Premier Urgent Care Center, LLC
2400 W. Sample Road, Ste 4
Pompano Beach, FL 33073
954-580-1036 Phone 954-580-1099 Fax
www.premierurgentcarefl.com

PIP – INITIATION OF TREATMENT

Date: _____

Auto Insurance Carrier: _____

Address to submit claim: _____

City:_____ State _____ Zip: _____

Phone No. _____ Fax No. _____

Adjustor's Name: _____

Patient Name: _____

Date of Accident; _____

Date of Initial Visit: _____

Claim Number: _____

To Whom It May Concern:

In accordance with Florida Statue 627.736. (5)(b), PREMIER URGENT CARE CENTER, LLC., is informing the above named Auto Insurance Company that the above named patient/insured has requested treatment by our facility. This notice transmitted by return receipt mail within 21 days of the initiation of care permits our billing for services rendered to be performed within 60 days from each service provided.

_____ _____
Patient's Signature Xunda A. Gibson, M. D.
Medical Director

_____
Patient's name

ASSIGNMENT OF BENEFITS/POLICY RIGHTS

PATIENT: _____

I, the undersigned Patient, have and do assign any and all rights and benefits of insurance of any and all applicable personal injury protection, medical payments, and/or insurance to PREMIER URGENT CARE CENTER, LLC for services and/or supplies rendered for the treatment of personal injuries sustained in the incidents of _____, to the undersigned Patient and covered by Personal Injury Protection (P.I.P.) Coverage or other insurance coverage under my policy, in accordance with Florida Statute 627.736. I have read the information herein and it is true to the best of my knowledge and belief.

This Assignment includes, but is not limited to, all right to collect benefits directly from the insurance company for services that I have received and all rights to proceed against the insurance company obligated to provide benefits including legal suit if for any reason the insurance company fails to make payments of benefits to which I am due. Specifically, this assignment includes the right to collect payment for the reasonable costs connected with copying and mailing records to the insurer at the insurers request and in accordance with Florida Statute 627.736. This Assignment also includes any right to recover attorney's fees and costs for such action brought by the provider as Patient's assignee. I agree that PREMIER URGENT CARE CENTER, LLC, may select any attorney of choice and understand and agree that the attorney selected by them may be different that the attorney handling my personal injury/bodily injury claim or case.

I hereby instruct the insurance carrier that, in the event the subject medical benefits are disputed for any reason, including medical relatedness, reasonableness, and/or necessity, that the amount of benefits claims by PREMIER URGENT CARE CENTER, LLC is to be set aside and not disbursed until the dispute is resolved. As part of this Assignment of rights and benefits, I further instruct the insurance carrier to notify the provider immediately of any dispute as to payment to that she my exercise their legal rights. I have read the information herein and it is true to the best of my knowledge and belief.

_____ _____

Patient's Signature **Date**

_____

Print Patient's Name

Premier Urgent Care Center, LLC ● 2400 W. Sample Road, Suite 4 ● Pompano Beach, FL 33073
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Standard Disclosure and Acknowledgement Form
Personal Injury Protection – Initial Treatment or Service Provided

The undersigned injured person (or guardian of such person) affirms:

1. The services 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. This means that no person has initiated contact with me and/or persuaded me to use the doctor or licensed professional, clinic or medical institution that provided the services.

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 amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the mount of the reduction up to $500.00.

The undersigned licensed medical professional 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. I have explained the services rendered 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 the 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.

Insured Person **(patient receiving treatment)** or Legal Guardian of Insured Person:

_____	_____	_____
Name (Print or Type)	Signature	Date

Licensed Medical Professional Rendering Treatment (Signature by his or her own hand):

_____	_____	_____
Name (Print or Type)	Signature	Date

*Any person knowingly 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 627.763(4)(b), Florida Statutes and may not be electronically furnished. Failure to furnish this form may result in non-payment of this claim.

Standard Disclosure and Acknowledgement Form
Personal Injury Protection – Initial Treatment or Service Provided

The undersigned injured person (or guardian of such person) affirms:

6. The services set forth below were actually rendered. This means that those services have already been provided.
   _____
   _____

7. I have the right and the duty to confirm that the services have already been provided.

8. I was not solicited by any person to seek any services from the medical provider of the services described above. This means that no person has initiated contact with me and/or persuaded me to use the doctor or licensed professional, clinic or medical institution that provided the services.

9. The medical provider has explained the services to me for which payment is being claimed.

10. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the mount of the reduction up to $500.00.

The undersigned licensed medical professional affirms the statement numbered 1 above and also:

E. 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.

F. I have explained the services rendered to the insured person, or his or her guardian, sufficiently for that person to sign this form with informed consent.

G. 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.

H. The coding of the 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.

Insured Person **(patient receiving treatment)** or Legal Guardian of Insured Person:

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Name (Print or Type)	Signature	Date

Licensed Medical Professional Rendering Treatment (Signature by his or her own hand):

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