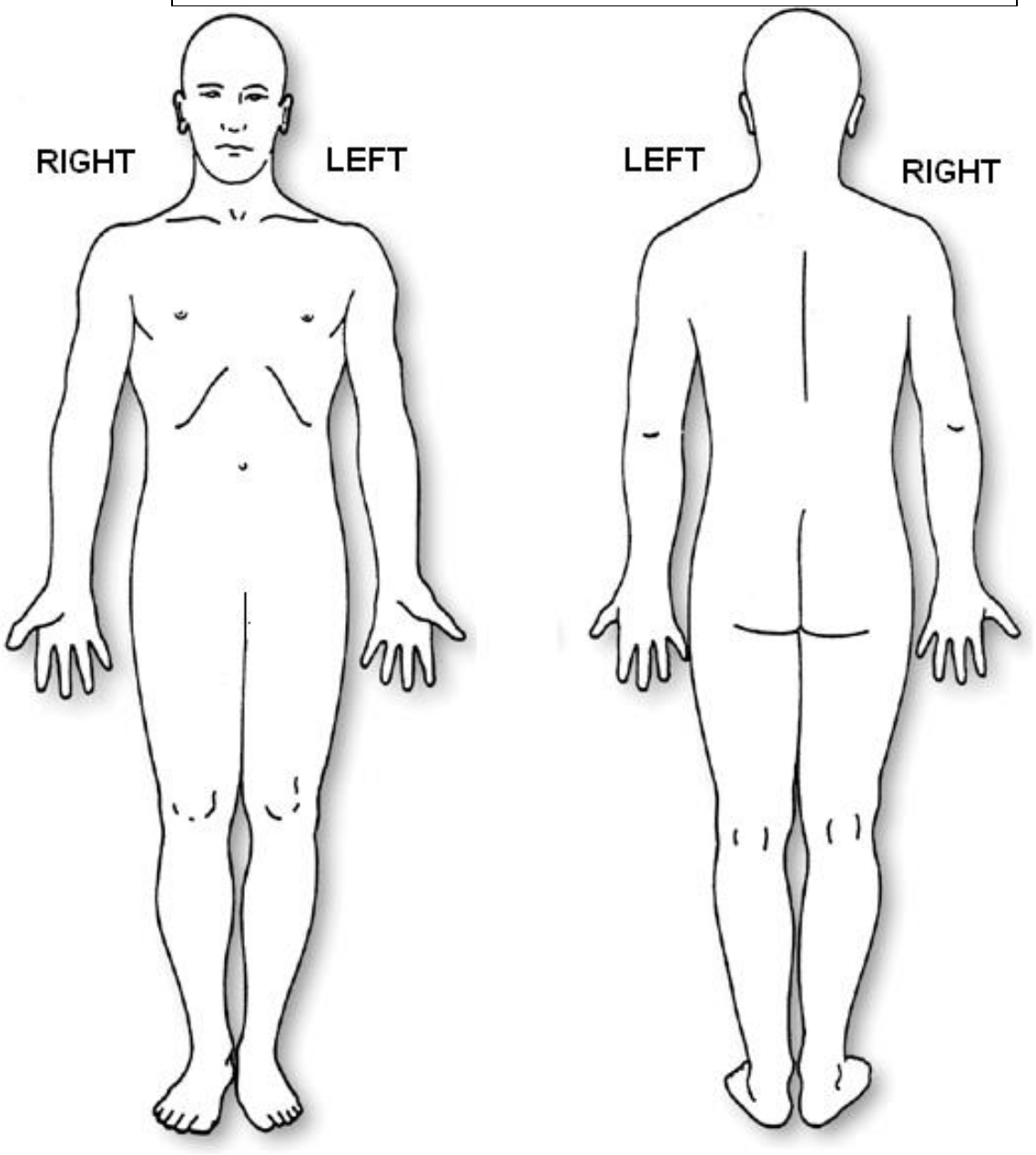
Alive Healthy List any health problems:_____
_____
_____

What is your height:_____ **What is your weight:**_____

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

Please mark the location of your pain using the Symbols below:

