Auto Related Accident

1) About You

Name: _____
Today's Date:_____
Medical Claim Number: _____
Adjuster's Name: _____
Adjuster's Email & Phone Number: _____

2) Auto Related Accident

In your own words, please describe the accident:
_____
_____
_____

Date & Time of Accident_____

Were you the: ____Driver ___Front Passenger ___Rear Passenger

If a Traffic Violation was issued, to whom was it issued? _____

Number of people in accident vehicle: _____

Did the police come to the accident site?	YES	NO
Was a police report filed?	YES	NO
Were there any witnesses?	YES	NO
Were you wearing your seat belt?	YES	NO
Was this vehicle equipped with airbags?	YES	NO
If YES, did it/they inflate?	YES	NO

In relation to the base of your skull, where was the headrest?
___ Above ___ Below ___ At Base of Skull

What did your vehicle impact? ___Another Vehicle ___Other
If Other Explain: _____

Did any part of your body strike anything in the vehicle? ___YES ___NO
If yes, please describe: _____

Make & Model of the vehicle you were occupying? _____

Name of the location/street on which you were traveling?
_____
_____

In which direction were you heading? ___N ___S ___E ___W

What was the approx. speed of your vehicle? _____

Did the impact to your vehicle come from the: __Front __Rear __Left Side __Right Side __Other
During impact, were you facing: __ Right __ Left __ Forward

Were you: __ Aware OR __ Surprised by the impact?

If accident vehicle made impact with another vehicle:
Make and model of that other vehicle? _____

Direction other vehicle was headed? __N __S __E __W

Speed of the other vehicle? _____

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3) After Injury

Did accident render you unconscious? YES NO
If YES, for how long? _____
Pleas describe how you felt immediately after the accident: _____
_____

Have you gone to a Hospital or seen any other Doctor? __YES __NO
When did you go? __Just after accident __The next day __2 days plus
How did you get there? __Ambulance __Private transportation

Name of Hospital and/or attending Doctor: _____
Was he/she a: __D.C. __M.D. __D.O __D.D.S.
Describe any treatment you received: _____
_____

Were X-Rays taken? …… ..YES NO
Was medication prescribed?.....YES NO
Have you been able to work since this injury? ……..YES NO
Are your work activities restricted as a result of this injury?..YES NO
Indicate the symptoms that area result of this accident:

__Dizziness	__Difficulty Sleeping	__Jaw Problems	__Nausea
__Memory Loss	__Irritability	__Arms/Shoulder Pain	__Back Pain
__Headache(s)	__Fatigue	__Numb Hands/Fingers	__Lower Back Pain
__Blurred Vision	__Tension	__Chest Pain	__Back Stiffness
__Buzzing in Ear	__Neck Pain	__Shortness of Breath	__Leg Pain
__Ears Ringing	__Neck Stiffness	__Stomach Upset	__Numb Feet/Toes

__Other_____

Is your condition getting worse? __YES __NO __CONSTANT __COMES AND GOES

Have you retained an attorney: __YES __NO
If yes, whom: _____
His/Her Phone #: _____

4) Recovery

To evaluate the effect that continuing work will have on your recovery please complete the following:

How many hours are in your normal week day? _____

Please indicate your daily job duties and any activities which you are occasionally asked to perform.

__Standing	__Driving	__Operating equipment
__Sitting	__Twisting	__Working with arms above head
__Walking	__Crawling	__Typing
__Lifting	__Bending	__Stooping

__Other _____

What positions can you work in with minimum physical effort and for how long?

_____ __ N/A

Prior to the injury were you capable of working on an equal basis with others your age?

