David M. Wall, MD

Specializing in Minimally Invasive Spine Care

1700 McMullen Booth Road, Suite A2-1, Clearwater, FL 33759
P: 727-724-6373 F: 727-724-6377

Patient Information

Date_____ Home Phone_____ Email_____

Name_____ SS#_____

Address_____ Cell Phone_____

City_____ State_____ Zip_____

Sex ☐M ☐F DOB_____ ☐Married ☐Widow ☐Single ☐Divorced/Separated ☐Minor

Patient Employer/School_____ Occupation_____

Employer/School Address_____ Phone_____

Emergency Contact_____ Phone_____

Family/Referring Dr_____ Phone_____ Fax_____

Primary Insurance

Insured Name_____ DOB_____

Address (if different than above)_____ Phone_____

City_____ State_____ Zip_____ SS#_____

Insured Employer_____ Wk Phone_____

Insurance Company_____

Subscriber ID #_____ Group #_____

Insurance Address_____ Phone_____

City_____ State_____ Zip_____ Fax #_____

Do you have secondary insurance? ☐Yes ☐No (If yes) Insurance Co._____

Worker's Compensation or MVA Information

Claim #_____ Date of Injury_____

WC/MVA Co. Name_____ Phone_____

Address for Claims_____

Adjuster Name_____ Phone_____ Fax_____

Attorney Name_____ Phone_____ Fax_____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize David M. Wall, MD or insurance company to release any information required to process my claims.

_____

Patient/Guardian Signature Date

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Patient:_____ Age: _____ DOB: _____
Height:_____ Weight:_____ _____ Auto/ Motorcycle Injury ____ Slip & Fall ___ Pedestrian
Date of Injury: _____ Today's Date:_____

What is your main pain complaint?

If this was as a result of an accident please explain exactly how you were injured, if not, skip to section 2 below _____

Were you the ___ Driver ___ Passenger ____ Front ___ Back Did you have on your seatbelt ___ Yes ___ No
Did you strike your head against the vehicle? ___ Yes ___ No Did you lose consciousness ___ Yes ___ No
Did any parts of your body strike the vehicle or the ground , please list which areas _____
_____, _____, _____, _____
Following the injury, did you go to the hospital ____ Yes ___ No Admitted? ___ Yes ___ No
Name of Hospital _____
Please indicate any of the procedures performed at the hospital ___ Surgery ___ CAT scan
____ X rays ____ Prescription for medications provided _____ Stitches (continue to Section 2)

Section 2

Please indicate all doctors you have seen for this medical condition and the type of care they have provided. If none, please skip

Doctor _____ Date seen _____
Treatments _____

Doctor _____ Date seen _____
Treatments _____

Doctor _____ Date seen _____
Treatments _____

Doctor _____ Date seen _____
Treatments _____

Doctor _____ Date seen _____
Treatments _____

Please check any of the following medical treatments you have had FOR YOUR INJURIES
_____ Surgery for _____ Name of doctor _____
_____ Injections Areas injected _____ Name of doctor _____
Did Treatment help? ____ Yes ____ No Explain _____

For below, please check if this pertains to your pain and complete the questions in that area
Please complete only for areas NOW painful that you would like the doctor to evaluate

_____ **Low Back Pain**
___ Ache ___ Burning ___ Sharp ___ Other _____
Does pain travel to either buttock or leg ___ Yes ___ No If yes, ___ Left ___Right leg
If yes, describe the pain _____
Please check any of the following you have in your legs ____ Numbness ____ Pins and needles
____ Weakness in my ____ Left / Right / Both leg(s)
Does anything lessen your pain? ___ Yes ___ No Describe _____
Does anything worsen your pain? ___ Yes ___ No Describe _____
BEFORE this accident, were you under the current care of a doctor for low back pain ____ Yes ____ No
_____

_____ **Neck Pain**
___ Ache ___ Burning ___ Sharp ___ Other _____
Does pain travels to either arm ___ Yes ___ No If yes ___ Left ___ Right arm
If yes, describe the pain _____
Please check any of the following you have in your arms ____ Numbness ____ Pins and needles
____ Weakness in my ____ Left / Right / Both arm(s)
Does anything lessen your pain? ___ Yes ___ No Describe _____
Does anything worsen your pain? ___ Yes ___ No Describe _____
BEFORE this accident, were you under the current care of a doctor for neck pain ____ Yes ____ No
_____

