MICHAUX FAMILY CHIROPRACTIC

Patient Demographic Information: **Today's Date: _____**

FULL LEGAL NAME (Last, First, Middle Initial): _____

Date of Birth: _____ Social Security #: _____ Age: _____ Gender: M / F

Relationship Status: ☐Married ☐Single ☐Widowed ☐Divorced ☐Separated ☐CU ☐Domestic Partner

Name of Significant Other: _____

Street Address / Apt No: _____

City: _____ State: _____ Zip Code + 4: _____

Phone Numbers: (Home) _____

(Cell) _____ (Work) _____

Which phone number would you prefer we contact you on? ☐ Home ☐ Cell ☐ Work

E-mail Address: _____

Occupation: _____ Employer: _____

Preferred Language: ☐ English ☐ Spanish: ☐ Other: _____

Smoking Status: ☐ Every Day Smoker ☐ Sometimes Smoker ☐ Former Smoker ☐ Never Smoker

How Did You Hear About Our Office?:

☐ Insurance ☐ Newsleader ☐ Disney Ad ☐ Commercial ☐ Walk / Drive By ☐ Facebook

☐ Family: _____ ☐ Friend: _____ ☐ Website: _____

☐ Event: _____ ☐ Attorney Referral: _____ ☐ Other: _____

Medication Information: Please list any medications that you are currently taking or provide us with a list of current medications. ☐ Not Currently Prescribed Any Medications ☐ See Attached List of Medications

Name of Medication:	Reason for taking this medication?	Dosage Information:	What form of medication is this?	How often do you take this medication?

Any medication allergies?: Yes / No If yes, please list them: _____

Primary Insurance Information: **Insurance Company Name**: _____

Member/ Subscriber ID #: _____ Group #: _____

Phone Number: _____ Are you the primary insured on this policy? Yes / No

If you are not the primary insured, please provide the following information:

Name of Guarantor: _____ Guarantor's Date of Birth: _____

Relationship of Patient to the Guarantor: _____

Secondary Insurance Information: **Insurance Company Name**: _____

Member/ Subscriber ID #: _____ Group #: _____

Phone Number: _____ Are you the primary insured on this policy? Yes / No

If you are not the primary insured, please provide the following information:

Name of Guarantor: _____ Guarantor's Date of Birth: _____

Relationship of Patient to the Guarantor: _____

TERMS OF ACCEPTANCE AND CONSENT FOR CARE

THIS DOCUMENT CONSTITUTES INFORMED CONSENT FOR CHIROPRACTIC CARE

Our office has one goal, to aid the patient in achieving optimal health as quickly and safely as possible, through the removal of interference in the body's ability to heal. We do this through safe and gentle chiropractic care.

We will attempt to identify and diagnose any ailments that the patient may have that may be corrected through chiropractic care, massage therapy, and/or active or passive rehabilitation techniques. If any condition or disease that is out of our scope of practice is found to be present, we will refer the patient to an appropriate physician to diagnose and/or treat that condition.

Our primary focus is the detection and correction of vertebral subluxation. This is the misalignment of one or more spinal bones that can cause interference to the nervous system. Any interference to the nervous system may or may not cause a variety of differing symptoms. Again, our focus is to correct the cause of the interference, not the symptoms themselves.

Vertebral subluxations are brought on by physical, chemical, and/or emotional stress or trauma. Through specific chiropractic adjustments, we reduce and/or correct these subluxations. It is also important to note that the sooner we are able to treat a patient's subluxation and the associated degenerative processes, the faster and more completely the patient's body can respond and heal. It may be necessary to perform an examination of the patient each time a new injury or trauma occurs, and often additional x-rays and/or imaging may be medically necessary to maintain the utmost safety when dealing with the patient's body. The risks of chiropractic care, massage therapy, and active or passive rehabilitation are minimal when dealing with a licensed professional; however, if you have concerns about these risks, please discuss them with the doctor prior to the examination and/or treatment session.