///// = **Ache** xxxx = **Pain** ooo = **Tingling** --- = **Numb**



1. I, the undersigned patient or person responsible for the patient, do hereby direct and authorize CENTER FOR ORTHOPEDIC AND SPINAL SURGERY, to furnish my insurance company, attorney, personal physician, or any representative thereof, any and all information which may be pertinent regarding my medical condition and medical treatment rendered to me.
2. I, the undersigned patient or person responsible for the patient, do hereby acknowledge that I am responsible for the payment of fees for medical services rendered to me by CENTER FOR ORTHOPEDIC AND SPINAL SURGERY to act as my agent in assisting me to obtain payment from my insurance company of bills for medical services rendered. I authorize and direct CENTER FOR ORTHOPEDIC AND SPINAL SURGERY, to furnish upon request medical or other information necessary to process claims to any insurance company responsible for payment of fees for medical services rendered on my behalf be CENTER FOR ORTHOPEDIC AND SPINAL SURGERY.
3. I, the patient or person responsible for the patient, do hereby authorize and direct that payment of bills for medical services rendered by CENTER FOR ORTHOPEDIC AND SPINAL SURGERY, be made directly to CENTER FOR ORTHOPEDIC AND SPINAL SURGERY, on my behalf. I permit a copy of this authorization to be used in place of the original.
4. I hereby declare by my signature below that I have read and understand all of the provisions above.

Signature: _____ Date: _____

Witnessed By: _____ Date: _____

POWER OF ATTORNEY AND MEDICAL RELEASE

POWER OF ATTORNEY TO ENDORSE CHECKS AND OR SIGN ANY PIECE OF PAPER WHICH WILL ENHANCE OR EXPEDITE PAYMENT TO PROVIDER FOR SERVICES RENDERED, INCLUDING BUT NOT LIMITED TO, RELEASE OF MEDICAL RECORDS AND ASSIGNMENT OF BENEFITS AUTHORIZATION TO PAY.

Know by all these present that The undersigned has made, constituted and appointed and by these presents does hereby make constitute and appoint CENTER FOR ORTHOPEDIC AND SPINAL SURGERY, and any of its duly authorized agents and employees as and to be the undersigned's true and lawful attorney for and in the undersigned's name, place and stead to endorse any and all checks, draft and money orders which made payable to the undersigned alone or to the undersigned and the said CENTER FOR ORTHOPEDIC AND SPINAL SURGERY, INC, which checks, drafts or money orders are made payable for the services which have been made by CENTER FOR ORTHOPEDIC AND SPINAL SURGERY, INC, at the request or with the knowledge and approval of the undersigned and/or the marker of the check, draft or money order.

Furthermore, the undersigned allows CENTER FOR ORTHOPEDIC AND SPINAL SURGERY, INC, or any of its agents to sign any paper that will be necessary to enhance, expedite and/or allow payment said provider. This may include affidavits of non-ownership of vehicles, insurance forms and other statements.

The undersigned by these present does give grant the said CENTER FOR ORTHOPEDIC AND SPINAL SURGERY, INC, as attorney the full power and authority to do and perform all and every act whatsoever and requisite and necessary to be done in and about fine premises as fully to all intents and purposes as the undersigned might or could do to personally present insofar as the endorsing and cashing of said checks are checks are concerned as well as any other document.

MEDICAL RELEASE

A photocopy of this document shall be sufficient to authorize any person having records of medical treatment, services, or supplies pertaining to me to release true copies of same to CENTER FOR ORTHOPEDIC AND SPINAL SURGERY, or any other insurer providing coverage to me in connection with the processing of any claim for benefits made by me or by the assignee herein. A photocopy of this document shall be as binding as an original signature page.

The undersigned does hereby ratify and confirm any and all actions taken by the said attorney in accordance with this special power and which the said attorney shall do or cause to be done by virtue of these presents.