_____ **Headaches** that are in ____ Front of head ____ Back of head ____ All of head
with ____ dizziness ____ change in vision ____ passing out ___ nausea and vomiting
Additional comments _____

Additional Painful Area (where?)_____
___ Ache ___ Burning ___ Sharp ___ Other _____
Does pain travels to another area of your body from original area ___ Yes ___ No
If yes, describe _____
Does anything lessen your pain? ___ Yes ___ No Describe _____
Does anything worsen your pain? ___ Yes ___ No Describe _____
Additional comments (ex. Popping, Locking)_____

Additional Painful Area (where?)_____
___ Ache ___ Burning ___ Sharp ___ Other _____
Does pain travels to another area of your body from original area ___ Yes ___ No
If yes, describe _____
Does anything lessen your pain? ___ Yes ___ No Describe _____
Does anything worsen your pain? ___ Yes ___ No Describe _____
Additional comments (ex. Popping, Locking)_____

Past Medical History

Check all that apply

_Diabetes
_Asthma
_Hypo/Hyper Thyroid
_Kidney disease
__Other:_____

_High Blood Pressure
_Bronchitis or Emphysema
_Rheumatoid Arthritis
_Hepatitis
_ HIV+ (this will not be disclosed)

_Heart Disease
_Seizure history
_History of Cancer
type: _____

_Heart Attack
_Ulcers
_Blood Clots

Past Surgical History

Please list any surgeries you have had _____, _____
_____, _____, _____

CURRENT MEDICATIONS (List all medications you are taking NOW -use back of this sheet if you need more room)

MEDICATION	DOSAGE	# Per Day /Frequency	Reason for Taking (if known)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

ARE YOU ALLERGIC TO ANY MEDICATIONS: YES NO List name and describe reaction

_____
_____

Family Medical History

Has anyone in your family had a high fever reaction to anesthesia: Yes No
No

Social History

Who do you live with now: SPOUSE BY YOURSELF OTHER FAMILY FRIENDS OTHER
_____

Do you smoke tobacco? YES NO How much? _____ packs per day How long? _____ years
Do you drink alcohol? YES NO How much? _____drinks per day How long? _____years
Do you use any street drugs? YES NO (These may interact with medication we prescribe so we must know)
Occupation _____ Time lost from work _____
Have you returned to your workplace ____ Yes ___ No

DO YOU HAVE ANY PROBLEMS RELATED TO THE FOLLOWING?

Neurological
Tremors Y N
Dizzy Spells Y N

Gastrointestiona
Abdominal Pain Y N
Nausea/Vomiting Y N
Rectal Bleeding Y N
Ulcers Y N