I have read and fully understand the statements and terms listed above. I hereby give consent to MICHAUX FAMILY CHIROPRACTIC to evaluate me to determine my condition and treat me for such condition. I also understand that I may, at anytime, discontinue care with the examination, x-rays, and/or any treatment or therapies if I choose.

_____	_____	_____
Print Patient Name	Patient / Legal Guardian Signature	Date

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for MICHAUX FAMILY CHIROPRACTIC (hereinafter referred to as the PRACTICE) to use and disclose protect health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). The PRACTICE's 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. The PRACTICE 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. Kurtis D. Michaux, D.C., Privacy Officer, 4347 South US Highway 27, Clermont, FL 34711

With this consent, the PRACTICE may call my home or other alternative locations and leave a voicemail message or speak to me in person in reference to any items that may assist the PRACTICE in carrying out TPO, such as appointment reminders, insurance questions, and any calls pertaining to my clinical care, including but not limited to, laboratory and imaging results.

With this consent, the PRACTICE may mail to my home or 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, the PRACTICE may e-mail to my home or alternative locations any items that assist the PRACTICE in carrying out TPO such as appointment reminders, updates to office hours, or patient statements. I have the right to request that the PRACTICE restrict how it uses or discloses my PHI to carry out TPO. However, the PRACTICE is not required to agree to my requested restrictions. If the PRACTICE does agree to my restrictions it is bound to this agreement.

By signing below, I am consenting to the PRACTICE'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, the PRACTICE may decline to provide treatment to me.

_____	_____	_____
Print Patient Name	Patient / Legal Guardian Signature	Date

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRATICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

_____	_____	_____
Print Patient Name	Patient / Legal Guardian Signature	Date

OFFICE POLICIES

It is our office policy that any patient and/or insurance company that makes a payment up front or in advance of services being provided is entitled to an administrative discount.

The fee paid for the medically necessary x-rays taken upon examination is for analysis only. The film itself is the property of this office as per Florida State Statue 460.413. Once the films are used for treatment purposes, they cannot be released. Films can be duplicated for additional treatment purposes, however, there will be a charge for this and a request must be submitted in writing.

If you have a co-insurance, copayment, deductible, or any other out-of-pocket responsibility due at the time of service, what will be your primary method of payment?

☐ Cash / Check ☐ CareCredit ☐ Credit Card ☐ Attorney Settlement / Letter of Protection

I understand and agree that health insurance and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that MICHAUX FAMILY CHIROPRACTIC will prepare any necessary reports and forms to assist in making collections from my insurance company and that any amount authorized to be paid directly to MICHAUX FAMILY CHIROPRACTIC will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

I also understand that if I suspend or terminate my care at MICHAUX FAMILY CHIROPRACTIC, any outstanding charges for professional services rendered to me will be immediately due and payable. I agree that I will be responsible for all attorney and legal fees if legal action becomes necessary to collect this amount.

_____	_____	_____
Print Patient Name	Patient / Legal Guardian Signature	Date

COMMUNICATION INFORMATION

Emergency Contact: _____ Relationship: _____

Street Address / Apt No.: _____

City: _____ State: _____ Zip Code +4: _____

Phone Number: _____

Please note that your emergency contact should also be listed below as being authorized to receive healthcare information on your behalf.

In the event that we would need to communicate your healthcare and/or financial information, to whom may we do so? Please list the name of the person to which we can release the information, as well as, which information you would like be to released to them.

