MY EMC DOC

Personal Information

First Name: _____Last Name:_____

Home Address: _____

City State _____ Zip Code_____

Cell Phone:_____ Email:_____

Date of Birth: _____ Social Security Number:_____

Attorney Name _____Attorney Phone Number:_____

Auto Insurance Company _____

Claim # _____ Policy # _____

Treating Physician: _____

Emergency Contact

Name _____ Phone Number_____

Relationship_____

Signature

Telehealth Informed Consent

NOTICE TO PATIENT:

Telehealth, telemedicine, and related terms generally refer to the exchange of medical information from one site to another through electronic communication to improve a patient's health. These are non-face-to-face patient-initiated communications.

PATIENT ACKNOWLEDGEMENT:

I understand the concept of telemedicine and the particular electronic format this office uses. I understand that there has been great advancement in telemedicine technology, however, there may be problems in the communication. I understand that there may be limitations beyond our control. I understand that I may need to seek a face-to-face encounter with another healthcare provider instead of accepting these telemedicine visits. I understand that these telemedicine visits may be only a one-time occurrence and that follow-up treatment may require a face-to-face encounter. I understand that specific procedures may require an additional informed consent process. I understand that there are no guarantees with telemedicine.

Signature

Limited Power of Attorney and Medical Release

POWER OF ATTORNEY TO ENDORSE CHECKS AND/OR TO SIGN ANY PAPER WHICH WILL ENHANCE OR EXPEDITE PAYMENT TO PROVIDER FOR SERVICES RENDERED INCLUDING BUT NOT LIMITED TO A RELEASE OF MEDICAL RECORDS and ASSIGNMENT OF BENEFITS/AUTHORIZATION TO PAY.

Signature

Medical Records Release

Patient Name:_____

Date of Birth: _____

Date of Accident:_____

A photocopy of this document shall be sufficient to authorize any person or medical office having records of medical treatment, services, or supplies pertaining to me to release true copies of same to My EMC Doc, LLC or any insurer providing coverage to me in connection with the processing of any claim for benefits made by me or by the assignee herein. A photocopy of this document shall be as binding as an original signature page. The undersigned does hereby ratify and confirm, and all actions were taken by the said attorney in accordance with this special power and which said attorney shall do or cause to be done by virtue of these present.

I hereby permit My EMC Doc, LLC to obtain any pertinent medical records related to this incident.

All records will be uploaded to the Physician Portal by your treating physician.

Signature

Assignment of Benefits

I, _____Hereby authorize

To: (Auto Insurance)_____ (Name of Attorney)_____

Payable and mailed directly to: **My EMC Doc, LLC**
931 Village Blvd. Ste 135
West Palm Beach, FL 33409

The medical benefits otherwise payable to me for their services,but not to exceed the charges of those services. I hereby IRREVOCABLY ASSIGN to My EMC Doc, LLC any rights and benefits under any policy of insurance, indemnity agreement, or any other collateral source as defined in Florida Statues for any service and or charges provided by My EMC Doc, LLC.

Signature

History & Complaints

Patients Name: _____

Date of Incident: _____

Were you the driver or passenger?

- ☐ Driver
- ☐ Passenger
- ☐ Back Seat

Briefly describe how the accident happened.

_____

_____

_____

_____

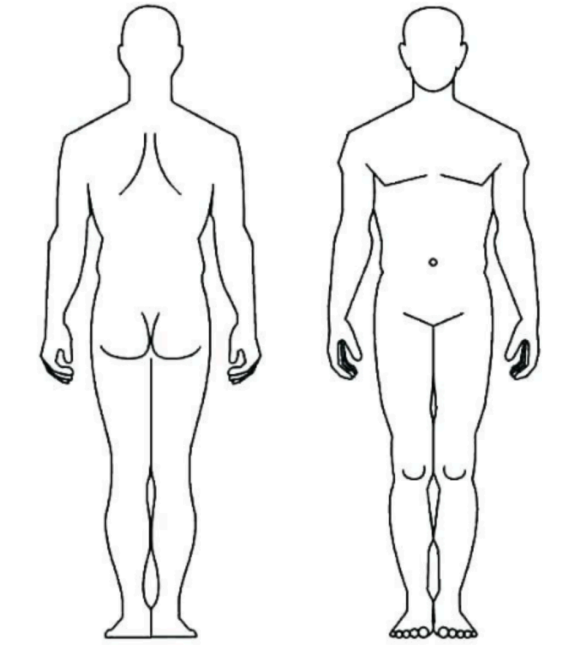
Please describe your current complaints.

_____

_____

_____

Draw on the Image to show where you are in pain.



Additional neurological symptoms

- ☐ Headache
- ☐ Light Headed
- ☐ Double Vision
- ☐ Memory Loss
- ☐ Blurred Vision
- ☐ Ringing in the Ears
- ☐ Loss of Balance
- ☐ Dizziness
- ☐ Sensitivity to light
- ☐ TMJ / Jaw Problems

Did you go to the Hospital after the incident?

- ☐ Yes
- ☐ No

Did you have an MRI for the injuries related to this incident?

- ☐ Yes
- ☐ No

Do you know the results of the MRI? If so, please indicate below.

_____

_____

Are you currently taking any medication either OTC or Prescription?
If yes please list. If none type None. Be as specific as possible.

_____

_____

Signature

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.**

Consultation and evaluation for determination if an Emergency Medical Condition exists.

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.

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