Respiratory
Frequent Cough Y N
Short of Breath Y N
Wheezing Y N

Hemotologic/Lymphatic
Blood Clots Y N
Easy Bleeder" Y N

General
Fever Y N
Weiight loss Y N

Cardiovascular
Chest Pain Y N
High B.P. Y N
HeaH Failure Y N

Musculoskeletal
Joint Pain Y N
Muscle Adches Y N
Fiibromyalgia Y N

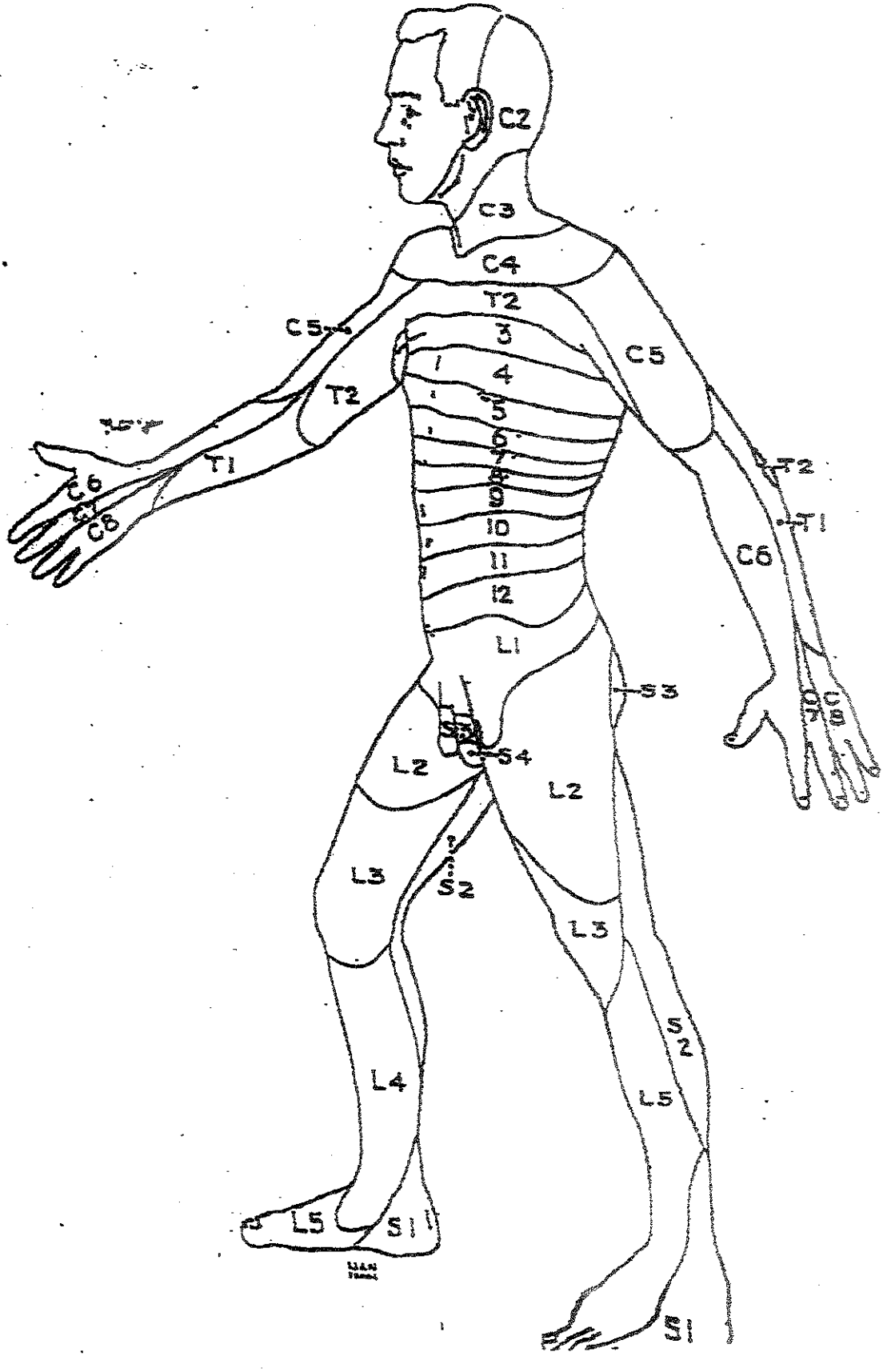
Psychologic
History of depression Y N
History of bipolar disorder Y N
History of schizophrenia Y N