Spouse: _____ ☐ Healthcare ☐ Financial

Parent: _____ ☐ Healthcare ☐ Financial

Child: _____ ☐ Healthcare ☐ Financial

Other: _____ ☐ Healthcare ☐ Financial

May we leave voicemail messages regarding your PHI on an answering device? Yes / No

PRIMARY CARE PHYSICIAN / SPECIALIST INFORMATION

Please list the name of your primary care physician/specialist, if you have one: _____

Street Address / Suite No.: _____

City: _____ State: _____ Zip Code +4: _____

Phone Number: _____ Fax Number: _____

It is our intention to communicate with your primary care physician/specialist to coordinate with them on the care provided at MICHAUX FAMILY CHIROPRACTIC. This is in an effort to maintain the highest quality of care for you and your family. Please check one of the boxes below to indicate your preference in regards to this communication.

☐ You are welcome to communicate with my primary care physician and/or other treating physicians.

☐ I would prefer that you DO NOT communicate with my primary care physician and/or other treating physicians unless it is medically necessary.

I have read and fully understand the above statements.

_____ _____ _____

Print Patient Name Patient / Legal Guardian Signature Date

RECORDS RELEASE AUTHORIZATION

Print Patient Name: _____ Patient Date of Birth: _____

Patient Social Security Number: _____ Date of Injury / Illness: _____

To Doctor and / or Hospital:

Clinic / Hospital Name: _____

Doctor's Name: _____

Facility's Address: _____

_____

Phone Number: _____ Fax Number: _____

I hereby authorize and request the release of my protected health information to:

Michaux Family Chiropractic
4347 South US Highway 27
Clermont, FL 34711
Phone: 352-243-7300 Fax: 352-243-7355
www.MichauxFamilyChiropractic.com

I would like the following information released to Michaux Family Chiropractic:

☐ History and Records Pertaining to Illness / Treatment During Time Period From: _____ To: _____

☐ Imaging Reports (X-rays, CT Scans, MRIs, ext.) ☐ Lab Reports ☐ Actual Images (Films or CD)

☐ ALL RECORDS IN YOUR POSSESION

_____	_____	_____
Print Patient Name	Patient / Legal Guardian Signature	Date
_____	_____	_____
Print Witness Name	Witness Signature	Date

This records request is effective from the above listed date for one year or until _____ and can be revoked upon request.

HEALTH RECORDS AND PROVIDER'S LIEN

Law Firm: _____

Attorney's Name: _____

Attorney's Address: _____

Attorney's Phone Number:_____ Attorney's Fax Number: _____

I hereby authorize Michaux Family Chiropractic to furnish you, my attorney, with a full report of this examination, diagnosis, treatment, prognosis, etc., of myself in regard to the injury in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to Michaux Family Chiropractic, such sums as may be due and owed them for medical services rendered to me, both by reason of this injury, and by reason of any other bills that are due their office. I also authorized you to withhold sums from any settlement, judgment, and/or verdict as may be necessary to adequately protect said provider.

I further give a lien on my case to Michaux Family Chiropractic against any and all proceeds of any settlement, judgment and/or verdict which may be paid to me as a result of the injuries for which I have been treated or injuries in connection herewith.

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

I forbid you, my attorney, from paying my provider any sums less than the full amounts owed to said provider without written consent.

_____ _____ _____

Print Patient Name | Patient / Legal Guardian Signature | Date

The undersigned, being the attorney of record for the above listed patient, does hereby agree to observe all of the terms aforementioned and agrees to withhold such sums from any settlement, judgment, and/or verdict as may be necessary to adequately protect Michaux Family Chiropractic.

_____ _____ _____

Print Attorney Name | Attorney Signature | Date

Please sign, date, and return on copy to Michaux Family Chiropractic, P.A. and keep a copy for your records.

LIEN AGREEMENT

I hereby authorize and direct you, my attorney and/or insurance company, to pay directly to the corporation, Michaux Family Chiropractic, P.A., here forward referred to as MFC or corporation, such sums as may be due and owed them for chiropractic services rendered to me both by reason of this accident and by reason of any other bills that are due to MFC and withhold such sums from any settlement, judgment, and/or verdict as may be necessary to adequately protect and fully compensate said corporation. This agreement is not with any one doctor at MFC and is payable only to MFC even in the event that the treating doctor/doctors are no longer employed by MFC at the time a settlement, judgment, and/or verdict is reached.