_____	_____	_____
Patient Signature	Patient Name (PLEASE PRINT)	Date

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). I have certain rights to privacy regarding my protected Health Information. I understand that this information can and will be used to:

- *Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly*
- *Obtain payment from third-party payers.*
- *Conduct normal healthcare operations such as quality assessments and physicians and certifications.*

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to the address below to obtain a current copy of the Notice of Privacy Practices.

CENTER FOR ORTHOPEDIC AND SPINAL SURGERY

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date:	**Initials:**	**Reason(s):**

HEALTHCARE ARBITRATION AGREEMENT

ARTICLE 1: *GENERAL PROVISIONS*

The patient agrees that any controversy, including any malpractice claim, arising out of or in any way relating to the diagnosis, treatment, or care of that patient by the undersigned physician, including any partners, agents, or employees of the physician, shall be submitted to binding arbitration.

The patient further agrees that any controversy arising out of or in any way relating to the **past** diagnosis, treatment, or care of the patient by a provider or medical services, or the provider's agents or employees, shall likewise be submitted to binding arbitration.

INITIAL: _____

Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of a binding arbitration.

ARTICLE 2: *ALL CLAIMS MUST BE ARBITRATED*

It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or services provided by the provider of medical services, including any spouse or heirs of the patient and any children, whether born or unborn at the time of the occurrence giving rise to the claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

ARTICLE 3: *PROCEDURES*

Within fifteen days after a party to this agreement has given written notice to the other of demand for arbitration of a dispute or controversy, the parties to the dispute or controversy shall each appoint an arbitration and give notice of such appointment to the other. Within a reasonable time after such notices have been given the two arbitrators so selected shall select a neutral arbitrator and give notice of the selection thereof to the parties. The arbitrators shall hold a hearing within a reasonable time from the date of notice of selection of the neutral arbitrator.

Expenses of the arbitration shall be shared equally by the parties to this agreement. Except as herein provided, the arbitration shall be conducted and governed by the provisions of the Florida Arbitration Code, Florida Statutes s. 682.01 et. seq.

In the even that any party to this agreement refuses to go forward with arbitration, the party compelling arbitration reserves the right to proceed with arbitration, the appointment of an arbitrator, and hearings to resolve the dispute, despite the refusal to participate or absence of the apposing party. Submission of any dispute under this agreement to arbitration may only be avoided by a valid court order, indicating that the dispute is beyond the scope of the arbitration agreement, or contains an illegal aspect precluding the resolution of the dispute by arbitration. Any party to this agreement who refuses to go forward with arbitration hereby acknowledges that the arbitrator will go forward with the arbitration hearing and render a binding decision without the participation of the party opposing arbitration or despite its absence at the arbitration hearing.

ARTICLE 4: ***PATIENTS RIGHT TO CANCEL ARBITRATION AGREEMENT***

The patient has the right to rescind this agreement by written notice to the provider of medical services within 7 days after the agreement has been signed and executed. The patient may rescind by merely writing "canceled" on the face of his copies of the agreement, signing his name under such word, and mailing, by certified mail, return receipt requested, such a copy to the provider of medical services within such 7 day period.

ARTICLE 5: ***ARBITRATION AS EXCLUSIVE REMEDY***

With respect to any dispute or controversy that is made subject to arbitration under the terms of this agreement, no suit at law or in equity based on such dispute or controversy shall be instituted by either party, except or enforce the ward of the arbitrators.

ARTICLE 6: ***DEATH OF PARTY NOT TO AFFECT SUBMISSION***

This submission shall not be withdrawn or affected by the death of either of the parties pending a final award, but the executor, administrator, or other representative of the party shall be deemed to be a party to this submission made, any rule of law or equity to the contrary notwithstanding. The parties agree that this agreement is to be binding on the parties assign, heirs, executors, and administrators.

ARTICLE 7: ***ACKNOWLEDGMENTS***

The patient, by signing this agreement, also acknowledges that he or she has been informed that:

1) Medical or hospital care, diagnosis, or treatment will be provided whether or not the patient signs the agreement to arbitrate;
2) The agreement may not be submitted to a patient for approval when the patient's condition prevents the patient from making a rational decision whether or not to agree;
3) The decision whether or not to sign the agreement is solely a matter for the patient's determination without any influence by the physician or hospital;
4) The patient must be furnished with a copy of this agreement upon request.

