Multi-Care Medical

11270 Pines Blvd, Pembroke Pines, FL 33026 PH) 954.441.7246 FX) 954.441.7241

DATOS PERSONALES

FECHA: _____/_____/_____ NOMBRE: _____

☐ MASCULINO FECHA DE NACIMIENTO: ____/____/____ EDAD: _____ SS#: _____
☐ FEMENINO

DIRECCION: _____CIUDAD:_____ESTADO:_____ZIP:_____

CASA #: ___ ___ ___- ___ ___ ___- ___ ___ ___ ___ TRABAJO #: ___ ___ ___- ___ ___ ___- ___ ___ ___ ___

CELL #: ___ ___ ___- ___ ___ ___- ___ ___ ___ ___ EMAIL: _____

EMPLEADOR: _____SU POSICION: _____

ESTADO CIVIL: ( ) Menor ( ) Soltero ( ) Casado ( ) Divorciado ( ) Separado ( ) Viudo

NOMBRE DE SU CONYUGE: _____

LA RAZON DE SU VISITA

LA RAZON DE SU VISITA ES POR CONSEQUENCIA DE: __AUTO __ WORK __SPORTS ___TRAUMA

POR FAVOR, EXPLIQUE:

_____

_____

DESCRIBA EL DOLOR Y DONDE LO SIENTE:

_____

_____

CUANDO OCCURIO? ____/_____/_____

SU MALESTAR HA EMPEORADO? ___SI ___NO ____ES CONSTANTE____VA Y VIENE

ESTE MALESTAR ESTA INTERFIRIENDO CON: _____TRABAJO _____DORMIR _____RUTINA DIARIA
HA SUFRIDO ESTA CONDICION O ALGO SIMILAR EN EL PASADO? _____ SI _____ NO

UN MEDICO LO HA TRATADO POR ESTA CONDICION? _____SI _____NO

UN MEDICO LO HA TRATADO POR ESTA CONDICION? ___SI ___NO

QUE MEDICO? _____

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HISTORIA MEDICA

QUES MEDICAMENTOS ESTA TOMANDO?

☐ Analgesicos ☐ Relajantes de musculos ☐ Estimulantes ☐ Anti-Analgesicos ☐Insulina

HA SUFRIDO ALGUNA DE LAS SIGUIEBNTES ENFERMEDADES O CONDICIONES?

☐Paro Cardiaco/Ataque Cerebral	☐Cirugia del Corazon/Marca Paso	☐Murmullo del Corazon
☐Abuso e drogas/Alcohol	☐Prolapso de la valvula Mitral	☐Valvulas artificales
☐Enfermedad congenital del Corazon	☐Enfermedades Venereas	☐Hepatitis
☐SIDA/HIV	☐Herpes Zoster o Culebrilla	☐Cancer
☐Frecuentes Dolores del Cuello	☐Enfisema/Glaucoma	☐Anemia
☐Presion arterial alta o baja	☐Problemas Siquiatricos	☐Fiebre Reumatica
☐Dolor de Cabeza	☐Problemas Renales	☐Ulceras/ Colitis
☐Desmayos/Epilepsia	☐Problemas de sinusitis	☐Asma
☐Diabetes/ Tuberculosis	☐Dificultad para respirar	☐Quimoterapia
☐Problemas de la espalda	☐Huesos o coyunturas artificiales	☐Ulcers/Colitis

ENUMERE OTRAS CONDICIONES QUE TENGA O HAYA TENIDO:

ENUMERE SUS ALERGIAS:

ENUMERE PREVIAS OPERACIONES/TRATAMIENTOS Y FECHA:

ENUMERE ACIDENTES SERIOS, Y FECHAS:

HISTORIA MEDICA FAMILAR:

USTED FUMA ☐SI ☐NO EJERCICIOS ☐SI ☐NO

DIETA ESPECIAL? ☐SI ☐NO

PARA MUJERES: ESTA EMBARAZADA? ☐SI ☐NO

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ACIDENTE DE AUTOMOBIL

FECHA Y HORA DEL ACGIDENTE: _____ ☐AM ☐PM

ERA USTED EL: ☐CONDUCTOR ☐PASAJERO ASIENTO ADELANTE ☐PASAJERO ASIENTO ATRAS

QUIEN RECIBIO LA CITACION? _____ CUANTAS PERSONAS IBAN EN EL CARO? _____

LA POLICIA VISITO EL LUGAR DEL ACIDENTE? ☐SI ☐NO REPORTE POLICIAL? ☐SI ☐NO
TESTIGOS? ☐SI ☐NO CINTURON DE SEGURIDAD? ☐SI ☐NO
EL VEHICULO TENIA BOLSAS DE AIRE? ☐SI ☐NO SE INFLARON? ☐SI ☐NO

EN RELACION A LA BASE DE SU CRANEO-DONDE ESTABA LA CABECERA DE SU ASIENTO?

☐ALTA ☐BAJA ☐A LA BASE DE SU CRANEO

CONTRA QUIEN SE ACIDENTO? ☐OTRO VEHICULO ☐OTRO _____

SE GOLPEO ALGUNA PARTE DE SU CUERPO CON EL VEHICULO? ☐SI ☐NO_____

MARCA Y MODELO DEL VEHICULO QUE USTED OCUPABA? _____

NOMBRE DEL AREA O CALLE EN QUE USTED VIAJABA? _____

EN QUE DIRECCION SE DIRIJIA USTED?

☐NORTE ☐SUR ☐ESTE ☐OESTE VELOCIDAD APROXIMADA DE SU VEHICULO: _____

EN QUE LUGAR FUE IMPACTADO SU VEHICULO:

☐DETRAS ☐LADO DERECHO ☐LADO IZQUIERDO ☐OTRO

DURANTE EL IMPACTO, USTED ESTABA MIRANDO A: ☐LA DERECHA ☐IZQUIERDA ☐ADELANTE

USTED: ☐SE DIO CUENTA O ☐FUE SORPRENDIDO POR EL IMPACTO?

MARCA Y MODELO DEL OTRO VEHICULO: _____

DIRECCION EN QUE ESE OTRO VEHICULO SE DIRIJIA:

☐NORTE ☐SUR ☐ESTE ☐OESTE VELOCIDAD APROXIMADA DE SU VEHICULO _____

EN SUS PROPIAS PALABRAS, POR FAVOR DESCRIBA EL ACIDENTE:

_____

_____

_____

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DESPUES DE LA LESION

CAYO USTED INCONSIENTE? ☐SI ☐NO SI RESPONDIO SI, POR CUANTO TIEMPO? _____

DESCRIBA COMO SE SINTIO IMMEDIATAMENTE DESPUES DEL ACIDENTE:

_____

FUE USTED AL HOSPITAL DESPUES DEL ACIDENTE? ☐SI ☐NO

CUANDO FUE? ☐DESPUES DEL ACIDENTE ☐AL PROXIMO DIA ☐DESPUES DE 2 DIAS

COMO LLEGO AL HOSPITAL? ☐AMBULANCIA ☐TRANSPORTE PARTICULAR

NOMBRE DEL HOSPITAL? _____

LE TOMARON RADIOGRAFIAS? ☐SI ☐NO **LE PRECIBIERON MEDICAMENTOS?** ☐SI☐NO

HA PODIDO TRABAJAR ?☐SI ☐NO

INDIQUE ☑ LOS SINTOMAS QUE HAN RESULTADO DE ESTE ACIDENTE:

