Motor Vehicle Accident History Form

First Name:_____ **Last Name:**_____ **MI**:_____

Date of Birth:_____ **Marital Status:** ▢ Married ▢ Single ▢ Widowed ▢ Divorced

Gender: ▢ Male ▢ Female

Home Address:_____

City:_____ **State:**_____ **Zip:**_____**Email:**_____

*We do not share your email with any outside vendors, but if you wish for us NOT to use your email to share updates & educational information, initial here:____

Preferred Phone: _____ ▢ Cell ▢ Home ▢ Work

Secondary Phone:_____ ▢ Cell ▢ Home ▢ Work

How would you like to be communicated with (select all that apply): ▢ **Phone Call** ▢ **Text** ▢ **Email**

Local Pharmacy:_____Cross Streets or Phone #:_____

Language: ▢ English ▢ Spanish ▢ Other:_____

Race: ▢ African American ▢ White ▢ Asian ▢ American Indian ▢ Prefer not to answer ▢ Other: _____

Ethnicity: ▢ Not Hispanic or Latino ▢ Hispanic or Latino ▢ Prefer not to answer

Emergency Contact Name:_____**Relationship:**_____

Phone #:_____ Address:_____ City:_____ State:___ Zip:_____

HIPAA: Please list anyone with whom we may discuss your health information:

May we discuss your private medical information with your Emergency Contact? ▢ Yes ▢ No

Anyone else you authorize us to discuss your private health information?

Name/Relationship:_____

Guarantor, who is responsible for the bill?: ▢ Self ▢ Same as Emergency Contact

▢ Other: Name_____ Relationship:_____

Phone #:_____ Address:_____ City:_____ State:___ Zip:_____

Insurance Information: Do you have a copy of your insurance card? ___Yes ___No

Who was cited as at fault? ▢ Your Vehicle ▢ Other Vehicle

Your Insurance Information:

Vehicle Insurance:_____Policy #:_____

State Policy was issued in: __Florida ___Other:_____

Policy Holder's Name:_____

Adjuster Name:_____Phone #:_____

Personal Injury Claim Number:_____ *(may be different than your claim #)*

Have you retained an attorney? ▢ Yes ▢ No

Attorney Name:_____ Phone #:_____

Case Manager:_____

Accident Information

Accident Date:_____ Time:_____AM/PM

Vehicle Type: ▢ Car Make/Model:_____ ▢ Motorcycle

Accident Location: City_____Street_____

Position in vehicle, please circle one: ▢ Driver ▢ Front Passenger ▢ Rear Passenger Side

▢ Rear Driver's Side ▢ Motorcycle Driver ▢ Motorcycle Passenger ▢ ▢ Scooter

Wearing Seatbelt? ▢ Yes ▢ No ▢ N/A **Airbag Deploy?** ▢ Yes ▢ No ▢ N/A

Where was the impact on the vehicle: ▢ Front End ▢ Rear End ▢ Driver's Side ▢ Passenger Side

Approximate Speed of your vehicle at impact: ▢ Stopped ▢ Approximate mph:_____ ▢ unknown

What did you collide with? ▢ Car Make/Model:_____

▢ Motorcycle ▢ Tree ▢ Other:_____

Did the Vehicle Overturn? ▢ Yes ▢ No **Where you ejected from the vehicle?** ▢ Yes ▢ No

Did the Windshield Stay Intact? ▢ Shattered ▢ Spidered ▢ Cracked

Police on Scene? ▢ Yes ▢ No **Accident Report Filed?** ▢ Yes ▢ No

Did Ambulance Respond to the Accident? ▢ Yes ▢ No

Did they transport you? ▢ Yes ▢ No

Did you go to the Hospital? ▢ Yes ▢ No If yes, which hospital?_____

Where you admitted to the hospital overnight? ▢ Yes ▢ No

Did you lose consciousness? ▢ Yes ▢ No **If yes, how long?_____**

Please circle any of the following areas your body hit:

Head	Windshield	Steering Wheel	Window	Dashboard	Unknown	None
Chest	Windshield	Steering Wheel	Window	Dashboard	Unknown	None
R. Arm	Windshield	Steering Wheel	Window	Dashboard	Unknown	None
L. Arm	Windshield	Steering Wheel	Window	Dashboard	Unknown	None
R. Leg	Windshield	Steering Wheel	Window	Dashboard	Unknown	None
L. Leg	Windshield	Steering Wheel	Window	Dashboard	Unknown	None