ARTICLE 8: ***AWARDABLE DAMAGES***

The damages awardable at arbitration are limited to those available under Florida Law.

BY SIGNING THIS CONTRACT YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL

Date:_____ **By:** _____
Physician: _____

Date:_____ **By:** _____

Patient: _____
(Signature)

Patient: _____
(Print name)

By: _____
(Parent or Guardian if patient is a Minor)

It is our pleasure to serve you at CENTER FOR ORTHOPEDIC AND SPINAL SURGERY. As many people are uninsured but still require medical assistance, CENTER FOR ORTHOPEDIC AND SPINAL SURGERY welcomes payment from third-party settlements. The cost of medical care has become difficult for many people. We are here to help. Please read the following to ensure that you understand your medical charges. If you have legal representatives, please review this agreement and our changes prior to your treatment and prior to submission for settlement.

CENTER FOR ORTHOPEDIC AND SPINAL SURGERY does have a cancellation policy in effect that 48 hour notice must be given to cancel any appointment and/or procedure. Should 48 hour notice not be provided in advance for an office appointment a $100 fee will be accessed. If 48 hour notice is not provided for any procedure a $1000 fee will be accessed.

I agree that I have reviewed any and all charges from CENTER FOR ORTHOPEDIC AND SPINAL SURGERY for my medical care. I have discussed these charges with my attorney prior to their submission for demand for a third-party settlement. I hereby waive my rights to contest these charges once the bills have been submitted for a third-party settlement. I understand and agree that upon any third-party settlement in this matter, I agree to have my attorney pay CENTER FOR ORTHOPEDIC AND SPINAL SURGERY charges in full within thirty (30) days of settlement.

In the event that any collection efforts need to be initiated to collect said charges due to CENTER FOR ORTHOPEDIC AND SPINAL SURGERY, as mentioned above, I agree to pay attorney's fees to CENTER FOR ORTHOPEDIC AND SPINAL SURGERY.

I have read and consent to this agreement in its entirety.

Printed Name	Patient Signature	Date


CENTER FOR ORTHOPEDIC AND SPINAL SURGERY
ROBERT D. SIMON M.D.

701 Northlake Blvd, Suite #201
North Palm Beach, FL 33408

ASSIGNMENT OF INSURANCE BENEFITS, RELEASE & DEMAND

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

I, the undersigned patient/insured knowingly, voluntarily and intentionally assign the rights and benefits of my automobile insurance, also known as Personal Injury Protection (hereinafter PIP) , 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 and that this document will allow the provider to file suit against an insurance company for payment of the insurance benefits. I understand the provider may file a lawsuit against my insurer for payment and if the provider's bills are paid or applied to a deductible I agree this will serve as a benefit to me and I authorize and request such litigation. This assignment of benefits includes the cost of transportation, medications, supplies, overdue interest and an 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. The undersigned directs the insurer to pay the health care provider directly without reductions and 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 the insurance resulting in the policy of insurance is declared voided, rescinded, or canceled, I, as the 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 the file suit for recover 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.

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. The insured and the 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 insurer schedules a defense examination or examination under oath (hereinafter "EUO") the insurer is hereby INSTRUCTED to send a copy of said notification to this provider. The provider or the provider's attorney is expressly authorized to appear at any EUO or IME set by the insurer. The health care provider is not the agent of the insurer or the patient for any purpose.

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; to obtain insurance coverage information (declaration sheet & policy of insurance) in writing 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 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 and the insurer is not authorized to provide these medical records to anyone without the patients 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 insurer is directed to pay this provider first before the policy is exhausted. In the event of the provider's medical bills are disputed or reduced by the insurer for any reason, or amount, the insurer is to; set aside the entire amount disputed or reduced; escrow the fill amount at issue; and most pay the disputed amount to anyone or any entity, including myself, until the dispute is resolved by a Court. Do not exhaust the policy. The insurer is instructed to inform, in writing, the provider of any dispute.