☐VERTIGO	☐INSOMNIO	☐PROB DE LA MANDIBULA
☐NAUSEAS	☐DESMEMORIADO	☐IRRITABILIDAD
☐DOLOR BRAZOS/HOMBROS	☐DOLOR DE ESPALDA	☐DOLOR DE CABEZA
☐FATIGA	☐DEDOS/MANOS INSENSIBLES	☐DOLOR DE ESPALDA BAJA
☐VISION BORROSA	☐TENSION	☐DOLOR DE PECHO
☐ZUMBIDO EN LOS OIDOS	☐DOLOR DE CUELLO	☐RESPIRACION CORTA
☐DOLOR DE PIERNAS	☐TIMBRE EN LOS OIDOS	☐CUELLO RIGIDO
☐MALESTAR DE ESTOMAGO	☐PIES/DEDOS INSNSIBLES	

☐OTROS _____

SU CONDICION HA EMPEORADO? ☐SI ☐NO ☐CONSTANTE ☐VA Y VIENE

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INDIQUE EL NIVEL DE DOLOR CUANDO HACE ALGUNA DE LA SIGUIENTES ACTIVIDADES:

	COMODO	INCOMODO	DOLOROSO
ACOSTADO BOCA ARRIBA	☐	☐	☐
ACOSTADO DE LADO	☐	☐	☐
ACOSTADO BOCA ABAJO	☐	☐	☐
SENTADO	☐	☐	☐
PARADO	☐	☐	☐
ESTIRANDOSE	☐	☐	☐
CAMINANDO	☐	☐	☐
CORRIENDO	☐	☐	☐
DEPORTES	☐	☐	☐
TRABAJANDO	☐	☐	☐
LEVANTANDO ALGO	☐	☐	☐

PARA PODER EVALUAR EL EFECTO QUE REGRESAR A SU TRABAJO LE CAUSARIA A SU RECUPERACION, POR FAVOR RESPONDA A ESTAS PREGUNATAS:

☐ESTA DE PIE ☐CONDUCE ☐USA MAQUINARIA ☐ESTA SENTADO

☐GIRA SU CUERPO ☐TRABAJA CON LAS MANOS ELEVADAS ☐CAMINA

☐LEVANTA ☐ESCRIBE A MAQUINA ☐AGACHADO

☐OTROS_____

- Cuantas horas al dia trabaja? _____
- Antes de lesionarse, podia usted trabajar igual que otras personas de su edad? ___S ___N
- Trabaja con personas que puedan ayudarle levanter cosas pesadas? ___S ___N
- Mientras se recupera, hay algun trabajo suave que pueda usted solicitar? ___S ___N

Autorizo al personal a realizer cualquier servicio necesario durante el diagnostic y tratamiento. Ademas, autorizo al proveedor, o otra agencia de salud, suplir cualquier informacion requerida para rocesar el seguro. Tengo pleno conocimiento de la informacion anterior y garantizo que es complete y correcta en mi entender. Entiendo que es mi responsabilidad informar a esta oficina de cualquier cambio en mi estado medico.

Firma: _____ Fecha: _____

ASSIGNMENT OF INSURANCE BENEFITS, RELEASE, & DEMAND

I, the undersigned patient/insured knowingly, voluntarily and intentionally assign the rights and benefits of my automobile Insurance, a/k/a Personal Injury Protection (hereinafter PIP), Uninsured Motorist, and Medical Payments policy of insurance to **Multi Care Medical, LLC**. 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 **Multi Care Medical, LLC** 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 the cost of transportation, medications, supplies, over due 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 **Multi Care Medical, LLC** in writing within five days of receipt of this document. Failure to inform **Multi Care Medical, LLC** 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 & 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 **Multi Care Medical, LLC** 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 **Multi Care Medical, LLC** is directed to mail the patient/name insured a check, which represents the difference between the medical bills and the premiums paid.

