1561 W. Fairbanks ave Suite 300, Winter Park, FL 32789
Phone: (407)605-5335 Fax: (407)960-4908

PATIENT REGISTRATION FORM

(Please give your insurance information and accident report to the receptionist)

TODAYS DATE: DATE OF ACCIDENT:

LAW FIRM: **Handling Attorney:** **Phone #:**

LAST NAME: FIRST: MIDDLE INTIAL:

MARITAL STATUS: (CIRCLE ONE): SINGLE / MARRIED / DIVORCED / SEPERATED / WIDOWED

IS THIS YOUR LEGAL NAME? **YES / NO** IF NOT, WHAT IS YOUR LEGAL NAME?

DATE OF BIRTH: AGE: SEX: M / F SSN:

STREET ADDRESS: CITY: STATE/ZIP:

CELL PHONE #: HOME PHONE #:

WORK PHONE #: E-MAIL:

OCCUPATION: EMPLOYER:

PRIMARY CARE PHYSICIAN: PHONE #:

IN CASE OF EMERGENCY

Name of Contact: Relationship: Phone #:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Sterling Medical Group or insurance company to release any information required to process my claims.

PATIENT SIGNATURE: DATE:

AUTOMOBILE INSURANCE INFORMATION

INSURANCE COMPANY NAME: EFFECTIVE DATE:

POLICY ID: CLAIM:

IN YOUR OWN WORDS, PLEASE DESCRIBE THE ACCIDENT:

STERLING MEDICAL GROUP
1561 W. Fairbanks ave Suite 300, Winter Park, FL. 32789
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PATIENT POST ACCIDENT MEDICAL & PHYSICAL QUESTIONNAIRE

Patient Name: _____ DOB: _____ DOA: _____ Today's Date: _____
Gender: Male Female Dominant Hand: Right Left Height: _____ Weight: _____ Rendering Provider: _____

Please describe current medical problem including date of onset and correlate with pain chart using the symbols below:

Description of pain:

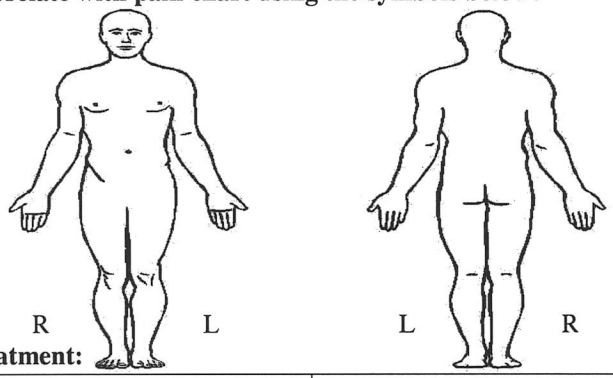
Ache: ^^^^^^^

Burning: xxxx

Numbness: ////

Pins/Needles: 000

Stabbing: -------



Details of accident, medical complications, prescribed medication & treatment:

1) Details of accident

☐**S/F:** _____

_____

☐**Work Related Injury:** ___

_____

☐**MVA**

☐**At Fault:** ☐Yes ☐No
You were the:

☐Driver

☐Passenger

☐Other: _____

_____

Seatbelt: ☐Yes ☐No
Your Vehicle at that time
Make & Model: _____

_____

Other Vehicle involved
Make & Model: _____

_____

Your traveling speed was _____ mph
OR you were stopped at:

☐Stop Light ☐Stop Sign

☐Pedestrian Crosswalk

Other vehicles traveling speed was _____ mph

☐T-Boned

☐Rear-Ended

☐Side Swiped, **Striking the:**

☐Front: _____

☐Back: _____

of the:

☐Driver Side: _____

_____

☐Passenger Side: _____

_____

2)Hospital/Treatments

Did the airbags deploy?

☐Yes ☐No

Any loss of consciousness:

☐Yes ☐No

Did you go to Hospital after the accident?

☐Yes ☐No

Went ____ Days(s)/Week(s) after accident.