I hereby further give lien on my case to said corporation against any and all proceeds of my settlement, judgment, and/or verdict which may be paid to you, my attorney, or to myself, as a result of the injuries for which I have been treated or injuries in connection herewith. I fully understand that I am directly and fully responsible to MFC for all medical bills submitted by MFC for services rendered to me and that this agreement is made solely for said corporation's protection and in consideration of MFC's awaiting payment. I further understand that such payment is not contingent on any settlement, judgment, and/or verdict by which I may eventually recover said fees. I also fully understand that if a payment is not made as agreed upon, that I (customer, patient, buyer, client, etc.) shall be responsible for any and all interest at 1.75% per month or 21% per annum, as well as reasonable attorney fees, cost of collection, and court costs incurred in efforts to enforce this agreement.

I hereby authorize my attorney to release ultimate settlement figures, final disbursement, and/or a copy of the final settlement check regarding my accident/injury to MFC. I agree to promptly notify MFC of any change to or addition of an attorney(s) used by me in connection with this accident. I instruct my attorney(s) to do the same and to promptly deliver a copy of this lien to any such substituted or added attorney(s).

Please acknowledge receipt of this letter by signing below and returning it to Michaux Family Chiropractic, P.A.

I have been advised that if my attorney does not wish to cooperate in protecting the aforementioned doctors' interest, the doctor will not await payment but may declare the entire balance due as payable.

_____	_____	_____
Print Patient Name	Patient / Legal Guardian Signature	Date

The undersigned, being the attorney of record for the above mentioned patient, does agree to hold such sums from any settlement, judgment, and/or verdict as may be necessary to adequately protect and fully compensate Michaux Family Chiropractic, P.A.

_____	_____	_____
Print Attorney Name	Attorney Signature	Date

Please sign, date, and return on copy to Michaux Family Chiropractic, P.A. and keep a copy for your records.

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 (15) and (16), 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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Pub. 1/2004

ASSIGNMENT OF BENEFITS AND DIRECTION TO PAY BENEFITS OWED (Page 1)

I, the undersigned insured or beneficiary of an insurance policy, irrevocably assign to Michaux Family Chiropractic, P.A., hereafter referred to as MFC, whatever rights I have under any policy of insurance and under Florida law, including, without limitation, any and all claims for attorney's fees, costs, interest, and/or damages pursuant to Florida Statute 624.155. This Assignment of Benefits (AOB) includes an assignment of any potential claim for common law or statutory bad faith. If the Insurer disputes the validity of this AOB, then the Insurer is instructed to notify the provider in writing within 10 days of receipt of this document. Failure to do so shall result in the provider relying on this AOB for direct payment and could constitute a waiver by the Insurer to contest the validity of this document. I do hereby confirm that this AOB is irrevocable and instruct any insurance company or other collateral source for which I am entitled to benefits to pay for monies owed as a result of medical services rendered by MFC to promptly make payment in the name of and directly to MFC or its chosen billing service.

Pursuant to this AOB, MFC is authorized to file suit on my behalf against any insurance company that reduces or denies benefits for medical services rendered to me and to collect any damages awarded or settlement monies for services rendered, plus interest, costs, reasonable attorney's fees, and a contingency fee multiplier. I understand that in any such lawsuit, my name and other identifying information will need to be included in and/or portions of my medical file attached to pleading and/or formal discovery. I waive any confidentiality of my records and/or information but only to the extent necessary to prosecute a claim for unpaid or owed medical expenses against the insurance company or any other responsible party.

I acknowledge that MFC objects to any reductions or partial payments by the Insurer. Any partial or reduced payment, regardless of the accompanying language, issued by the Insurer and deposited by MFC shall be done 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. MFC reserves the right to seek the full amount of the bill submitted from the insurance company(ies) or me. Accordingly, the Insurer is hereby instructed to set aside (escrow) any and all reduced or denied benefit payments for medical services rendered by this provider and not pay the disputed amount to anyone until the dispute is resolved.