DISPUTES: The insurer is directed by **Multi Care Medical, LLC** 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 (specifically the office manager) and the insurer as to the amount payable under the insurance policy. The insured and **Multi Care Medical, LLC** 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 **Multi Care Medical, LLC** shall be done so under protest, at the risk of the insurer, and the deposit shall not be deemed a waiver, accords, satisfaction, discharge, settlement or agreement by the provider to accept a reduced amount as payment in full. The pay claims at 200% of Medicare then the insurer is instructed & directed to provide **Multi Care Medical, LLC** 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 speaking with the office manager, and mailed to the specific attention of the Office Manager. See Fla. Stat. 673.3111.**

EUOs and IMEs: If the insurer schedules a defense examination r examination under oath (hereinafter "EUO") the insurer is hereby INSTRUCTED to send a copy of said notification to **Multi Care Medical, LLC**. The 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. **Multi Care Medical, LLC** 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 authorize **Multi Care Medical, LLC** 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; to obtain insurance coverage information (declaration sheet & policy of insurance) in writing and telephonically from the insurer; 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, the property damage 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. **Multi Care Medical, LLC** 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 provider's prior express written permission.

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 to the above provider within 15 days. The insurer is directed to pay the bills in the order they are received. However, if a bill from **Multi Care Medical, LLC** and a claim from anyone else are received by the insurer on the same day the insurer is directed to not apply this provider's bill to the deductible. If the insurer receives a bill from this provider and claim from anyone else on the same day then the insurer is direct 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 **Multi Care Medical, LLC** of any dispute.

Certification: I certify that: I have read and agree to the above; I have no been solicited or promised anything in exchange for receiving health care; I have not received any promises or guarantees from anyone as to results that may be obtained by any treatment or service; and I agree the provider's treatment and supplies are medically necessary and pertaining to my injuries. **Caution: Please read before signing. If you do not completely understand this document please ask us to explain it to you. If you sign below we will assume you understand and agree to the above.**

Patient Name: _____ Patient Signature: _____ Date: _____

Multi-Care Medical

Multi-Care Medical

11270 PINES BLVD. PEMBROKE PINES, FL 33026
(954) 441-7246

AUTHORIZATION FOR MEDICAL TREATMENT

I the undersigned, patient in this office hereby authorize **Multi Care Medical, LLC** and/or the physicians of **Multi Care Medical, LLC** (and whomever they designate as their assistants) to administer such treatments as is necessary and to perform the following therapy and manipulation and such additional therapy or procedures as are considered therapeutically necessary on the basis of findings during the course of said treatment.

I hereby certify that I have read and fully understand the above Authorization for Medical Treatment, the reason why the above named treatment is considered necessary, its advantages and possible complications, if any as well as possible alternative modes of treatment which are explained to me by **Multi Care Medical, LLC** and/or the physicians of **Multi Care Medical, LLC**.

I also certify that no guarantee or assurance has been made as to the result that may be obtained.

Date:_____ Signed:_____

Witness:_____ Patient's Name:_____

APPLICATION FOR FLORIDA "NO FAULT" BENEFITS

NAME OF INSURANCE COMPANY

DATE	OUR POLICY HOLDER	DATE OF ACCIDENT	FILE NUMBER

TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE FLORIDA PERSONAL INJURY PROTECTION LAW, PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURANCE COMPANY MAKES A STATEMENT OF CLAIM CONTAINING ANY FALSE INCOMPLETE OR MISLEADING INFORMATION, IS GUILTY OF A FELONY OF THE THIRD DEGREE.

YOUR NAME	PHONE NO.	HOME	BUSINESS

YOUR ADDRESS (NO, STREET, CITY OR TOWN, STATE AND ZIP CODE)	DATE OF BIRTH	SOCIAL SECURITY NO.

PERMANENT ADDRESS, IF DIFFERENT	HOW LONG HAVE YOU LIVED IN FLORIDA?

DATE AND TIME OF ACCIDENT	PLACE OF ACCIDENT (STREET, CITY OR TOWN AND STATE)

BRIEF DESCRIPTION OF ACCIDENT AND VEHICLES INVOLVED:

DESCRIBE MOTOR VEHICLE YOU OWN -	DESCRIBE MOTOR VEHICLE OWNED BY ANY MEMBER OF YOUR FAMILY-

AS A RESULT OF THIS ACCIDENT, WERE YOU INJURED? IF YOUR ANSWER IS YES, COMPLETE THE REST OF THIS FORM. IF NO, SIGN HERE AND RETURN THIS FORM TO US.