Genitourinary
Unrine Retention Y N
Loss of bladder control Y N

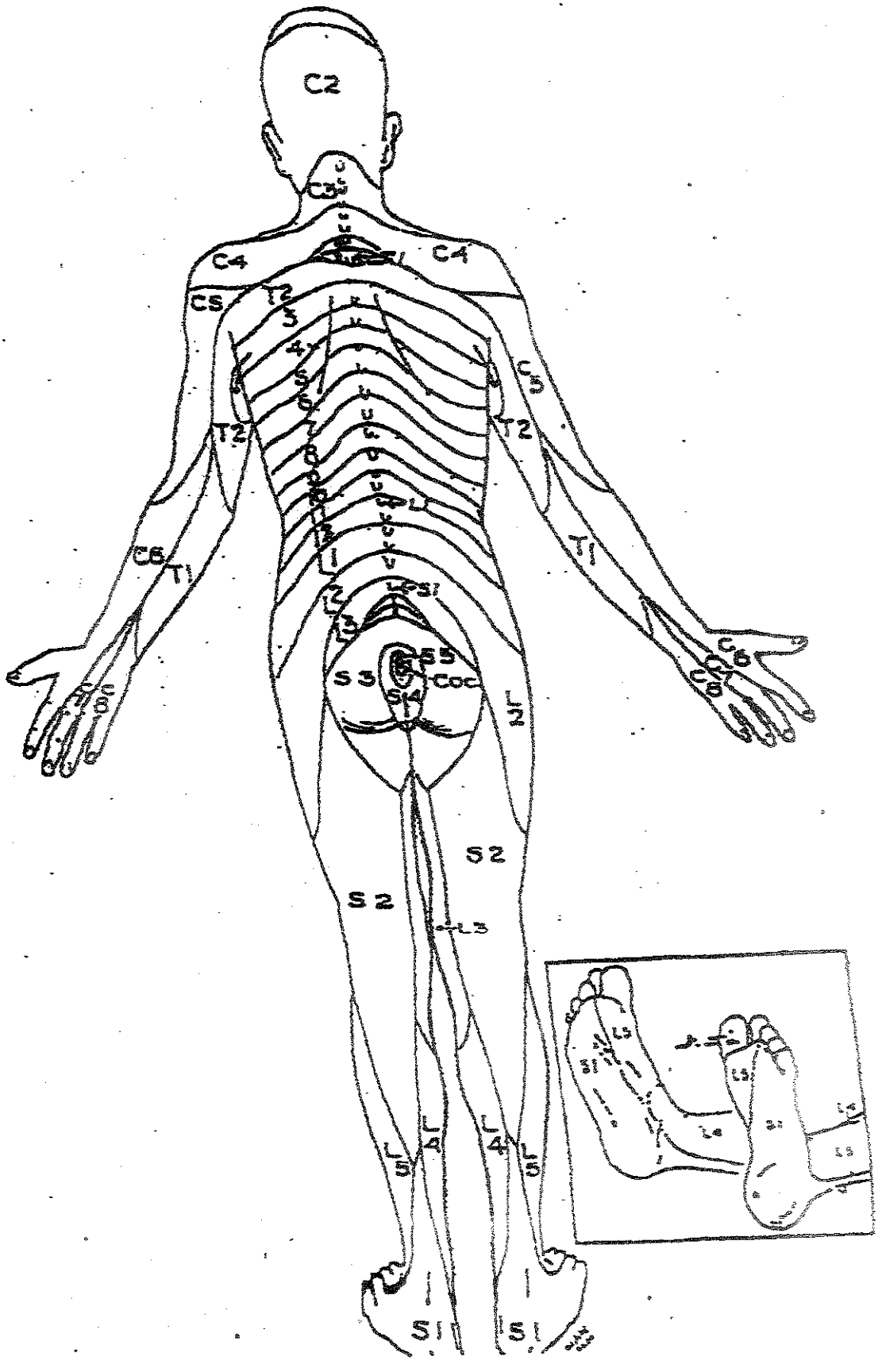
Other Medical Conditions that we should be aware of that you have not mentioned so far:

_____
_____

PLEASE COLOR IN THE AREA THAT HURTS



PLEASE COLOR IN THE AREA THAT HURTS



PATIENT / PHYSICIAN AGREEMENT

PRESCRIPTION REFILLS

Please don't wait until you run out of medicine to call for a refill. In fact, call at least two days ahead. In order to protect you, your doctor must review your medical file before renewing a prescription. Therefore please do not call for medications after hours or on weekends when records are unavailable. **It could take up to 48 hours after you call before your doctor can review your file and call in any prescription.** The files are reviewed and prescriptions are called to pharmacies at the end of office hours after all patients have been seen. By law, doctors cannot order refills for certain narcotics over the phone. A written prescription is required in those cases. I have read, understand, and agree with the above.

Patient/Guardian Signature:_____ Date:_____

MEDICAL RECORDS

Your records are kept in strict confidence as part of our permanent file. We will release copies only if we have your written permission. We prefer to mail copies of records, but we will give them to you in person to hand-carry if time is critical. **Please give us at least 48 hours notice prior to coming in and picking up records as it does take some time to get things together for you.** I have read, understand, and agree with the above.

Patient/Guardian Signature:_____ Date:_____

STATEMENT OF FINANCIAL RESPONSIBILITY

I the undersigned realize that all medical and surgical charges incurred by me or my dependent/s are my financial responsibility. All court fees, attorney fees, and other fees necessary to collect this amount are payable by me. I grant consent to David M. Wall, MD to use and disclose my protected health information for the purposes of diagnosing or providing treatment and conducting surgical operations. My protected health information includes demographic information which is collected from me, created or received by my physician or another health care provider, and my employer. This protected information relates to my past, present, and future physical and mental health condition/s. I can receive from David M. Wall, MD a copy of the Notice of Privacy Practices prior to signing this document and understand it is subject to change. I understand that diagnosis and treatment of me David M. Wall, MD may be conditioned upon my consent as evidenced by my signature on this document. I have read, understand, and agree with the above.