---

Physical Health Information

Please tell us about your chief complaints today from the accident:

1. _____
2. _____
3. _____
4. _____

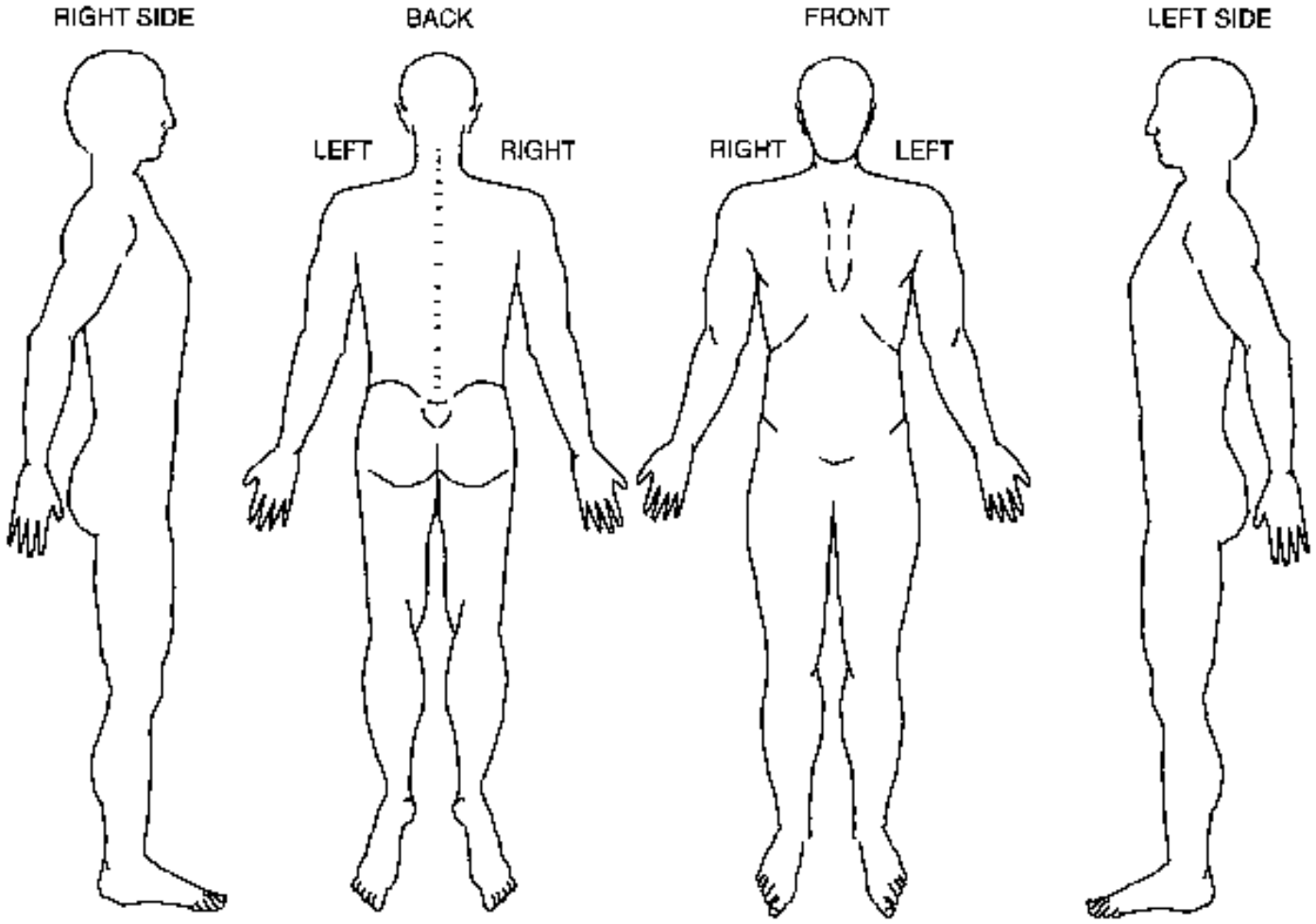
Please Check any of the following you have been experiencing since the accident:

▢ Headache	▢ Dizziness/Lightheadedness	▢ Loss of Balance
▢ Memory Loss	▢ Poor Concentration	▢ Forgetfulness/Confusion
▢ Blurred Vision	▢ Fatigue	▢ Anxiety or Panic Attacks
▢ Depression	▢ Irritability/Nervousness	▢ Trouble Sleeping
▢ Loss of Taste	▢ Loss of Hearing	▢ Ringing in Ears
▢ Nausea/Vomiting	▢ Diarrhea	▢ Constipation
▢ Fever	▢ Shortness of Breath	▢ Fainting Episodes

Other:

Please circle the area you are experiencing symptoms, use the initials to indicate the symptoms you are experiencing

P- pain **S-** Stiffness **BR**- Bruise **C**- Cut/laceration **A**- Abrasion/scratch **N**-Numbness



Other:

Do you take any medications or supplements? ___No ___Yes, please list:_____

_____

_____

Are you allergic to any medications, foods or substances? No____Yes____ If yes, please list:_____

_____

Medical Conditions: NOW or in the PAST (Please check all that apply) ▢ No Medical Conditions

▢ Anxiety/Depression	▢ Thyroid Disease	▢ Tuberculosis	▢ Bleeding Disorder
▢ High blood pressure	▢ Stroke/TIA	▢ Sinus/Allergies	▢ Kidney Disease
▢ Heart Disease/Angina	▢ Diabetes	▢ Reflux.GERD	▢ Prostate Disease
▢ Heart Stents	▢ Asthma	▢ Diverticulitis	▢ Arthritis
▢ CHF (heart failure)	▢ COPD/Emphysema	▢ Glaucoma	▢ Osteoporosis
▢ High Cholesterol	▢ Pneumonia	▢ Seizures	▢ Cancer:
▢ A Fib	▢ Pulmonary Embolism	▢ HIV	▢ Hepatitis A, B, C
Other Medical Conditions not listed:_____			
Prior Surgeries:_____			

Family Medical History:

Mother: ___ Living ___ Deceased Medical Condition: _____

Father: ___ Living ___ Deceased Medical Condition: _____

Sibling: ___ Living ___ Deceased Medical Condition: _____

Social History:

Do you feel safe at home? Yes _____No_____

Tobacco Use: Never _____Quit _____Yes____ If yes, packs per day ?_____

Do you drink Alcohol? No _____Yes_____ If yes, how much per day?_____

Health Maintenance: Tetanus Booster Date_____ Pneumonia Vaccine Date_____

Flu Vaccine Date_____ Shingles Vaccine Date_____

CONSENT FOR TREATMENT

I,_____give permission for The Center For Urgent Care to provide me with medical treatment.

I understand that:

- I have the right and am encouraged to discuss any medical treatments with my provider.
- I have the right to refuse any procedure or treatment.

I allow The Center For Urgent Care to file for insurance benefits to pay for the care I receive.

I understand that:

- The Center For Urgent Care may need to send my medical record information to my insurance company.
- I must pay my share of the costs.
- I must pay for the cost of these services if my insurance does not pay or I do not have insurance.

I acknowledge that I received the Privacy Notice and have been given an opportunity to discuss with the office staff. I understand that I may ask questions of the staff at any time regarding the use and protection of my protected health information.

Patient Signature:_____Date_____

If patient is a minor or legally unable to give consent:

Parent/Guardian Name (Please Print):_____

Parent/Guardian Signature:_____Date_____

Relationship: ▢ Parent ▢ Legal Guardian ▢ Medical Power of Attorney

Motor Vehicle Accident
Irrevocable Lien to The Center for Urgent Care

I, _____, hereby authorize **The Center For Urgent Care,** and its assigns, to furnish my attorney full reports of medical services rendered me in regard to the accident in which I was involved on:_____.

I hereby direct my attorney or third party payor to pay directly to **The Center For Urgent Care** sums as may be due and owing for medical services rendered me by reason of this accident, and to **withhold** sums from any settlement, judgement, or verdict as may be necessary to adequately protect **The Center For Urgent Care.**

I further hereby give a lien on my case to the **The Center For Urgent Care** or its assigns, against any settlement, judgment or verdict which may be paid to my attorney, or to myself, as a result of the injuries for which I have received treatment at **The Center For Urgent Care**.

I understand that I hold direct and full responsibility to **The Center For Urgent Care** for services rendered.