SIGNATURE: **DATE:**

DESCRIBE YOUR INJURY

WERE YOU TREATED BY A DOCTOR?		DOCTOR'S NAME AND ADDRESS
IF YOU WERE TREATED IN A HOSPITAL, WERE YOU AN IN PATIENT ____ OUT PATIENT ____		HOSPITAL'S NAME AND ADDRESS

AMOUNT OF MEDICAL BILLS TO DATE	WILL YOU HAVE MORE MEDICAL EXPENSE?	AT THE TIME OF YOUR ACCIDENT, WERE YOU IN THE COURSE OF YOUR EMPLOYMENT?

DID YOU LOSE WAGES OR SALARY AS A RESULT OF YOUR INJURY?	IF YES, AMOUNT OF LOSS TO DATE	WHAT IS YOUR AVERAGE WEEKLY WAGE OR SALARY?

IF YOU LOST WAGES:	DATE DISABILITY FROM WORK BEGAN	DATE YOU RETURNED TO WORK

HAVE YOU RECEIVED, OR ARE YOU ELIGIBLE FOR, PAYMENTS UNDER ANY WORKMEN'S COMPENSATION OR EMPLOYMENT LAW?	IF YES, AMOUNT PER WEEK	PER MONTH

LIST NAMES AND ADDRESSES OF YOUR PRESENT EMPLOYER(S) AND GIVE YOUR OCCUPATION AND DATES OF EMPLOYMENT FOR EACH

EMPLOYER AND ADDRESS	YOUR OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	YOUR OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	YOUR OCCUPATION	FROM	TO

AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES?	IF YES, EXPLAIN ON REVERSE SIDE
SIGNATURE: DATE:	

IMPORTANT: 1. TO BE ELIGIBLE FOR BENEFITS COMPLETE AND SIGN THIS APPLICATION
2. SIGN AND ATTACH AUTHORIZATION(S)
3. RETURN PROMPTLY WITH ANY MEDICAL BILLS YOU HAVE RECEIVED TO DATE

DO NOT DETACH

ANY PERSON WHO KNOWLINGLY AND WITH INTENT TO IN-
JURE DEFRAUD, OR DECEIVE ANY INSURANCE COMPANY
OR FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE,
INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF
A FELONY OF THIRD DEGREE

AUTHORIZATION FOR MEDICAL INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY HEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY CONDITION WHILE UNDER YOUR OBSERVATION OR TREATMENT, INCLUDING THE HISTORY OBTAINED; X-RAY AND PHYSICAL FINDINGS DIAGNOSIS AND PROGNOSIS. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE FLORIDA "NO FAULT" AUTO INSURANCE LAW (CHAPTER 71-252F.S.).

SIGNATURE _____ DATE _____

ANY PERSON WHO KNOWLINGLY AND WITH INTENT TO IN-
JURE DEFRAUD, OR DECEIVE ANY INSURANCE COMPANY
OR FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE,
INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF
A FELONY OF THIRD DEGREE

DO NOT DETACH

AUTHORIZATION FOR WAGE AND SALARY INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY HEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY WAGES OR SALARY WHILE EMPLOYED BY YOU. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE FLORIDA "NO FAULT" AUTO INSURANCE LAW (CHAPTER 71-252F.S.).

SIGNATURE _____ DATE _____

SOCIAL SECURITY NO. _____

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.

MULTI CARE MEDICAL

11270 PINES BLVD
PEMBROKE PINES, FL 33026

PH) 954.441.7246 FX)954.441.7241

NOTICE OF PRIVACY PRACTICES ACKNOWLEDEGMENT

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclose to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: ____ Self ____Other _____

Signature: _____ Date: _____

OFFICE USE ONLY

WITNESS: _____