Patient/Guardian Signature:_____ Date:_____

CONFIDENTIALITY

The physician will diagnose your illness according to your complaints, symptoms, test results, and medical history. In order to treat the patient appropriately, the patient understands and authorizes treating physician and/or facility to obtain any and all medical records relating to the patient and to communicate with previous physicians by any method that can assist with the care of the patient. I have read, understand, and agree with the above.

Patient/Guardian Signature:_____ Date:_____

INDIVIDUAL PATIENT AUTHORIZATION

Name the people and/or organization and their relationship to you that are authorizing to use and/or disclose your personal health information:

_____

IRREVOCABLE MEDICAL LIEN

I hereby do authorize any and all parties, including any insurance company and my attorney (if applicable), to pay directly to David M. Wall, MD sums as may be due and owing for medical services rendered to me by David M. Wall MD and medical entities owned by David M. Wall MD including Wall Healthcare and/ or Tampa Bay Orthopedic and Spine (TBOS) and to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect David M. Wall, MD and these owned medical entities. If applicable, I also authorize my attorney to **release any and all information** without limitation regarding any legal proceedings, judgments, or settlements that will aide in the recovery of David M. Wall, MD's unpaid sum.

I fully understand that I am directly and fully responsible to David M. Wall, MD for all medical bills incurred by me for services rendered in consideration of waiting for payment. I further understand that such payment is **not** contingent on any settlement, judgment, or verdict by which I may eventually recover said fee.

I hereby authorize my attorney that represents me in my personal injury claim/case to provide David M. Wall MD with any and all information necessary to assist in the payment of medical bills incurred with David M .Wall MD/ Wall Healthcare and/or TBOS. I further authorize and irrevocably instruct said attorney(s) to withhold such sums from any insurance payments made from any settlement reached or from any verdict or judgment paid, and to pay David M. Wall MD said funds in payment of my medical bill with David M. Wall MD/ Wall Healthcare and/ or TBOS and to deposit any disputed amount in the registry of the Court of Pinellas county, Florida. The parties agree that David Wall MD is an interested party in the outcome for my claim of damages and shall remain an interested party until the balance owed by me to David M. Wall MD is paid in full even if I should decide to substitute counsel or represent myself.

I hereby further give my authorization to David M. Wall, MD to record a Uniform Commercial Code Form (UCC-1) to protect this medical lien and to send any unpaid sum to the Tortfeaser. I have read, understand, and agree with the above.

Patient/Guardian Signature:_____ Date:_____

I CERTIFY THAT, TO THE BEST OF MY KNOWLEDGE, THE INFORMATION IN THE PATIENT INTAKE FORMS ARE ACCURATE.

Patient/Guardian Signature:_____ **Date:**_____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

At Wall Healthcare, Inc. we have always kept your health information secure and confidential. The Health Insurance Portability and Accountability Act hat requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice. The law permits us to use or disclose your health information to those involved in your treatment. For example, reviews of your file by a specialist doctor whom we may involve in your care. We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer. We may use your information to contact you. For example, we may send newsletters or other information. We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone. In an emergency, we may disclose your health information to a family member or another person responsible for your care. We may release some or all of your health information when required by law. If this practice is sold, your information will become the property of the new owner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization. You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.

You have the right to transfer copies of your health information to another practice. We will mail your files for you. You have a right to receive a copy of your health information, with a few exceptions. Please provide us with a written request regarding the information you want to have copied, however, we may charge you a reasonable fee for the copies.

You have the right to request and amend your health information. Please provide us with your request to make changes in writing. If you wish to include a statement in your file, please provide it to us in writing. We may or may not make the changes that you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will neither move nor alter earlier documents, but will add new information.

You have the right to receive a copy of this notice at any time upon request.

If we change any details of this notice we will notify you in writing.

You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, Washington, D.C. 20201. You will not be retaliated against for filing a complaint. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Privacy Officer: Barbara Knapp at (727) 446-5681. This notice went into effect on October 01, 2007.

Acknowledgement: I have read, understand, and agree with the above Notice of Privacy Practice.

Patient/Guardian (Please Print Name) Patient/Guardian (Signature) Date

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Pain Medication Policy

To All New and Existing Patients

Due to the recent change in the Florida Prescription Laws the following policies are now in effect at our office.