I further instruct my insurance company to cooperate with the above-captioned provider in resolving all medical billing disputes. Cooperation includes, but is not limited to, providing any and all declaration pages, PIP logs, payout ledgers, explanations of benefits, copies of checks, and any and all other documents or information to MFC and/or its attorneys, employees, or other representatives acting on behalf of MFC. If the Insurer schedules a defense examination, examination under oath (EUO), or independent medical examination (IME) of the patient, the Insurer is hereby instructed to send a copy of said notification to this provider and the provider's attorneys. The provider and/or the provider's attorneys are authorized to appear at any patient EUO or IME set by the Insurer. THIS ASSIGNMENT OF BENEFITS DOES NOT ASSIGN ANY RIGHTS OR OBLIGATIONS UNDER THE POLICY OF INSURANCE TO SUBMIT TO AN EUO OR RECORDED STATEMENT. I further direct and authorize you to speak to an attorney, employee, or any other representative of MFC or anyone

ASSIGNMENT OF BENEFITS AND DIRECTION TO PAY BENEFITS OWED (Page 2)

acting on their behalf over the phone and provide them with any and all information you may have or documentation not previously listed above that they may request.

I, as the patient, agree to remain personally liable for the amounts billed by MFC regardless of the amount paid by the insurance company, unless ordered by a court of law. I fully understand that said health care services were provided to me in consideration for an unconditional promise to pay and for me providing these instructions to my insurance company. I, as the patient, further agree to be liable for reasonable attorneys' fees and costs incurred in collecting any delinquent accounts or unpaid balances. By executing this document, I am placing my insurance company(ies) on notice that the claims for medical treatment rendered by MFC are related to my accident, injury, or covered conditions and should be paid directly to MFC pursuant to this assignment of benefits and Florida law. Any delay in paying benefits owed under the insurance policy could adversely affect me.

BY EXECUTING THIS DOCUMENT, I AM PLACING MY INSURANCE COMPANY ON NOTICE THAT THIS IS A DIRECT ASSIGNEMENT OF BENEFITS PURSUANT TO FLORIDA LAW. AS THE INSURED OR BENEFICIARY OF SAID INSURANCE POLICY, I AM IRREVOCABLY ASSIGNING WHATEVER RIGHTS I HAVE UNDER MY POLICY OF INSURANCE (LESS THE DUTY TO ATTEND AN EUO) AND UNDER FLORIDA LAW TO THIS HEALTH CARE PROVIDER. A photocopy of this assignment shall be considered as effective and valid as the original.

Print Patient Name: _____ Date of Birth: _____

Print Name of Policy Holder / Claimant: _____

Signature of Policy Holder / Claimant: _____ Date: _____

Acceptance By MFC: _____ Date: _____

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 (15) and (16), 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

ASSIGNMENT OF BENEFITS AND DIRECTION TO PAY BENEFITS OWED (Page 1)

I, the undersigned insured or beneficiary of an insurance policy, irrevocably assign to Michaux Family Chiropractic, P.A., hereafter referred to as MFC, whatever rights I have under any policy of insurance and under Florida law, including, without limitation, any and all claims for attorney's fees, costs, interest, and/or damages pursuant to Florida Statute 624.155. This Assignment of Benefits (AOB) includes an assignment of any potential claim for common law or statutory bad faith. If the Insurer disputes the validity of this AOB, then the Insurer is instructed to notify the provider in writing within 10 days of receipt of this document. Failure to do so shall result in the provider relying on this AOB for direct payment and could constitute a waiver by the Insurer to contest the validity of this document. I do hereby confirm that this AOB is irrevocable and instruct any insurance company or other collateral source for which I am entitled to benefits to pay for monies owed as a result of medical services rendered by MFC to promptly make payment in the name of and directly to MFC or its chosen billing service.

