INSURANCE COMPANY:_____

For and in consideration of the above-mentioned provided agreeing to pursue my insurance provider for payment of benefits due me and not requiring prepayment for services. I hereby irrevocably assign to the aforementioned medical provided (Alexander Medical Group, PLLC) any Personal Injury Protection benefits I may have in accordance with Florida Statue 627.756(5). This in includes any benefits from my insurance company or any other entity that may be responsible for expenses incurred, and I authorize the provider to prosecute said action and collect legal expenses as they see fit. This DOCUMENT CONSTITUES AN ASSIGNMENT OF BENEFITS. I hereby further give a lien to the Provider against any and all insurance benefits named herein, and any and all proceeds of any settlement, judgment or verdict, which may be paid to me as a result of the injuries or illness for which the Provider has treated me. This is to act as an irrevocable assignment of my rights and benefits to the extent of the services provided. I agree to cooperate with the Provider and any attorney that the Provider chooses and to do all things reasonable to effect payment of the bills by the insurance company to the Provider including, but not limited to, disclosing patient's medical condition and treatment. This assignment concerns only the bills for the Provider and those costs (including, but not limited to attorney's fees, court costs and interest) necessary in procuring payment form the above named insurance company, etc. This assignment is not intended to assign any other causes of action that may belong to the undersigned patient. I agree to pay any applicable deduction or co-payment not covered by the PIP insurance coverage. I understand that this is a benefit and convenience to me in that the Provider will pursue collection against the insurance company on my behalf. I hereby instruct and direct my insurance company to pay my benefits by check, made payable to and mailed to the Provider at the address listed above. If my current policy prohibits direct payment to doctors, then I hereby instruct and direct my insurance company to make the check payable to me and mail it to the Provider at the address listed above. Furthermore, I hereby give the Provider limited power of attorney to endorse/sign my name on any and all checks for payment to the Provider. This agreement is intended to serve as an assignment of the patient's rights and benefits under his/her aforementioned insurance policy in favor of the Provider, if any language within this agreement has the effect of invalidating this assignment, that language shall be deemed void and the assignment shall remain in full force and effect. A photocopy of this assignment shall be considered as effective and valid as the original.

_____
PRINTED NAME

_____ _____
PATIENT SIGNATURE DATE

_____ _____
WITNESS SIGNATURE DATE

Alexander Orthopaedic Associates

MVA / Pedestrian Accident Form

Please complete this form in addition to principle intake if your visit is in relation to an accident.

Patient Name: _____

Today's Date: _____ / _____ / _____

DOB: _____ / _____ / _____ Date of Accident: _____ / _____ / _____

Please complete all fields. If it does not apply, please mark N/A

Were you the: driver / passenger / pedestrian

Were you struck from: behind / front / drivers side / passenger side / other

Did another car stike yours? Yes / No Did your car strike another car? Yes / No

Were you wearing your seatbelt? Yes / No Was a citation issued to you? Yes / No

Did airbags deploy? Yes / No Did you go to the hospital? Yes / No

By Ambulance? Yes / No / N/A Did you lose consciousness? Yes / No / I don't recall

---

What part of the body did you injure? (Please specify right or left)

_____

_____

Please circle the symptoms you've been experiencing since this accident.

Headache	Tingling in Arms	Buzzing in Ears
Neck Pain	Tingling in Legs	Loss of Balance
Neck Stiffness	Numbness in Toes	Fainting
Dizziness	Numbness in Fingers	Diarrhea
Back Pain	Shortness of Breath	Stomach Upset
Back Stiffness	Fatigue	Constipation
Nervousness	Light Sensitivity	Cold Sweats
Chest Pain	Loss of Memory	Fever
Sleep Disruption	Ringing Ears	Other

What is your chief complaint today?

_____

Have you been treated for this accident? Yes / No

If yes, by whom? (list all doctors, physical therapists, Hospital ER, etc.)

_____

_____

Are you taking any medications for this injury? Please list.

_____

Have you had any diagnostic testing for this injury? (MRI, CT, X-Ray) Please indicate facility and date.

_____

_____

Rate your pain by circling the number that best describes your pain at it's worst

No pain - 0 1 2 3 4 5 6 7 8 9 10 - Pain as bad as you can imagine

Rate your pain by circling the number that best describes your pain on average

No pain - 0 1 2 3 4 5 6 7 8 9 10 - Pain as bad as you can imagine

What makes your pain better?

_____

What makes your pain worse?