Certification: I certify that; I have read and agree to the above; I have not been solicited or promised anything in exchange for receiving health care; I have not received any promises or guarantees from anyone as to the results that may be obtained by any treatment or service; and I agree the provider's prices for medical services, treatment and supplies are reasonable, usually and customary

Caution: Please read before singing. Please ask to view a copy of our charges. 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.

Patient's Name: _____ Patient's Signature: _____ Date: _____

LIEN ASSIGNMENT

I, _____ (patient's name) residing at the following address, _____, Hereby enter into the following agreement with **CENTER FOR ORTHOPEDIC AND SPINAL SURGERY,** hereinafter known as "the provider" in order to guarantee payment for services rendered by "the provider" to me. I understand that I am directly and fully responsible to "the provider" for all medical bills for services rendered to me. I understand that I am directly and fully responsible to "the provider" for any remaining balance on all medical bills for services rendered to me that were submitted on my behalf to the responsible insurance carrier. This document further serves to acknowledge my responsibility to repay all remaining balances subsequent to all applicable insurance payments. I agree to make myself available to appear or correspond with "the provider" as often as may be necessary for any collections effort that is undertaken.

I agree to comply with all Insurance Company regulations including, but not limited to examinations under oath and independent medical examinations. I understand that any failure on my part to comply with any condition precedent to insurance coverage, may, at the election of the medical provider, serve to revoke any assignment of benefits.

The provider agrees to seek compensation from the appropriate insurance carrier prior to invoking the terms of this lien based on the accuracy of the information the patient has provided. The patient shall provide all necessary insurance information, police reports, and any additional documentation or information deemed necessary by the provider for the submission of the aforementioned insurance claim as applicable. Failure to provide accurate insurance information leading to a viable source of coverage may serve to invalidate any executed assignment of benefits.

I hereby give and grant this lien on my case to "the provider" against any and all proceeds of any settlement, judgment, verdict, or other disposition of any litigation filed or contemplated on my behalf that may be paid to me OR MY ATTORNEY as a result of the injuries for which I have been treated. I grant "the provider" the aforesaid lien against such sums of the aforesaid settlement, judgment, verdict or other disposition of any litigation filed or contemplated on my behalf as may be necessary to adequately reimburse "the provider" for services rendered to me and towards all outstanding balances. I hereby agree to provide accurate contact information for the attorney pursuing any litigation on my behalf.

I hereby direct and authorize direct payment to "the provider", such sums as may be due and owing for medical services rendered to me. I further direct my ATTORNEY to honor the aforesaid lien and to withhold such sums from any settlement, judgment, verdict, or other disposition of any litigation filed or contemplated on my behalf as may be necessary to adequately reimburse "the provider" for services rendered to me towards all outstanding balances.

I understand that this document may not be rescinded and that my ATTORNEY shall not honor any such rescission. I hereby instruct that in the event any ATTORNEY is substituted in my case, the new ATTORNEY honor this lien as inherent to the settlement, judgment, verdict, or other disposition of any litigation filed or contemplated on my behalf and enforceable upon the case as if it were executed by him/her. I hereby direct my attorney, on demand, to provide the status of such litigation to "the provider" or his attorney engaged in any collection efforts. Furthermore, I direct my attorney to contact "the provider" prior to disbursement of any funds to ascertain any outstanding balances due to owing to CENTER FOR ORTHOPEDIC AND SPINAL SURGERY.

NOTICE TO MY ATTORNEY – I UNDERSTAND AND AGREE THAT I AM INDEBTED TO CENTER FOR ORTHOPEDIC AND SPINAL SURGERY FOR MY OUTSTANDING MEDICAL CHARGES. I UNDERSTANDS AND AGREE THAT FLORIDA BAR RULE 5-1.1(F) REQUIRES MY ATTORNEY TO WITHHOLD THE ENTIRE AMOUNT OF ANY DISPUTED CLAIM IN THE ATTORNEY'S TRUST ACCOUNT UNTIL THAT MATTER IS RESOLVED.