Narcotic Pain Medication will ONLY be prescribed under the following circumstances

1. Patients who have had recent traumatic injuries (Example Automobile accident) These medications will be prescribed for a reasonable period of time to be determined based on medical appropriateness
2. Patients who have had recent surgery. These medications will be prescribed for a reasonable period of time based on medical appropriateness.
3. Patients who have had recent invasive procedures. These medications will be prescribed for a reasonable period of time based on medical appropriateness.

Our office can NOT prescribe narcotic pain medication for ongoing, chronic pain management. We recognize that there are patients that fail surgery or interventional procedures that do require this legitimate medical approach in specific conditions. However, if your medical condition requires chronic use of narcotic medication these medications will have to be obtained through another medical provider. Unfortunately we do not have a list of providers who are willing to provide these services. We suggest you speak with your family medical doctor or, if you do not have a family medical doctor, search the Internet for Pain Management physicians who prescribe pain medication for chronic pain.

As the vast majority of our patients to whom we prescribe narcotics fall into the categories numbered 1 though 3 above, we hope this will inconvenience only a very small percentage of our patients.

Thank you for your understanding.

David M. Wall MD

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The purpose of this agreement is to give you information about the medications you will be taking for pain management and to assure that you and your physician comply with all state and federal regulations concerning the prescribing of controlled substances. A trial of opioid therapy can be considered for moderate to severe pain with the intent of reducing pain and increasing function. The physician's goal is for you to have the best quality of life possible given the reality of your clinical condition. The success of treatment depends on mutual trust and honesty in the physician/patient relationship and full agreement and understanding of the risks and benefits of using opioids to treat pain.

1. You should use **ONE** physician to prescribe and monitor all opioid medications and adjunctive analgesics.

2. You should use **ONE** pharmacy to obtain all opioid prescriptions and adjunctive analgesics prescribed by your physician.

   Pharmacy: _____ **Phone Number:** _____

3. You should inform your physician of all medications you are taking, including herbal remedies, medications, especially cough syrup that contains alcohol, codeine or hydrocodone.

4. You will be seen on a regular basis and given prescriptions for enough medication to last from appointment to appointment, plus usually two to three days extra. This extra medication is **NOT** to be used without the explicit permission of the prescribing physician unless an emergency requires your appointment to be deferred one or two days.

5. Prescriptions for pain medicine or any other prescriptions will be done only during and office visit or during regular office hours. **NO** refills of **ANY** medications will be done during the evening or on weekends.

6. You must bring back **ALL** opioid medications and adjunctive medications prescribed by your physician in the original bottles.

7. You are responsible for keeping your pain medication in a safe and secure place, such as a locked cabinet or safe. You are expected to protect your medications from loss or theft. **Stolen medications should be reported to the police and to your physician immediately!** If your medications are lost, misplaced or stolen, your physician may choose not to replace the medications or to taper and discontinue the medications.

8. You may not give or sell your medications to any other person under any circumstances. If you do, you may endanger that person's health. It is also against the law!

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9. Any evidence of drug hoarding, acquisition of any opioid medication or adjunctive analgesia from other physicians (which includes emergency rooms), uncontrolled dose escalation or reduction, loss of prescriptions, or failure to follow the agreement may result in termination of the doctor/patient relationship.

10. You will communicate fully to your physician to the best of your ability at the initial and all follow-up visits, your pain level and functional activity along with any side effects of the medications. This information allows your physician to adjust your treatment plan accordingly.

11. You should not use any illicit substances, such as cocaine, marijuana, etc… while taking these medications. This may result in a change to your treatment plan, including safe discontinuation of your opioid medications when applicable or complete termination of the doctor/patient relationship.

12. The use of alcohol and opioid medication is contraindicated

13. You agree and understand that your physician reserves the right to perform random unannounced urine drug testing. If requested to provide a urine sample, you agree to cooperate. If you decide not to provide a urine sample, you understand that your doctor may change your treatment plan, including safe discontinuation of your opioid medications when applicable or complete termination of the doctor/patient relationship. The presence of a non-prescribed drug(s) or illicit drug(s) in the urine can be grounds for termination of the doctor/patient relationship. Urine drug testing is not forensic testing, but is done for your benefit as a diagnostic tool and in accordance with certain legal and regulatory materials on the use of controlled substances to treat pain.