_____

Have you missed work? Please list dates

_____

Is your condition preventing you from participating in certain activities? Yes / No - Please list.

_____

_____

Have you had any previous injuries not related to this accident? (Previous auto accidents, fractures, surgeries, etc.) Please list the year.

_____

Alexander Orthopaedic Associates

12416 66th Street North, Suite A. Largo, Fl. 33773
2438 Dr. ML King Jr Street North St Petersburg, FL 33704
1532 Oakfield Dr. Brandon, FL 33511
(P) 727-547-4700 (F) 727-394-8661

MEDICAL RECORDS RELEASE AGREEMENT AND HEALTH INSURANCE DISCLOSURE

Patient Name: _____

Date of Injury: _____

I hereby authorize Alexander Orthopaedic Associates (AOA) to furnish my attorney of record, with a full report of my examination, diagnosis, imaging, treatment, prognosis, etc. concerning the injury/illness for which I am treated.

A photocopy of this document shall be sufficient to authorize any person having medical treatment, services, or supplies pertaining to me, to release copies of the same to Alexander Orthopaedic Associates (AOA) or any insurer providing coverage in connections with processing any claim pertaining to payment for care. A photocopy of this document shall be as binding as an original signature page.

If I currently do not have an attorney, but retain an attorney in the future, or change my attorney of record, I understand I am responsible for communicating that change to AOA as soon as possible.

I constitute and appoint AOA to endorse any checks, drafts, or money orders written in both our names where such check is in payment for services regarding my injury. Furthermore, I allow AOA to sign any document that will be necessary to enhance, expedite, and / or allow payment to said provider. This may include insurance forms and other statements.

I understand that I may have health insurance or be a member of an HMO and that I may be a third party beneficiary of an agreement between my health insurer. After careful consideration, it is my decision to decline benefits available through my personal or group health insurance. I understand the reason for this is related to properly pre-approving care, timely filing limits of claims, and other such standards and rules pertaining to health insurance payments. By signing this acknowledgement, I knowingly waive any rights I may have as a third party beneficiary to any agreements my healthcare provider may have with any insurance company.

If I have Medicare Insurance and I am treating for a liability related injury, I understand that the provider has a choice of billing the liability insurer, filing a lien against the court settlement, or billing Medicare. I authorize AOA to release to the Centers of Medicare (CMS) any information needed to determine these benefits, or benefits payable to related services. I agree to pay any portion of my charges that my Medicare carrier deems my responsibility.

I am also fully aware that in the event of an unfavorable judgment in my personal injury matter, I am responsible for all charges incurred for my care at AOA.

Today's Date: _____

Patient Printed Name: _____

Patient Signature: _____

11/13/17

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PATIENT FINANCIAL AGREEMENT
& AUTHORIZATION FOR LIEN ON SERVICES

_____
Patient Name

_____
Date of Accident

In the event that I, _____ recover funds from a settlement of my claim relating to the accident dates above, I direct my attorney to withhold from my settlement sufficient funds to pay for all medical care provided by Alexander Medical Group, LLC dba Alexander Orthopaedic Associates FEIN#16-1626040, up to the lesser of a.) funds received from the recovery of the above named patient / client or b.) the balance of the account, unless otherwise approved.

My attorney will use his / her best efforts to request a confirmation of my account balance when the recovery is imminent.

If the net recovery of settlement is less than the total outstanding charges owes to all healthcare providers covered by a letter of protection or any other lien holder, excluding Medicare or Medicaid, Alexander Orthopaedic Associates has priority to have the account balance paid first, after attorney fees and costs.

In the event that I am no longer represented by an attorney, I authorize any and all lien holders to pay Alexander Orthopedic Associates directly, for all funds due on my account related to the above accident.

I understand that if I object to the amount of the bill, my attorney or any other lien holder will withhold an amount sufficient to pay my bill in a trust account. My attorney or any other lien holder will not thereafter pay any portion of the funds withheld, either to the doctor or myself, until a written agreement is made by all parties involved. The only exception is an Order of Court competent jurisdiction directing that such funds be paid to either myself, or Alexander Orthopaedic Associates.

By signing below, I have read and understand the above written statements. I authorize my attorney to protect my bills for the treatment outlined above. I also understand and agree that I am ultimately responsible to Alexander Orthopaedic Associates for the payment of all services rendered for my benefit.

_____ _____
Name of Representing Attorney **Signature of Patient** **Date**

OFFICE USE ONLY

_____ **Patient given copy of Financial Agreement / Lien on Services**

_____ **Copy faxed to Representing Attorney**