Ambulance Escort:

☐Yes ☐No

Hospital Stay:

☐Yes ☐No

☐___Hour(s) ☐___Day(s)

Treatment to date: ☐EMG

☐Oral Steroids ☐NSAIDS

☐Chiro ☐Physical Therapy

☐Pain management consult

☐Pain management epidurals
How many times?

☐1 ☐2 ☐3
Last Injection Date: _____
Area of Injection: _____
Are these treatments helping?

☐Yes ☐No
If so, how much and how long?_____
Still continuing treatment?

☐Yes ☐No
Date beginning care: _____
Company Name: _____

_____
Provider: _____

☐MRI of: _____

☐Xray of: _____

3)Neurologic

List ALL Affected Areas. **L=Left side, R=Right side, M= in the Middle**

☐**Brain/Head:**

Pain Starts: ☐L ☐R ☐M
Does pain travel? If so, where?
☐Around: ☐Down: ☐Up:

_____
☐L:_____ ☐R:_____

☐**Cervical/Neck/Upper-back**

Pain Starts: ☐L ☐R ☐M
Does pain travel? If so, where?
☐Around: ☐Down: ☐Up:

_____
☐L:_____ ☐R:_____

☐**Thoracic/Mid-back**

Pain Starts: ☐L ☐R ☐M
Does pain travel? If so, where?
☐Around: ☐Down: ☐Up:

_____
☐L:_____ ☐R:_____

☐**Lumbar/Low-back**

Pain Starts: ☐L ☐R ☐M
Does pain travel? If so, where?
☐Around: ☐Down: ☐Up:

_____
☐L:_____ ☐R:_____

4)Orthopedic

L=Left side, R=Right side, B=Both

☐**Finger(s)** _____

☐**Hand:** ☐L ☐R ☐B
Describe pain in that area:____

_____

☐**Wrist:** ☐L ☐R ☐B
Describe pain in that area:____

_____

4) Orthopedic continued

List ALL Affected Areas.
L=Left side, R=Right side, B=Both

☐**Forearm:** ☐L ☐R ☐B
Describe pain in that area:____

_____

☐**Elbow:** ☐L ☐R ☐B
Describe pain in that area:____

_____

☐**Arm:** ☐L ☐R ☐B
Does pain travel? If so, where?
☐Around: ☐Down: ☐Up:

_____

☐**Shoulder:** ☐L ☐R ☐B
Does pain travel? If so, where?
☐Around: ☐Down: ☐Up:

_____

☐**Hip:** ☐L ☐R ☐B
Does pain travel? If so, where?
☐Around: ☐Down: ☐Up:

_____

☐**Femur:** ☐L ☐R ☐B
Does pain travel? If so, where?
☐Around: ☐Down: ☐Up:

_____

☐**Knee:** ☐L ☐R ☐B
Does pain travel? If so,where?
☐Around: ☐Down: ☐Up:

_____

☐**Ankle:** ☐L ☐R ☐B
Does pain travel? If so, where?
☐Around: ☐Down: ☐Up:

_____

☐**Foot:** ☐L ☐R ☐B

☐**Toe(s):**_____

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Patient: _____ Age: _____ DOB: _____
Date: _____ Height: _____ Weight: _____ Motor Vehicle Accident OR Slip & Fall Date of accident: _____
What is the main reason you are here for: _____

Medications

1._____ 5._____ 9._____
2._____ 6._____ 10._____
3._____ 7._____ 11._____
4._____ 8._____ 12._____

ARE YOU ALLERGIC TO ANY MEDICATIONS: YES NO If so, what _____

Past Medical History

Check all that apply

_Diabetes _High Blood Pressure (Hypertension) _Blood Clots _HIV
_Asthma _Rheumatoid Arthritis _Ulcers _AIDS
_Bronchitis _Heart Disease _History of Cancer Type:____ _Hepatitis A B C
_Emphysema _Pneumonia _Hyperthyroid _Tuberculosis
_High Cholesterol _Heart Attack _Hypothyroid _MRSA

Past Surgical History

_Appendix (Appendectomy) _Breast Surgery _Tonsillectomy
_Gall Bladder (Cholecystectomy) _Back Surgery _Hysterectomy
_Heart Bypass _Total Joint Replacement _Arthroscopy
_Prostate _Other: _____ _Other:_____