Pursuant to this AOB, MFC is authorized to file suit on my behalf against any insurance company that reduces or denies benefits for medical services rendered to me and to collect any damages awarded or settlement monies for services rendered, plus interest, costs, reasonable attorney's fees, and a contingency fee multiplier. I understand that in any such lawsuit, my name and other identifying information will need to be included in and/or portions of my medical file attached to pleading and/or formal discovery. I waive any confidentiality of my records and/or information but only to the extent necessary to prosecute a claim for unpaid or owed medical expenses against the insurance company or any other responsible party.

I acknowledge that MFC objects to any reductions or partial payments by the Insurer. Any partial or reduced payment, regardless of the accompanying language, issued by the Insurer and deposited by MFC shall be done 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. MFC reserves the right to seek the full amount of the bill submitted from the insurance company(ies) or me. Accordingly, the Insurer is hereby instructed to set aside (escrow) any and all reduced or denied benefit payments for medical services rendered by this provider and not pay the disputed amount to anyone until the dispute is resolved.

I further instruct my insurance company to cooperate with the above-captioned provider in resolving all medical billing disputes. Cooperation includes, but is not limited to, providing any and all declaration pages, PIP logs, payout ledgers, explanations of benefits, copies of checks, and any and all other documents or information to MFC and/or its attorneys, employees, or other representatives acting on behalf of MFC. If the Insurer schedules a defense examination, examination under oath (EUO), or independent medical examination (IME) of the patient, the Insurer is hereby instructed to send a copy of said notification to this provider and the provider's attorneys. The provider and/or the provider's attorneys are authorized to appear at any patient EUO or IME set by the Insurer. THIS ASSIGNMENT OF BENEFITS DOES NOT ASSIGN ANY RIGHTS OR OBLIGATIONS UNDER THE POLICY OF INSURANCE TO SUBMIT TO AN EUO OR RECORDED STATEMENT. I further direct and authorize you to speak to an attorney, employee, or any other representative of MFC or anyone

ASSIGNMENT OF BENEFITS AND DIRECTION TO PAY BENEFITS OWED (Page 2)

acting on their behalf over the phone and provide them with any and all information you may have or documentation not previously listed above that they may request.

I, as the patient, agree to remain personally liable for the amounts billed by MFC regardless of the amount paid by the insurance company, unless ordered by a court of law. I fully understand that said health care services were provided to me in consideration for an unconditional promise to pay and for me providing these instructions to my insurance company. I, as the patient, further agree to be liable for reasonable attorneys' fees and costs incurred in collecting any delinquent accounts or unpaid balances. By executing this document, I am placing my insurance company(ies) on notice that the claims for medical treatment rendered by MFC are related to my accident, injury, or covered conditions and should be paid directly to MFC pursuant to this assignment of benefits and Florida law. Any delay in paying benefits owed under the insurance policy could adversely affect me.

BY EXECUTING THIS DOCUMENT, I AM PLACING MY INSURANCE COMPANY ON NOTICE THAT THIS IS A DIRECT ASSIGNEMENT OF BENEFITS PURSUANT TO FLORIDA LAW. AS THE INSURED OR BENEFICIARY OF SAID INSURANCE POLICY, I AM IRREVOCABLY ASSIGNING WHATEVER RIGHTS I HAVE UNDER MY POLICY OF INSURANCE (LESS THE DUTY TO ATTEND AN EUO) AND UNDER FLORIDA LAW TO THIS HEALTH CARE PROVIDER. A photocopy of this assignment shall be considered as effective and valid as the original.

Print Patient Name: _____ Date of Birth: _____

Print Name of Policy Holder / Claimant: _____

Signature of Policy Holder / Claimant: _____ Date: _____

Acceptance By MFC: _____ Date: _____