A P M I
Advanced Pain Medicine Institute
Reza Ghorbani, MD, ABIPP, FIPP
President and Medical Director

YOU WERE INVOLVED IN AN AUTOMOBILE ACCIDENT AS A DRIVER OR PASSENGER

What we need from you:

- State and date of the accident
- Name of auto insurance covering the vehicle
- Claim number
- Claim adjuster name and phone number

What you need to know:

- For the Maryland auto insurance policies, we will submit the medical bills to your auto insurance. Your personal injury protection included on your insurance policy is going to pay until the maximum amount is met.
- This is called the PIP. Usually the average amount is $2500.00. It can be as high as $10000.00 it depends on your policy.
- When the amount of your bill has met, the maximum amount allowed by your PIP. The medical bills become your responsibility.

You have two options:

1. You do not wish to have your medical bills sent to your health insurance please sign the waiver of health insurance (page 2). We will not send the medical bills to your health insurance and you or your attorney will be fully responsible for payment of the account amount after closure of the case.
2. You do wish to have your medical bills sent to your health insurance please sign the refusal waiver and provide insurance information. We will send the bills to your health insurance and you will be responsible for the copays and deductibles (page 3)

Attorney:

- You have an attorney who is representing you in the case please sign a A/A that gives him/her access to your file and make him/her responsible for your bills.

If your policy is from the District of Columbia or the state of Virginia we must submit the claims to your health insurance first and there is a denial sent to your PIP coverage.

IN ANY CASE PAGE 4 NEEDS TO BE COMPLETED

7501 Greenway Center Drive | Suite 660 | Greenbelt, MD 20770
5530 Wisconsin Avenue | Suite 1550 | Chevy Chase, MD 20815
Tel : 301-220-1333 | Fax : 301-220-1533

To: APMI Date: ___/____/___

AUTHORIZATION AND ASSIGNMENT

You hereby authorize to disclose and/or furnish my attorney(s), _____ of

(Firm Name) _____ address:
_____ possession which they request in reference to all illnesses and injuries suffered by including but not limited to the injuries sustained on:

Date: _____, Patients name, (please print) _____

I further irrevocably assign to APMI, Dr. Reza Ghorbani, to the extent of their bill, the proceeds of any recovery arising from the accident for which I am being treated, and I authorize and direct said attorneys to pay from the proceeds of any recovery in my case all fees charged for medical services rendered as a result of the injury or condition heretofore mentioned, written reports, copies of records, and for preparation of an actual testimony, in collection with any legal claims that I may make arising from said injury or conditions. I understand that this in no way relieves me of my personal primary obligation to pay for such services and that the signing of this form does not prohibit customary billing by you or relieve me of my primary responsibility to pay for these services when a statement is rendered. I also understand that charges will be made for physician appointments that are not kept and not canceled with 24-hour notice.

This Authorization and Assignment shall not apply in any Workers Compensation case in which an award is granted by Workers Compensation Commission.

It is further understood that the statute of limitations in this state is three years from the time said services were performed, and I further understand that because of long delays in trial dockets many cases are not tried or settled until a date that is beyond the three years after the last service was performed. In view of this, I hereby agree to waive the defense of the statute of limitations if a claim is filed against me by reason of unpaid bill and I will not raise the statute of limitations as a defense.

In the event I transfer, substitute or otherwise enlist the assistance of any other attorney(s) to work with me, or in my pace on the case, I agree that I will first have said attorney(s) execute and be bound by this agreement. Failure to do so, will make me liable for continuing compliance with the terms of this agreement as f no transfer had been made.

The parties agree that a copy of the Authorization and Assignment shall be deemed to be an original for all purposes.

I understand that APMI, expects payments of its actual fees from the proceeds of any recovery and that I am responsible for the entire balance regardless of the source of recovery. Balances are due and payable within 30 days of settlement. Interest will be accessed on balance, not paid within 30 days of settlement. If I default on payment of my bills to APMI and collection activities become necessary, I understand that attorney's fees, will be added to any outstanding balance I have with APMI. I further agree to allow "Y" attorney to furnish any home or work related information pertaining to myself or family to aid in collection of the bill.