Patient Signature_____Date:_____

If Minor- Parent/Guardian Signature:_____Date:_____

Print Parent/Guardian Name:_____

Dr. J. Albert Avila MD_____Date:_____

IRREVOCABLE ASSIGNMENT OF INSURANCE BENEFITS, RELEASE, & DEMAND

Insurer and Patient, Please Read the Following in its Entirety

I, _____, the undersigned patient/insured knowingly, voluntarily and intentionally irrevocably assign the rights and benefits of my automobile Insurance, also known as Personal Injury Protection (hereinafter PIP), Uninsured Motorist and Medical Payments policy of insurance to the above health care provider. I understand it is the intention of the provider to accept this assignment of benefits in lieu of demanding payment at the time services are rendered. I understand this document will allow the provider to file suit against an insurer for payment of the insurance benefits or an explanation of benefits and to seek §627.428 damages from the insurer. If the provider's bills are applied to a deductible, I agree this will serve as a benefit to me. This assignment of benefits includes transportation, medications, supplies, overdue interest and any potential claim for common law or statutory bad faith/unfair claims handling. If the insurer disputes the validity of this assignment of benefits then the insurer is instructed to notify the provider in writing within five days of receipt of this document. Failure to inform the provider shall result in a waiver by the insurer to contest the validity of this document. Failure to inform the provider shall result in a waiver by the insurer to contest the validity of this document. The undersigned directs the insurer to pay the health care provider the maximum amount directly without any reductions and without including the patient's name on the check. To the extent the PIP insurer contends there is a material misrepresentation on the application for insurance resulting in the policy of insurance is declared voided, rescinded, or canceled, I as the named insured under said policy of insurance, hereby assign the right to receive the premiums paid for my PIP insurance to this provider and to file suit for recovery of the premiums. The insurer is directed to issue such a refund check payable to this provider only. Should the medical bills not exceed the premium refunded, then the provider is directed to mail the patient/named insured a check which represents the difference between the medical bills and the premiums paid.

Disputes: The insurer is directed by the provider and the undersigned to not issue any checks or drafts in partial settlement of a claim that contain or are accompanied by language releasing the insurer or its insured/patient from liability unless there has been a prior written settlement agreed to by the health provider and the insurer as to the amount payable under the insurance policy. The insured and provider hereby contests and objects to any reductions or partial payments. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by the provider shall be done so 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. The insurer is hereby placed on notice that this provider reserves the right to seek the full amount of the bills submitted. If the PIP insurer states it can pay claims at 200% of the Medicare Fee Schedule or any other fee schedule contained within F.S. 627.736 then the insurer is instructed and directed to provide this provider with a copy of the policy of insurance within 10 days. Any effort by the insurer to pay a disputed debt as full satisfaction must be mailed to the address above, after appropriate verbal notification with written notification mailed to the medical provider See Fla. Stat. §673.3111.

If the insurer schedules a defense examination or Examination Under Oath (hereinafter "EUO") the insurer is hereby INSTRUCTED to send a copy of said notification to this medical provider. The medical provider or the provider's attorney is expressly authorized to appear at any EUO or IME set by the insurer. The health care provider is not the agent of the insurer or the patient for any purpose.

This assignment applies to both past and future medical expenses and is valid even if undated. A photocopy of this assignment is to be considered as valid as the original. I agree to pay any applicable deductible, co-payments for services rendered after the policy of insurance exhausts and for any other services unrelated to the automobile accident. The health care provider is given the power of attorney to: endorse my name on any check for services rendered by the above provider; and to request and obtain a copy of any statements or examinations under oath given by patient.

Release of information: I hereby authorize this provider to: furnish an insurer, an insurer's intermediary, the patient's other medical providers, and the patient's attorney via mail, fax, or email, with any and all information that may be contained in the medical records; and for my insurance carrier to send insurance coverage information (declaration sheet & policy of insurance) in writing and telephonically to the above-named provider; request from any insurer all explanation of benefits (EOBs) for all providers and non-redacted PIP payout sheets; obtain any written and verbal statements the patient or anyone else provided to the insurer; obtain copies of the entire claim file and all medical records, including but not limited to: documents, reports, scans, notes, bills, opinions, X-rays, IMEs, and MRIs, from any other medical provider or any insurer. The provider is permitted to produce my medical records to its attorney in connection with any pending lawsuits. The insurer is directed to keep the patient's medical records from this provider private and confidential. The insurer is not authorized to provide these medical records to anyone without the patient's and the provider's prior express written permission. PLEASE NOTE: The insurer is not authorized to release protected health information (PHI) to third party vendors that schedule independent medical examinations or independent medical examination physicians.

