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.

ASSIGNMENT OF BENEFITS FORM
NEUROSURGICAL ASSOCIATES OF TAMPA BAY, INC.
THOMAS J. STENGEL, M.D.
KIRK W. JOBE, M.D.
CEDRIC D. SHORTER, M.D.
603 7TH STREET S., SUITE #540
ST. PETERSBURG, FL 33701
PHONE: 727-828-8400 FAX: 727-828-8401

PATIENT NAME: _____ DOB: _____

Pursuant to Florida Statute 627.736(5), the undersigned patient hereby assigns the benefits of insurance and any and all causes of action available under the policy of automobile insurance with _____Insurance Company for Neurosurgical Associates of Tampa Bay, Inc. to receive payment for services rendered to the undersigned and which are payable under Personal Injury Protection Coverage (PIP) and/or Medical Payments Coverage of the policy of automobile insurance provided by _____ Insurance Company.

As prescribed by Florida Statute 627.730 – 622.741, all payments shall be overdue if not paid within 30 days after the insurer is furnished a written notice of a covered loss and the amount of same. All overdue payments shall bear simple interest at the rate of 10% per annum.

By virtue of this assignment, the undersigned directs that all payments should be issued solely in the physician's name and forwarded directly to the office of Neurosurgical Associates of Tampa Bay, Inc.

In the event, assuming there is no coverage remaining at the time the company receives the physician's bill and the company fails to pay Neurosurgical Associates of Tampa Bay, Inc the full amount of the treatment bill submitted, to avoid the exhaustion of coverage while _____ Insurance Company pursues the rights under this Assignment, I authorize and direct the Insurance Company to set aside and place in escrow, until the dispute is resolved in the appropriate forum.

Further, I authorize and direct my Insurance Company to provide Neurosurgical Associates of Tampa Bay, Inc and/or their Attorney, an updated copy of the PIP payment record as needed.

It is agreed that this assignment will remain in full force until 48 hours after _____ Insurance Company receives written notice that it is being revoked. It is specifically agreed that any such revocation of this Assignment will not apply to any