Family Medical History

Has anyone in your immediate family died of heart disease: Yes No
Has anyone in your family had an adverse reaction to anesthesia: Yes No
List any medical illnesses that run in your family: _____

Social History

Who do you live with now: SPOUSE BY YOURSELF OTHER FAMILY FRIENDS OTHER _____
Do you smoke tobacco? YES NO How much? _____ packs per day How long? _____years
Do you drink alcohol? YES NO How much? _____ drinks per day How long? _____years

DO YOU NOW OR HAVE YOU HAD ANY PROBLEMS RELATED TO THE FOLLOWING?

Constitutional Symptoms
Fever Y N
Chills Y N
Headache Y N
Other _____

Eyes
Blurred Vision Y N
Double Vision Y N
Pain Y N
Other _____

Allergic
Hay Fever Y N
Drug Allergies Y N
Other _____

Ear/Nose/Throat
Ear infection Y N
Sore Throat Y N
Sinus Problems Y N

Genitourinary
Urine Retention Y N
Painful Urination Y N
Urinary Frequency Y N

Neurological
Tremors Y N
Dizzy Spells Y N
Numbness/Tingling Y N
Ulcers Y N

Endocrine
Excessive Thirst Y N
Too hot/cold Y N
Tired/Sluggish Y N
Other:_____

Gastrointestinal
Abdominal Pain Y N
Nausea/Vomiting Y N
Rectal Bleeding Y N
Other: _____

Respiratory
Frequent Cough Y N
Short of Breath Y N
Wheezing Y N
Other: _____

Hemotologic/Lymphatic
Swollen Glands Y N
Blood Clots Y N
Bleeding Prob. Y N
Other:_____

Cardiovascular
Chest Pain Y N
Varicose Veins Y N
High B.P. Y N

Integumentary
Skin Rash Y N
Boils Y N
Persistent Itch Y N

Musculoskeletal
Joint Pain Y N
Neck Pain Y N
Back Pain Y N

Psychologic
History of depression Y N
History of bipolar disorder Y N
History of schizophrenia Y N

Other Medical Conditions: _____

Signature of Patient **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(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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ASSIGNMENT OF BENEFITS

I hereby authorize and direct you, my insurance company _____ and/or my attorney to pay directly to **Sterling Medical Group** ("Assignee") such sums as may be due and owing Assignee for services rendered by reason of accident, illness, and for any other bills due Assignee, and to withhold such sums from any disability benefits, medical payments, No-Fault benefits, or any other insurance benefits obligated as reimbursement from any settlement, judgment or verdict on my behalf as may be necessary to adequately protect said Assignee. In the event I do not have insurance coverage, I understand I remain personally responsible for payment of services rendered. I further give an irrevocable lien to said assignee gains 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 I have been treated by the Assignee. This is to act as an assignment of my rights and benefits to the extent of the Assignee's services provided. In the event my insurance company is obligated to make payment to me upon charges made by the Assignee for its services, refuses to make such payment, upon such cause of action, that I might have or that might exist in my favor against such company, authorize Assignee to prosecute said cause of action either in my name or Assignee's and further authorize Assignee to compromise, settle or otherwise resolve said claim of action as they see fit.

Direction of Payment

I hereby authorize any insurance company or attorney to pay directly to Assignee the amount of this and/or future bills for services rendered. I also agree to pay in a current manner any difference between the total charges and the amount paid by the insurance company directly to Assignee.

PIP Log & Declaration Sheet Request

I hereby authorize Assignee to release requested information, which is pertinent to my case, to my insurance company or the attorney involved in this case. Pursuant to 627.4137 Florida Statues (2001). I hereby request a copy of the pip log and declaration sheet, which reflects the policy limits available at the time of this accident, to be provided to this Assignee. I hereby authorize this Assignee to request and receive a copy of my pip log periodically as they deem necessary. If any term or provision of this Assignment, Lien and Authorization or the application thereof to any person or circumstance shall to any extent be invalid or unenforceable, the remainder of this Assignment, Lien and Authorization, or the application of such term or provision to persons or circumstances other than those as to which it is held invalid or unenforceable, shall not be affected thereby, and each term and provision of this Assignment, Lien and Authorization shall be valid and enforced to the fullest extent of the law.