Demand: Demand is hereby made for the insurer to pay all bills within 30 days without reductions and to mail the latest non-redacted PIP payout sheet and the insurance coverage declaration sheet, and the insurance policy to the above provider within 15 days, as well as notify the provider pursuant to F.S. 627.736(6)(f) when benefits have been exhausted. The insurer is directed to pay the bills in the order they are received. However, if a bill from this provider and a claim from anyone else is received by the insurer on the same day the insurer is directed to not apply this provider's bill to the deductible. If a bill from this provider and claim from anyone else is received by the insurer on the same day then the insurer is directed to pay this provider first before the policy is exhausted. In the event the provider's medical bills are disputed or reduced by the insurer for any reason, or amount, the insurer is to: set aside the entire amount disputed or reduced; escrow the full amount at issue; and not pay the disputed amount to anyone or any entity, including myself, until the dispute is resolved by a Court. Do not exhaust the policy. The insurer is instructed to inform, in writing, the provider of any dispute.

Certification: I certify that: I have read and agree to the above; I have not been solicited or promised anything in exchange for receiving health care; I have not received any promises or guarantees from anyone as to the results that may be obtained by any treatment or service; I agree the provider's prices for medical services, treatment and supplies are reasonable and customary.

Caution: Please read before signing. **If you do not completely understand this document please ask us to explain it to you. Your signature constitutes acknowledgement and understanding of the document.**

Patient Signature_____Date:_____

If Minor- Parent/Guardian Signature:_____Date:_____

Print Parent/Guardian Name:_____

The Center For Urgent Care
10940 East State Rd 70 Suite 103
Lakewood Ranch, FL 34202
941-243-3088

After an Auto Accident, What You Need to Know?

Documents We Will Need for Your Visit

- Driver's License
- Your Auto Insurance Information
    - Card (Primary)
    - Policy & Claim #
    - Insurance Adjuster Name & Contact
- Health Insurance Card (in the event your automobile insurance benefits are exhausted)
- Police Report within 48 hours of your visit (this is especially critical if you were not at-fault)
- Attorney Information- Name & Contact Number

What you Can Expect With Your Visit

- Medical Evaluation, diagnostic imaging, and other tests as determined appropriate based on the accident details, your physical condition, and symptoms you may be experiencing
- We are able to prescribe many of the medications that you may need right here during your visit
- If physical therapy is indicated, we set up your initial evaluation by a professional therapist who specializes in post motor vehicle accident recovery
- If you have an attorney, we will coordinate with them to help expedite your claim processing so you are not responsible for charges and fees

Important Information & Definitions

Personal Injury Protection (PIP)- Automobile Insurance benefit that covers any medical care needed due to the accident. Law requires you to seek care within 14 days of the accident for coverage to be granted. If care is not sought after 14 days, PIP coverage is lost.

Deductibles: There are 2 deductibles you may have to pay- Automobile Insurance policies have individual deductibles for the vehicle (property) damage and personal Injury (medical care). These deductibles are commonly $250, $500, and $1000 for each- but are dependent on your individual insurance policy.

What you may be required to pay (even if you were not at fault)

- Your Automobile insurance deductible for health care (personal injury)
- Your health insurance deductible (if you benefits are exhausted and roll over to health insurance)
- Any amount after your maximum benefits are exhausted if you do not have health insurance

Why some people chose a trust-worthy attorney to represent them

Florida is a "No-Fault" state, which means that no matter who is at fault, you MUST file and process the claim under your personal automobile insurance (Not your health insurance). This means, whatever your auto insurance deductible is ($250, $500, $1000), you will be required to pay that for both your vehicle and your medical treatment/personal injury.

- If you don't know where the money for deductible, cost-share, or out of pocket expenses will come from, an attorney can help you
- Representation to coordinate insurance benefits converging out of pocket expenses
- Help with lost work related to injuries
- Can help facilitate claim with insurance- especially if you were not at fault
- Can help facilitate coverage of your costs when another driver is at fault
- Will facilitate holding off paying deductibles until claim is settled
- Can navigate the very complex process of post vehicle accident care so you are not harmed
- Take the stress out of the process
- Case management
- Current and future expenses covered

Please call or email us for any questions regarding your claim:
Phone **941-336-5410** email **billing@thecenterforurgentcare.com**