Date: _____ Patient's Signature: _____

STANDARD MEDICAL LIEN/LETTER OF PROTECTION

I, the patient, _____do hereby authorize ____Robert D. Simon, M.D._____, **Center for Orthopedic and Spinal Surgery**, (hereinafter "this provider") to furnish me and/or my attorney'(s), with pre-paid copies of the medical records relevant to my injury or accident. I further authorize and direct my attorney to pay directly to this provider, such sums of monies as may be due and owing to them, (a) for medical services rendered to me for the injury and/or, (b) for any other services, supplies, or reports, and/or (c) legal medical (i.e., impairment rating reports, attorney-physician conferences, and depositions) and to withhold such sums from any settlement, insurance proceeds of any kind or judgment as may be necessary to adequately protect and pay for my treatment. While I am injured and need care, I cannot financially afford to pay your bill at the time services are rendered. I, therefore, grant this provider a lien on my claim against any and all proceeds of any settlement, insurance benefits or judgment which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated for/or other related services. I understand that this provider has agreed to provide me with quality medical services and to wait for payment as a courtesy to me until such time as my potential claim against either the person or entity which caused my injuries or the insurance company providing said person with insurance resolves. **We understand insurance companies have unlimited resources, will hire defense lawyers and defense experts that will cause our payment to be delayed for months or years.**

HOWEVER, REGARDLESS OF THE OUTCOME OF THE TRIAL AND REGARDLESS OF WHAT THE JURY AWARDS, THE PATIENT SHALL REMAIN LIABLE TO THE PHYSICIAN FOR MEDICAL SERVICES RENDERED. THE PATIENT'S BILL IS NOT CONTINGENT ON TESTIMONY FROM HIS/HER HEALTHCARE PROVIDER AND THE HEALTHCARE PROVIDER SHALL ONLY BE REQUIRED TO TESTIFY IF SUBPOENAED TO DO SO.

I fully understand that such payment is not contingent on any insurance company's determination, with the exception of a recognized workers compensation case or PIP case, as to the appropriateness of services rendered and/or fees charged. Alternative third party payment, if accepted, is done as a courtesy provided by this provider.

Our practice is committed to providing the best treatment possible for our patients and we charge what is usual and customary for our area. In the event you default on payments, we may have to seek help from a collection agency. If this situation should occur, you will be responsible for any and all collection fees as well as for your existing balance. A fee of $25 will be charged for returned checks. I further agree to pay this medical provider's legal fees and costs if I am sued by this provider, or its assignees, for payment of my unpaid medical expenses.

Your attorney, who will be placed on notice of this lien and, regardless of whether this agreement is countersigned by him/her, is ethically and legally bound to honor same and protect our interest. In the event that there is a dispute as to proper payment, all funds received from the settlement and claimed by this provider shall remain in the attorney's trust account or placed in the Court registry pending Judicial resolution of said dispute.

Upon resolution of my injury case, I hereby authorize my attorney to advise this provider of the total

settlement amount as well as all reductions any other provider has agreed to accept.

I agree that if I discharge my existing attorney and retain new counsel that this agreement is binding on said new counsel regardless of whether it is countersigned by him/her. Furthermore, I agree to notify this provider within 10 day of discharging my counsel.

By my signature below, I hereby waive and/or relinquish my right to contest and/or otherwise make any legal objections as to the appropriateness of this agreement and that my attorney has advised me of same. I understand that this agreement shall be governed by the laws of the State of Florida.

_____ _____

Patient Signature Date

ATTORNEY AGREEMENT AND ACCEPTANCE

The undersigned being the attorney for the above client (patient), does hereby agree to observe all the terms of the above agreement and to withhold such sums from any settlement or judgment as may be necessary to adequately protect the above listed health care providers and to promptly pay such sums to them upon receipt of payment of any settlement or judgment without demand.

_____ _____

Attorney Signature Date

State Bar Number: _____

CENTER FOR ORTHOPEDIC & SPINAL SURGERY
ROBERT D. SIMON, MD
701 NORTHLAKE BLVD, STE #201
NORTH PALM BEACH, FL 33408
PH: (561) 845-7078
FAX: (561) 845-8030

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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