FLORIDA EMERGENT CARE

Automobile Accident Patient Form

Please Note: Under Florida law you are only able to file a claim for your injuries **WITHIN 14 days** of the date of your accident. Any claims filled after that time will be denied by your insurance company. We **DO NOT** have any control over this and cannot make any exceptions. I understand that if this occurs i am responsible for payment and will be billed personally for the full cost of any services performed.

Patient Name: _____ **Patient D.O.B:** _____

Date of Accident: _____ **Date of Service:** _____

Insurance Company Claim Number: _____

Insurance Company Name: _____

Insurance Company Address: _____

_____

_____

Insurance Company Contact Name: _____

Insurance Company Contact Phone: _____

Insurance Contact Fax #: _____

_____ _____

Patient/Guardian Signature Patient/Guardian Printed Name

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ASSIGNMENT OF BENEFITS

I hereby assign from any and all automobile, health or casualty insurance which provide medical benefits or non-fault benefits, all benefits, rights, title, and interest to "Florida Emergent Care" as, Assignee, for services rendered unto me both by reason of accident of illness. This is to act as a limited assignment of my rights and benefits to the extent of the assignee's services provided and in no way should be construed as a delegation of any duties by the assignor to assignee, or a delegation of any conditions precedent under the above referenced insurance policies.

ASSIGNMENT OF CAUSE OF ACTION

In the event my insurance company fails to pay assignee the full amount due to owing to assignee after notice is given, I hereby assign and transfer to assignee any and all cause of action and proceeds from such causes of action, that i might have or that might exist in my favor against such insurance company and authorize assignee to prosecute said cause of action either in my name of assignee's name and further I authorize assignee to compromise, settle or otherwise resolve said claim or cause of action in assignee's sole discretion.

DIRECTION OF PAYMENT

I hereby authorize my or any insurance company or attorney to pay directly to assignee the amount of this and/or any future bills of services rendered to me. 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. I further agree to pay any applicable deductible or co-payment not covered by my insurance. In the event that i do not have insurance coverage, I understand that i remain personally responsible for payment of services rendered. I hereby further give irrevocable lien to said assignee again any and all insurance benefits named herein and any and all proceeds of any settlement, judgement 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.

PIP LOG REQUEST

I hereby authorize my insurance company to release any information requested that is pertinent to my case to assignee. I hereby request a copy of the PIP log, declaration sheet and copy of the insurance policy, which reflects the policy limits available at the time of this accident, to be provided to assignee. I further authorize assignee to request and receive a copy of my PIP log periodically as they deem to be necessary.

RESERVATIONS OF BENEFITS

Please be advise that I am hereby placing you on notice that, pursuant to Florida case law, should you deny, reduce or fail to pay either a portion of or an entire bill submitted on my behalf from this healthcare provider, I am requesting that you reserve or hold aside, that same amount until this dispute is resolved.

If any terms of this assignment or the application thereof to any person or circumstances shall be determined invalid or unenforceable the remainder of this assignment shall not be affected thereby, and each term and provision of this assignment shall be valid and enforced to the fullest extent of the law.

Patient: _____ Date: _____

Guardian: _____ Date: _____