Signature: _____ Date: _____

Date of Birth: _____

THE UNDERSIGNED ATTORNEY FOR THE PATIENT REFERRED TO ABOVE HEREBY AGREES TO COMPLY FULLY WITH THE FOREGOING "AUTHORIZATION AND ASSIGNMENT" AND AGREES TO ADVISE THE NAMED ASSIGNEE IN WRITING THE STATUS OF THE CLAIM OF THE PATIENT WITHIN 10 DAYS OF THE REQUEST AND TO NOTIFY THE ASSIGNEE IF THE ATTORNEY CEASES TO REPRESENT THIS APTIENT OR IF THE CLAIM IS DROPPED. I AGREE TO REQUIRE ANY ATTORNEY TO WHOM THE UNDERSIGNED REFERS THIS CASE, TO HONOR ON LIEN, AS A CONDITION OF REFERRAL.

ATTORNEY SIGNATURE: _____

Witness: _____ Date: _____

WAIVER OF HEALTH INSURANCE BENEFITS

I, _____ HAVE AGREED TO WAIVE MY HEALTH INSURANCE POLICY FOR ALL TREATMENT AND CARE RECEIVED FOR MY INJURY. WHICH OCCURRED ON _____/_____/_____. I CHOOSE NOT TO FILE FOR HEALTH INSURANCE BENEFITS OR MEDICARE AND WAIVE THEIR RESPONSIBILITY FOR ONE OR MORE OF THE FOLLOWING OPTIONS:

1. Because of the nature of my injuries and/or legal case, I have chosen not to use my health insurance benefits or Medicare to cover any of the health care I received for this no fault injury
2.

I agree and understand that I am accepting total responsibility to pay for any treatment rendered. Herein, I have instructed my health provider not to process your claims through my health insurance for treatments received for an injury related to an auto accident that occurred on: _____/_____/_____.

This decision has been made freely and voluntarily by me without interference or pressure and was made with the understanding of responsibility that arise therefrom.

_____ _____

Patient Signature Date

REFUSAL TO WAIVE HEALTH INSURANCE

I, _____, HAVE INSTRUCTED _____ M.D. TO FILE THE BILL FOR THIS AUTOMOBILE ACCIDENT WITH THE HEALTH INSURANCE COMPANY.

HOWEVER, I UNDERSTAND THE DOCTOR WILL NOT ASSIST THE ACCIDENT CASE IN MY MANNER, OTHER THAN THAT REQUIRED BY THE LAW. AUTOMOBILE ACCIDENT CASES REQUIRE A SIGNIFICANT AMOUNT OF ADDITIONAL WORK, TIME AND EXPENSE. I UNDERSTAND THE HEALTH INSURANCE COMPANY WILL NOT PAY THE DOCTOR FOR ANY OF THE ADDITIONAL WORK INVOLVED IN THE ACCIDENT CASE.

I UNDERSTAND THAT THE DOCTOR WILL NOT PROVIDE MY ATTORNEY WITH ANY COURTESIES NOT LEGALLY REQUIRED SINCE THE DOCTOR WILL NOT BE PAID FOR THIS EXTRA WORK. THIS PROVIDER MADE IT CLEAR THEY ARE READY AND WILLING TO SUBMIT THIS CLAIM TO MY HEALTH INSURANCE COMPANY.

_____ _____

Patient Signature Date

MOTOR VEHICLE ACCIDENT

Name of Patient: _____

DOB: _____/_____/_____

If you have been involved in a motor vehicle accident and today's visit is related to injuries sustained during this accident, we will need some information from you to bill as correctly as possible.

What is your vehicle insurance name? _____

Claim Number: _____

Phone Number: (_____)_____-_____ Date of accident: _____/_____/_____

State: _____ Adjusters name: _____

When the PIP associated with your health insurance will be expired what is the procedure you want to us to proceed with:

1. Bill your health insurance. Please provide us with the information (card). If your insurance requires a referral call your PCP today and have a referral issued starting with today's date. If a change in your insurance information occurs during your treatment, please provide us with the new insurance information.
   Name of your insurance co.: _____
   Referral needed? _____ Yes _____ No
2. You decide to have an attorney take care of your case. We will not bill your health insurance but move the amount not payable by the PIP to your responsibility. You will receive a statement and we will provide your attorney with all the information he/she needs. We will need your signature to do so. Please during this time update us on your case: court date, change of attorney, etc.
   Name of Attorney: _____
   Telephone: (_____)_____-_____
   A/A signed: ___ ___ ___ ___