Reservation of Benefits

Be further advised, I am hereby placing you on notice pursuant to Florida case law that should you (the insurance company/carrier) deny, reduce or fail to pay any part of, or an entire bill which was submitted on my behalf from this health care provide, I (the assignor) as well as the assignee (health care provider) are requesting, in advance, that you reserve, or "act-aside," the amount reduced or denied until the dispute is resolved. Should you submit a check to this health care provider which is less than the correct contractual amount, and contains any language referring to payments as "Full and Final Payment," I have instructed this health care provider to return the check to you (the carrier) and consider the bill still due and owing (i.e. a late payment as defined in F.S. 627.736). Additionally, should the remaining amount of my benefits approach an amount where there would be insufficient funds to pay the amount reduced, or failed to pay, please notify me (the assignor) and this health care provider (the assignee).

Patients Name and Date

Print Name _____

Signature _____

Date _____

Health Care Provider

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LETTER OF PROTECTION

Patient's Name: _____ Date of Birth _____

Date of Incident: _____

I do hereby authorize **Sterling Medical Group** to furnish my attorney will a full report of this examination, diagnosis, treatment, prognosis, etc regarding myself for medical conditions related to the accident dated above.

I hereby authorize and direct you my attorney, to pay directly to the doctor such sums as may be due and owing him for reasonable and necessary medical services rendered to me for evaluation or treatment for conditions related to this accident. I hereby further give a lien on my case to the doctor against any and all proceeds of my settlement, judgment or verdict which may be paid to you by my attorney or myself as a result of the injuries of which I have been treated or injuries in connection therewith.

I fully understand that I am responsible to the doctor for all reasonable medical bills submitted by him for necessary services rendered to me and the payments for such bills will be paid solely out of my settlement, judgment or verdict. I further understand that this agreement is made for the doctor's protection in consideration of his awaiting payment. I understand and agree that my directions to you, as my attorney, are irrevocable until either the satisfaction of my financial account with Sterling Medical Group occurs of Sterling Medical Group releases such Letter of Protection.

I agree to promptly notify the doctor of any change or addition of attorney(s) used by me in connection of the accident and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted or added attorney.

Please acknowledge this letter by signing below and return it to the doctor's office.

Patient's Signature: _____ Date: _____

I, being the attorney of record for the above patient, do hereby agree to observe all the terms of the above and agree to withhold such sums for any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate the doctor named above in payment of his fees.

Attorney's Signature: _____ Date: _____

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HARDSHIP AGREEMENT

To whom it may Concern:

The clinic Named above has agreed to accept assignment on the undersigned patient. The mentioned office has also conditionally agreed to accept what the insurance pays only as full payment for services rendered the undersigned patient.

It has been established that this patient is in need of Medical Care and treatment; However, He/She is unable to pay for these services at this time due to a drastic Financial Hardship.

In the event that undersigned patient's income increases, A settlement is made, or other financial gain occurs and He/She is able to pay the co-payment or any other part of the outstanding balance. This Agreement will become null and void at that time.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

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MEDICAL RECORDS / X-RAY RELEASE FORM

STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Date: _____ Account #: _____

Persons Authorized to Use or Disclose Information
Information listed above will be used or disclosed by: _____

Persons to Whom Information May Be Disclosed
Information described above may be disclosed to STERLING MEDICAL GROUP.

Name: _____ Social Security #: _____

Date of Birth: _____

I hereby request and authorize that the following medical documents/records to be released and that they be promptly transferred to STERLING MEDICAL GROUP.

_____ X-Ray Films
_____ Complete Medical file
_____ Medical Reports
_____ Daily Notes
_____ Other _____

Expiration Date of Authorization
This authorization is effective through ____/____/____ unless revoked or terminated by the patient or the patient's personal representative.

Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to Sterling Medical Group. You should contact the Compliance Office to terminate this authorization.

Potential for Re-disclosure
Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

_____
Patient Signature Date

_____
Representative Signature / Please Print Name Date