__YES __NO __N/A

Do you work with others who can help you with any heavy lifting? __YES __NO __N/A

While in recovery, is there any light duty wok you could request? __YES __NO __N/A

5) Additional Insurance

2nd Insurance Source of Auto Insurance

Type of Insurance: _____

Co. Name: _____

Address: _____

Phone #: _____

Insured's Name: _____

Policy #:_____ Claim #:_____

Insured's SS#:_____ D.O.B. _____

Insured's Employer: _____

Agent's Name: _____

If any of your medical or account information has changed, please inform our front desk personnel. Please remember you are ultimately responsible for your account

_____ _____

Signature Date

Dr. Erica Lopez, LLC
730 S. Sterling Ave, Suite 214
Tampa, FL 33609

SIGNATURE ON FILE

Please initial by each:

_____ I authorize use of this form on all my insurance submissions

_____ I authorize release of information to all my Insurance Companies

_____ I understand that I am responsible for my bill

_____ I authorize my doctor to act as my agent in helping me obtain payment from my Insurance Companies.

_____ I authorize payment directly to my doctor

_____ I permit a copy of this authorization to be used in place of the original

Patient Name: _____

Patient Signature: **_____**

Date: _____

POWER OF ATTORNEY AND MEDICAL RELEASE

POWER OF ATTORNEY TO ENDORSE CHECKS AND/OR TO SIGN ANY PIECE OF PAPER WHICH WILL ENHANCE OR EXPEDITE PAYMENT TO PROVIDER FOR SERVICES RENDERED, INCLUDING BUT NOT LIMITED TO A 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 present does hereby make, constitute and appoint **Dr. Erica Lopez, LLC** 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, drafts and money orders which are made payable to the undersigned alone or to the undersigned and the said **Dr. Erica Lopez, LLC** which checks, drafts or money orders are payable for services which have been made by **Dr. Erica Lopez, LLC** at the request or with knowledge and approval of the undersigned and/or the maker of the check, draft or money order.

Furthermore, the undersigned allows **Dr. Erica Lopez, LLC** or any of its agents to sign any paper that will be necessary to enhance, expedite and/or allow payment to said provider. This may include affidavits of non ownership of vehicles, insurance forms and other statements.

The undersigned by these present does give and grant the said **Dr. Erica Lopez, LLC** as attorney the full power and authority to do and perform all and every act whatsoever requisite and necessary to be done in and about the 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 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 the same to **Dr. Erica Lopez, LLC** or any 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 the 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.

ASSIGNMENT OF BENEFITS

I, _____ Hereby authorize_____
(Name of Insured / Patient) (Name of Insurance Carrier)
to make medical benefits payments otherwise payable to me for services rendered by **Dr. Erica Lopez, LLC** but not to exceed the charges of those services, payable and mailed directly to:

Dr. Erica Lopez, LLC
730 S Sterling Ave, Suite 214
Tampa, FL 33609

Furthermore, I hereby **IRREVOCABLY ASSIGN** to **Dr. Erica Lopez, LLC** the rights and benefits under any policy of insurance, indemnity agreement, or any other collateral source as defined in Florida Statutes for any service and/or charges provided by **Dr. Erica Lopez, LLC.**

IN WITNESS WHEREOF the undersigned have hereunto set their hands this _____ day of _____, 20____.

_____ _____
Patient Signature Patient Name (PRINTED)

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.

DR. ERICA LOPEZ, LLC
730 S Sterling Ave, Suite 214
TAMPA, FL 33609
(813)280-9696

Patient Consent for Use and Disclosure of Protected Health Information

Dr. Erica Lopez, LLC

I hereby give my consent for Dr. Erica Lopez, LLC to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

Dr. Erica Lopez, LLC Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Dr. Erica Lopez, LLC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Dr. Erica Lopez, LLC Privacy officer at:

730 S Sterling Ave, Suite 214, Tampa, FL 33609

With this consent, Dr. Erica Lopez, LLC may call my home or alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Dr. Erica Lopez, LLC may mail to my home or other alternative locations any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, Dr. Erica Lopez, LLC may email to my home or other alternative locations any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Dr. Erica Lopez, LLC restricts how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Dr. Erica Lopez, LLC's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it Dr. Erica Lopez, LLC may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Patient's Name **Date**

_____
Print Name of Patient or Legal Guardian