14. There are side effects with opioid therapy, which may include, but not exclusively, skin rash, constipation, sexual dysfunction, sleeping abnormalities, sweating, edema, sedation, or the possibility of impaired cognitive (mental status) and/or motor ability. Overuse of opioids can cause decreased respiration (breathing)

15. Physical dependence and/or tolerance can occur with the use of opioid medication.

    Physical dependence means that if the opioid medication is abruptly stopped or not taken as directed, a withdrawal symptom can occur. This is a normal physiological response. The withdrawal syndrome could include, but not exclusively, sweating, nervousness, abdominal cramps, diarrhea, chills, and alterations in ones mood.

    It should be noted the physical dependence does not equal addiction. One can be dependent on insulin to treat diabetes or dependent on prednisone (steroids) to treat asthma, but one is not addicted to the insulin or prednisone.

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Addiction is a primary, chronic neurobiological disease with genetic, psychosocial and environmental factors influencing its development and manifestation. It is characterized by behavior that includes one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and cravings. This means the drug decreases ones quality of life.

Tolerance means a state of adaption in which exposure to the drug induces changes that result in diminution of one or more of the drugs effects over time. The dose of the opioid may have to be titrated up or down to a dose that produces maximum function and a *realistic* decrease of the patient's pain.

16. If you have a history of alcohol or drug misuse/addiction, you must notify the physician of such history since the treatment with opioids for pain MAY increase the possibility of relapse. A history of addiction does not, in most instances, disqualify one for opioid treatment of pain, but starting or continuing a program for recovery is a must.

17. You agree to allow your physician to contact any health care professional, family member, pharmacy, legal authority, or regulatory agency to obtain or provide information about your care or actions *if the physician feels it necessary.*

18. You agree to a family conference with a close friend or significant other *if the physician feels it necessary.*

I agree to these terms so that David Wall, MD and his staff can provide quality pain management using opioid therapy to decrease my pain and increase my function.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

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Assignment of Benefits

Patient:_____ Date of Loss:_____

Insurance Carrier:_____ Claim #:_____

Policy Owner's Name:_____ Policy #:_____

For and in consideration of (PATIENT'S NAME):_____ agreeing to pursue the responsible automobile insurance carrier for payment of benefits due and not requiring prepayment of services, I hereby irrevocably assign ALL rights and benefits to WALL HEALTHCARE, INC for Personal Injury Protection, Medical Payment Coverage and other benefits which I may have in accordance with Florida stature 627.736. This includes any benefits from my insurance company and any other entity which may be responsible for medical expenses incurred. I further authorize WALL HEALTHCARE, INC. to collect payments & prosecute any necessary actions to collect payment for services as they see fit and allowable by law and contract. THIS DOCUMENT CONSTITUTES AN ABSOLUTE ASSIGNMENT OF RIGHTS AND BENEFITS AS CONTEMPLATED IN PROGRESSIVE AMERICAN INS. CO. V. STAND-UP MRI OF ORLANDO, 990 SO.2D3 (FLA. 5TH DCA 2008).

I hereby further give a lien to WALL HEALTHCARE, INC. against any and all insurance benefits named herein, and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of injures or illness for which I have been treated by WALL HEALTHCARE, INC. as a result of the above stated loss date. This document acts as an irrevocable and absolute assignment of all my rights and benefits under all policies of insurance for which I am entitled to coverage thereupon. I agree to cooperate with all employees of WALL HEALTHCARE, INC. and their attorney's (at their choosing), and to do all things reasonable to effect payment of the bills by the insurance company or other entity to WALL HEALTHCARE, INC. including but limited to: disclosing my medical condition, being available for factual discovery, or any other means of cooperation.

WALL HEALTHCARE, INC. hereby 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 agreed by the provider to accept a reduced amount as payment in full.

This assignment concerns amounts due WALL HEALTHCARE, INC. and those costs including but limited to: attorney fees, court costs, special report or narrative fees, other costs, and interest necessary to procuring payment from the above-named insurance company and/or other entities. This assignment is not intended to assign any other causes of action that may belong to the undersigned patient. I agree to pay any applicable deductible/s, co-insurance/s, co-payment/s, or any not covered items by any policy of the insurance cited above. I understand that as a benefit and convenience to me, WALL HEALTHCARE, INC. will bill and pursue collection against the insurance company or other responsible party on my behalf. I hereby instruct and direct my insurance company to pay benefits directly to WALL HEALTHCARE, INC. at the address provided on the bill.

