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.

Tampa Bay Neurology,Inc

Bharatkumar Patel,MD

8370 W.Hillsborough Ave. Suite#103, Tampa,FL 33615

Phone:813-336-3337 Fax:813-336-3338

AUTO ACCIDENT PATIENT QUESTIONNAIRE

Patient Name ______________________________ DOB ______________

Date of Accident: ______________________________

Were you wearing a Seat Belt? ______________________________

Were you the Driver or Passenger? ______________________________

If Passenger, were you in the front or back seat? ______________________________

Describe the accident in your own words: ______________________________

____

____

____

Were you struck in the front, rear, driver side or passenger side of the vehicle? __________

____

Were you knocked unconscious? __________ If yes, How Long? __________

Did you feel immediate Pain? YES/ NO Where? ______________________________

Did you go to the hospital? YES/ NO What Hospital ______________________________

Were x-rays taken? YES / NO Medication Given? ______________________________

What was your Diagnosis? ______________________________

Have you been treated by another physician since the accident? ______________________________

Name of Physician: ______________________________

Treatment: ______________________________

Did you have symptoms prior to the accident? ______________________________

Are the symptoms improving, getting worse or the same? ______________________________

Have you been in an auto accident before? ______________________________

Date and Injury: ______________________________

____

Patient/Guardian Signature: ______________________________ **Date** ______________