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WALL HEALTHCARE, INC.'s medical care is being provided for a reasonable fee for treatment casually related to the above loss date and is medically necessary. I instruct my insurance carrier or other responsible entity to pay these bills to the full extent of my available benefits under the insurance policy and Florida law. I hereby give WALL HEALTHCARE INC. limited Power of Attorney to endorse and sign my name on any draft for payment to WALL HEALTHCARE, INC.

This agreement is intended to serve as an absolute assignment of rights and benefits under my policy of insurance in favor of WALL HEALTHCARE, INC. If any language within this agreement has the effect of invalidating this agreement, that language shall be deemed void and the remainder of the assignment shall maintain full force and effect. A photocopy of this agreement shall be considered as effective and valid as the original.

As WALL HEALTHCARE, INC. stands in my shoes by virtue of this assignment, the following constitutes rights now owned by WALL HEALTHCARE, INC., as I have directed herein, and WALL HEALTHCARE, INC. hereby demands, including but limited to:

A. Providing a copy of any applicable insurance policy, declaration page, all applicable endorsements.
B. Transcripts and/or copies or recorded statements, examinations under oath, affidavits of the claimant, affidavits of any provider who treated me, or other sworn statements pursuant to Addison v. Geico General Ins. Co., 17 Fla. L. Weekly Supp. 272a (Hills. Cty. Ct. 2010).
C. Copies of independent or compulsory evaluation, including peer reports or other reports pursuant to 627.736(7) of me.
D. Any police or accident report my insurance company may have for the above listed date of loss.
E. A listing of all PIP benefits paid to date on my behalf of AND to me which shall include claims were received, the amount of the claim before reductions or repricing, payment amount or denial of each claim, the amount of the deductible and the claims applied thereto, and whether benefits have been exhausted and the amount of PIP benefits available, commonly known as a "PIP LOG" of "PIP PAYOUT LOG". This is specific to include ALL medical, disability, and death claims under accordance with Florida statute 627.736 and the names of each biller and payee.
F. Providing notice or any request under any cooperation clause of the policy, including but not limited to: requests for EUO or IME attendance to our office as WE STAND IN THE SHOES OF THE INSURED. Any EUO or IME taken without providing us reasonable notice and allowing counsel of our choosing to attend is INVALID.
G. All notices and requests for information under Florida Statute 627.736(6)(b) are to be directed to our attorney, PHILLIP A. FRIEDMAN, ESQ., FL LEGAL GROUP, 501 E Kennedy Blvd., Ste. 810, Tampa, Florida 33602

Patient/Guardian's Name Patient/Guardian's Signature Date

IF PATIENT IS INCAPACITATED OR UNDER THE AGE OF 18, PLEASE INDICATE THE PATIENT NAME, GUARDIAN NAME RELATION TO PATIENT, AND OBTAIN GUARDIAN 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.**

99204

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)* Patient	Signature - Patient	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(14) and (15), 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**)*:

David M. Wall, MD		
Name *(PRINT or TYPE)*	Signature – Physician	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.

David M. Wall, MD

Specializing in Minimally Invasive Spine Care and Treatment of Pain

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P: 727-724-6373 F: 727-724-6377

Medical Records Release Authorization
In order to avoid a delay this form must be completed in its entirety.
PLEASE PRINT CLEARLY

Patient Name:_____ Maiden Name:_____

D.O.B. **(Required)**_____ SS#**(Required)**_____

Home Phone:_____ Work Phone: _____

Permission is hereby granted to David M. Wall, MD to release medical information to the individual / organization as noted below or to have records released to David M. Wall, MD:

Mail to ☐ Name:_____

Address:_____

City/State/Zip:_____

☐ Fax to another medical entity (____)_____ ☐ call when ready for pick up (____)_____ ☐ Person picking up records

Please check information to be released:

☐ All records, excluding records from other physicians.
☐ Surgical Records
☐ Therapy reports
☐ Diagnostic test results
☐ Other _____
☐ Office Notes only
☐ X-ray/MRI films
☐ X-ray/MRI reports
☐ Patient information

This authorization will be valid for two years after the date of the patient's signature as it appears below and will authorize any documentation created thereafter.

_____
Patient Signature Date

I understand I have the right to refuse this authorization, in writing, and David M. Wall, MD is released from all legal liability that may arise from the released information requested.

_____ _____
Signature of patient/Legal Guardian Date